STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051002	A. BUILDING: ONE B. WING	R 02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HOME CARE OF JOHNSTON COUNTY I	474 JERRY ROAD SELMA, NC 27576

(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 conducted an annual and follow-up survey on 02/15/22 to 02/16/22.	D 000	We will continue to make sure all four exit door alarms remain on 24 hours daily. All four electrical door alarms are operational and are in good working order - two of the four exit doors had battery back-up alarms. On 2/18/22 we installed the battery back up alarms on the two remaining doors. As of 2/18/22 all four exit doors have hardwired electrical alarms and battery backup alarms.	
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 4 of 4 exit doors accessible for a resident who was known to be intermittently disoriented, wandered, and who eloped from the facility without staff knowledge (Resident #2) were equipped with a sounding device when the door was opened. The findings are: Review of the facility's "Identification and Supervision of Wandering Residents Policy"	D 067		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: THOMAS WHITE, CO | TITLE: ADMINISTRATOR | (X6) DATE: 03/15/2022.

STATE FORM 6899 PNIY11 If continuation sheet 1 of 13

RECEIVED
MAR 29 2022
BY:

Reviewed and Acknowledged — AT 04.08.22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 067	Continued From page 1 dated 10/29/04 revealed staff should: -Staff were to check door alarms regularly to assure they are working properly. -Staff were to notify the Administrator when alarms fail and request extra precautions for residents at risk of wandering. -Repair alarm system as soon as practicable. Observation upon entrance to the facility on 02/15/22 at 9:00am revealed the facility had 4 exit doors, two exit doors at the opposite ends of the main hallway, one exit door in the den, and one exit door in the kitchen. Observation of the exit door at the end of the right-side hallway on 02/15/22 at 12:30pm and 1:30pm revealed: -The door alarm did not sound when the door was opened. -The door exited to a patio and the parking lot. Observation of the exit door by the staff bedroom on 02/15/22 at 2:46pm revealed: -The door alarm did not sound when the door was opened. -The alarm switches on the doors were set to "off." -The door opened to a field next to the road. -There was no fence around the facility. Observation of facility exit door by Resident #2's room on 02/15/22 at 3:22pm revealed: -The alarm on the exit door was off. -The alarm did not sound when the door was opened. -There was a light switch in the hallway 35 feet from the exit door. -The switch was in the off position. Interview with the medication aide (MA) on	D 067	THOMAS WHITE, ADMINISTRATOR WILL MONITOR THE SITUATION DAILY TO ENSURE IT WILL NOT OCCUR AGAIN. COMPLETION DATE = 2/18/22	

3/15/22

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D 067	Continued From page 2 02/15/22 at 3:23pm revealed the light switch in the hallway was the switch to the facility-wide alarm, which she referred to as the "big alarm." Observation of facility exit door in the kitchen on 02/16/22 revealed: -At 8:07am, personal care aide (PCA) entered the kitchen through the exit door and the door alarm did not sound. -At 8:13am, the Administrator entered the kitchen through the exit door and the door alarm did not sound. Observation of Resident #2 on 02/15/22 at 2:25pm revealed: -Resident #2 was ambulating down the hall and entered the den, which was near the exit door at the right-side hallway. -Resident #2 had a picture of her parents wrapped in a blanket and said she needed to leave to go home to hang the picture up. Review of Resident #2's FL-2 dated 10/28/21 revealed: -Diagnoses included dementia and she was intermittently disoriented. -She was ambulatory, and an assistive device for ambulation was not indicated. -The recommended level of care was for a domiciliary. Review of Resident #2's care plan dated 10/12/21 revealed the resident did not have wandering behaviors. Review of Resident #2's December 2021 medication administration record (MAR) revealed: -On 12/29/21 at 4:30am, the MA woke up to Resident #2 standing over the MA, looking down at her while she was sleeping.	D 067		

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D 067	Continued From page 3 -Resident #2 woke all the other residents up and staff had to redirect resident out of another resident's room. Review of Resident #2's January 2022 MAR revealed: -On 01/07/22 at 5:15pm, Resident #2 went out the back door near her room. -The MA found her close to the barn on the facility grounds. -Resident #2 had a branch in her hand saying she was going to kill a snake. -The resident was looking for her deceased husband. -On 01/30/22 at 2:00pm, Resident #2 went out the kitchen door in her house coat. -Resident #2 made it to the pump house on the facility grounds before anyone could get her. -Resident #2 reported she was going to her house to take a pot off her stove. Interview with a MA on 02/15/22 at 2:54pm revealed: -Resident #2 became more confused and disoriented in the afternoon and evening and it had gotten worse recently. -Resident #2 regularly talked about needing to go to home. -She was concerned resident will leave without staff knowing and had done so before. -On the 01/07/22 incident, Resident #2 went out the door and MA did not know where she went. -The MA had to search the grounds for Resident #2. -The MA was concerned because Resident #2's room was near the exit door. -The MA was concerned because of Resident #2's wandering behavior. -The small alarms on the hall doors should always be on but someone would turn them off.	D 067		

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D 067	Continued From page 4 -The kitchen and den doors were on the facility-wide alarm. -The "big alarm" was turned off because if it triggered when it was too cold outside, it would not stop sounding. -Staff would keep the "big alarm" off to prevent it from sounding and not stop alarming. -If staff were in the kitchen or administering medications, staff would not know Resident #2 went out the exit doors because the alarms on the doors would not be on or activated. -She was very concerned at nighttime because the staff slept at the end of the hall. -She said staff worked 24 hour shifts and were expected to sleep in the facility during their shift. -The door alarms were needed because if staff was in the kitchen or administering medications, staff may not know Resident #2 went through the hall exit doors. Interview with second MA on 02/16/22 at 10:46am revealed Resident #2 would go out the doors looking for her family and staff would go outside to bring her back inside. Staff would watch her leave the building and allow her to walk outside within sight. Interview with the Administrator on 02/15/22 at 3:58pm revealed: -The door alarms were off during the day. -The door alarms should be turned on by staff in the evening when the doors were locked and the residents settled for the evening. -Resident #2 would become confused and "sundowned" in the evening. Interview with Resident #2's primary care provider (PCP) on 02/16/22 at 10:19am revealed: -Resident #2's dementia had been getting worse recently.	D 067		

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D 067	Continued From page 5 -She expected staff to monitor the resident especially when she was not with other residents. Refer to Tag D0270 10A NCAC 13F .0901(b) (Type B Violation) The facility failed to ensure 4 of 4 exit doors accessible for residents' use were equipped with a sounding device alerting staff when activated with Resident #2 who was known to be intermittently disoriented, a wanderer, and had a history of exit seeking behaviors and who had exited the facility without staff knowledge. 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 002/15/22 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2022.	D 067		
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	D 270	WITH ALL 4 EXIT DOORS ALARMS ACTIVATED 24 HOURS A DAY STAFF WILL CONTINUE SUPERVISION OF RESIDENTS IN ACCORDANCE TO THEIR ACCESSED NEEDS, CARE PLAN AND CURRENT	

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D 270	Continued From page 6 Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance to resident's assessed needs for 1 of 3 sampled residents (Resident #2) known to be intermittently disoriented, who wandered, had a history of exit seeking behaviors, and who had exited the facility without staff knowledge. The findings are: Review of the facility's "Identification and Supervision of Wandering Residents Policy" dated 10/29/04 revealed: -The facility would identify residents who walk or wheel around unrestricted and are a threat to leave the facility unattended due to their confusion. -Review FL-2 and obtain information from family regarding any history or the risk of wandering. -Inform staff at admission and as necessary if the potential exists for a resident to wander. -Supervise and implement routine checks, monitoring devices and/or techniques according to the need of each resident. Review of Resident #2's current FL-2 dated 10/28/21 revealed: -Diagnoses included dementia and the resident was intermittently disoriented. -She was ambulatory, and an assistive device for ambulation was not indicated. -The level of care recommended was domiciliary. Review of Resident #2's care plan dated 10/12/21 indicated she did not have wandering behaviors. Observation of the facility on 02/15/22 at 12:30pm revealed: -There was a two-lane road in front of the facility. -There was no posted speed limit on the road.	D 270	~~staff~~ symptoms and continue to inform family and physicians of changes in status of residents. THOMAS WHITE, ADMINISTRATOR will monitor the situation daily. Completion date → 2/18/22	

3/15/22

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D 270	Continued From page 7 -There was no shoulder or sidewalk on the road. -There was no fence surrounding the facility. Review of Resident #2's December 2021 medication administration record (MAR) revealed: -On 12/29/21 at 4:30am, medication aide (MA) woke up to Resident #2 standing over MA, looking down at her while she was sleeping. -Resident #2 woke all the other residents up and staff had to redirect resident out of another resident's room. Review of Resident #2's January 2022 MAR revealed: -On 01/07/22 at 5:15pm, Resident #2 went out the back door near her room. -The MA found her close to the facility barn. -Resident #2 had a branch in her hand saying she was going to kill a snake. -The resident was looking for her deceased husband. -On 01/30/22 at 2:00pm, staff discovered Resident #2 went out the kitchen door in her house coat. -Resident #2 made it to the facility pump house beyond the parking lot before anyone could get her. -The resident reported she was going to her house to take a pot off her stove. Observation of Resident #2 on 02/15/22 at 2:25pm revealed: -Resident #2 was ambulating down the hall and entered another resident's room. -Resident #2 had a picture of her parents wrapped in a blanket and said she needed to leave to go home to hang the picture up. Interview with a MA on 02/15/22 at 2:54pm revealed:	D 270		

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D 270	Continued From page 8 -She considered Resident #2 a potential "runaway" because she would leave the facility. -Resident #2 became more confused and disoriented in the afternoon and evening and had recently gotten worse. -Resident #2 regularly talked about needing to go to home. -She was concerned the resident would leave without staff knowing and had done so before. -On the 01/07/22 incident, Resident #2 went out the door without her knowledge and the MA did not know where she went. The MA searched the grounds for her. -Resident #2 was found near the facility barn, which was behind building 1. -Last summer, Resident #2 left the facility without staff knowledge and had been found at the house across the street. -The MA was concerned because Resident #2's room was near the exit door and the resident could go out of the door without staff knowledge. -She was concerned because there were large trucks that went down the road in front of the facility and the resident could get injured. -The two hall exit doors were not within line of sight of the kitchen. -If staff were in the kitchen or administering medications, staff would not know Resident #2 went out the exit doors because the alarms on the doors would not be on or activated. -She was very concerned at nighttime because the staff slept at the end of the hall. -She said staff worked 24 hour shifts and were expected to sleep in the facility during their shift. -The primary intervention that had been implemented for Resident #2 were changes in her medications. -Resident #2's medications had been adjusted in December 2021 and January 2022, and she was now receiving Haldol 2mg (used for delusions),	D 270		

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D 270	Continued From page 9 Seroquel 25mg (used for delusions), and Valium 2.5mg (used for anxiety). -No other formal intervention had been initiated, such as routine checks or special monitoring because the facility was changing her medications. Interview with a second MA on 02/16/22 at 10:46am revealed: -Resident #2 would go out the doors looking for her family and staff would go outside to bring her back inside. -Staff were constantly on alert before Resident #2's most recent medication change to Haldol because of her exit seeking behaviors. -Resident #2 would become more confused and disoriented in the evening. -Resident #2 would try to get into other resident rooms, knocking and talking loudly to other residents, waking up all of the residents. -The primary intervention that had been implemented for Resident #2 were changes in her medications. -No other formal intervention had been initiated, such as routine checks or special monitoring, due to physician adjusting medications. Interview with the Administrator on 02/15/22 at 3:58pm revealed: -There were no incident reports pertaining to Resident #2 leaving the facility. -Incident reports were done only when a resident had a fall with injury. -Staff were expected to document incidents on the back of the MAR. -He was contacted when a resident left the facility unaccompanied. -He then notified the primary care provider (PCP) and family. -He did not remember the incident last summer	D 270		

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D 270	Continued From page 10 where the resident was found across the street. -He had spoken with Resident #2's family on 01/03/22 and discussed if the resident continued to leave the facility unaccompanied, the facility would need to discuss moving her to a secure unit. -The primary intervention was medication changes to stop resident from leaving. -The PCP had changed medications and medication dosages in December 2021 and January 2022. -The PCP prescribed Haldol two weeks prior, which family had reported had worked well for the resident in the past. -No other formal intervention had been initiated, such as routine checks or special monitoring because it was believed the medication changes would stop Resident #2's wandering behaviors. Interview with Resident #2's PCP on 02/16/22 at 10:19am revealed: -Resident #2's dementia had been getting worse in the past 2-3 months. -The resident was becoming more confused and disoriented earlier in the day. -Resident #2's medication changes had been made due to the resident's dementia and behaviors, including agitation, irritability, and to regulate her anxiety. -The PCP had ordered a trial of Risperdal (used for mood stabilization), changes to the resident's order for Valium, trial of Seroquel, and Haldol. -The Risperdal had been discontinued and the Haldol initiated in February 2022. -She expected staff to monitor the resident especially when she was not with other residents. -She had been made aware of the resident's exit-seeking behavior and incidents of leaving the building.	D 270		

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D 270	Continued From page 11 Interview with Resident #2's family member on 02/16/22 at 11:04am revealed: -Resident #2 had moved into the facility from another nursing facility after a short-term rehabilitation stay. -Family had been notified of the resident leaving the facility in 01/2022. -Resident #2 believed someone was coming to pick her up so she would go to the parking lot to see if they were there yet. -They believed staff was providing constant supervision of resident because staff was always nearby when the resident would call family. -The changes in Resident #2's medication would prevent her from leaving the facility and she would sleep more. _____ The facility failed to ensure supervision for 1 of 3 sampled residents (Resident #2) in accordance with the facility's policy and the resident's needs who began exhibiting wandering and exit seeking behaviors and eloped from the facility at least once without staff knowledge. 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 02/15/22 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2022.	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:	D912	We will continue to make sure all four exit door alarms remain on 24 hours	

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D912	Continued From page 12 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, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Physical Environment and Personal Care and Supervision. The findings are: 1.Based on observations, interviews, and record reviews, the facility failed to ensure 4 of 4 exit doors accessible for a resident who was known to be intermittently disoriented, wandered, and who eloped from the facility without staff knowledge (Resident #2) were equipped with a sounding device when the door was opened. [Refer to Tag D0067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 2.Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance to resident's assessed needs for 1 of 3 sampled residents (Resident #2) known to be intermittently disoriented, who wandered, had a history of exit seeking behaviors, and who had exited the facility without staff knowledge. [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D912	DAILY. ALL FOUR ELECTRICAL DOOR ALARMS ARE OPERATIONAL AND ARE IN GOOD WORKING ORDER - TWO OF THE FOUR EXIT DOORS HAD BATTERY BACK UP ALARMS - ON 2/18/22 WE INSTALLED THE BATTERY BACKUP ALARMS ON THE TWO REMAINING DOORS. AS OF 2/18/22 ALL FOUR EXIT DOORS HAVE HARD-WIRED ELECTRONIC ALARMS AND BATTERY BACKUP ALARMS - THOMAS AND STAFF WILL CONTINUE SUPERVISION OF RESIDENTS IN ACCORDANCE TO THEIR ASSESSED NEEDS, CARE PLAN AND CURRENT SYMPTOMS AND CONTINUE TO INFORM FAMILY AND PHYSICIAN OF CHANGES IN STATUS OF RESIDENTS - THOMAS WHITE, ADMINISTRATOR WILL MONITOR THE SITUATION DAILY. 2/18/22 Completion DATE	

3/15/22