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THE LITTLE FLOWER ASSISTED LIVING	8700 LAYWERS ROAD CHARLOTTE, NC 28227

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 20, 2022.	D 000		
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 7 of 8 exit doors accessible to residents had audible alarms activated when opened for the safety of 2 of 3 sampled residents (#2, #3) who were documented as disoriented. The findings are: Review of the facility's current license effective 01/01/22 revealed: -The facility was licensed for 49 beds. -The facility only served elderly residents and did	D 067		

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not have a special care unit or serve residents with Alzheimer's or dementia.

Review of the facility's current census on 10/20/22 revealed there were 26 residents residing in the facility.

Review of current FL-2s for all residents residing in the facility on 10/20/22 revealed:
-There were 12 residents who were assessed and either intermittently or constantly disoriented who were also ambulatory or semi-ambulatory.
-There were 10 residents who did not have a cognition assessment but were assessed as being ambulatory or semi-ambulatory.
-There were 2 residents who did not have a cognition or ambulatory assessment.
-There were 2 residents who were assessed cognitively as oriented.

Review of the facility's Safety Alarms Protocol policy (undated) revealed:
-Residents would be assessed for elopement risk on admission and routinely.
-Residents who scored high on the elopement risk would be placed on a Resident at Risk list.
-The resident's physician would be notified of the elopement risk status.
-Functioning of the door sensors would be checked weekly and documented.
-Any anomalies would be reported immediately to the Administrator or Resident Care Coordinator (RCC).

Observation of the left side entrance door on 10/20/22 at 7:45am revealed upon entrance to the facility the door was unlocked and did not audibly alarm when opened.

Observations during initial tour of the facility on

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D 067	Continued From page 2 10/20/22 from 8:32am to 9:10am revealed: -Seven of the 8 exit doors accessible to residents did not audibly alarm when opened. -All 8 exit doors were equipped with sounding devices but only 1 of 8 doors audibly alarmed when opened and were activated. -The exit door next to the nurses' station on the right hall was the only audibly alarmed door. -The exit door next to the nurses' station on the right hall was the only audibly alarmed door. Observation of the right hall back door on 10/20/22 at 9:08am revealed: -The door opened to the back of the facility leading to a courtyard and a hill that went down to a wooded area. -The door did not audibly alarm when opened. -A personal care aide (PCA) asked the Resident Care Coordinator (RCC) why the door did not alarm when opened after being prompted by surveyor. Observation of the facility's front door entrance on 10/20/22 at 10:20am revealed a contracted hospice employee entered the facility and there was no audible alarm. Observation of the left hall private dining room door on 10/20/22 at 10:45am revealed: -Two maintenance employees went in and out of the door multiple times while performing work in the courtyard. -The door did not audibly alarm when opened. -The maintenance employees completed their work at left the area at 11:00am. Observations of multiple doors on 10/20/22 from 11:16am to 11:20am revealed: -The left hall back door did not audibly alarm when opened.	D 067		

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D 067	Continued From page 3 -The left side-entrance door did not audibly alarm when opened. -The left hall private dining room door did not audibly alarm when opened. -The right hall private dining room door did not audibly alarm when opened. -There was no response by staff to any of the doors being opened. Observation outside of the facility on 10/20/22 from 12:45pm until 1:04pm revealed: -The front door of the facility was approximately 100 feet from the main road where there was a two-lane road with a speed limit of 45 miles per hour. -There was an intersection with a stoplight on the two-lane road directly across from the facility front door. -Over the course of one minute, approximately 21 cars passed on the main two-lane road outside of the facility. -The left side entrance of the facility emptied into the parking lot. -The right-side entrance of the facility lead down a path around the back of the facility. -The back of the facility had a hill that went down into a wooded area and partial fence. Observation of the right hall private dining door on 10/20/22 at 1:08pm revealed the door did not audibly alarm when opened. 1. Review of Resident #2's current FL-2 dated 05/09/22 revealed: -Diagnoses included Alzheimer's, dementia, urinary incontinence, cardiovascular accident, anxiety, sleep apnea, depression, insomnia, and hearing loss. -The resident was constantly disoriented, semi-ambulatory.	D 067		

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D 067	Continued From page 4 Review of Resident #2's Resident Register dated 04/08/18 revealed: -The resident was admitted to the facility on 05/08/18. -She required assistance with orientation to time and place and was forgetful and required reminders. -The resident used assistive devices including a walker, hearing aid, and eyeglasses. -The resident's hobbies included walking and looking at nature. Review of Resident #2's Elopement Shared Risk Agreement dated 05/08/18 revealed: -The resident's family and the facility Administrator signed the agreement on 05/08/18. -The resident had been identified as having a desire to leave the facility without supervision. -Risk behaviors could include pointless wandering and attempted elopement which could result in injury, medical problems, or death. -The facility was not locked, and the family acknowledged the intimate relationship between the facility and the resident choosing to maintain the resident's home at the facility despite the risks. Review of Resident #2's current Care Plan dated 05/09/22 revealed: -The resident had intermittent confusion and an history of dementia and depression -She would forget she ate meals and would sometimes become agitated if only offered a snack in lieu of a full meal. -She would ambulate on the sidewalk but had not attempted to leave the premises. -She did not like to wear her glasses or hearing aids. -She was independent with transfers, required	D 067		

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supervision with eating and ambulation, and extensive assistance with toileting, bathing, dressing, and grooming.

Review of Resident #2's mental health (MH) provider's visit note dated 09/08/22 revealed:
-The resident was oriented to herself only and suffered from dementia and insomnia.
-She was a poor historian with poor insight regarding judgement, insight, and impulse control decision making.
-She ambulated with a rollator walker.

Observation of the hallway by the front door on 10/20/22 at 8:55am revealed Resident #2 approached a surveyor asking her where the bathroom was located; and the surveyor redirected the resident to the RCC.

Observation of Resident #2 on 10/20/22 at 1:10pm revealed:
-The resident was ambulating independently with her walker without staff supervision.
-The resident attempted to enter the dining room, which was closed, and the lights were off and there was an unlocked door at the back of the dining room that led to an unsecured back courtyard.
-An employee redirected the resident upon request of the surveyor.

Interview with Resident #2 on 10/20/22 at 8:55am revealed:
-She did not like living at the facility because she wanted to go home.
-She asked to eat breakfast even though she had been observed to have eaten breakfast 15 minutes prior to the interview.
-She asked the interviewer's name three times in a 5-minute timeframe.

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D 067	Continued From page 6 Interview with Resident #2's family member on 10/20/22 at 2:04pm revealed: -She visited with the resident approximately 1-2 times per week. -The resident was confused and was not supposed to go outside without supervision and permission. -The front door was usually locked when she visited and she rang a doorbell to enter, but she could not recall if all the doors alarmed when opened. Interview with a personal care aide (PCA) on 10/20/22 at 1:01pm revealed: -Resident #2 was confused and often could not find her room requiring direction. -Resident #2 frequently wandered throughout the facility and into other resident rooms. Interview with the RCC on 10/20/22 at 1:12pm revealed: -Resident #2 required heavy care which entailed prompting, verbal directions, and safety checks. -Resident #2 would wander throughout the facility usually looking for her room or food. -Resident #2 was known to walk outside of the facility to sit on the front porch or walk on the sidewalks almost every day without staff supervision unless it was cold or rainy. -Staff sometimes saw Resident #2 outside because the offices and nurse station had windows in the front, and they could watch her. -It was a safety concern that Resident #2 went outside by herself, but the facility had her family sign an elopement risk disclosure letting them know and they chose to keep her at the facility instead of placing her in a locked facility somewhere else.	D 067		

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Interview with Resident #2's mental health (MH) provider on 10/20/22 at 12:32pm revealed:
-The resident had moderate to several cognitive impairment and was ambulatory with a walker.
-The resident required redirection and queuing for safety and to complete activities of daily living (ADL).

Refer to interview with a personal care aide (PCA) on 10/20/22 at 9:40am.

Refer to interview with another personal care aide (PCA) on 10/20/22 at 1:01pm.

Refer to interview with a medication aide (MA) on 10/20/22 at 12:49am.

Refer to interview with the maintenance manager on 10/20/22 at 2:30pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/20/22 at 1:12pm.

Refer to interview with the Administrator on 10/20/22 at 1:32pm.

Refer to telephone interview with Resident #2 and #3's MH provider on 10/20/22 at 12:32pm.

2. Review of Resident #3's current FL-2 dated 08/03/22 revealed:
-Diagnoses include mild cognitive disorder, gait instability, hypertension, osteopenia, hyperlipidemia, vertigo, insomnia, muscle weakness, and ileus.
-She was semi-ambulatory.
-She was constantly disoriented.

Review of Resident #3's Resident Register revealed:

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-She was admitted 08/06/18 to the facility.
-She required assistance for ambulation, bathing, and toileting (sometimes).
-She was forgetful and needed reminders.

Review of Resident #3's current care plan dated 08/03/22 revealed:
-She required maximum assistance for toileting, ambulation, bathing, dressing, grooming, and transfer.
-She was alert and oriented to self.

Observations during the initial tour on 10/20/22 at 9:08am revealed Resident #3's room was at the end of the right hall directly next to the back exit door leading to the back courtyard and hill.

Interview with a personal care aide (PCA) on 10/20/22 at 1:35pm revealed:
-Resident #3 required two-person assistance to transfer.
-Resident #3 mainly stayed in her recliner and did not like to attend activities or leave her room.
-She was not aware of Resident #3 ever attempting to leave the facility independently.

Interview with a personal care aide (PCA) on 10/20/22 at 1:35pm revealed:
-Resident #3 required two-person assistance to transfer.
-Resident #3 mainly stayed in her recliner and did not like to attend activities or leave her room.
-She was not aware of Resident #3 ever attempting to leave the facility independently.

Telephone interview with Resident #3's mental health (MH) provider on 10/20/22 at 12:32pm revealed:
-Resident #3 was wheelchair bound and she was not aware of her ambulating or self-propelling in

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her wheelchair.
-Resident #3 had severe cognitive impairment and was agitated at times but was now controlled with medications.

Attempted interview with Resident #3's responsible person on 10/20/22 at 1:21pm was unsuccessful.

Based on observation, interviews, and record reviews, it was determined that Resident #3 was not interviewable.

Refer to interview with a personal care aide (PCA) on 10/20/22 at 9:40am.

Refer to interview with another personal care aide (PCA) on 10/20/22 at 1:01pm.

Refer to interview with a medication aide (MA) on 10/20/22 at 12:49am.

Refer to interview with the maintenance manager on 10/20/22 at 2:30pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/20/22 at 1:12pm.

Refer to interview with the Administrator on 10/20/22 at 1:32pm.

Refer to telephone interview with Resident #2 and #3's MH provider on 10/20/22 at 12:32pm.

_____

Interview with a personal care aide (PCA) on 10/20/22 at 9:40am revealed:
-The side and back doors were to always be alarmed.
-They did not turn on the front door alarms during the day because "they would be running all day to

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turn off alarms" because a lot of people came in and out of the facility during the day.

Interview with another personal care aide (PCA) on 10/20/22 at 1:01pm revealed:
-All exit doors were supposed to audibly alarm when opened.
-She was not sure who was responsible to ensure all doors were audibly alarming properly or how often they were checked.

Interview with a medication aide (MA) on 10/20/22 at 12:49am revealed:
-The front door was supposed to always remain locked.
-All exit doors were supposed to audibly alarm at the nurse's stations when opened.
-It was the responsibility of all staff to respond to a door when an alarm audibly sounds to see who opened the door and secure it properly ensuring resident safety.

Interview with the maintenance manager on 10/20/22 at 2:30pm revealed:
-The facility had residents who were confused, and he was not aware if any of them would go outside without supervision.
-He ensured doors closed properly and alarmed when opened once weekly but did not document this.
-Door alarms were to only be turned off when someone was working at the door, and it needed to stay open until the task was complete.
-All doors were to be activated at all times; for the exception of the side and front doors which were often not activated because of the frequent traffic of visitors and staff.
-He was not aware the door alarms were turned off that day and he was unsure how often clinical staff checked to ensure the alarms were working

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D 067	Continued From page 11 as expected. Interview with the Resident Care Coordinator (RCC) on 10/20/22 at 1:12pm revealed: -All residents had some level of confusion at the facility except for one regardless of what was documented in their resident record. -The majority of the facility's residents should be documented as either intermittently or constantly confused and required prompting. -None of the residents were exhibiting behaviors, agitation, or frequent redirection except one. -Some exit door alarms were often turned off because a lot of people would come and go during busy times of the day. -Another staff member had turned off the exit door alarms that day, 10/20/22, and she had not realized the alarms were turned off until a PCA brought it to her attention. -All exit doors were supposed to audibly alarm at night when less staff were in the building. -During the day, when more staff were in the building, only certain doors remained alarmed and the front door, back hall, side exits, private dining rooms, and dining room doors will be unalarmed so that residents, staff, and visitors could go outside to the back courtyard or front porch. -Residents could get confused and wander off if not supervised, but the facility was not a "locked facility" so the residents each had elopement disclosures signed by their family to ensure they understood the risk. -If residents wandered off, there was the potential they could fall, incur other injuries, walk to the road, or go missing, "anything could happen". -She was not aware that the regulatory rule stated the facility's doors had to be audibly alarmed and always activated when residents were assessed as confused or had wandering behaviors.	D 067		

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D 067	Continued From page 12 -There was no process in place to ensure door alarms were activated to work properly daily by staff, but when turned activated and turned on, all exit door alarms were in working order. Interview with the Administrator on 10/20/22 at 1:32pm revealed: -She was not aware of any residents who were confused to the point they had wandering and/or exit seeking behaviors, but some residents required more redirection than others. -There were no residents that went outside or left the facility unattended or supervised by staff or family members. -All exit door alarms were expected to be turned on and always activated. -The clinical staff were expected to ensure door alarms were working properly at each change of shift during handoff. -During the day, some door alarms were sometimes turned off so that staff, residents, and visitors could come and go, usually through the front door and the side door for staff to come and go during change of shift, but visitors would still ring the doorbell to be let in. -The facility was not a locked unit and residents who were confused were expected to receive extra supervision from the staff. -There were two residents she could recall who were confused and required increased supervision of at least every two hours and while going outside but neither of them were exit seekers. -She was not aware that multiple exit door alarms were not activated until it had been brought to her attention that day, 10/20/22. -She expected facility staff to be mindful that the doors were alarming properly and understood the importance of alarmed doors for resident safety.	D 067		

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THE LITTLE FLOWER ASSISTED LIVING	8700 LAYWERS ROAD CHARLOTTE, NC 28227

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D 067	Continued From page 13 -If exit door alarms were not working properly, residents could go outside at any time and if staff were busy and did not realize it, the resident(s) could be placed in danger, or someone could enter the facility putting residents and staff in danger. -Staff were trained to ensure doors alarmed properly upon hire and at monthly quality assurance and safety meetings, but sometimes forgot and did not make it a primary focus as they should. Telephone interview with Resident #2 and #3's MH provider on 10/20/22 at 12:32pm revealed: -She expected all exit doors in the facility to audibly alarm per regulatory guidelines when residents were assessed as disoriented or had wandering behaviors. -She expected to be notified of any wandering or exit seeking behaviors. -She expected the facility to implement the use of wander guards for residents who had wandering or exit seeking behaviors. -She had not been notified of any residents that exhibited wandering or exit seeking behaviors. -She expected disoriented residents to receive 24-hour care with supervision checks every 2 hours for resident safety and more often if residents exhibited wandering or exit seeking behaviors. _____ The facility failed to ensure 7 of 8 exit doors were activated to alert staff with a sounding device when opened with 12 out of 26 residents assessed and known to be intermittently or constantly disoriented and ambulatory or semi-ambulatory, with at least 1 resident who had wandering behaviors (#2) and would go outside unsupervised daily. The facility's exit doors led to a busy two-lane road where the speed limit was	D 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060109	A. BUILDING: _____ B. WING _____	10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 067	Continued From page 14 45 mph and an intersection with a stoplight directly outside of the front door. Around the back of the facility there was a hill that went down into a wooded area and was partially fenced from multiple exits. This failure was detrimental to the residents' health, safety and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/20/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 4, 2022.	D 067		