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CLAYTON HOUSE	145 DAIRY ROAD CLAYTON, NC 27520

(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 07/20/22-07/22/22.	D 000		
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, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#1 and #5) with a history of a falls resulting in 2 unwitnessed falls within a two week time-frame and a subsequent head laceration injury (#1), and 2 episodes of elopement within one month (#5). The findings are: Review of the facility's fall assessments policy revealed: -The facility evaluated each resident's fall risk on admission and at readmission, and documented interventions according to care needs and physician orders. -Residents were evaluated at each fall and reports completed with each new intervention and a 72-hour fall management follow-up. -The Resident Care Coordinator or designee added the new intervention to the orders in the	D 270		

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resident's electronic medical record.

Review of the facility's supervision of confused or wandering resident's policy revealed:
-The facility identified residents who were a threat to leave the community unattended due to their confusion.
-Window, door and gate keypad code locking systems should be checked twice a week and documented by maintenance personnel or designee.

Review of the facility's missing resident policy revealed:
-It was the facility's policy to provide for the safety and security of each resident.
-Each entry/exit door was equipped with a keypad code locking system, and management/staff managed the codes.

1. Review of Resident #1's current FL-2 dated 05/10/22 revealed:
-Diagnoses included dementia, diabetes, coronary artery disease, high cholesterol, and hypertension.
-He was constantly disoriented and was ambulatory with a walker.
-The resident was admitted to a special care unit (SCU) level of care.

Review of Resident #1's care plan dated 06/08/22 revealed:
-He required limited assistance with toileting and eating.
-He required extensive assistance with bathing, dressing, and grooming.
-He required supervision with ambulation and was independent with transferring.
-He was always disoriented and had significant memory loss.

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-He was occasionally incontinent with bowel and bladder.
-The resident's primary care provider (PCP) signed the care plan on 06/13/22.

Review of Resident #1's subsequent care plan dated 06/15/22 revealed:
-He required limited assistance with toileting and eating.
-He required extensive assistance with dressing and grooming.
-He was independent with ambulation and transferring.
-He was sometimes disoriented and had significant memory loss.
-He was occasionally incontinent with bowel and bladder.
-The resident's PCP signed the care plan on 06/22/22.

Review of Resident #1's Incident/Accident report dated 06/29/22 revealed:
-The resident had an unwitnessed fall in his room and was found sitting on the floor beside his bed.
-The resident complained of head and lower back pain.
-The resident was sent to the hospital for evaluation.
-The facility's fall prevention program was initiated.
-An order for a fall mat and hospice referral was requested from the resident's PCP.
-The resident's PCP and power of attorney (POA) were notified.

Review of Resident #1's emergency room (ER) discharge summary dated 06/29/22 revealed:
-A diagnosis of a fall with a neck sprain and back strain.
-Imaging diagnostics were negative for fractures

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or other acute processes.

Review of Resident #1's physician orders dated 06/30/22 revealed there was an order for a fall mat at bedside.

Review of Resident #1's PCP visit notes dated 07/04/22 revealed:
-Staff reported the resident had a fall on 06/29/22 when he was getting up from his chair, leaned too far forward, fell, and hit his head on the floor.
-Staff and the resident were educated on fall prevention strategies.

Review of Resident #1's Incident/Accident report dated 07/10/22 revealed:
-The resident had an unwitnessed fall in his room and was found sitting on the floor beside his bed.
-First aid was administered in the form of pressure applied to an unspecified area.
-The resident was sent to the hospital and was admitted for observation.
-The facility's fall prevention program was initiated.
-The resident's PCP, hospice nurse, and POA were notified.

Review of Resident #1's ER discharge summary dated 07/12/22 revealed:
-A diagnosis of a fall with a scalp laceration that required closure with surgical staples.
-Imaging diagnostics were negative for fractures or other acute processes.

Observation of Resident #1's room on 07/20/22 at 4:02pm revealed:
-The resident was asleep in his bed, laying on his left side with his legs bent and knees hanging off the edge of the bed.
-There was a blue fall mat folded and tucked

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under the resident's bed.
-The resident's walker was at his bedside.

Interview with Resident #1's family member on 07/26/22 at 8:32am revealed:
-She visited the resident every week and sometimes twice a week.
-The facility had reported the resident falls to her.
-The resident required reminders to use his walker when getting out of bed.
-The resident did not require staff assistance to go to the restroom.
-The facility requested a fall mat after the resident had some falls out of bed.
-The resident last fell out of bed or near his bed around 07/10/22 and required staples for a cut to his head.
-She was not sure if the fall mat was in place when the resident fell on 07/10/22.

Interview with a personal care assistance (PCA) on 07/20/22 at 4:16pm revealed:
-She was not aware Resident #1 had a fall mat and did not know why it was folded up and under his bed.
-All residents were routinely checked on every 2 hours, but staff were usually up and down the halls every 30 minutes.

Interview with the Administrator on 07/20/22 at 4:42pm revealed:
-The facility's fall prevention protocol included checking on resident's every 15 minutes for 72 hours after they had a fall or after they returned from the hospital with fall related injuries.
-Additional interventions for fall prevention included clearing room of floor clutter, slip resistant footwear or socks, improving lighting in the rooms, and fall mats.
-Staff routinely checked on all resident every 2

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hours.
-Resident #1 was provided a fall mat to be placed at his bedside while the resident was in his bed.
-PCAs were responsible to make sure the resident's fall mat was in place beside his bed while the resident was in bed.
-Medication aides (MAs) were responsible to check behind the PCAs to make sure the fall mat was in place.
-There was no documentation that Resident #1's fall mat was placed beside his bed while he was in bed.

Interview with a MA on 07/21/22 at 9:42am revealed:
-Residents were routinely checked every 2 hours.
-Residents with falls were checked on every 15 minutes for 72 hours after having a fall.
-Fall mats should be placed at the residents' bedside while they were in bed.

Interview with the Resident Care Coordinator (RCC) on 07/21/22 at 12:25pm revealed:
-Resident #1 required increased supervision and reminders to use his walker, especially at night when he gets up to go to the bathroom.
-Resident #1's fall mat should be placed beside the bed while he was in in bed by the PCAs.
-The MAs should check behind the PCAs to make sure the fall mat was in place.
-Some of the MAs did not know Resident #1 had a fall mat ordered.
-MAs were responsible to communicate the fall mat requirements to the oncoming MA at the change of shift.
-There was nowhere for staff to document or check-off the resident's fall mat was in place while he was in bed.

Interview with Resident #1's PCP on 07/22/22 at

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D 270	Continued From page 6 12:25pm revealed: -The resident's falls had become more frequent due to his cognitive decline. -The resident was placed on hospice care and a fall mat was ordered to be placed at bedside when the resident was in his bed. -The fall mat was ordered to prevent the resident from directly hitting the concrete floor. -The severity of injuries increased if the resident fell directly on the concrete floor. -She was not aware the fall mat was not always placed bedside when the resident was in his bed. -She expected the fall mat to be used correctly when the resident was in his bed. 2. Review of Resident #5's current FL-2 dated 04/19/22 revealed: -Diagnoses included dementia, expressive dysphasia, and anxiety. -He had wandering behaviors and was ambulatory. -There was no admission date documented. -The resident was admitted from home to a memory care/special care unit (SCU) level of care. Review of Resident #5's care plan dated 05/19/22 revealed: -He had wandering behaviors and always disoriented. -He had significant memory loss and required redirection. Review of Resident #5's Resident Register dated 05/03/22 revealed the resident's admission date was 05/03/22. Review of Resident #5's Incident/Accident report dated 05/03/22 revealed: -The resident was discovered outside on the	D 270		

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facility grounds.
-The resident did not have any injuries.
-The resident was placed on increased supervision with every 15-minute checks.
-The staff were notified to ensure that exit doors were closed behind them as they entered and exited the facility.
-The resident's primary care provider (PCP) and power of attorney (POA) were notified.

Review of Resident #5's Incident/Accident report dated 05/18/22 revealed:
-The resident eloped from the facility out of the break room door and was found outside on the facility grounds.
-An aide was assisting another resident with eating and observed Resident #5 walk by the door.
-The aide heard the breakroom door close and then noticed Resident #5 on the other side.
-The aide immediately assisted the resident back into the facility without injury.
-The resident was placed on increased supervision with every 15-minute checks for 72 hours and a sitter was provided for 1:1 supervision and monitoring for exit seeking behaviors.
-The staff were notified to ensure that exit doors were closed behind them as they entered and exited the facility.
-The resident's PCP and POA were notified.

Interview with the Resident Care Coordinator on 07/21/22 at 9:42am revealed:
-Resident #5 had a history of elopement and wandering behaviors at home prior to admission.
-The resident first eloped from the facility on the day he admitted to the facility.
-The first elopement occurred when a kitchen staff member was exiting the facility at the end of

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her shift and the resident walked out behind her.
-The kitchen staff reported she thought the resident was a visitor.
-Staff were reminded to make sure the exit doors locked behind them after they entered or exited the facility.
-The second elopement occurred about 2 weeks after the first elopement.
-The previous maintenance staff had disabled the lock on the exit door at the end of the 100 hallway for easier access in bringing in items for a work project.
-A staff member saw Resident #5 had exited through the 100 hallway exit door and out another exit door to the front of the building.
-Staff were able to immediately get the resident back into the facility.
-The resident was placed on continuous checks every 15-minutes.
-Resident #5's exit-seeking behaviors have improved since his mental health provider has adjusted his anxiety medications.

Interview with the Administrator on 07/22/22 at 9:43am revealed:
-Anytime a resident stepped past the threshold of an exit door without supervision of family or staff was considered and reported as an elopement.
-Resident #5 eloped from the facility on his first day when he exited through the employee exit door, following behind a kitchen staff member as she exited and walked along the sidewalk to the front of the facility.
-The kitchen staff reported she thought the resident was a visitor.
-The staff increased the resident's supervision to checks every 15 minutes for 72 hours.
-All staff were reminded to ensure exit doors closed and locked behind them whenever they entered and exited.

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D 270	Continued From page 9 -The exit door should not have been left unlocked for any reason. -The second time Resident #5 eloped from the facility was when he exited an exit door at the end of the 100 Hallway when the previous maintenance man left the exit door unlocked while bringing in his work supplies. -The resident exited to the front of the building from the room at the end of the 100 Hallway on the other side of the interior exit door. -The previous maintenance man should not have left the exit door unlocked because all resident's in the facility were at risk to wander and elope. Interview with Resident #5's primary care provider (PCP) on 07/22/22 at 12:25pm revealed: -She was aware of Resident #5's two elopement episodes that occurred in May 2022. -The resident was in a special care facility with locked doors to provide safety due to his wandering behaviors. -She expected the facility to keep exit doors locked and secured at all times. -Unlocked or unmonitored exits doors raised concerns for resident's safety if staff were not able to immediately discover and recover the resident, especially being so close to a busy road. _____ The facility failed to provide supervision of one resident with a history of falls which resulted in one fall at bedside with an open head wound requiring sutures (#1), and another resident with exiting seeking behaviors eloping from the facility, located near a busy road, twice in one month (#5). This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/22/22.	D 270		

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D 270	Continued From page 10 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 05, 2022.	D 270		
D 311	10A NCAC 13F .0904(f)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (1) Sufficient staff shall be available for individual feeding assistance as needed. This Rule is not met as evidenced by: Based on observations, interview and record reviews, the facility failed to assure there was sufficient staff available to provide feeding assistance for 2 of 6 sampled residents (#4,#9) resulting in delayed assistance with eating meals while sitting in the dining room with other residents eating the meal (#9) and a resident waiting to be served in his room while other residents while eating their meal (#4). The findings are: 1. Review of Resident #4's current FL-2 dated 12/01/21 revealed: -Diagnosis included Alzheimer's dementia and diabetes mellitus type II. -Resident #4 was ordered a puree diet with nectar thick liquids and double portions. -He was non-verbal. Resident of Resident #4's care plan dated 03/03/22 revealed: -The resident required staff assistance with	D 311		

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feeding for all meals and snacks.
-He was totally dependent on staff assistance for feeding.
-The resident had poor swallowing and eating.
-The resident had contracted muscles in his hand and could not move much on his own.

Observation of the breakfast meal service on 07/21/22 from 8:00am to 8:51am revealed:
-There were five residents seated in the dining that required feeding assistance.
-There were five staff members seated in the dining room feeding five of the residents that required feeding assistance.
-Resident #4 that required feeding assistance was laying in his bed in his room.
-Resident #4 had not been served his meal.
-At 8:51am facility staff was prompted to serve Resident #4 his meal and provide feeding assistance.
-At 8:55am a personal care aide (PCA) started to feed Resident #4 his meal.

Interview with a personal care aide (PCA) on 07/21/22 at 8:50am revealed:
-There were more residents that required feeding assist than there was staff available to provide feeding assistance.
-She provided feeding assistance to residents that required feeding assistance in the dining room before she provided feeding assistance to Resident #4.
-The time varied daily on when she provided feeding assistance to Resident #4.
-Some days he would have to wait for a long period of time before she could provide him with feeding assistance.
-Resident #4 was not able to verbally communicate.

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Based on observations, record reviews and interviews it was determined Resident #9 was not interviewable.

Refer to interview with the Administrator on 07/21/22 at 8:56am.

2. Review of Resident #9's current FL-2 dated 02/16/22 revealed:
-Diagnosis included Alzheimer's dementia, hyperlipidemia, hypertension, gastroesophageal reflux disease (GERD).
-Resident #9 was non-ambulatory and required assistance with feeding.
-She was able to communicate her needs verbally.

Review of Resident #9's care plan dated 04/04/22 revealed:
-She had limited range of motion in her upper extremities.
-She was always disoriented and had significant memory loss.
-She was totally dependent on staff for feeding assistance.

Observation of the dinner meal service on 07/20/22 from 5:00pm to 5:26pm revealed:
-There were five residents seated in the dining room that required feed assistance.
-There were four staff members seated in the dining room feeding four of the five residents that required feeding assistance.
-Resident #9 was seated at a table with another resident that required feeding assistance.
-The resident that was seated with Resident #9 received her meal and received feeding assistance from a staff member.
-Resident #9 had not been served her meal.
-At 5:26pm facility staff was prompted to serve

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D 311	Continued From page 13 Resident #9 her meal and provide feeding assistance. -At 5:30pm Resident #9 was served her meal and a medication aide (MA) provided her with feeding assistance. Interview with a medication aide (MA) on 07/20/22 at 5:19pm revealed: -Resident #9 did not receive feeding assistance because the facility staff was assisting other residents that required feeding assistance. Based on observations, record reviews and interviews it was determined Resident #9 was not interviewable. Refer to interview with the Administrator on 07/21/22 at 8:56am. _____ Interview with the Administrator on 07/21/22 at 8:56am revealed: -She had six residents that required feeding assistance at each meal. -She had enough facility staff to provide feeding assistance to all six of the residents that required feeding assistance. -Facility staff assisted residents that required feeding assistance in the dining room first before they provided Resident #4 with feeding assistance in his room. -She did not know why it took twenty-six minutes for Resident #9 to receive feeding assistance on 07/20/22.	D 311		
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	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051041	A. BUILDING: _____ B. WING _____	R 07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON HOUSE	145 DAIRY ROAD CLAYTON, NC 27520

(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
D912	Continued From page 14 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, interviews and record reviews, the facility failed to ensure residents were free from mental and physical abuse, neglect, and exploitation and in compliance with relevant federal and state laws and rules and regulations related to Personal Care and Supervision. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#1 and #5) with a history of a falls resulting in 2 unwitnessed falls within a two week time-frame and a subsequent head laceration injury (#1), and 2 episodes of elopement within one month (#5).[Refer to Tag 270 10A NCAC 13F. 0901(b) Personal Care and Supervision (Type B Violation)]	D912		