Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049036	A. BUILDING: _____ B. WING _____	R-C 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE	1372 EUFOLA ROAD STATESVILLE, NC 28677

(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 a follow-up survey and complaint investigation from 08/22/23 to 08/23/23. The complaint investigation was initiated by the Iredell County Department of Social Services on 08/17/23.	D 000	Responses to the cited deficiencies do not constitute an admission of agreement by the facility of the truth of the facts alleged or conclusions set forth in this statement of deficiencies or corrective action report. The plan of correction is prepared solely as a matter of compliance with state law. 10A NCAC 13F .0901(B) PERSONAL CARE AND SUPERVISION 1. ALL NEW EMPLOYEES DURING ORIENTATION ARE EDUCATED ON THE EXIT SEEKERS AND COMMUNITY EXPECTATIONS. BOM OR DESIGNEE. 2. ALL EMPLOYEES WERE RE-EDUCATED ON SUPERVISION OF RESIDENTS AND ELOPEMENT. (9/6/23 & ongoing)ADMINISTRATOR OR DESIGNEE. 3. MONTHLY STAFF MEETING WILL INCLUDE EDUCATION ON ELOPEMENT AND SUPERVISION. ADMINISTRATOR OR DESIGNEE. 4. ADMINISTRATOR WILL REVIEW ALL NEW EMPLOYEE FILES WEEKLY FOR 3 MONTHS AND THEN MONTHLY ASSURE COMPLIANCE. 5. CORRECTION DATE: 9/6/23 AND ON-GOING TRAINING.	
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 interviews, and record reviews, the facility failed to provide supervision for 1 of 4 sampled residents who had a diagnosis of dementia and a history of wandering behaviors (#3) resulting in the resident eloping from the Special Care Unit (SCU) facility. The findings are: Review of Resident #3's current FL2 dated 03/21/23 revealed: -Diagnoses included dementia and schizoaffective disorder. -The level of care was SCU. -The resident was ambulatory and intermittently disoriented.	D 270		

Jaynee Hatley Administrator 9/27/23

Reviewed and acknowledged on 10/10/23.
Sharon Dunton RN

	-Resident #3's behaviors included wandering.			

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D 270	Continued From page 1 Review of Resident #3's resident profile dated 08/01/23 revealed: -The resident was independent with ambulation. -The resident had a history of wandering behaviors and would try to get outdoors. -She would hit, scratch, punch, and bite when trying to push through the door. Review of Resident #3's Care Plan dated 08/01/23 revealed: -She was ambulatory and did not require assistive devices. -She was sometimes disoriented. -She was physically abusive, and had a history of wandering and exit seeking behaviors. -There was no documentation of interventions related to Resident #3 attempting to leave the facility. Review of Resident #3's Mental Health Provider's (MHP) progress note dated 07/20/23 revealed the resident had paranoia and attempted to exit seek. Review of Resident #3's progress note dated 08/01/23 revealed: -The resident was outside on 08/01/23 and broke a gate trying to leave the facility. -Resident #3's MHP was notified of the incident and new orders obtained for hydroxyzine 25mg, three times daily as needed for three days for anxiety. Review of Resident #3's Primary Care Provider's (PCP) progress note dated 08/11/23 revealed: -The resident appeared anxious, was agitated and had impaired insight. -The resident had made attempts to leave the facility. -Resident #3 was recently prescribed hydroxyzine for anxiety episodes.	D 270		

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D 270	Continued From page 2 -New orders included lorazepam 0.5mg, one tablet every 8 hours as needed for agitation or anxiety. Review of Resident #3's progress note dated 08/15/23 at 5:45am revealed: -Resident #3 exited the facility when a staff member was taking the trash out. -The staff member attempted to keep the resident inside the facility but was unable. -The resident was in the parking lot of the facility. -The staff member left the resident to get help from a co-worker. -When the staff members returned to the parking lot, the resident was no longer in sight. -Staff placed calls to the Business Office Manager (BOM), the Special Care Unit Coordinator (SCC), the Administrator and called 911. -The resident was located in a house behind the facility. Review of an incident report dated 08/15/23 revealed: -Resident #3 got outside of the facility when a staff member took the trash out. -The staff member attempted to stop the resident but was unable to get the resident back into the facility. -The law enforcement agency was notified on 08/15/23 at 6:30am. -After the resident was located, she was checked for injury and sent to the hospital for evaluation. Review of the law enforcement agency's investigation report dated 08/15/23 revealed: -They were called to the facility on 08/15/23 at 6:33am to investigate a missing person. -Video surveillance reviewed by law enforcement officers (LEO) and displayed Resident #3	D 270		

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D 270	Continued From page 3 struggled with a personal care aide (PCA) before walking away from the facility on 08/15/23 at 5:46am. -There was a "substantial amount of time" between the time the facility noticed the resident was missing and when the facility called the law enforcement agency to report the missing resident. -Resident #3 was found in a house on the facility property. -Resident #3 was transported to the hospital for evaluation. Telephone interview with a PCA on 08/23/23 at 6:33am revealed: -She was taking out the trash on 08/15/23 at approximately 5:00am when Resident #3 pushed her through the exit door that opened to the parking lot. -She tried to guide the resident back into the facility but was unable. -The resident was running around the parking lot, trying to get into the parked cars. -She was by herself with Resident #3 outside of the building approximately 5-10 minutes and knew she needed to get help. -She left the resident in the parking lot and ran into the facility to get help. -She located another PCA in the facility and asked for help immediately. -Resident #3 was not in the parking lot when the two staff members got back outside. -She did not know how long it took to get help, but thought it was only 2-3 minutes. -She had training when she was hired but it did not cover what to do if a resident eloped. -The PCA's responsibility was to call the Administrator who would provide further	D 270		

	directions. -She should have stayed with the resident and			

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D 270	Continued From page 4 not left her alone. Telephone interview with a second PCA on 08/23/23 at 6:53am revealed: -Resident #3 was awake most of the night shift on 08/14/23 to 08/15/23, going to the door to look out or watching television. -She was making rounds about 5:30am when another PCA yelled for help. -Resident #3 was outside and they looked for her in the bushes, around the cars, and down the road. -The medication aide (MA) immediately made the Administrator aware the resident was outside. -Three staff members were on duty the night of the elopement. -Staff looked for the resident about 30 minutes before law enforcement was called. Interview with a MA on 08/22/23 at 2:35pm revealed: -She was the MA on duty the morning of 08/15/23 when Resident #3 eloped from the facility. -Resident #3 did not sleep much the night of 08/14/23 but she was not agitated. -The staff monitored Resident #3 at least every 2 hours, but she was monitored more that night because she was up watching television and walking down the hall to the entrance door. -The entrance door was always locked so staff knew Resident #3 could not get out. -On 08/15/23 at approximately 5:30am, Resident #3 pushed the PCA out of the facility door. -The PCA tried to get the resident back into the facility but was unable. -She was made aware of the elopement when the PCA came down the hall to get help because Resident #3 had gone out the facility door. -She went out to help get Resident #3 back into the building, but the resident was gone.	D 270		

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D 270	Continued From page 5 -She called the Administrator on 08/15/23 at approximately 5:53am and called law enforcement on 08/15/23 at approximately 6:00am. -She and a PCA continued to look for Resident #3 while a second PCA stayed in the facility with the other residents. -Law enforcement arrived at the facility at approximately 6:30am and the Administrator arrived shortly after. -Resident #3 was found in a house located on facility property where the BOM lived. -The resident did not appear to have any injuries. -Resident #3 was missing approximately 45 minutes. -Resident #3 was sent to the hospital to be evaluated. -The MA's responsibility was to call the Administrator after Resident #3 eloped and could not be found. -The Administrator instructed her to call law enforcement. Interview with the MA on 08/23/23 at 10:21am revealed: -The surveillance camera showed the entrance door and some of the cars in the parking lot. -Law enforcement reviewed the surveillance footage to get the time Resident #3 pushed the PCA out of the facility door. -Her responsibility was to call law enforcement, but she was busy looking for Resident #3 and time just got away. Telephone interview with a LEO on 08/22/23 at 1:10pm revealed: -He was the LEO that received the call on 08/15/23 at approximately 6:30am from the facility regarding a missing person. -Staff was unable to give him an exact time when	D 270		

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D 270	Continued From page 6 Resident #3 left the facility. -He looked at the surveillance camera inside the facility to get the time Resident #3 left the facility. -Resident #3 left the building on 08/15/23 at 5:46am. -He felt the facility should have called local law enforcement immediately after the resident left the building. -The resident was gone approximately 45 minutes before the staff called local law enforcement. -Resident #3 was found asleep in the house owned by the facility on the facility's property. Interview with the SCC on 08/23/23 at 3:03pm revealed: -She was called to the facility on 08/15/23 at approximately 6:00am to help look for Resident #3. -She arrived at the facility at approximately 6:30am and the MA had already called law enforcement. -Law enforcement found Resident #3 in the house beside the facility. Interview with the Administrator on 08/23/23 at 4:14pm revealed: -Resident #3 would go out on walks with staff at times to the parking lot or to the mailbox but never tried to walk away. -Resident #3 had taken walks around the BOM's house with staff and knew she lived there. Attempted telephone interviews with Resident #3's responsible party on 08/22/23 at 10:38am and 3:31pm were unsuccessful. Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable.	D 270		

PRINTED: 09/13/2023
FORM APPROVED

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D 270	Continued From page 7 The facility failed to provide supervision for Resident #3 who had a history of exit-seeking behaviors and wandered which resulted in the resident eloping from the facility after pushing past a staff member and was found 45 minutes later at a home next to the facility by law enforcement officers. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/22/23 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 7, 2023.	D 270	10A NCAC 13F. 09069F040 OTHER RESIDENT CARE AND SERVICES 1. ALL STAFF RE-EDUCATED ON SUPERVISION AND EXIT SEEKERS. ADMINISTRATOR, BOM OR DESIGNEE. STAFF RE-EDUCATED OM CALLING 911 IMMEDIATELY AND STAFF REMAINING 1:1 IF EXIT OCCURS. ADMINISTRATOR OR DESIGNEE. 2. ALL STAFF HAVE BEEN EDUCATED ON ELOPEMENT AND TRAININGS WILL CONTINUE AT MONTHLY STAFF MEETINGS. (9-6-23 and ongoing) OUTLINE WILL BE LEFT IN TRAINING NOTEBOOK FOR THOSE NOT IN ATTENDANCE. ADMINISTRATOR OR DESIGNEE. 3. DURING ORIENTATION ALL NEW HIRES EDUCATED ON EXIT SEEKERS AND ELOPEMENT/SUPERVISION. BOM OR DESIGNEE. 4. BOM OR DESIGNEE WILL BE RESPONSIBLE TO ENSURE COMPLIANCE. 5. CORRECTION DATE: 9/6/23 AND ON-GOING	
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to immediately notify law enforcement when Resident #3 eloped from the facility and was not immediately located.	D 328		

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D 328	Continued From page 8 The findings are. Review of Resident #3's current FL2 dated 03/21/23 revealed: -Diagnoses included dementia and schizoaffective disorder. -The level of care was special care unit (SCU). -The resident was ambulatory and intermittently disoriented. -Resident #3's behaviors included wandering. Review of Resident #3's resident profile dated 08/01/23 revealed: -The resident was independent with ambulation. -The resident had exit seeking behaviors, and would try to get outdoors. -She would hit, scratch, punch, and bite when trying to push through the door. Review of Resident #3's Care Plan dated 08/01/23 revealed: -She was ambulatory and did not require assistive devices. -She was sometimes disoriented -She wandered, was physically abusive, and was exit seeking. Review of Resident #3's Mental Health Provider's (MHP) progress note dated 07/20/23 revealed the resident had paranoia and attempted to exit seek. Review of Resident #3's Primary Care Provider's (PCP) progress note dated 08/11/23 revealed: -The resident appeared anxious, was agitated and had impaired insight. -The resident had made attempts to leave the facility. Review of Resident #3's facility progress note dated 08/15/23 at 5:45am revealed:	D 328		

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D 328	Continued From page 9 -Resident #3 got out of the facility when a staff member was taking the trash out. -The staff member attempted to keep the resident inside the facility but was unable. -The resident was found in the parking lot of the facility. -The staff member left the resident to get help from a co-worker. -When the staff members returned to the parking lot, the resident was no longer in sight. -Staff placed calls to the Business Officer Manager (BOM), the Special Care Unit Coordinator (SCC), the Administrator and then called 911. Review of an incident report dated 08/15/23 revealed: -Resident #3 got outside of the facility when a staff member took the trash out. -The law enforcement agency was notified on 08/15/23 at 6:30am. Review of the law enforcement agency's investigation report dated 08/15/23 revealed: -They were called to the facility on 08/15/23 at 6:33am to investigate a missing person. -Video surveillance footage was reviewed by law enforcement officers (LEO) and displayed Resident #3 struggled with a personal care aide (PCA) and got away from the locked facility on 08/15/23 at 5:46am. -There was a "substantial amount of time" between the initial loss of the elderly resident and when the facility called the law enforcement agency to report the missing resident. Telephone interview with a LEO on 08/22/23 at 1:10pm revealed: -He was the LEO that received the call on 08/15/23 at approximately 6:30am from	D 328		

	the facility regarding a missing person.			

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D 328	Continued From page 10 -Staff was unable to give him an exact time when Resident #3 left the facility. -He looked at the surveillance camera footage inside the facility to get the time Resident #3 left the building. -Resident #3 left the building on 08/15/23 at 5:46am. -He felt the facility should have called local law enforcement immediately after the resident left the building. Interview with a MA on 08/22/23 at 2:35pm revealed: -She was the MA on duty the morning of 08/15/23 when Resident #3 eloped from the facility. -On 08/15/23 at approximately 5:30am, Resident #3 pushed the PCA out of the facility door. -She was made aware of the elopement when the PCA came down the hall to get help because Resident #3 had gone out the facility door. -She called the Administrator on 08/15/23 at approximately 5:53am and called law enforcement on 08/15/23 at approximately 6:00am. A second interview with the MA on 08/23/23 at 10:21am revealed: -It was her responsibility was to call law enforcement, but she was busy looking for Resident #3 and time just got away. -If it happened again, she would call law enforcement immediately. Interview with a PCA on 08/23/23 at 6:33am revealed: -She was the PCA who was pushed out of the facility door by Resident #3. -The PCA's responsibility was to call the Administrator, but the MA had already made the Administrator aware of the elopement.	D 328		

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D 328	Continued From page 11 Interview with a second PCA on 08/23/23 at 6:53am revealed she did not know why it took so long to call law enforcement because that was not her responsibility. Interview with the SCC on 08/23/23 at 3:03pm revealed she was trained to contact the Administrator when an elopement occurred, to look for the resident, and as a last resort to call law enforcement. Interview with the Administrator on 08/23/23 at 4:14pm revealed: -Staff followed the facility policy to look for the resident prior to calling law enforcement. -She was unaware the regulation stated to call law enforcement immediately after a resident was missing. -She would change the policy and make staff aware of the change.	D 328		