Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Addison of Fuquay-Varina
Address: 6516 Johnson Pond Rd, Fuquay-Varina, NC 27526
II. Dates of Visits: 4/09/24, 4/15/24, 4/17/24, 4/18/24, 4/25/24, 4/29/24, 5/02/24, 5/03/24, 5/07/24

County: Wake
License Number: HAL-092-219
Purpose of Visit(s): Elopement Investigation

Exit/Report Date: 5/15/24

Instructions to the Provider ***(please read carefully)*****:**

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c)**, indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: **Personal Care & Supervision, 10A NCAC 13F .0901 (b)**	POC Approved: RSB as revised 6/27/24.	
Rule/Statutory Reference: **Personal Care & Supervision, 10A NCAC 13F .0901 (b),** Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan, and current symptoms.		
Level of Non-Compliance: Type A2 Violation		
Findings: Based on observations, record reviews, and interviews the facility failed to ensure 1 of 5 residents sampled (Resident #1) with diagnoses of advanced dementia, Alzheimer's Disease, Traumatic Brain Injury (TBI), and osteoarthritic knee pain who exhibited confusion eloped into city street areas without the facility's knowledge. The Findings are: Review of the facility's *Resident Identified as Missing* policy dated 4/19/21 revealed: -When a resident could not be found in their hall area, staff were to check the sign in book for possible appointment or family leave information.	Interviewed PCAs & MTs on floor to identify confused residents. — Area Nurse Assessed residents in EL for their Cognitive level & submitted the assessments & list of resident disoriented to PCP. — Area Nurse	5/21/24 5/22/24

Fabi — 5/15/24

-If the resident was not signed out, staff were to search all possible resident room areas. -If the resident remained missing, the Facility Nurse (FN) or designee were to notify the Concierge to initiate a building search. -The FN, or designee, notified the Executive Director (ED) and Director of Nursing (DON) or designee of a missing resident. -If the resident was not found by facility search within 10 minutes, the FN was to notify the ED and DON to contact local Law Enforcement (LE) for search assistance. -The ED was to notify LE, responsible parties, the hospital, and corporate office, if the resident elopement resulted in injuries. -The ED would update the responsible party and physician if the resident continued to go missing. -The staff who located the missing resident was to notify the facility nurse, who was to notify the ED, who then notified the corporate office.	PCP started Lab workups & Cognitively evaluation for the disoriented residents in DL & Send the finally identified residents back to management team. - PCP provider. Team started working on moving process based on the list of residents from PCP. Actions are:	5/21/24 5/30/24 5/30/24
Review of Resident #1's FL-2 dated 10/27/23 revealed: -A diagnosis of Traumatic Brain Injury (TBI). -Resident #1 was disoriented. -Resident #1 was semi-ambulatory with a rollator walker. -Resident #1 required total care with her Activities of Daily Living (ADLs), including ambulation and transfers. -Physical Therapy (PT) was ordered for gait and strengthening. -Resident #1's recommended level of care was Assisted Living (AL).	1. UA/UC screening 2. PCP evaluation 3. obtaining new FL-2 4. Arranged family meeting 5. Finding placements for residents 6. Discussing discharge plans with families -HUD/RCC/MCD/ED	6/3/24 5/21-5/30 6/3/24 6/3/24 & 6/14/24 6/3/24 6/3/24 & Ongoing
Review of Resident #1's Resident Register dated 10/23/23 revealed: -Resident #1 was admitted to the facility on 10/23/23. -Resident #1 had adequate memory. -Resident #1 used a wheelchair and walker to ambulate. -Resident #1 required assistance to ambulate, with toileting, and dressing.		
Review of Resident #1's Primary Care Provider (PCP) evaluation dated 10/30/23 revealed: -Resident #1 had a diagnosis of dementia with disorientation. -Resident #1 complained of knee pain. -Resident #1 required a wheelchair or walker to ambulate.		
Review of Resident #1's initial Care Plan dated 11/02/23 revealed: -Resident #1 was disoriented and had a forgetful memory.		

-Resident #1 scored in the mild neurocognitive disorder range. -Resident #1 did not appear to need Special Care Unit (SCU) placement. -Resident #1 had limited ambulation abilities (unspecified) without device. Review of Resident #1's Care Plan undated and signed by the Primary Care Provider (PCP) 2/19/24 revealed: -Resident #1 was disoriented and was forgetful. -Resident #1 had limited ambulation ability. -Resident #1 required supervision with ambulation. -Resident #1 required hands-on assistance with transfers and toileting. -Resident #1 may require escort and cues while ambulating. Resident #1's PCP evaluation note dated 1/25/24 revealed Resident #1's diagnoses included severe (advanced) dementia with mood disturbance and Alzheimer's Disease with Late Onset. Review of Resident #1's Saint Louis University Mental Status Examination (SLUMS) administered by the Memory Care Director (MCD) with a test prior to her admission dated 10/20/23 revealed: -Test scores of 27-30 indicated a normal cognition. -Test scores of 21-26 indicated a mild neurocognitive disorder. -Test scores of 1-20 indicated dementia. -Resident #1 scored 22.5 indicating mild neurocognitive disorder. The SLUMS Examination is used for early detection of cognitive impairment and mild dementia. SLUMS Examination does not represent a clinical diagnosis and requires a full assessment and evaluation by a qualified healthcare or psychiatric professional. Telephone interview with the Memory Care Director (MCD) 4/15/24 at 3:30pm and 5/07/24 at 11:19am revealed: -She thought the SLUMS test assessed an adult's memory and education. -The SLUMS test was the sole assessment used by the facility to determine residents' memory and unit placement needs for every resident with a dementia diagnosis upon admission. -The facility required residents to submit psychological assessments upon admission with a dementia diagnosis.	Slums Assessment (Cognitive exam) will be conducted for all new move-ins and every 6 month for all residents & every 3 month for MC residents as scheduled. HWD/RCC/MCD Slums scores will be submitted to PCP to decide if current level of care is appropriate for resident's current conditions. HWD/RCC/MCD This change has been built to Senior Life Style policy to ensure residents safety. Director of Nurse Policy Review Completed with MCD/MCC/RCC/HWD by Director of Nurse	5/21/24 & ongoing 5/21/24 & ongoing 1/23/24 6/5/24

-Psychological assessments were not performed upon admission for residents with disorientation &/or memory diagnosis. -The PCP referred residents for psychological assessments as indicated upon initial examination. -Dementia diagnoses, disorientation and confusion histories did not result in psychological assessment referrals or SCU placement. -A SLUMS score below 20 points initiated higher supervision and/or sitter services at a score at/below 15 points on AL. -A SLUMS score at/below 15 points could also indicate SCU placement need. -A "911 Huddle" (corporate nurses) was initiated with residents with borderline cases of memory impairment or family who insisted upon Assisted Living (AL) admission, despite a SLUMS test indication for SCU placement. -Resident #1 was not psychologically assessed upon admission since she 'passed' her SLUMS test. -Increased supervision from the standard AL 2 hours was not indicated with a SLUMS test of above 20. -Resident #1 passed the SLUMS test with a 22.5 score, so Resident #1 was admitted to AL with the standard 2-hour supervision plan. -One-hour supervision checks or sitters were utilized when residents displayed increased disorientation. -Resident #1 did not display confusion, wandering, or elopement behavior prior to 4/04/24. -She wrote Resident #1's Care Plan 2/19/24. -Resident #1's supervision care plan did not change since she was unaware of Resident #1's severe dementia and confusion. -She was not aware of any elopement in the fall of 2023 or other date prior to 4/04/24. Review of Resident #1's PCP evaluation note dated 1/25/24 revealed: -Resident #1's diagnoses included severe dementia, knee pain, severe protein calorie malnutrition, gout, and Chronic Pain Syndrome. -Resident #1 had arthritic changes to her knees and reduced the range-of-motion with her left knee. -Resident #1's memory and judgement were severely impaired. -Staff were to monitor Resident #1 for changes in cognition, activities, and behavior. Review of Resident #1's PCP fall follow-up evaluation dated 2/12/24 revealed: -Resident #1 reported tripping and falling over her feet on 2/11/24.	Actively Hiring more staff members & to provide close monitoring to disoriented residents in AL. RCC/HWD/MCD Hired 5 PCAs & AMTs Employees orientation was held on 5/28 RCC/HWD/MCD Adding more PCAs on A. B & D halls to ensure residents safety. RCC/MCC/MCD/HWD Daily schedules will be reviewed by ED & team to ensure more PCAs are available. While we're discussing & arranging the placement for the identified residents. ED/HWD/MCD/RCC	5/21/24 & Ongoing. 5/28/24. 6/3/24 6/5/24 & Ongoing

-Resident #1 sustained right forearm, hand, and right scalp area abrasions and pain. -Her head contusion caused a slow, intracranial re-bleed to from a September 2023 fall, causing increased cranial hemorrhaging. -Resident #1 had bruising to her right hand and 4th/5th digits. -Diagnoses included severe dementia and unspecified gait and mobility abnormality. -Staff were to observe Resident #1 for changes in activities and behaviors. Review of Resident #1's PT service notes 1/16/24 through 4/01/24 revealed: -Resident #1 required PT for gait issues, rollator training, knee pain management, safety training, and strengthening. -The PT educated staff on falls prevention (unspecified) for Resident #1. -Resident #1 required a rollator to ambulate. -She notified Resident #1's PCP of Resident #1's increased confusion on 3/08/24. Interview with Resident #1's Physical Therapist (PT) on 4/15/24 at 10:00am revealed: -Resident #1 was confused and had severe and chronic memory issues upon admission to the facility. -Resident #1 often forgot where she was walking in the facility. -Resident #1 had poor safety awareness. -Resident #1 had difficulty differentiating safe places to walk and sit. -Resident #1 had a history of falls with injuries. Telephone interview with a Medication Aide (MA) 5/07/24 at 11:35am revealed: -Resident #1 felt faint and light-headed on 4/02/24. -Resident #1 did not faint 4/02/24 and her vitals were within range. -She monitored her closely for 2 hours and provided water. -Resident #1 stopped feeling faint. Interview with a MA on 4/15/24 at 10:00am revealed: -Resident #1 and other AL residents were on 2-hour checks. -About 12-15 AL residents were confused and disoriented. -Resident #1 knew her name. -Resident #1 was not observed to have wandering behavior. -Resident #1 often forgot where the dining room and her room was. -Resident #1 could not walk far, usually from her room to the dining room.	monthly schedules is edited by team under supervision of ED to meet residents' needs & to ensure residents' safety in AL. – ED/HUD/RCC Education in personal care & supervision has been provided to team members. See attached Inservice record. – MCD/Area Nurse Education in Elopement prevention has been provided to team members. See attached Inservice record. – HUD	6/3/24 5/31/24 & 6/3/24 5/1/24

Telephone interview with a MA on 4/14/24 at 3:30pm revealed: -Resident #1 was confused as usual on 4/04/24. -There were 15 AL residents with dementia. -All AL residents were on 2-hour checks, including Resident #1. -The last time she saw Resident #1 was at breakfast on 4/04/24 at approximately 8:30am. -She did not know which door Resident #1 exited on 4/04/24. Interview with a MA on 4/17/24 at 11:35am revealed: -Resident #1 was confused since admission, thinking at 10:30pm it was time for breakfast. -All AL residents were on 2-hour checks, including Resident #1. -She decided she would check Resident #1 every 45 minutes to 2 hours, since Resident #1 was so confused. -Resident #1 occasionally sat on the front porch with her roommate in March 2024. -She saw Resident #1 doing a word search puzzle in her room the morning of 4/04/24. -Resident #1 began pacing the halls the morning of 4/04/24. -Resident #1 often forgot where her room was. -She last saw Resident #1 in the dining room at 12:00pm for lunch on 4/04/24. Measurement of the distance from the facility to the residential address Resident #1 walked to was .2 miles. Observation of the approximate route Resident #1 walked on 4/04/24 to a local residential subdivision revealed: -The facility was situated on a 2-lane, 35 mph commercial/ residential street. -The facility front porch sidewalk encircled 2, small parking lots and connected to the city sidewalk. -The city sidewalk ran to a church and school to the South and a subdivision to the North. -School carpool lines backed up onto the city street and street shoulder to the facility at 8:30am and 2:20pm. -A daycare was located across the street. -The subdivision opened into a cul-de-sac to the right and a neighborhood to the left. -The cul-de-sac homes and driveways on a steep, downward sloping hill.	Education in alarms, chimes, close monitoring of exits and response has been provided to team members. ED/ maintenance Director / MCD Education in level of care on F1-2 has been provided to sales & marketing director by DNA Nurse. Geri-Psych referral will be arranged for residents with history of mental illnesses. HWD/RCC Condition changes includes acute delirium will be reported to PCP for immediate actions. HWD/RCC	5/15/24 6/5/24 6/5/24 & Ongoing 6/5/24 & Ongoing

Review of Resident #1's Incident/Accident (I/A) Report dated 4/04/24 revealed: -Resident #1 eloped from the facility on 4/04/24 at approximately 1:05pm. -Resident #1 was found by a local citizen on 4/04/24. -The citizen called the facility to inform staff of discovering Resident #1 walking around his neighborhood. -The facility Medication Aide (MA) and Sales Director (SD) picked Resident #1 up from the citizen's home (at an unspecified time) on 4/04/24 and returned to the facility. -Resident #1's Primary Care Physician (PCP) was on site and performed a physical and cognitive assessment of Resident #1 4/04/24. -Resident #1 had no visible injuries 4/04/24. -The PCP ordered a urinalysis (UA) to rule out a urinary tract infection (UTI) as the cause for her increased confusion. -The PCP ordered Special Care Unit (SCU) placement for Resident #1 on 4/04/24.	SLUMS Test+Medical history will be evaluated by PCP at resident's admission and upon change of conditions. Education provided to PCP by Area Nurse on 6/14/24	6/14/24
Interview with the Health & Wellness Nurse (HWN) on 4/15/24 at 4:20pm and 5/07/24 at 11:19am revealed: -She was a new hire as of 3/18/24. -The MCD wrote Resident #1's 2/19/24 care plan. -She thought there were 3 residents with dementia on AL. -Resident #1 had dementia. -She was not familiar with Resident #1's baseline prior to, and on, 4/04/24. -She was unaware of Resident #1's advanced dementia or need for increased supervision for care plan change. -She did not notice Resident #1 display confusion, wandering or other behaviors. -She heard of no prior verbalizations or acts of elopement by Resident #1. -Resident #1 was to be checked every 2-hours. -Sitters were used for extra supervision when a family requested and provided one. Resident #1 had no sitter. -She did not know what time Resident #1 eloped. -She did not work 4/04/24; she was in a training and meeting. -She was not aware of the PCP and PT's notes Resident #1 was severely impaired with a diagnosis of dementia. -The PCP's assessment of Resident #1 after the resident eloped 4/04/24 found Resident #1 to be more disoriented than her baseline. -An order for SCU placement was sought on 4/04/24 for Resident #1's safety.	Residents with any mental illness, brain disorders, and/or disorientation will be referred to Geripsych services by pcp at admission and upon change of conditions. Education provided to PCP by Area Nurse on 6/14/24	6/14/24
Review of Resident #1's Progress Notes by the HWN dated 4/04/24 at 1:45pm revealed: -Resident #1 was found in a residential area nearby.		

-Resident #1 was assessed by her PCP 4/04/24 after the resident's elopement. -Resident #1 exhibited altered mental status and was severely impaired. -Resident #1 believed she was a college student and studying. -The PCP ordered a urinalysis (UA) to rule out a urinary tract infection (UTI). -Resident #1 was placed in the SCU for safety upon return, until the UA results came back. -The PCP ordered SCU placement on 4/04/24 for Resident #1. -The Power-of-Attorney (POA) agreed with SCU placement. -Resident #1 was moved to the SCU on 4/04/24 at 5:15pm. Telephone interview with the Power-of-Attorney (POA) on 4/11/24 at 4:15pm revealed: -Resident #1 dementia and confusion increased in 2022. -He notified the facility RCC of Resident #1's history of exit-seeking, wandering, and an attempted elopement at a previous facility after Resident #1's elopement on 4/04/24. -Resident #1 attempted to leave the previous facility but did not get far from the doors of that facility. -Resident #1 had skilled nursing rehabilitation for a traumatic brain bleed injury from a fall at the previous facility. -The facility was concerned about Resident #1 on AL, but there were no SCU beds at the time of Resident #1's admission. -He asked the facility for a wandering device for Resident #1 upon admission. -He did not inform the facility of Resident #1's attempted elopement and wandering behaviors at the previous facility. -Admitting staff did not ask for an indication for a wandering device and told him, wandering devices were not used at the facility. -Resident #1's memory declined over the past 4-6 months. -Resident #1 could ambulate 200 feet with her rollator. -Resident #1 was not safety aware, so she did not use her rollator at times. -Resident #1 rarely went outside unless it was with staff on the back patio. Telephone interview with Resident #1's PCP on 4/10/24 at 11:45pm revealed: -Resident #1 had a history of dementia, confusion, stroke, traumatic brain injury, multiple falls with injuries, hypertension, and osteoarthritis in her knees. -She expected staff to provide supervision for AL residents, including Resident #1. -She agreed with the facility's supervision plan to have staff in the halls to monitor Resident #1.	SLUMS Test & medical history will be provided to pcp at residents' admission and upon change of conditions. Responsible persons are: HWDI RCC/MCD/MCC. Residents with any mental illness, brain disorders, and/or disorientation will be added on pcp's to-see list to have Geri-Psych Services arranged at admission and upon change of conditions. HWDI RCC/MCD	6/1/24 & Ongoing 6/1/24 & Ongoing

-Resident #1's knee pain did not allow her to ambulate far. -Resident #1 began a slow, steady cognitive decline over the past few months. -Resident #1's memory lapses with repetitive comments increased with each visit. -She did not modify Resident #1's care plan related to supervision when Resident #1 began to decline; the facility was responsible for Resident #1's supervision plans. Interview with a Personal Care Aide (PCA) on 4/19/24 at 1:35pm revealed: -The AL residents were checked every 2 hours. -Resident #1 could be confused and forgot where her room and dining room were, so staff would re/direct Resident #1. -She was not given special instructions for supervision or care of Resident #1. -She was coming back from her lunch break on 4/04/24, when staff reported, Resident #1 was gone (had eloped). -She did not know who covered for her when she went on break 4/04/24. -She did not know what door Resident #1 exited 4/04/24. Interview with the PCA assigned to Resident #1's hall on 5/06/24 at 11:15am revealed: -Resident #1 became confused conversing believing family members were visiting when they were not present or forgetting facts common to her. -Resident #1 knew her name and how to find her room. -She was told to check on Resident #1 every 2 hours without further special instructions. -She was not assigned on Resident #1's A-Hall on 4/04/24 but on one side of B-Hall and D-Hall. -She clocked out at 12:00pm on 4/04/24. -She did not remember covering any staff's break on 4/04/24. -The last time she saw Resident #1 was at breakfast. Telephone interview with a homeowner on 4/23/24 at 4:00pm revealed: -He was in his front yard doing yard work on 4/04/24 around 12:00pm, when he saw Resident #1 on his neighbor's front porch. -Resident #1 then began to wander around the cul-de-sac. -He did not recognize Resident #1 as a neighbor. -Resident #1 wore a call pendant. -Resident #1 appeared feeble and walked slow and wobbly with her rollator. -He intervened, meeting her halfway, when Resident #1 began walking down his steep driveway with her rollator, fearing she would fall.		

-He tried to apply the rollator's brakes, but the brakes did not work, so he had to physically hold her and her rollator, while holding onto his rollator. -Resident #1 could not remember her name. -Resident #1 kept asking to go to another city. -Resident #1 reported crossing a couple streets. -He called the facility to notify them of Resident #1's location. -Two staff picked up Resident #1 10 minutes later and returned her to the facility. Interview with a MA/PCA on 4/17/24 at 11:35am revealed: -On 4/04/24, she had ended her shift at 12:30/1:00pm and turned her pager off. -A local citizen called the facility 4/04/24 at 1:00pm to report Resident #1 walking around their cul-de-sac. -She and the Sales Director (SD) immediately took the facility van to get Resident #1. -The citizen reported, Resident #1 stopped at his neighbor's driveway. -The citizen intervened when Resident #1 rested on her rollator at the top of his steep driveway. -The citizen reported, Resident #1 could not remember her name or where she lived. -Resident #1 appeared calm, confused, and without injuries. -Resident #1 told her, she was headed to a city 2 hours away. -Resident #1 returned to the facility willingly with her and the SD. -Resident #1 did not recognize the facility as where she lived. -Upon return around 1:30pm, they took Resident #1 to her room. -Resident #1 reported her leg felt stiff but declined pain medication. -The PCP was already in the facility, so the PCP assessed the resident, wrote orders for a UA and SCU placement. -The MAs alternated, keeping Resident #1 with them to supervise, until Resident #1 was placed in the SCU later the afternoon of 4/04/24. -She did not think Resident #1 had eloped before. Interview with the Sales Director (SD) on 4/18/24 at 2:00 pm revealed: -Resident #1 was with PT the morning of 4/04/24. -The 2nd MA/PCA received a call at 1:00-1:30pm Resident #1 was found in a nearby neighborhood. -She grabbed the van keys; then she and the MA drove to pick up Resident #1. -As the 2nd homeowner worked in his front yard, he noticed Resident #1 stop at his mailbox at the top of his driveway, realizing she was not a neighbor.		

-Resident #1 was pulling weeds at another citizen's yard at 1:15pm. -Resident #1 had her rollator with her. -Resident #1 had no visible injuries. -Upon return to the facility 4/04/24 at approximately 1:30/1:45pm, the MA/PCA took care of Resident #1 from there. -She was unaware of Resident #1 eloping from the facility before. Review of Resident #1's PCP evaluation dated 4/04/24 revealed: -The facility requested her to conduct a post-elopement assessment of Resident #1 on 4/04/24. -Resident #1 walked a long distance to another neighborhood. -Resident #1 was found wandering around a cul-de-sac. -Resident #1 thought she was in the city she grew up, visiting friends. -The PCP performed a mini-mental assessment. -Resident #1 was oriented to self, only. -Resident #1's dementia appeared more progressed. -Resident #1's memory continued to be severely impaired. -Resident #1 could not perform basic figure drawings. -Resident #1 had no visible injuries and no UTI. -There was concern Resident #1 would elope, again, due to her severely impaired memory and judgement. -She recommended a sitter or SCU placement. Telephone interview with Resident #1's PCP on 4/10/24 at 11:45pm revealed: -Resident #1's judgment gradually declined over the past month. -She was at the facility already when Resident #1 was returned to the facility by staff sometime the afternoon of 4/04/24. -She was already at the facility when Resident #1 eloped. -She performed physical and abbreviated mental assessments of Resident #1. -Resident #1's dementia and judgement appeared to have further declined. -Resident #1's orientation was limited to self. -Resident #1's memory continued to be severely impaired. -Resident #1 thought she was visiting friends in another city. -She recommended a sitter while waiting for UA results. -When the UA was negative for a UTI, Resident #1 was moved to the SCU.		

Telephone interview with Resident #1's POA on 4/11/24 at 4:15pm revealed: -The facility informed him on 4/04/24 Resident #1 eloped on 4/04/24. -He was not informed how long Resident #1 was gone. -Resident #1 appeared calm, with her usual confusion, and without injuries upon her return to the facility on 4/04/24. -On 4/04/24, Resident #1 thought she was living in another city where she grew up. -He observed staff check on Resident #1 in her room 10/2023 to 4/2024. Interview with the Resident Care Coordinator (RCC) on 4/15/24 at 5:00pm revealed: -Resident #1 was confused what days she had showers and needed stand-by assistance with bathing and dressing. -There were 15 residents with disorientation &/or dementia on AL. -All AL residents were on 2-hour supervision checks. -Increased supervision was not required for residents with dementia or otherwise disoriented if they passed the SLUMS test. -Residents were re-evaluated with the SLUMS test when disorientation or functioning appeared to decline. -Resident #1's supervision plan was for 2-hour checks since she passed the SLUMS test. -Resident #1 was not assessed as high risk for elopement since Resident #1 could only ambulate from her room to the dining room. -PT and PCP assessment updates and orders were read by her and the HWN. -The PT and PCP did not inform the facility Resident #1 was found to have increased confusion prior to 4/04/24. -She did not know when Resident #1 eloped since she was in a manager's meeting from 12:00pm-1:30pm. -She was not aware of an autumn 2023 or other previous elopement for Resident #1. Interview with the Executive Director (ED) on 4/15/24 at 5:45pm and 4/25/24 at 11:35am revealed: -She did not know how many AL residents had dementia &/or disorientation. -Resident #1 had a Traumatic Brain Injury (TBI). -Resident #1 passed the SLUMS test with a score above 20 and appeared oriented to person and place. -She would not admit anyone to AL who scored below 15 on the SLUMS test. -Residents were re-tested with the SLUMS test when increased disorientation and/or daily functioning was noted by staff.		

-Resident #1 resided on AL, so she was on 2-hour checks. -Resident #1 had no known history of wandering, exit-seeking, or elopement behaviors. -She was not made aware of a citizen report of Resident #1 eloping in the fall of 2023 or at any other time. -Resident #1 was at her usual, cognitive baseline 4/0/4/24. -Resident #1 had finished PT the morning of 4/04/24. -Resident #1 told the PT she was not finished with PT. -Staff reported, Resident #1 continued to walk in the facility. -She did not know what door Resident #1 exited on 4/04/24. -She was in a meeting with a family on 4/04/24, when a MA received a call from a citizen who found Resident #1 on 4/04/24 at 1:05pm. -The PCA scheduled to work on Resident #1's hall (A-Hall) on 4/04/24 worked on another hall, D-Hall. -A 3rd PCA 'floated' between A-Hall and D-Hall.		
The facility failed to provide supervision for 1 of 5 residents, Resident #1, who resided on Assisted Living who had a steady cognitive decline over the previous month and eloped into residential and business areas without the facility's knowledge. This failure resulted in substantial risk for injury and constitutes a Type A2 Violation.		
The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 4/09/24.		
CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED: June 15, 2024.		
Rule/Statute Number: **Physical Plant, 10A NCAC 13F .0305 (h),(4)**	☐ POC Accepted _____ *DSS Initials* Door chimes/Alarms and doorbells hallebeen installed to all exit doors in AL-maintenance Director ED, HWD, RCC or designees.	completed. 5/7/24
Rule/Statutory Reference: ***Physical Plant,*** **(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.	All alarms on ABD halls will be monitores closely that they are working properly on all shifts Responsible: HWD, RCC ED or designees.	5/7/24 ongoing
Level of Non-Compliance: Type A2 Violation		
Findings: Based on observations, interviews, and record reviews the facility failed to ensure 7 of 7 Assisted Living (AL) exit doors accessible to residents with dementia were armed with a sounding device that activated when opened.		

The Findings are:

Observations upon entrance to the facility on 4/09/24, 4/15/24, 4/17/24, 4/18/24, and 4/25/24 at intermittent times throughout the day from 9:00am until 5:30pm revealed:
-The Executive Director's (ED) office, with intermittently open or shut door, was beside the front door.
-A concierge sat at a desk in an office approximately 4 feet from the front door.
-There was no audible sounding alert when the facility's front entrance door was opened.
-The door was unlocked.

Door chimes/Alarms & doorbells is included to be one part of general orientation for new employees. — Maintenance Director & ED. 4/30/24 & Ongoing

Observation of the exit door at the end of the North, A-Hall activity room of the facility on 4/18/24 at intermittent times from 2:13pm until 4:00pm revealed:
-A cleaning cart was beside the exit door.
-The exit door was propped open with a 6-inch-long block of wood.
-The exit door was unlocked.
-There was no device that audibly sounded when the door was opened.
-The exit door opened out onto a wide, screened-in porch with unlatched door.
-The porch opened out onto to a facility road, maintenance garage, thin wooded patch, residential area straight out in front.
-The facility road connected to a facility sidewalk which led to the front parking lot and city sidewalk.
-Staff did not arrive when exit door was opened and did not audibly sound on 4/18/24.

Education of all staff members on door chimes, alarms rounds & supervision provided by managers on 5/1, 5/15 & 6/3. 5/1/24 5/15/24 5/29 6/3/24

Observation of the activity room midway on the A-Hall on 4/18/24 at intermittent times from 2:13pm until 4:00pm revealed:
-The double French exit doors were propped open wide.
-No staff was nearby.
-There was no device that audibly sounded with the doors open.
-This exit opened onto a paved, landscaped patio without surrounding fence.
-The patio opened directly on to an open field with a long, wide patch of wooded area beyond, with a residential neighborhood on the other side.

Sign in & sign out binders have been placed at front entry for residents families, visitors and 3rd party providers to sign in and out entering & leaving community, in addition to Accushield. — ED & Concierge. 5/1/24

Observation of the exit door at the end of the East, B-Hall on 4/18/24 at intermittent times from 2:13pm until 4:00pm revealed:
-The exit door was unlocked.

-There was no device that audibly sounded when the door was opened.
-The exit door opened onto a long, screened-in porch with unlatched door, which led to the facility sidewalk, parking lot, and connected to the city street.
-Staff did not arrive when exit door was opened on 4/18/24.

Observation of the dining room door centered between the halls on 4/18/24 at intermittent times from 2:13pm until 4:00pm revealed:
-The dining room exit door was propped open wide to a sidewalk that wrapped around the back of the dining room to a patio without fence.
-The patio opened directly on to a wide-open field with long, thick patch of woods, with a residential area beyond it.
-A staff, residents, and an entertainer were on the patio.
-No staff was in the dining room.
-There was no device that audibly sounded with the door open.

Observation of the exit door at the end of the South, D-Hall on 4/18/24 at intermittent times from 2:13pm until 4:00pm revealed:
-The exit door was unlocked.
-There was no device that audibly sounded when the door was opened.
-The exit door opened out onto a long, screened-in porch with unlatched door, which led to a facility sidewalk and road.
-The facility sidewalk wrapped around to the front of the facility.
-A narrow lawn separated the exit door sidewalk from bushes separating a lawn that surrounded a large church and parking lot.
-The church property was situated next to a large elementary school, with 2 parking lots in the front, 9 smaller buildings in the back with a bus parking lot, and woods behind it.
-Staff did not check when the exit door was opened on 4/18/24.

Observation of the facility alarm system on the AL on 4/25/24 at intermittent times from 2:00-3:00pm revealed:
-The D-Hall exit door opened.
-A visual and barely audible alert showed on the alarm monitor at the nurse's station that the D-Hall door opened.
-No staff checked the D-Hall exit door from approximately 2:00pm-3:00pm.

Observation of the activity room on the D-Hall on 4/18/24 at intermittent times from 2:13pm until 4:00pm revealed:
-The door was unlocked.
-There was no device that audibly sounded when the exit door was opened.
-No staff checked the D-Hall activity room exit door from approximately 2:00pm-3:00pm.

Interview with a Medication Aide (MA) on 4/15/24 at 10:00am revealed:
-About 12-15 AL residents were confused and disoriented since admission.
-Exit doors alerted the main alarm system.
-Resident pendants alerted staff pagers.
-Alarm system and pagers worked without problems 4/04/24.
-Staff were expected to immediately check any exit door that alerted the alarm monitor at the nurse's station.

Telephone interview with a MA on 4/14/24 at 3:30pm revealed there were 15 AL residents with dementia.

Interview with a MA on 4/17/24 at 11:35am revealed:
-Door alarms were to be activated at all times.
-Opened exit doors alerted staff pagers and alarm monitor at the central nurse's station.
-Exit doors alerted staff's pagers and the nurse's station alarm.
-Staff were expected to immediately check an exit door that alerted on the main alarm system.
-Alarms were de-activated at the nurse's station alarm monitor or on wall keypads by some exit doors.

Interview with the Maintenance Director (MD) on 4/25/24 at 12:15pm revealed:
-The MD who worked on 4/04/24 no longer worked at the facility.
-He began as MD on 4/16/24.
-Opened doors relayed an alert to the main alarm monitor at the nurse's station.
-All staff were expected to immediately check an alerting exit door.
-He was still learning the alarm system and was unaware of any alarm or pager issues.

V. CAR Received by:	Administrator/Designee (print name): Valerie Davis / Pam Mayo
	Signature: Date: 5/15/24
	Title: Administrator

VI. Plan of Correction Submitted by:	Administrator (print name): Valerie Davis
POC DUE BY: June 6, 2024	Signature: Date: 6/5/24

VII. Agency's Review of Facility's Plan of Correction (POC)	
☐ *POC Not Accepted*	By: Roberta Schmidt-Beebe Date: 6/5/24, 6/14/24, 6/27/24
Comments:	
POC approval contingent on recommendations added to include medical(psych.) history with SLUMS test for PCP evaluation upon admission and upon change of condition, (2.) Residents' diagnosis on FL-2s/documentation with diagnosis of "mental illness", brain disorders, and/or disorientation will receive PCP and geri-psych. evaluation for placement and follow-up pysch. care upon admission and upon change of condition.	
☒ *POC Accepted*	By: Roberta Schmidt-Beebe Date: 6/27/24
Comments:	

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		

Interview with the Resident Care Coordinator (RCC) on 4/15/24 at 5:00pm revealed: -There were 15 residents with disorientation &/or dementia on AL. -Call pendants alerted staff pagers. -Exit door openings alerted the main alarm monitor at the nurse's station but not staff pagers. -All staff were expected to immediately check any alerting exit door. -Pagers and alarm system were functioning without problems prior to and on 4/04/24. Interview with the Executive Director (ED) on 4/15/24 at 5:45pm and 4/25/24 at 11:35am revealed: -She did not know how many AL residents had dementia &/or disorientation. -Facility cameras did not show persons exiting the facility. -Opened exit doors alerted staff pagers and on the alarm system monitor at the nurse's station. -The alarm system and staff pagers worked without problem prior to and on 4/04/24. -She expected staff to immediately check any alerting door. -The front door was not alarmed. -Exit door openings were relayed to the monitor but had no audible sound at the doors or inside the facility. -She did not know exit doors assessable to AL residents with disorientation &/or dementia were required to sound. [Refer to A2 Violation *Personal Care & Supervision, 10A NCAC 13F .0901(b).*]		
The facility failed to ensure each exit door accessible by residents who are determined by a physician or are otherwise known to be disoriented or a wanderer had a functioning alarm or alert system device that activated when the door was opened. This failure resulted in substantial risk for injury and constitutes a Type A2 Violation.		
The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 4/29/24.		
CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED: June 15, 2024.		

IV. Delivered Via:	Electronic Delivery	Date: 5/15/24
DSS Signature:	Roberta Schmidt-Beebe	***Return to DSS By*: 5/15/24**

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	
POC DUE BY: June 6, 2024	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☒ *POC Not Accepted*	By: Roberta Schmidt-Beebe	Date: 6/5/24, 6/14/24
Comments: POC approval contingent on recommendations added to include medical(psych.) history with SLUMS test for PCP evaluation upon admission and upon change of condition, (2.) Residents FL-2s with "mental illness", brain disorders, and/or disorientation will receive PCP and geri-psych. evaluation for placement and follow-up psych. care upon admission and upon change of condition.		
☐ *POC Accepted*	By:	Date:
Comments:		

diagn

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		