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)**		
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.		

-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. 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). 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.		

-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.		

-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 4^{th}/5^{th} 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.		

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.

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. 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. 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.		

-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*	
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.		
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.

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.

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.

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.

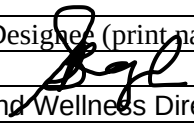
Telephone interview with a MA on 4/14/24 at 3:30pm revealed there were 15 AL residents with dementia.

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.

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): Sunny Ragenel
	Signature:  Date:05/15/2024
	Title: Health and Wellness Director

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:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
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.*			