[redacted]

From: [redacted]
Sent: Tuesday, November 23, 2021 3:55 PM
To: [redacted]@thedaviscommunity.org'
Cc: [redacted]
Subject: FW: [External] RE: Champions Assisted Living 2021-10-14 SOD Z5FJ11; Champion Assisted Living 2021-11-04 SODBL HS1B12-Z5FJ11
Attachments: 20211123155558820.pdf

Hi [redacted]
Thank you for your response.
I am forwarding this information to [redacted] for review and follow up if needed.
Thank you and Happy Thanksgiving.
Hope

[redacted]
Facility Survey Consultant
Adult Care Licensure Section, Division of Health Service Regulation
NC Department of Health and Human Services

Office: [redacted]
Fax: [redacted]

801 Biggs Drive, Brown Building
2708 Mail Service Center
Raleigh, NC 27699

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From: [redacted]@thedaviscommunity.org>
Sent: Tuesday, November 23, 2021 3:48 PM
To: [redacted]@dhhs.nc.gov>
Cc: [redacted]@thedaviscommunity.org>
Subject: [External] RE: Champions Assisted Living 2021-10-14 SOD Z5FJ11; Champion Assisted Living 2021-11-04 SODBL HS1B12-Z5FJ11

Reviewed and Acknowledged
11/24/21 AV

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[redacted]

Please see the attached plan of correction. I hope you and your team find it acceptable. If you have any questions please feel free to reach out to me.

Thank you and Happy Thanksgiving,

[redacted]
Administrator, Champions Assisted Living
Office: 910-686-6462
Direct: 910-686-8301
Fax: 910-686-8320
Cell: 910- 284-4700

From: [redacted]@dhhs.nc.gov>
Sent: Thursday, November 4, 2021 5:25 PM
To: [redacted]@thedaviscommunity.org>
Cc: DHSR.AdultCare.Star <DHSR.AdultCare.Star@dhhs.nc.gov>; [redacted]@nhcgov.com>; [redacted]@nhcgov.com>; dhsr.adultcare.email6 <dhsr.adultcare.email6@dhhs.nc.gov>; [redacted]@dhhs.nc.gov>
Subject: Champions Assisted Living 2021-10-14 SOD Z5FJ11; Champion Assisted Living 2021-11-04 SODBL HS1B12-Z5FJ11

CAUTION: This email originated from outside of the organization. Do not click links or open attachments unless you recognize the sender and know the content is safe.

Dear [redacted]

Please find the Statement of Deficiencies and accompanying letter for the annual and follow up survey completed on October 14, 2021 attached to this e-mail. If the Statement of Deficiencies includes citations or violations for which a plan of correction is required, please read the attached letter carefully for instruction on completing the plan of correction. **PLEASE NOTE: WE WILL NOT ACCEPT A FAXED PLAN OF CORRECTION! We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted.** A response to the plan of correction will be sent ONLY if the plan of correction is not approved. Please retain a copy for your files.

The attached letter also contains information regarding your right to request an Informal Dispute Resolution (IDR) of any cited deficiencies or violations. For more information about the IDR process please visit our website at https://info.ncdhhs.gov/dhsr/acls/idr.html.

If you have any questions regarding the information provided in or attached to this email, please call Alison Vogt at 919-817-4383. Please be aware that information sent via electronic mail is immediately available for release to the public. Therefore, the information contained in and attached to this e-mail is now public information.

Sincerely,

[redacted]

Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

STAR RATING

If the Statement of Deficiencies attached to this email is a result of an annual, follow-up or complaint inspection a star rating certificate and worksheet will be issued within 45 days of the date of this email. If you would like to know more information about the NC Star Rated Certificate Program or view facility ratings, please visit the star rating website at https://info.ncdhhs.gov/dhsr/acls/star/index.html. If you have questions about this facility's star rating or the rating program in general, please send an email with your questions to the star rating customer service email address at DHSR.AdultCare.Star@dhhs.nc.gov.

We strive to improve the services we provide to licensed health care providers across the state of North Carolina and invite your feedback through a confidential Customer Service survey located at:
https://info.ncdhhs.gov/dhsr/customerservice.html.
(Please note: Survey Max does is not supported by all browsers; therefore, please access survey with Internet Explorer).

Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, Division of Health Service Regulation, at 919-855-3750.

[redacted]
Facility Survey Consultant
Adult Care Licensure Section, Division of Health Service Regulation
NC Department of Health and Human Services

Office: [redacted]
Fax: [redacted]
[redacted]

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065020	A. BUILDING: _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPIONS ASSISTED LIVING	1007 PORTERS NECK ROAD WILMINGTON, NC 28411

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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted a follow-up and an annual survey from October 12, 2021 to October 14, 2021.	D 000	Champions Assisted Living acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written assertion of compliance.	
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 exit doors accessible for residents' use was equipped with a sounding device that activated for the safety of 7 of 7 sampled residents who were disoriented and 1 sampled resident (Resident #6) with a history of exit seeking behavior who eloped from the facility without staff knowledge. The findings are:	D 067	Responses to the stated deficiencies does not denote agreement with the statement of deficiencies nor does it constitute and admission that any deficiency is accurate. Further, Champions Assisted Living reserves the right to refute and incorporates by reference any rebuttal of deficiency on this statement of deficiencies that it submits through informal dispute resolution, formal appeal and/or other administrative or legal procedures.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Caitlin Fleetwood, Executive Director 11/23/21

Reviewed and Acknowledged
11/24/21 AV

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D 067	Continued From page 1 Observations upon entrance to the facility on 10/12/21 at 8:45am and intermittently throughout the day until 5:00pm revealed there was no alarm sounding device when the front/entrance door to the facility was opened. Observations upon entrance to the facility on 10/13/21 at 7:30am and intermittently throughout the day until 5:00pm revealed there was no audible sounding device when the front door was opened. Observation of the entrance door on 10/14/21 at 8:30am revealed there was no audible sounding device when the front door was opened. Review of Resident #6's FL-2 dated 11/11/20 revealed: -Diagnoses included early onset Alzheimer's, myocardial infarction, coronary artery disease, bradycardia, and dyslipidemia. -She was intermittently disoriented. -She was ambulatory, and an assistive device was not indicated. Review of Resident #6's care plan dated 12/10/20 revealed: -She was always disoriented. -She had significant memory loss and had to be directed. -She had severe short-term memory loss that varied throughout the day and day by day. Review of Resident #6's incident/accident (I/A) report dated 09/26/21 at 11:26am revealed: -The licensed practical nurse observed Resident #6 walking down a 2-lane road; outside of facility grounds. -There was no identified injury and she had no complaints of pain.	D 067	10A NCAC 13F .0305(h)(4) Physical Environment Champions has installed an alarm at the door to audibly alarm when the door is opened. Staff to be educated on new system. ED or designee to monitor weekly for one month to ensure compliance.	11/28/21

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D 067	Continued From page 2 -Resident #6 stated she was going to meet her family member at the water. -A staff member did not witness the elopement. -The immediate interventions were Resident #6 was brought to a supervised area for closer observation, a wander guard was placed on her right ankle, and she was placed on hourly checks. Continued review of Resident #6's I/A report dated 09/26/21 at 11:26am revealed the immediate interventions were Resident #6 was brought to a supervised area for closer observation, a wander guard was placed on her right ankle, and she was placed on hourly checks. Interview with the Administrator on 10/14/21 at 1:00pm revealed: -Every day, 7 days a week, from 8:30am-7:00pm there was a receptionist at the front entrance of the facility; and the door alarm was not activated during this time. -Every day, 7 days a week, from 7:00pm-8:30am the doors at the front entrance of the facility were locked. -During the receptionist's breaks through the day a morning break (10:00am-10:30), a lunch break (12:30pm-1:00pm), and an afternoon break (3:30pm-4:00pm); the facility's housekeeper/designee would provide coverage for the receptionist. -The receptionist was responsible to monitor resident traffic through the front entrance of the facility. -If the receptionist noticed a resident leave through the front door it was the receptionist's responsibility to re-direct the resident or if the resident walked outside to follow and stay with the resident and call for assistance. -She was not aware the regulation related to the exit door accessible to residents included both	D 067		

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D 067	Continued From page 3 residents who were determined by a physician to be either a wanderer or disoriented. -The facility's current process in place to prevent residents from leaving the facility was to have the receptionist at the front door of the facility. -Wandering behaviors such as roaming through the building or if the resident was exit seeking a wander guard would be implemented. -If a resident had a wander guard on, the wander guard would trigger an alarm prior to reaching the front door if the resident was attempting to exit the facility. -With having the front door sounding device silenced when the door was opened from 8:30am-7:00, she had resident safety concerns if Resident #6 had been identified with wandering behaviors. -She was not aware of Resident #6's previous elopement before her admission to assisted living in 11/2020. -Resident #6 had a previous elopement while living in independent living. -From her investigation about Resident #6's elopement on 09/26/21, there was a receptionist present at the front desk at the front entrance of the facility and at that time Resident #6 was not identified to have wandering behaviors. -The receptionist at the front desk had told her Resident #6 was outside with her family on 09/26/21. -The receptionist observed Resident #6 saying goodbyes with her family members, but the family members did not notify the receptionist or staff Resident #6 was still outside on facility's grounds. -She was not aware of Resident #6's previous wandering behaviors; Resident #6 was intermittently disoriented and was easily re-directed. -She had concerns for residents with dementia without the sounding device at the front entrance,	D 067		

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D 067	Continued From page 4 but the receptionist was responsible for monitoring the front door and when the receptionist was not there the front door was locked. Attempted telephone interview with Resident #6's PCP on 10/14/21 at 10:42am was unsuccessful. Attempted telephone interview with a receptionist who worked on 09/26/21 on 10/14/21 at 2:56pm was unsuccessful. The social worker was not available for interview from 10/12/21-10/14/21. The facility failed to ensure 1 of 3 exit doors were equipped with a sounding device that activated when doors were opened for 7 of 7 sampled residents residing at the facility who were assessed to be intermittently to constantly disoriented which resulted in a resident with known disorientation eloping from the facility on 09/26/21 without staff knowledge (Resident #6). This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/14/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 28, 2021.	D 067		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and	D 270		

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D 270	Continued From page 5 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: Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs and the facility's elopement protocol for 1 of 7 sampled resident (#6), with a history of exit-seeking behavior who eloped from the facility without staff knowledge. The findings are: Review of the facility's elopement policy and procedure dated 08/18/06 revealed: -In the event a resident left the facility unattended and without the knowledge of the facility staff, a specific and coordinated search of the facility and the surrounding area would begin immediately. -The licensed practical nurse (LPN) supervisor or supervisor would them put into action the coordinated effort to notify all personnel in the building of the possible elopement. This would begin with notifying the Administrative offices, to include the receptionist of the situation. The Administrator and the Resident Care Coordinator are informed immediately. -The facility would use the words CODE X to communicate to all staff about the elopement while not alarming residents or family members. -CODE X would be typed into the beeper/phone system on a group page to ensure all personnel are informed. -Once an employee got the CODE X message, he or she would immediately account for their	D 270	10A NCAC 13F .0901 Personal Care and Supervision An audit of all resident care plans and FL2s was completed to ensure that wandering status match and are correct. Wandering residents who choose to spend time outside will be escorted to their destination and monitored continuously . Pictures of residents who wander will be kept at the front desk. Executive Director (ED) or designee to monitor weekly for one month. Residents will receive an elopement assessment within 30 days of admission to determine whether or not they are at risk of elopement. RCD to monitor monthly for three months.	11/28/21

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D 270	Continued From page 6 residents and complete a head count. All rooms are to be searched at that time. The search should include all rooms, closets, bathrooms, hallways, stairwells, offices, kitchens, dining rooms, and all public space that was located on the assigned floor. -If the room-to-room search was unsuccessful in locating the resident, the search would then be extended to the grounds to include the health care center, pharmaceutical services, and any other buildings on the campus should be informed at that time that we are in a CODE X status. -The front of the building, sides, and rear of the building should be searched including all structures, vehicles, etc. -If the search does not return immediate results in a timely manner, the Administrator, Resident Care Coordinator, Director Facility Management or Executive Director would contact local law enforcement. Review of Resident #6's FL-2 dated 11/11/20 revealed: -Diagnoses included early onset Alzheimer's, myocardial infarction, coronary artery disease, bradycardia, and dyslipidemia. -She was intermittently disoriented. -She was ambulatory, and an assistive device was not indicated. Review of Resident #6's care plan dated 12/10/20 revealed: -She was always disoriented. -She had significant memory loss and had to be directed. -She had severe short-term memory loss that varied throughout the day and day by day. -There was no documentation related to wandering behaviors.	D 270	Elopement history question will be added to the admission paperwork to identify potential wanderers in a timely manner. Staff members to be educated on new systems put into place.	

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D 270	Continued From page 7 Review of Resident #6's incident/accident (I/A) report dated 09/26/21 at 11:26am revealed: -The LPN observed Resident #6 walking the road; outside, not on facility grounds. -There was no identified injury and she had no complaints of pain. -Resident #6 stated she was going to meet her family member at the water. -A staff member did not witness the elopement. -The immediate interventions were Resident #6 was brought to a supervised area for closer observation, a wander guard was placed on her right ankle, and she was placed on hourly checks. -The interventions were marked as effective. -There was a care plan meeting scheduled for 09/28/21. -The falls prevention program initiated was checked yes. Review of Resident #6's progress note dated 09/26/21 at 6:42pm revealed: -The LPN received a phone call at 12:26pm, caller stated an elderly Caucasian woman was observed walking on the road. -The caller was concerned it may be a resident from the facility. -The LPN got in her private vehicle and drove down the road to see if she could identify the elderly woman. -The LPN observed Resident #6 walking down the road and pulled over. -The LPN greeted Resident #6 and asked if she could give her ride to where she was going, and she entered the LPN's private vehicle without incident. -The LPN asked Resident #6 where she was going and she replied, "to the ocean, to see her family member." -The LPN and Resident #6 returned to the facility at 12:35pm.	D 270		

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D 270	Continued From page 8 -She was assisted up to her room, she had no complaints, the staff were notified Resident #6 was to be checked on hourly. -Resident #6 had not left her floor since returning, and she had not voiced she wanted to leave the facility since her return. -The LPN attempted to place a wander guard several times however she was cutting up newspapers most of the afternoon. -At dinner, the LPN was able to enter Resident #6's room and removed 1 pair of scissors, 4 personal butter knives, 1 set of toenail and fingernail clippers, and placed the items in a locked exam room with her name and room number for safe keeping. -The LPN placed the wander guard on Resident #6's right ankle. -The LPN tested the wander guard at the facility's front door before placing it on her. -She was placed on every 1-hour checks and would remain on every 1- hour checks. -The LPN left a detailed message for Resident #6's PCP, the Administrator, and family member. Review of Resident #6's progress note dated 09/29/21 at 11:59am revealed: -A care plan meeting was held with Resident #6's family member. -Her family member stated the wandering occurred because Resident #6's schedule was interrupted, and a family member did not clearly explain to Resident #6 that her family member had gone back home. -Her family member stated this had happened at independent living once before. -The Administrator was not aware of this prior to the incident dated 09/26/21. -Resident #6's family member wanted her wander guard removed and the Administrator stated at this time it was not an option, the staff would	D 270		

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D 270	Continued From page 9 continue to monitor for any behaviors and would re-evaluate later. -Resident #6's family member requested she be moved to the second floor of the facility for more stimulation. -Staff advised the Special Care Unit (SCU) may be better fit due to the level of prompting and cueing required of her and the incident dated 09/26/21. -Resident #6's family member was hesitant about the SCU and stated she would like to set up a tour later. -Resident #6's family member asked if a staff member could take her outside for daily walks and due to staffing concerns it was advised that a sitter may best for this scenario. Review of Resident #6's progress note dated 10/04/21 at 9:49pm revealed: -Resident #6 cut off her wander guard. -Staff found device in her room. -Resident #6 was educated to keep it on her ankle. -The LPN reapplied it with a new strap to the right ankle. -The scissors were confiscated from her room and put in the LPN's office. -Staff would continue to monitor Resident #6 closely. Review of Resident #6's progress note dated 10/04/21 at 3:20pm revealed: -Resident #6 attempted to exit front door stating she was going to see her family member. -She was re-directed and escorted back to her room times two. -Her wander guard was in place. -Her family member was notified, and a voicemail was left.	D 270		

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D 270	Continued From page 10 Telephone interview with an LPN supervisor on 10/14/21 at 9:35am revealed: -She was the LPN supervisor at the facility on the weekends and worked 12-hour shifts, 7:00am-7:00pm. -She was working the weekend of 09/25/21-09/26/21. -Resident #6 was last seen by the PCA working on her assigned floor at 11:00am. -At approximately 12:26pm, she received a phone call from a motorist was driving down the road that ran parallel to the facility. -The motorist observed an elderly woman walking along the road outside of the facility's grounds and was wondering if the woman was resident from the facility or a nearby facility. -There was a lot of traffic on this road due to the increase in the building of homes. -The LPN supervisor exited the facility to head to her personal vehicle to investigate the situation and verify if the woman was a resident at the facility. -The LPN supervisor observed Resident #6 walking down the road and pulled over. -Resident #6 was observed on the right side of road; and she had made it to three streets prior to the 4-way traffic intersection. -She was not sure the approximate distance this what from the facility. -The LPN supervisor greeted Resident #6 and she entered the LPN's personal vehicle without incident. -The LPN supervisor asked Resident #6 where she was going and she replied, "to the ocean, to see her family member." -The LPN supervisor and Resident #6 returned to the facility at 12:35pm. -She was assisted up to her room and she had no complaints. -Resident #6 had not exhibited exit seeking	D 270		

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D 270	Continued From page 11 behaviors until 09/26/21. -Resident #6's family member attributed her 09/26/21 elopement due to a recent visit from a family member from out of state. -On 09/26/21, the LPN supervisor was made aware that Resident #6 had a previous elopement when she was living in independent living which also occurred around another visit from a family member visit from out of state. -The LPN supervisor placed the wander guard on Resident #6's right ankle and the staff were notified Resident #6 was to be checked on hourly. Observations on 10/13/21 at 7:15am revealed: -There was a 4-lane traffic intersection approximately 1 mile away from the facility. -There was a 2-lane road leading to the facility. -The speed limit on the road outside of facility grounds was 45 miles per hour. -Upon entrance to the facility grounds there was an iron fence and a gate at the entrance and exit of the facility. -The gate was activated by the motion of a vehicle upon approach. Review of Resident #6's hourly supervision checks from 09/26/21-09/29/21 revealed: -Staff was to check on the resident hourly and check all common areas. -Resident #6's hourly supervision checks were initiated on 09/26/21 at 2:00pm. -Resident #6's hourly supervision checks were completed on 09/26/21 starting at 2:00pm through 09/29/21 and ended at 6:00am. Review of Resident #6's September 2021 electronic medication administration record (eMAR) revealed: -The start date was 09/26/21 with the end date documented as open ended.	D 270		

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D 270	Continued From page 12 -There was an entry to check the placement of wander guard at least once a shift, right ankle. -The check of the wander guard was scheduled for 7:00am-3:00pm, 3:00pm-11:00pm, and 11:00-7:00am. -Staff initials were documented for all three shifts and it was indicated if the wander guard was off or on. Review of Resident #6's October 2021 eMAR revealed: -The start date was 09/26/21 with the end date documented as open ended. -There was an entry to check the placement of wander guard at least once a shift, right ankle. -The check of the wander guard was scheduled for 7:00am-3:00pm, 3:00pm-11:00pm, and 11:00-7:00am. -Staff initials were documented for all three shifts and it was indicated if the wander guard was off or on. Review of Resident #6's elopement risk assessment dated 10/01/21 at 4:41pm revealed: -The assessment was completed by a registered nurse. -If the score was 5 or greater, the resident was at risk for elopement. -It was documented yes to the question if Resident #6 had dementia/Alzheimer's. -It was documented yes to the question if she was able to be independently mobile with/without a device. -It was documented yes to the question if she paced, wandered, tried to get out of the door, to find family/friends, perceived they need to be doing something other than what they are doing. -It was documented yes to the question if she exhibited signs of disorientation; her orientation was documented as intermittent.	D 270		

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D 270	Continued From page 13 -It was documented yes to the question she did have a history of elopement/wandering off at home or in the facility. -The short description included Resident #6 had walked out of the facility. Review of Resident #6's Licensed Health Professional Support dated 10/07/21 revealed she was elopement risk. Interview with a medication aide (MA) on 10/13/21 at 10:23am revealed: -The standard of care for residents' rounds was every two hours by staff. -The staff rounds completed every 2 hours included verifying the resident's location; the staff would determine if the resident needed anything, for example, assistance with a shower or laundry. -The 2-hour staff rounds were not documented by staff. -Resident #6 was not elopement risk, she had not attempted to leave the facility when the MA worked with her. -She thought 1-hour supervision checks were in place for Resident #6, but she was not sure. Interview with the Administrator on 10/14/21 at 8:45am revealed: -The facility did not have a supervision policy. -A resident would receive increased supervision for suicidal ideations or wandering behaviors, for example, a resident that went in and out of other residents' rooms. -The increased supervision parameters would be initiated by the LPN supervisor or the medication aide/supervisor (MA/S) if an LPN supervisor was not within the facility and discussed with the resident's primary care provider (PCP). -The frequency of the resident's increased supervision monitoring would also be determined	D 270		

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D 270	Continued From page 14 by the LPN supervisor or the MA/S. -The increased supervision monitoring would be documented by the MAs and the PCAs. -The hourly supervision checks were kept within a binder containing the resident's activities of daily living within the resident's designated area. -The LPN supervisor or the MA/S would ensure the completion of the hourly supervision checks. -The hourly checks documentation included the date, time, initials of the staff, and the location of the resident. -Resident #6 was not receiving increased supervision monitoring prior to 09/26/21 because she did not have exit seeking behaviors. -Hourly supervision checks were completed for Resident #6 from 09/26/21-09/29/21. -Resident #6 had a recent visit from a family member around 09/26/21 and she left the facility to go see the family member. -She was unsure how Resident #6 eloped from facility grounds due to the facility being gated. Interview with a second LPN supervisor on 10/14/21 at 9:05am revealed: -A resident would receive increased supervision for suicidal ideations, an occurrence of an elopement, or if a resident was experiencing a decline for example having frequent falls. -The LPN supervisor would initiate increased supervision for a resident, or the MA/S could call the LPN supervisor for example during night shift (11:00pm-7:00am) to discuss the initiation of increased supervision for a resident. -The frequency of the resident's increased supervision monitoring would also be determined by the nurse supervisor or the MA/S. -The increased supervision monitoring of the resident by the MAs or the PCAs could be every 30 minutes for a resident experiencing suicidal ideations or every 1-hour post fall or elopement.	D 270		

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D 270	Continued From page 15 -The hourly checks were documented within a binder containing the resident's activities of daily living. -The LPN supervisor or the MA/S would ensure the completion of the hourly checks. -Once the resident's increased supervision monitoring was initiated the LPN supervisor or the MA/S would notify the resident's PCP and the resident's responsible party or power of attorney. -Resident #6 was ambulatory without an assistive device. -Resident #6 was intermittently disoriented; she was forgetful "at times." -Resident #6 was not elopement risk; she had a wander guard in place. -The wander guard has remained in place because the facility did not want to take the chance of an elopement happening again. -She was not sure if Resident #6 had eloped prior to 09/26/21. -Resident #6 did not have exit seeking behaviors; "every time" her family member came to visit her she would get used to meeting with the family member daily and was confused when the visits did not continue. Interview with the Receptionist on 10/14/21 at 9:15am revealed: -Resident #6 would go outside the facility quite often, and when she became agitated. -Resident #6 was hard to redirect. -Resident #6 argued. -She assisted residents when they came to the desk in the front lobby. -She was able to see residents and keep her eyes on the residents who left the inside of the facility by viewing the facility camera system. -She was not aware of Resident #6 leaving the facility grounds, but Resident #6 would go outside and walk around.	D 270		

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D 270	Continued From page 16 Telephone interview with Resident #6's power of attorney on 10/14/21 at 11:30am revealed: -Resident #6 transitioned to assisted living from independent living in November 2020. -The decision was made because she needed a "higher level of care"; she required more cognitive assistance with her care. -Also, upon her admission to assisted living, Resident #6 had two private aides/companions to assist with her care for approximately the first 6-months. -COVID-19 stopped the activities at the facility; Resident #6 stayed in her room; and she became "very isolated. -She had handwritten personalized care plans for Resident #6 with her needs outlined and gave them to facility staff. -Prior to her admission to assisted living, it was communicated with the facility that Resident #6 had a previous elopement from independent living approximately 1 ½ year ago; we had discussed the elopement at one of the healthcare meetings. -She had asked for a "higher level" from the beginning. -When she visited Resident #6, she would only see 1 PCA working on each assigned floor. -She had to go looking for staff on previous visits to the facility; her last visit to see Resident #6 was last week (the week of 10/04/21). -She would visit Resident #6 every 3-4 weeks. -Approximately at the end of September 2021, Resident #6's family member came to visit her. -On 09/26/21, she received a phone call from the facility notifying her Resident #6 had left facility grounds and was walking towards a local grocery store and restaurant within the same shopping center. -When Resident #6 's family member was in town	D 270		

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D 270	Continued From page 17 visiting her their typical day included a trip to the local grocery store and a restaurant down the road from the facility. -The family member did not say good-bye to Resident #6 prior to leaving town so she did not realize the family member had left and was no longer in town. -When her routine was disrupted from a family member's visit, it would take 3-4 days to reacclimate Resident #6 to her routine. Second interview with the Administrator on 10/14/21 at 1:00pm revealed: -The standard of care for residents' rounds was every two hours by staff. -Wandering behaviors such as roaming through the building or if the resident was exit seeking a wander guard would be implemented. -Every day, 7 days a week, from 8:30am-7:00pm there was a receptionist at the front entrance of the facility; the door alarm was not activated during this time. -Every day, 7 days a week, from 7:00pm-8:30am the doors at the front entrance of the facility were locked. -During the receptionist's breaks through the day a morning break (10:00am-10:30), a lunch break (12:30pm-1:00pm), and an afternoon break (3:30pm-4:00pm); the facility's housekeeper/designee would provide coverage for the receptionist. -The receptionist was responsible to monitor resident traffic through the front entrance of the facility. -If the receptionist noticed a resident leave through the front door it was their responsibility to re-direct the resident or if the resident walked outside to follow and stay with the resident and call for assistance. -Resident #6 had not been identified with	D 270		

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D 270	Continued From page 18 wandering behaviors during the admission process and she was not aware of Resident #6's previous elopement until 09/26/21. -It was not the facility's process to complete elopement risk assessments for residents upon admission. -Resident #6's did have an elopement risk assessment completed after the 09/26/21 elopement on 10/01/21 by the Resident Care Coordinator. -Resident #6's admission paperwork was completed prior to her start as the Administrator at the facility in January 2021. -From her investigation about Resident #6's elopement on 09/26/21, there was a receptionist present at the front desk at the front entrance of the facility and at that time Resident #6 was not identified to have wandering behaviors. -The receptionist at the front desk had told her Resident #6 was outside with her family on 09/26/21. -The receptionist observed Resident #6 saying goodbyes with her family members, but the family members did not notify the receptionist or staff Resident #6 was still outside on facility's grounds. -She was not aware of Resident #6's previous wandering behaviors; Resident #6 was intermittently disoriented and was easily re-directed. -She would have expected Resident #6's level of care assessment prior to her admission to include her previous elopement then an elope risk assessment would have been completed and other interventions could have been in place, for example, a wander guard. Attempted interview with Resident #6's PCP on 10/14/21 at 10:42am was unsuccessful. Attempted telephone interview with a receptionist	D 270		

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D 270	Continued From page 19 who worked on 09/26/21 on 10/14/21 at 2:56pm was unsuccessful. The social worker was not available for interview from 10/12/21-10/14/21.	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 observations, record reviews, and interviews, the facility failed to assure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to physical environment. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 exit doors accessible for residents' use was equipped with a sounding device that activated for the safety of 7 of 7 sampled residents who were disoriented and 1 sampled resident (Resident #6) with a history of exit seeking behavior who eloped from the facility without staff knowledge. [Refer to Tag D0067, 10A NCAC 13F. 0305(h)(4) Physical Environment (Type B Violation)].	D912	Refer to tag D 067 and D 270	11/28/21