Adult Care Home Corrective Action Report (CAR) #3

I. Facility Name: One Choice Family Care Home
Address: 7305 Perry Creek Rd, Raleigh, NC 27616
II. Dates/Visits: 9/17/25, 9/25/25, 10/06/25, 10/10/25, 10/13/25

County: Wake
License Number: FCL-092-284
Purpose of Visits: Routine Monitoring
Exit/Report Date: 11/04/25

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 CAR. 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, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *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: 10A NCAC 13G .0901 (b), Personal Care & Supervision	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: 10A NCAC 13G .0901 PERSONAL CARE & SUPERVISION (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	Based on the findings the Administrator had the staff to have the resident close by. Also the Administrator had the resident one on one until a Placement was made for him. Moving forward 11/5/25 the Administrator will not admit anyone with cognitive & memory changes
Level of Non-Compliance: Type A1 Violation	
Findings: Based on observations, interviews, and record reviews, the facility failed to ensure the supervision of 1 of 5 sampled residents (#1), who had a diagnosis of cognitive impairment with disorientation, and wandering behaviors who eloped twice from the facility.	

11/5/25

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13G .0901(b); 13G .0206(a)-(b)

The findings are:

Observation of the facility on 09/17/25 at 1:40pm and 09/25/25 at 10:30am revealed:
-The Supervisor was the only staff who was working in the Family Care Home (FCH).
-1 of 5 residents (#1) appeared disoriented and confused.
-Resident #1 did not have logical speech.
-The front door did not audibly sound when opened.
-The side door audibly sounded when opened but stopped when door closed.

Review of Resident #1's current FL-2 dated 08/20/25 revealed:
-Diagnoses included bradycardia (abnormally low heart rate).
-Resident #1 was disoriented.
-Resident #1 was ambulatory with urinary incontinence.
-The level of care was FCH.

Review of Resident #1's Resident Register revealed:
-Resident #1 was admitted to the FCH on 08/27/25.
-Resident #1 required orientation to time and place.

Review of Resident #1's Care Plan dated 09/02/25 revealed:
-Resident #1 was confused and disoriented.
-Resident #1 required supervision with bathing, dressing, and grooming.

Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 09/02/25 revealed:
-Resident #1 required prompts, due to confusion and disorientation.

a.) Review of Resident #1's Incident/Accident (I/A) Report dated 09/02/25 revealed:
-Resident #1 eloped from the FCH on 09/02/25 at 12:10pm.
-The Supervisor reported Resident #1's elopement to local Law Enforcement (LE) on 09/02/25 at 12:10pm, per FCH policy.
-A sheriff found Resident #1 in a heavy city traffic area (address and time not documented).
-LE returned Resident #1 to the FCH (time not documented).
-Resident #1 did not appear injured.
-The physician and family member were notified.

moving forward, 11/5/25 the administrator of the Family Care Home will ensure that before admitting any resident into the home she will make sure to gather information from both the potential resident's family and PCP to ensure he/she is suitable for the facility.

The Administrator will also ensure that the staff will be trained on how to deal with residents who are an elopement risk.

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Review of Resident #1's LE Report dated 09/02/25 revealed:
-The FCH Supervisor reported Resident #1 missing on 09/02/25 at 12:15pm.
- LE assigned could not find Resident #1 in the area.
-LE reported Resident #1 as a missing person to the county Sheriff's Department on the afternoon of 09/02/25.

Review of Resident #1's Emergency Medical Service (EMS) Report dated 09/02/25 revealed:
-LE found the resident wandering in busy city street areas the evening of 09/02/25.
-EMS assessed Resident #1 at 09:14pm on 09/02/25.
-Resident #1 smelled of urine.
-Resident #1 was cold to the touch from the outside night temperature.
-Resident #1 complained of his feet hurting from walking for a long time.
-Resident #1 had a history of his left arm paralysis, due to a stroke.
-Resident #1 presented with an altered mental status.
-Resident #1 was oriented to person but not place or time.
-A family member reported he wandered around another city nearby in July 2025 before being transported to a hospital.
-Resident #1 was transported to a local hospital.

Telephone interview with an EMS paramedic on 10/13/25 at 4:41pm revealed:
-The County Sheriff's Department received a call on 09/02/25 at 8:45-9:00pm about Resident #1 missing.
-EMS received a call from the county Sheriff's Department on 09/02/25 on the missing resident at 9:01pm.
-EMS found the resident 10-14 miles from his FCH, wandering on and beside a busy county road on 09/02/25 at 9:14pm.
-The county road had several curves with blind spots and was 1/4 of a mile from a large lake.
-Resident #1 tried to keep walking when EMS asked him where he was headed.
-Resident #1 initially reported heading to his family member's home.
-Resident #1 then stated he was headed to another family member's home.
-Resident #1 was cold to the touch, since the temperature was in the 50's that evening.
-Resident #1 was not oriented to place or time, only to self.

The facility Administrator will discharge a resident with a cognitive impairment as he/she declines to a non-ambulating facility 11/5/25

The facility nurse will train the staff on intervention and supervision as related to a resident at risk for elopement in areas of agitation and change in behavior 11/5/25

The facility will continue to provide one on one to a resident until a placement is made for him/or 11/5/25.

Per this report/finding the facility Administrator will ensure the resident appropriate for the facility will only be admitted to prevent further occurrence(s) of any potential elopement(s). This will commence on 11/5/25

-Resident #1 smelled of urine and alcohol.
-Resident #1 complained of foot pain from walking a far distance.
-Resident #1 did not appear to have injuries.
-Resident #1 was transported to a local hospital ED.

Review of the city's weather on 09/02/25 revealed the high was 79 degrees and the low was 51 degrees.

Telephone interview with a local LE Officer on 10/06/25 at 2:00pm revealed:
-Resident #1's facility reported the resident missing on 09/02/25 at noon.
-He received a call on 09/03/25 at 11:15am from a hospital 9.3 miles away that Resident #1 was hospitalized after wandering in the community.
-When he arrived at the hospital, medical staff began to assess Resident #1.
-Resident #1 appeared disoriented and confused.
-Resident #1 knew his name but did not know where he was.
-Resident #1 did not know when and how he left the FCH.
-Hospital staff notified Resident #1's family member, the resident was in the hospital.

Review of Resident #1's Hospital Discharge Summary dated 09/02/25 revealed:
-Resident #1 was found by EMS on 09/02/25 wandering over busy city streets, 9 miles away from the FCH.
-Resident #1 arrived at the Emergency Department (ED) at 10:15pm on 09/02/25.
-Resident #1 was confused about which family member he lived with and thought he lived in another city.
-Resident #1 reported he lived in a new neighborhood now.
-Resident #1 reported he left his family member's house on 09/02/25 to walk around.
-Resident #1 appeared oriented to self.
-Diagnoses included altered mental status, chest and abdominal discomfort, electrolyte abnormality, and acute kidney injury.
-Prior to his FCH admission, Resident #1 was hospitalized on 07/28/25 for 2 days after wandering another city's highway.
-On 07/28/25, Resident #1 was treated for acute kidney injury, alcohol use disorder, acute metabolic encephalopathy, and hyponatremia.
-Resident #1 reported alcohol consumption on 09/02/25.

The facility Admin Director will do her due diligence to make sure the proper information is collected from the family, resident's PCP or other specialist as related to the potential resident's conc

-Resident #1 complained of chest pain and abdominal discomfort.
-Resident #1 had no injuries or new conditions.
-Resident #1's family member reported Resident #1 lived at the FCH.
-The FCH Supervisor was called on 09/03/25 at 1:00pm for Resident #1's discharge.
-The Administrator picked Resident #1 up from the hospital on 09/03/25 at 2:26pm.

Telephone interview with Resident #1's primary care provider (PCP) on 09/29/25 at 2:02pm revealed:
-She began care of Resident #1 in August 2025.
-Resident #1's cognitive and memory conditions were diagnosed by another provider prior to August 2025.
-Resident #1's exhibited clear cognitive and memory impairments in August 2025.
-Resident #1 could not formulate logical sentences.
-Resident #1 scored "8"/severe dementia (Score 0-17) on the Mini Mental State Exam (MMSE) she administered 2 weeks ago. (A MMSE is an abbreviated, pre-assessment test of cognition and orientation administered by medical, therapy, and social worker professionals.)
-She expected the FCH to provide constant supervision of Resident #1.
-Resident #1 was not safe to leave the FCH without supervision, due to the resident's cognitive impairment.
-The FCH notified her that Resident #1 eloped into busy city traffic areas on 09/02/25.
-She diagnosed Resident #1 on 09/11/25 with cognitive impairment and to have wandering behavior.
-The FCH staff reported Resident #1 experienced anxiety.
-She made a referral for mental health services in September 2025.
-The mental health provider was not taking new patients, so she recommended the FCH seek another mental health provider.

Interview with the Supervisor on 09/17/25 at 1:50pm and 10/10/25 at 4:00pm revealed:
-Only the Supervisor was scheduled to work at the FCH.
-Resident #1 was confused and required orienting and cues.
-Resident #1 was too disoriented to be without supervision.
-Resident #1 eloped on 09/02/25 at 12:10pm.

-Resident #1 was sitting in the living room on 09/02/25 at 12:00pm.
-Resident #1 eloped on 09/02/25 at 12:10pm while unsupervised when the Supervisor was in the bathroom.
-When the Supervisor left the bathroom 10 minutes later, he noticed Resident #1 was missing from the living room.
-The exit doors did not audibly alarm.
-The side door did not alarm, and the front door had no alarm.
-The Supervisor looked both ways down the street but did not see Resident #1.
-FCH policy required the Supervisor to remain at the FCH with the other residents, instead of pursuing an eloping resident.
-He notified LE of Resident #1's elopement on 09/02/25 at 12:10pm, per FCH policy.
-LE found Resident #1 in a heavy city traffic area (time and location was not known) 09/02/25 sometime after 6:00pm.
-The Administrator picked Resident #1 up from the hospital the afternoon of 09/03/25.
-Resident #1 could not say where he was.
-Resident #1 was not injured and appeared oriented.
-Resident #1's PCP performed a routine evaluation of Resident #1 on 09/11/25.
-The PCP assessed Resident #1 as having cognitive impairment and to have wandering behaviors.
-Resident #1's supervision plan did not change.
-Additional staff were not scheduled for supervision.
-The PCP did not order a change in Resident #1's level of care.

b.) Review of Resident #1's Incident/Accident (I/A) Report dated 09/12/25 revealed:
-Resident #1 eloped on 09/12/25 at 11:55am when the Supervisor was preparing lunch.
-The Supervisor notified Law Enforcement (LE), the Administrator, and the responsible party.
-LE found Resident #1 in a heavy city traffic area (time and address unknown).
-LE did not know the route Resident #1 walked.
-LE returned Resident #1 to the FCH at 3:00pm.
-Resident #1 appeared oriented and without injuries.

Observation of the possible routes Resident #1 may have taken on 09/12/25 revealed:
-Intersecting 6 lanes and 4 lanes of heavy city traffic.
-Busy city intersecting 6-lane highway road with a 5-lane road.
-The posted speed limit was 45 and 55 mph.

The front door chime has been changed to one that is more audible upon opening the door

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-There was an 8-lane, heavy traffic toll road with overpass and 4 exits. -There was a long, wide river and a large, 28-mile-long lake. Review of a LE Report dated 09/12/25 revealed: -Resident #1 was reported missing 09/12/25 at 11:50am. -The FCH Supervisor reported, Resident #1 suffered from memory impairment and early dementia. -LE found Resident #1 on 09/12/25 at 2:00pm near a busy city intersection 9 miles away. -The route Resident #1 took on 09/12/25 was not documented. Telephone interview with Resident #1's primary care provider (PCP) on 09/29/25 at 2:02pm revealed: -The FCH staff reported Resident #1 experienced anxiety. -She was notified by the FCH that Resident #1 eloped a second time on 09/12/25 into busy city traffic areas over 9 miles away. -After Resident #1's 2nd elopement, she recommended locked memory care placement to the Administrator. -The Administrator requested her evaluation of Resident #1 on 09/27/25 for medication intervention for the resident's elopements. -Medication was not indicated for elopement behavior. -She recommended locked memory care for Resident #1 after Resident #1's 2nd elopement. Interview with the Supervisor on 09/25/25 at 2:00pm revealed: -Since August 2025, Resident #1 was not allowed to leave the FCH unsupervised since the resident was disoriented and confused. -Resident #1 frequently stated he wanted to go see his family member, especially when he was stressed. -Resident #1 went outside to smoke with another resident on 09/12/25 at 11:50am, while he prepared lunch. -He asked the other resident to report if Resident #1 tried to leave. -Resident #1 eloped while outside unsupervised on 09/12/25 at 11:55am. -He opened the side door 15 minutes later when lunch was ready, Resident #1 was gone. -He notified LE of Resident #1's elopement on 09/12/25 at 12:00pm. -LE arrived at the FCH at 12:45pm to take a report on Resident #1.	13G .0901(b); 13G .0206(a) (b)

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-LE found Resident #1 in a heavy city traffic area on 09/12/25 (time and location was unknown).
-LE returned Resident #1 to the FCH 09/12/25 at 3:00pm.
-Resident #1 appeared oriented and without injuries upon his return.
-Resident #1's PCP was notified.
-Resident #1 eloped twice to date.
-Resident #1's supervision plan did not change.
-Staffing was not increased to ensure the residents' supervision needs.
-Resident #1 did not have mental health services.
-The PCP ordered Xanax on 09/27/25 for Resident #1's anxiety and wandering behaviors. (Xanax is used to treat anxiety.)

Observation of Resident #1 on 09/25/25 at 11:05am revealed:
-Resident #1 was outside the FCH with the Supervisor and another resident.
-Resident #1 then walked to the driveway by the busy 5-lane city street, opened the Wake County Human Services Adult Home Specialist's (AHS) car, and sat in the car.
-Resident #1 appeared confused and disoriented.
-Resident #1 did not speak.
-Resident #1 required the AHS' cuing and redirection to leave the car and return to the FCH.

Telephone interview with a family member on 09/26/25 at 4:20pm revealed:
-She raised Resident #1 since he was 14 years old.
-Resident #1 was admitted to the FCH on 08/27/25.
-The FCH did not seek Resident #1's medical or behavioral history from her.
-Resident #1's cognition impairment and disorientation began in April 2025.
-She received calls from police and the FCH that Resident #1 eloped 3 times in September, 09/02/25, 09/12/25, and sometime last week (date not reported).
-Each time Resident #1 eloped, he told her he was trying to find his way back home but could not remember how to find her home.
-She did not know where Resident #1 was found at each elopement.

Telephone interview with the Administrator on 09/17/25 at 11:45am and 9/26/25 at 2:09pm revealed:

-She understood she was not licensed for non-ambulatory residents, but Resident #1 had no home.
-A local hospital contacted her for placement of Resident #1.
-She did not get medical history from the family member, due to alleged neglect by family.
-She thought disorientation on Resident #1's FL-2 meant Resident #1 had memory issues.
-Resident #1 did not appear disoriented upon admission.
-Resident #1 regularly asked to go see his family member.
-She told Resident #1, the FCH was his home now.
-Whenever Resident #1 became stressed, he wanted to go to his family member's home.
-She did not know Resident #1 had wandering behaviors.
-Resident #1 eloped from the FCH on 9/02/25 and 9/12/25.
-She did not increase staff for supervision after 09/02/25.
-Resident #1's was first diagnosed with cognitive impairment and wandering behaviors on 9/11/25, after Resident #1's elopement on 9/02/25, during the PCP's routine exam.
-Resident #1's PCP ordered Xanax and redirection last week for Resident #1's wandering and agitated behaviors.
-Xanax was not received or administered to date.
-She directed the Supervisor to keep Resident #1 with him at all times since she could not afford more staff at the FCH.
-She now planned to seek memory care for Resident #1.

Based on observation, attempted interview, and record review, Resident #1 was not interviewable or would understand how to independently evacuate in a fire drill or emergency.

Attempted telephone interview with Law Enforcement (LE) and the Sheriff's Department on 10/03/25 at 10:50am and 10/10/25 at 1:00pm was unsuccessful.

The facility failed to provide supervision for a resident (#1) who had a diagnosis of cognitive impairment with disorientation, and wandering behaviors. Following his admission to the facility, Resident #1 eloped 2 times in 10 days. The first elopement, Resident #1 wandered out of the family care home (FCH), across heavy city traffic areas to the large city's busy downtown area 9 miles where the resident was found by Emergency Medical Services and taken to a hospital. When the resident eloped the 2nd time, he wandered approximately 13+ miles away, across heavy city traffic, and required Law Enforcement to find and return the resident.

Upon admission and after each elopement, the FCH failed to increase supervision to meet Resident #1's residents' needs. This failure resulted in serious neglect and constitutes a Type A1 Violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 10/03/25.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED: 12/04/25.

Rule/Statute Number:
10A NCAC 13G .0302 (b), Design & Construction

☐ POC Accepted

DSS Initials

Rule/Statutory Reference:
10A NCAC 13G .0302, DESIGN AND CONSTRUCTION
(c) A family care home shall not offer services for which the facility was not planned, constructed, equipped, or maintained.

Level of Non-Compliance:

Type B Violation

Findings:

Based on observation, interviews, and record reviews the facility failed to ensure services in an ambulatory-licensed facility that were planned, constructed, equipped, and maintained for a resident (#1) residing in the facility with cognitive impairment, disorientation, and wandering behaviors which prevented the resident from independently evacuating the facility.

The Findings are:

Review of the facility's license effective January 1, 2024 revealed the facility was licensed for 6 ambulatory residents.

Observation of the Facility on 09/17/25 at 1:40pm and 9/25/25 at 10:30am revealed:
-The facility census was 5 residents.
-1 of 5 residents (#1) appeared disoriented and confused.

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Review of Resident #1's admitting FL-2 dated 08/20/25 revealed:
-Diagnoses included bradycardia (abnormally low heart rate).
-Resident #1 was disoriented.
-Resident #1 was ambulatory with urinary incontinence.
-Physician-ordered placement for Family Care Home (FCH) level of care.

Review of Resident #1's Resident Register revealed:
-Resident #1 was admitted to the FCH on 08/27/25.
-Resident #1 required orientation to time and place.

Review of Resident #1's Care Plan dated 09/02/25 revealed Resident #1 was confused and disoriented.

Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 09/02/25 revealed:
-Resident #1 had a bradycardia diagnosis.
-Resident #1 required reminders, due to confusion and disorientation.

a.) Review of Resident #1's Incident/Accident (I/A) Report dated 09/02/25 revealed:
-Resident #1 eloped from the FCH on 09/02/25 at 12:10pm.
-The Supervisor reported Resident #1's elopement to local Law Enforcement (LE) 09/02/25 at 12:10pm, per FCH policy.
-LE found Resident #1 in a heavy city traffic area (exact location not documented).
-LE returned Resident #1 to the FCH (time not documented).
-Resident #1 was not injured.

Review of Resident #1's LE Report dated 09/02/25 revealed:
-The FCH Supervisor reported Resident #1 missing on 09/02/25 at 12:15pm.
-LE could not find Resident #1 on 09/02/25.

Telephone interview with a local LE Officer on 10/06/25 at 2:00pm revealed:
-Resident #1's facility reported the resident missing on 09/02/25 at noon.

-He received a call on 09/03/25 at 11:15am from a hospital 9.3 miles away that Resident #1 was hospitalized after wandering in the community.
-When he arrived at the hospital, medical staff began to assess Resident #1.
-Resident #1 appeared disoriented and confused.
-Resident #1 knew his name but did not know where he was.
-Resident #1 did not know when and how he left the FCH.
-Hospital staff notified Resident #1's family member, Residen #1 was in the hospital.

Telephone interview with EMS paramedic on 10/13/25 at 4:41pm revealed:
-County Sheriff received a call on 09/02/25 at 8:45-9:00pm about Resident #1 missing.
-EMS received a call from the county Sheriff's Department on 09/02/25 on the missing resident at 9:01pm.
-EMS found the resident 10-14 miles from his FCH, wandering on and beside a busy county road on 09/02/25 at 9:14pm.
-The county road had several curves with blind spots and was 1/4 of a mile from a large lake.
-Resident #1 tried to keep walking when EMS asked him where he was headed.
-Resident #1 initially reported heading to his sister's.
-Resident #1 then stated he was headed to his cousin's.
-Resident #1 was cold to the touch, since the temperature was in the 50's that evening.
-Resident #1 was not oriented to place or time, only to self.
-Resident #1 smelled of urine and alcohol.
-Resident #1 complained of foot pain from walking a far distance.
-Resident #1 did not appear to have injuries.
-Resident #1 was transported to a local hospital ED.

Review of the city's weather on 09/02/25 revealed the high was 79 degrees and the low was 51 degrees.

Review of Resident #1's Hospital Discharge Summary dated 09/02/25 revealed:
-Resident #1 was found by EMS on 09/02/25 wandering over busy city streets, 9 miles away from the FCH.
-Resident #1 arrived at the Emergency Department (ED) at 10:15pm on 09/02/25.

In addition to the training and trainings on the supervision of residents according to their needs and how to respond to client in the event of an incident of elopement and providing interventions to prevent it from happening again

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-Resident #1 was confused about which family member he lived with and thought he lived in another city. -Resident #1 reported he lived in a new neighborhood now. -Resident #1 reported he left his family member's house on 09/02/25 to walk around. -Resident #1 appeared oriented to self. -Diagnoses included altered mental status, chest and abdominal discomfort, electrolyte abnormality, and acute kidney injury. -Prior to his FCH admission, Resident #1 was hospitalized on 07/28/25 for 2 days after wandering another city's highway. -On 07/28/25, Resident #1 was treated for acute kidney injury, alcohol use disorder, acute metabolic encephalopathy, and hyponatremia. -Resident #1 reported alcohol consumption on 09/02/25. -Resident #1 complained of chest pain and abdominal discomfort. -Resident #1 had no injuries or new conditions. -Resident #1's family member reported Resident #1 lived at the FCH. -The FCH Supervisor was called on 09/03/25 at 1:00pm for Resident #1's discharge. -The Administrator picked Resident #1 up from the hospital on 09/03/25 at 2:26pm.	This training was held on the 10th of November 2025
Telephone interview with Resident #1's primary care provider (PCP) on 09/29/25 at 2:02pm revealed: -She began care of Resident #1 in August 2025. -Resident #1's cognitive and memory conditions were diagnosed by another provider prior to August 2025. -Resident #1's exhibited clear cognitive and memory impairments in August 2025. -Resident #1 could not formulate logical sentences. -Resident #1 scored "8"/severe dementia (Score 0-17) on the Mini Mental State Exam (MMSE) she administered 2 weeks ago. (A MMSE is an abbreviated pre-assessment of cognition and orientation administered by medical, therapy, or social work professionals.) -She expected the FCH to provide constant supervision of Resident #1. -She diagnosed Resident #1 on 09/11/25 with cognitive impairment and to have wandering behavior. -Resident #1 was not safe to leave the FCH without supervision, due to the resident's cognitive impairment. -The FCH notified her that Resident #1 eloped into busy city traffic areas on 09/02/25. -The FCH staff reported Resident #1 experienced anxiety.	Due to the finding the facility Administrator will ensure the proper Vetting of a resident to make sure they/she is appropriate for admission based on their diagnosis - This will take effect on 11/5/25

-Resident #1 was not capable of knowing when to evacuate a facility in an emergency without cues or prompts.

Interview with the Supervisor on 09/17/25 at 1:50pm and 10/10/25 revealed:
-Only the Supervisor was scheduled to work at the FCH.
-Resident #1 was confused and required orienting and cues.
-Resident #1 was too disoriented to be without supervision.
-Resident #1 eloped on 09/02/25 at 12:10pm.
-Resident #1 was sitting in the living room on 09/02/25 at 12:00pm.
-Resident #1 eloped on 09/02/25 at 12:10pm while unsupervised when the Supervisor was in the bathroom.
-When the Supervisor left the bathroom 10 minutes later, he noticed Resident #1 was missing from the living room.
-The exit doors did not audibly alarm.
-The side door did not alarm, and the front door had no alarm.
-The Supervisor looked both ways down the street but did not see Resident #1.
-FCH policy required the Supervisor to remain at the FCH with the other residents, instead of pursuing an eloping resident.
-He notified LE of Resident #1's elopement on 09/02/25 at 12:10pm, per FCH policy.
-LE found Resident #1 in a heavy city traffic area (time and location was not known) 09/02/25 sometime after 6:00pm.
-The Administrator picked Resident #1 up from the hospital the afternoon of 09/03/25.
-Resident #1 could not say where he was.
-Resident #1 was not injured and appeared oriented.
-Resident #1's PCP performed a routine evaluation of Resident #1 on 09/11/25.
-The PCP assessed Resident #1 as having cognitive impairment and to have wandering behaviors.
-Resident #1's supervision plan did not change.
-Additional staff were not scheduled for supervision.
-The PCP did not order a change in Resident #1's level of care.

b.) Review of Resident #1's Incident/Accident (I/A) Report dated 9/12/25 revealed:
-Resident #1 eloped from the FCH on 9/12/25 at 11:55am while the Supervisor was preparing lunch.
-The Supervisor notified LE, the Administrator, and the responsible party.
-LE found Resident #1 in a heavy city traffic area (time and location unknown).

Moving forward the facility Administrator will ensure that the necessary information is collected from the family & Potential Resident's family before admission so as to stay in compliance from 11/5/25.

Also the facility Administrator has installed an front door alarm that is audible enough to be heard whenever any residents/visitors enter the facility. This was done on the 5th of November, 2025.

-LE returned Resident #1 to the FCH at 3:00pm.
-Resident #1 appeared oriented and without injuries.

Observation of the possible routes Resident #1 may have taken on 09/12/25 revealed:
-Intersecting 6 lanes and 4 lanes of heavy city traffic.
-Busy city intersecting 6-lane highway road with a 5-lane road.
-The posted speed limit is 45 and 55 mph.
-An 8-lane, heavy traffic toll road with overpass and 4 exits.
-A long, wide river and a large, 28-mile-long lake.

Review of LE Report dated 09/12/25 revealed:
-Resident #1 was reported missing 09/12/25 at 11:50am.
-The Supervisor reported, Resident #1 suffered from memory impairment and early dementia.
-LE found Resident #1 on 09/12/25 at 2:00pm near a busy city intersection 9 miles away.
-The route Resident #1 took on 09/12/25 was not documented.

Telephone interview with Resident #1's PCP on 09/29/25 at 2:02pm revealed:
-The FCH staff reported Resident #1 experienced anxiety.
-She made a mental health referral in September 2025.
-The mental health provider declined new patients, so a new provider was recommended.
-She was notified by the FCH that Resident #1 eloped a second time on 09/12/25 into busy city traffic areas over 9 miles away.
-After Resident #1's 2nd elopement, she recommended locked memory care placement to the Administrator.
-The Administrator requested her evaluation of Resident #1 on 09/27/25 for medication intervention for the resident's elopements.
-Medication was not indicated for elopement behavior.
-She recommended locked memory care for Resident #1 after Resident #1's 2nd elopement.

Interview with the FCH Supervisor on 09/25/25 at 2:00pm revealed:
-Since August 2025, Resident #1 was not allowed a Sign-Out Log, or leave the FCH unsupervised, since the resident was disoriented and confused.
-Resident #1 went outside to smoke with another resident on 09/12/25 at 11:50am.

-The Supervisor asked the other resident to report if Resident #1 tried to leave.
-Resident #1 eloped when unsupervised outside on 09/12/25 at 11:55am.
-He opened the side door 15 minutes later when lunch was ready, Resident #1 was gone.
-He notified LE of Resident #1's elopement 09/12/25 at 12:00pm.
-LE arrived at the FCH at 12:45pm to take a report on Resident #1.
-LE found Resident #1 in a heavy city traffic area on 09/12/25 (time and location was unknown).
-LE returned Resident #1 to the FCH 09/12/25 at 3:00pm.
-Resident #1 appeared oriented and without injuries upon his return.
-Resident #1's PCP was notified.
-Resident #1 eloped twice to date.
-Resident #1's supervision plan did not change.
-Staffing was not increased to ensure the residents' supervision needs.
-Resident #1 did not have mental health services.
-The PCP ordered Xanax on 09/27/25 for Resident #1's anxiety and wandering behaviors. (Xanax is used to treat anxiety.)

Observation of Resident #1 on 09/25/25 at 11:05am revealed:
-Resident #1 stood outside the FCH with the Supervisor.
-Resident #1 then walked to a car, opened the door, and sat in the car.
-Resident #1 appeared confused and disoriented.
-Resident #1 did not speak.
-Resident #1 required re-direction to leave the car and return to the FCH.

Telephone interview with Resident #1's PCP on 09/29/25 at 2:02pm revealed after Resident #1's 2nd elopement into heavy city traffic areas on 09/12/25, she recommended locked memory care to the Administrator.

Telephone interview with a family member on 09/26/25 at 4:20pm revealed:
-She raised Resident #1 since he was 14 years old.
-Resident #1 has been disoriented and incontinent since April-May 2025.

-When Resident #1 eloped each time in September 2025, he reported trying to find her home, but he could not remember the way.

Telephone interview with the Administrator on 09/17/25 at 11:45am and 9/26/25 at 2:09pm revealed:
-She understood she was not licensed for non-ambulatory residents, but Resident #1 had no home.
-A local hospital contacted her for placement of Resident #1.
-She did not get medical history from the family member, due to alleged neglect by family.
-She thought disorientation on Resident #1's FL-2 meant Resident #1 had memory issues.
-Resident #1 did not appear disoriented upon admission.
-She did not know Resident #1 had wandering behaviors.
-Resident #1 eloped from the FCH on 9/02/25 and 9/12/25.
-She did not increase staff for supervision after 09/02/25.
-She directed the Supervisor to keep Resident #1 with him at all times since she could not afford more staff at the FCH.
-Resident #1's was first diagnosed with cognitive impairment and wandering behaviors on 9/11/25, after Resident #1's elopement on 9/02/25, during the PCP's routine exam.
-Resident #1's PCP ordered Xanax and redirection last week for Resident #1's wandering and agitated behaviors.
-Xanax was not received or administered to date.
-She now planned to seek memory care for Resident #1.

Based on observation, attempted interview, and record review, Resident #1 was not interviewable or would understand how to independently evacuate in a fire drill or emergency.

Attempted telephone interview with Law Enforcement (LE) and the Sheriff's Department on 10/03/25 at 10:50am and 10/10/25 at 1:00pm was unsuccessful.

The facility failed to ensure services for a non-ambulatory resident (#1), who had cognitive impairment, disorientation, and wandering behaviors, to be admitted in an ambulatory-licensed facility which would prevent the resident from independently evacuating the facility safely. The failure of the facility to ensure services for the resident per the facility's licensed was detrimental to the safety and welfare of the resident and constitutes a Type B Violation.

Facility Name: One Choice Family Care

13G .0901(b); 13G .0206(a)-(b)

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/26/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED: 12/16/25.		

IV. Delivered Via:	Electronically Delivered	Date: 11/04/25
DSS Signature:	Roberta Schmidt-Beebe	Return to DSS By: 11/04/25

V. CAR Received by:	Administrator/Designee (print name): Helen Adewunmi	Date: 11/4/25
	Signature:	
	Title: Administrator	

VI. Plan of Correction Submitted by:	Administrator (print name): Helen Adewunmi	11/12/25
POC Due: 11/25/25	Signature:	Date: 11/12/25

VII. Agency's Review of Facility's Plan of Correction (POC)

☒ ***POC Not Accepted*** By: Roberta Schmidt-Beebe Date: 11/12. 11/17/25. 11/19/25

Comments: Remove commentary; keep Plans to Correct Supervision and Admission deficiencies 11/17/25, 11/19/25: Remove commentary; specify supervision training interventions especially with eloping disoriented residents, (2) How will supervision be increased, until secure unit can be secured for resident? is needed for POC Approval (to align with Rule)

☑ ***POC Accepted*** By: Roberta Schmidt-Beebe Date: 11/20/25

Comments: A Follow-Up monitoring will occur after due date to check for correction.

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.*