Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Haven in Highland Creek
Address: 5920 McChesney Drive
Charlotte, NC 28369

County: Mecklenburg
License Number: HAL-060-162

II. Date(s) of Visit(s): 07/18/25; 07/25/25; 08/09/25; 08/21/25; 09/08/25; 09/17/25

Purpose of Visit(s): Complaint Investigation

Exit/Report Date: 09/17/25

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 13F .0901 (b) Personal Care and Supervision	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: (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 A1 Violation		
Findings: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 5 sampled residents (#1, #2, #3) with a history of wandering and exit-seeking behaviors who eloped from the Special Care Unit (SCU) on two different occasions without staff knowledge. Review of the facility's Wandering and Elopement Policy effective 10/31/07 and revised on 08/01/22 and 03/19/24 revealed: -The purpose of this policy is to provide a system for identification of residents at risk for unsafe wandering and		

elopement, provide a program or supervision and interventions to minimize risk of resident elopements, improve resident safety through timely investigations of elopements and elopement attempts, and provide team member education in effective wandering/elopement management through in-services and elopement drills. -Elopement, all residents will be evaluated to determine their risk of elopement. The Elopement Risk Assessment evaluation will be used to identify further risk for an elopement. -The Elopement Risk Evaluation is completed upon admission; every 6-months; upon a change in status/condition as it relates to unsafe wandering or a significant change in mental status; after wandering or elopement attempt; or as required by state regulations. -Develop and/or update the resident's individualized service plan (ISP) as soon as practical and review with clinical team members if the resident is determined to be at risk for Elopement, and the ISP will include interventions to minimize the potential for resident elopement. Observation of the SCU on 07/18/25 at 10:25 am revealed: -Upon entering the facility, a reception desk was located on the right with a sitting area. -Walking through the doors of the sitting area, a hallway was observed where someone could go to the left or right. -There were double doors that had a keypad on the right. -The receptionist had to enter a code on the keypad to allow entry onto the SCU. -Upon entering the SCU, there was an ice cream parlor and three individual "neighborhoods." -Each neighborhood was observed with the doors opened to allow residents to move freely. -All three neighborhoods had a keypad entry to enter the neighborhood when the doors were closed. -Each neighborhood had keypad entry to exit each neighborhood. -Each neighborhood had a keypad to exit to a covered courtyard and a keypad to re-enter each neighborhood. 1. Review of Resident #1's FL-2 dated 09/15/24 revealed: -Diagnoses included dementia, vitamin B-12 deficiency, and anemia. -Resident #1 was ambulatory, intermittently disoriented, and continent of bowel and bladder. -Resident recommended level of care was a Special Care Unit (SCU).		

Review of Resident #1's Resident Registry revealed that the document was signed on 08/04/22 with the move-in date blank. Review of Resident #1's Face Sheet documented a move-in date of 08/06/22. Review of Resident #1's Special Care Unit Resident Profile date 07/01/25 revealed. -Resident #1's profile was completed by the Resident Care Coordinator Assistant (RCCA). -Resident #1 presented behaviors included wandering, paranoid/delusions, and sundowning. -Resident #1 required cueing/redirection for dressing; grooming; toileting; and eating. -She required partial assistance with bathing. -She was independent with ambulation and transferring. -Resident #1 could assist with dressing, grooming, bathing; toileting; eating; and ambulation. Review of Resident #1's undated Service Plan Report with a print date of 07/18/25 revealed: -She had wondering behaviors and was easily redirected. -She was confused at times and exit seeking. -Staff were to document her wandering behaviors, engage her in activities, and redirect her. -She was ambulatory without assistive devices. -She required supervision due to wandering behaviors. -Staff will provide supervision at my need level to keep me safe and monitor for exit seeking behaviors. -Interventions are moderate and requires some supervision in home and needs attendance when outside of the because she tends to wander. Review of Resident #1's accident/incident report dated 07/13/25 at 2:30 pm revealed: -The report was signed by the RCCA. -Resident #1 was able to leave the SCU with a large group of people visiting. -Resident #1 walked back inside the building. -When staffed realized it was Resident #1, they escorted Resident #1 back into the SCU. -Resident #1 sustained no injuries. -The responsible party and the physician were notified of the incident on 07/13/25. Review of the on-line historical weather for 07/13/25 at 4:52 pm revealed the temperature was 96 degrees Fahrenheit and partly cloudy.		

Review of Resident #1's progress notes revealed: -On 07/13/25, Resident #1 was "missing at around 4:30 pm when staff were trying to prepare dinner, but she was found by the concierge at the front desk coming in the door." The incident was reported to the Manager on Duty (MOD). -There were no interventions documented after the incident on 07/13/25. -On 07/16/25, Resident #1 continued to be exit seeking. "We kept redirecting her. We were not successful at first, so I took her outside to walk around the courtyard, but she kept trying to go to the gates to see if they were opened." -There were no interventions documented after the exit seeking behaviors on 07/16/25. -On 07/17/25, Resident #1 had exit seeking behavior today or resisted redirection. -There were no interventions documented after the exit seeking behaviors on 07/17/25. Review of Resident #1's Elopement Risk Screening completed on 07/13/25 revealed. -The document was completed by the RCCA. -Resident #1 scored a 26 (The document documented, "If the total score was 10 or greater; the resident should be considered to be at risk for elopement and prevention protocols should be followed and documented in the service plan.") -Her mobility was fully ambulatory. -She had a mental status of wandering aimlessly. -Resident #1's history of elopement attempts documented she had one elopement plus attempted elopements. -She was able to be redirected. -She was taking on medication that was considered antipsychotic or mood altering. -She had a diagnoses present of dementia. -Focus on goals for wandering and/or elopement behaviors and her safety. -The task will address wandering and elopement behaviors. -The interventions included wandering behavior and attempted interventions to provide with me with meaningful activities, validation and relationship-based redirection were to be documented. Telephone interview with Resident #1's Responsible Party (RP) on 09/08/25 at 11:34 am revealed: -She was told that Resident #1 left the facility with a crowd of people and was outside for about 10 minutes.		

-When the Regional Director of Operations (RDO) contacted her, she was told that the staff was putting cold paper towels around her neck to cool her off. -She became concerned about the elopement after a family member of another resident contacted her that Resident #1 did not leave the facility with her group of people. -Resident #1 was not sent out for evaluation, and the emergency medical services (EMS) was not called to evaluate her. -She did not request to have Resident #1 sent to the hospital for evaluation. -When she visited Resident #1, staff had to put in a code for her to enter onto the SCU main entrance and the hallway Resident #1 lived on. -If staff had to enter the code to get on and off the secured unit, someone should have recognized that Resident #1 was attempting to leave the SCU. Telephone interview with a visitor on 09/10/25 at 5:12 pm revealed: -She was visiting her family member with four other people. -She and her guests were able to enter the secure unit when the concierge entered the code on the keypad. -She observed Resident #1 messing with blinds on the window. -Resident #1 pushed on the doors trying to exit off the neighborhood, but the doors were locked. -A caregiver came to take Resident #1 to one of the neighborhoods for an activity. -Her and her guests left the facility around 4:00 pm as a group. -Her family member rung the bell for the concierge to enter the code to let them off the secure unit. -Resident #1 was not with her when her group left the facility. -She received a telephone call from the RDO asking if Resident #1 had exited the facility with her group when she left. Telephone interview with a medication aide (MA) on 09/08/25 at 10:05 am revealed: -On 07/13/25, she recalled seeing Resident #1 around 3:00 pm walking around the neighborhood. -When staff started getting residents ready for dinner, Resident #1 was not on the unit. -She received a call from the concierge that Resident #1 had just walked back into the building. -When she arrived in the concierge area, Resident #1 was there with a "very red face".		

-She thought Resident #1 had left with a group of people that afternoon, but she was not sure how she was able to leave the SCU. -She did not notify Resident #1's physician. -She informed the RCCA about the incident. -Resident #1 was placed on 30-minute checks. -The facility now closed the doors at 4:45 pm on each neighborhood to ensure the safety of the residents. Telephone interview with concierge on 09/08/25 at 11:50 am revealed: -She worked the afternoon of 07/13/25 when Resident #1 eloped from the facility. -She recalled letting a family group onto the SCU hallway to go onto the neighborhood for a visit and letting the same group off the SCU on 07/13/25 to the main lobby. -She had to enter a code on the keypad to let the family on the main entrance to the SCU and for the family to get off the SCU to the main lobby. -Resident #1 did not leave with the family group on 07/13/25. -Resident #1 walked into the building "looking distressed with a red face." -She thought a family member had dropped Resident #1 off at the door while they parked the car, but no one ever came into the building. -She radioed for someone to come to the main entrance of the facility. -The MA came to the front of the lobby with a "shocked expression on her face." -The MA asked her where she found Resident #1 because they had been looking for her. -There was never a call to the front that Resident #1 was missing. -The MA said, "Resident #1 must have left with that big family group." -She told the MA that Resident #1 was not with the family group when they exited the building. Interview with the Regional Director of Operations (RDO) on 07/18/25 at 10:40 am revealed: -She was told that Resident #1 went out with a group of people. -Resident #1 walked back into the building. -Staff was unaware that Resident #1 was not in Resident#1's neighborhood where she resided. -She contacted and interviewed the person that Resident #1 allegedly left with.		

-The person assured her that no resident left the building with her group of people. -The facility conducted their internal investigation and determined the issue was the same as a few months ago. -She believed an outside gate was left unattended and unlocked by a maintenance technician. -The maintenance technician had left the gate unlocked for a vendor to cut the grass on the outside courtyard. -The maintenance technician did not inform the staff the gate was unlocked. Observation of the courtyard on 07/18/25 at 12:43 pm revealed: -The walk from the patio to the fence in the courtyard was approximately 317 steps to exit outside the gate (white fence). -The area outside the gate was an uneven grassy hill. -There was a sidewalk on the property. -Standing on the sidewalk on the other side of the fence on the SCU courtyard, there were townhomes visible with a sign to travel 25 miles per hour in the neighborhood. -Down the hill, there was another sidewalk with shrubs. -From the sidewalk on the property, the walk to enter back into the facility was approximately 751 steps using a pedometer to count steps. Interview with the Resident Care Coordinator Assistant (RCCA) on 07/18/25 at 1:00 pm revealed: -He was working at the assisted living facility on 07/13/25 the day Resident #1 eloped. -He came to the facility to pick up extra supplies when he was informed Resident #1 had eloped. -Resident #1's face was "flushed and very red." -The facility was about to start dinner between 4:30 pm to 5:00 pm when the incident happened. -He did not know how long Resident #1 had been outside. -The gate in the courtyard did not have an alarm on it. -The gate in the back was used to gain access for ground keepers. Telephone interview with Resident #1's primary care provider (PCP) on 09/08/25 at 5:57 pm revealed: -She received a fax on 07/14/25 regarding an elopement for Resident #1. -The fax was sent over as a FYI. -Her office never received a phone call about the incident with Resident #1 leaving the SCU. -Resident #1 should have been evaluated if it was unknown how long she was outside in the heat.		

-The facility should have contacted the afterhours office number for guidance on how to treat Resident #1 after being outside in the heat. -"If a licensed registered nurse had seen Resident #1 to check her vitals, she would have been fine with that." -The advice of a medical professional was needed especially with staff reporting her face being "flushed." -Being outside in the heat without supervision put Resident #1 at risk for dehydration, heat stroke, getting lost in a neighborhood, or getting hit by a car. 2. Review of Resident #2's FL-2 dated 05/20/25 revealed: -Diagnoses included dementia and vitamin D deficiency. -Resident #2 was constantly disoriented and had a history of wandering behaviors. -He was ambulatory and incontinent of bowel and bladder. -Resident #2's recommended level of care was SCU. Review of Resident #2's Face Sheet documented a move-in date of 11/20/24. Review of Resident #2's Special Care Unit Resident Profile dated 04/30/25 revealed: -The document was completed by the RCCA. -The behaviors identified for Resident #2 included wandering and sundowning. -His degree of cognitive impairment included lack of orientation to place; lack of orientation to time; impaired short-term memory; and impaired long-term memory. -He was independent with ambulation and transfer. Review of Resident #2's undated Service Plan Report revealed: -Resident #2's Focus for Ambulation included a goal of maintaining his current level of function in ambulation. -The intervention was prompting/assistance to vacate the building in an emergency." -Resident #2's Focus for wandering and/or elopement behavior had a goal of "My safety will be maintained." -Resident #2 had a history of wandering into other resident's rooms inside the community and required supervision and redirection. -Resident #2's Focus for supervision needs had a goal of providing supervision at his need level to keep him safe. -Resident #2 required regular supervision in the home and could not leave home unattended due to Resident #2 being unaware of unsafe areas.		

Review of Resident #2's Elopement Risk Screening completed on 11/21/24 revealed. -The document was completed by the RCCA. -Resident #2 scored an 8 ("If the total score was 10 or greater; the resident should be considered to be at risk for elopement with prevention protocols should be followed and documented in the service plan.") -His mobility was fully ambulatory with a mental status of disoriented, no wandering behaviors. -Resident #2's history of elopement was no attempts. -His behavior management stated no behaviors noted. -He was taking no medication that was considered antipsychotic or mood altering. -He had a diagnoses present of dementia. Review of Resident #2's Elopement Risk Screening completed on 07/19/25 after the elopement revealed. -The document was e-signed by the Direct of Health and Wellness (DHW). -Resident #2 scored a 26 ("If the total score was 10 or greater; the resident should be considered to be at risk for elopement with the prevention protocols should be followed and documented in the service plan.") -His mobility was fully ambulatory with a mental status of wandering aimlessly. -The emotional status was documented as voices desire to leave. -Resident #2's history of elopement attempts documented he had one elopement plus attempts. -He was able to be redirected. -He was taking no medication that was considered antipsychotic or mood altering. -He had a diagnoses present of dementia. -Goals for wandering and/or elopement behaviors and "his safety will be maintained." -The task will address wandering and elopement behaviors. -The intervention included staff would observe his within his location in the community. Review of Resident #2's progress notes revealed: -On 06/27/25, Resident #2 was walking regularly to the double door trying to look if he can go out. "We redirected him." -There were no other interventions documented. -On 07/07/25, Resident #2 was packing all his clothes and came by the door many times. "We redirected him, he went to bed." -There were no other interventions documented.		

-On 07/18/25, Resident #2 was observed at 7:29 pm walking out of the front door of the main entrance of the community with another resident. He was seen by the Business Office Manager (BOM). Both residents were immediately escorted back to the secure unit of the community, Resident #2 was assigned supervision 1 on 1 until further evaluation. The responsible party was contacted by phone at 10:40 pm and made aware of the incident. The responsible party stated, "that he was not surprised and felt confident that Resident #2 could observe and learn the code to the secure doors. The Power of Attorney (POA) informed while Resident #2 may not be verbal, but he was cognitively clear and that he read very well. He was sure the resident could intentionally plan to exit the community." -There were no other interventions documented but the 1 to 1 supervision. -On 07/21/25, Resident #2 was redirected from trying to put in the code at the double doors on the unit during the evening. -There were no interventions documented. -On 07/24/25, Resident #1 was observed trying to punch in the code. He was redirected. Resident #2 continued to be provided 1 on 1 supervision. -There were no other interventions documented. Review of Resident #2's psychiatric note dated 01/03/25 revealed: -Resident #2 was being seen for anxiety. -Resident #2 was observed smiling and kept repeating he wanted a car. -Staff reported Resident #2 was not aggressive but walked around asking for a car. -He did not really follow through on answering questions but focused on wanting a car. -Resident #2 was showing significant memory loss consistent with dementia. -His thought process is linear but simple. -His insight and judgement were poor. -The Power of Attorney (POA) was contacted and agreed with the plan. -Trying Resident #2 on Zoloft was discussed with the POA, but they agreed to wait and see if he settled, and behavior improved in the community. Review of Resident #2's accident/incident report dated 07/18/25 revealed: -At 7:29 pm, Resident was observed by the BOM exiting the front door of the community with another resident.		

-The BOM escorted both residents back in the secured area of the community. -The assistant ED was notified. -The assistant ED notified the regional operational specialist who notified the regional leadership team. -All secured doors and gates were checked to ensure all were secured. -All doors and gates were properly secured. -The BOM interviewed all staff. -Staff were assigned to the neighborhood for the two residents were providing care. -There were no alarms that sounded. -There were no staff that left the community proceeding the incident. -"Based off of operation specialist discussion with family, interviews with staff, and observations of all secured doors, it was determined that the resident acquired the code to the secured doors." -According to the POA, "Resident #2 was cognitively intact reads well, and certainly would be able to observe the code to the secured doors and remember it. The family member believed Resident #2 would be able to and be very intentional about exiting the community." -To ensure the safety of Resident #2, one-on- one supervision was put in place until further evaluations and safety could be put in place. -All codes to the secured doors were scheduled to be changed on 07/19/25 at 8:00 am. -Hoods to cover the keypads to reduce the risk of residents observing the code being entered were ordered for all keypads. Telephone interview with Resident #2's Power of Attorney (POA) on 08/26/25 at 8:43 am revealed: -The facility notified him when Resident #2 eloped from the facility with another resident. -He was told that Resident was in the parking lot for about 10-15 minutes. -This elopement was not Resident #2 first attempt to leave the facility. Telephone interview with Resident #2's family member on 08/26/25 at 1:55 pm revealed: -She visited Resident #2 at least 2-3 times per week. -Prior to Resident #2 successful elopement on 07/18/25, a new receptionist let Resident #2 out of the SCU two weeks prior to his elopement by ringing the doorbell to get off the SCU as if he was a visitor.		

-During the pre-admission process, the facility was informed that Resident #2 was good with remembering numbers. -Resident #2 knew how to read and watch his surroundings. Interview with a Personal Care Aide (PCA) on 08/09/25 at 1:45 pm revealed: -Resident #2 would sit by the door and watch staff enter the code to let visitors in and out of the neighborhood. -Resident #2 had eloped from the facility on two different occasions. -Resident #2's first elopement occurred around March or April of 2025 on second shift. -He made it to a preschool center near the facility. -The Activity person was going to the daycare to pick up someone when she found the resident. -The Activity person took Resident #2 back to the facility. -Resident #2's second elopement occurred with another resident on second shift again when the two residents were found in the parking lot by the Business Office Manager (BOM). -Resident #2 was assigned a private sitter after the second elopement. -Resident #2 was "very smart" and "very alert". -Resident #2 was smart enough to get out of the facility. -The facility had an issue with the alarm system disengaging allowing the SCU to be unsecured. -She was unaware if there was an issue with the alarm system when Resident #2 was able to elope. -She was not advised of any interventions to use with Resident #2 after each elopement, to prevent a future elopement. Interview with a PCA on 07/25/25 at 11:40 am revealed: -A code was needed to get on and off the SCU neighborhood. -A code was also needed to go outside to sit in the secured courtyard. -Staff would take residents out to sit on the patio, and staff would enter the code on the keypad for visitors to sit on the patio with residents. -Visitors would need to knock on the door to get back onto the SCU neighborhood from the outside courtyard. -The lock on the fence gate was a padlock in the courtyard and did not require a code to exit -Residents were never left in the courtyard alone. Telephone interview with the Activity Coordinator on 09/10/25 at 9:23 am revealed:		

-She was getting off work one day and was walking to her car when she observed Resident #2 out the corner of her eye walking towards the daycare center near the facility. -She did not recall the exact date of the incident, but she knew it was before Resident #2 was found in the parking lot by the BOM. -Resident #2 was observed standing to the side of the preschool. -She was able to redirect Resident #2 back to the facility. -She took Resident #2 to his assigned unit where staff were looking for him to eat dinner. -Staff were unaware Resident #2 had eloped from the facility. -She did not know how Resident #2 was able to get past the secured doors almost to the preschool. -She was unaware how staff handled the elopement. -She was unaware of interventions put in place after the incident. -She thought Resident #2 was aware of his surroundings, but she was unsure if he could remember a code to enter on the keypad to get off the SCU. Telephone interview with Resident #2's PCP on 09/08/25 at 1:08 pm revealed: -He was informed that Resident #2 was able to leave the SCU by entering the code on the keypad. -He questioned that Resident #2 was able to enter the code on the keypad due to his dementia diagnosis. -Resident #2 had significant cognitive deficits. -He expected the facility to supervise Resident #2 to prevent an elopement. Telephone interview with Resident #2's Psychiatrist on 09/08/25 at 2:19 pm revealed: -He received referrals from the PCP or the facility made a referral when residents had behavioral issues. -Resident #2 did not communicate well. -Resident #2 was very confused and struggled to remember he was in a facility. -He was made aware that Resident #2 had eloped and allegedly entered a code on the keypad to exit the SCU. -He did not believe Resident #2 could remember a code to enter on a keypad to get out of a facility hours later. -He recommended that Resident #2 was monitored in the common area to keep eyes on him. -He last saw Resident #2 in June of 2025. -Resident #2 would respond with yes or no answers, but his comments were unclear. -Resident #2 continued to have one-on-one supervision.		

-"Given the level of confusion, he would need to be supervised to prevent an elopement." -If Resident #2 was able to get out again, "he would not be able to return on his on." -Resident #2 would be seen as someone walking, but not someone who eloped from the facility. Interview with the BOM on 07/25/25 at 2:05pm revealed: -On 07/18/25, she was sitting in her car waiting for the car to cool down before she left for the evening between 7:00 am to 7:45 pm on. -She observed Resident #2 walk out of the building to the parking lot. -Resident #2 said, "I am free." -She called caregivers to come outside to assist with getting the residents back in the SCU. -Staff offered the resident ice cream to get them back in the facility. -A MA opened the gate and helped her get the resident back inside the building. -She notified the Assistant Executive Director (AED) of the incident. -The AED notified the RDO of the incident. -She pulled the caregivers together and informed them that Resident #2 was observed outside in the parking lot. -Resident #2 would not talk a lot, but he was capable of reading and understanding what you are saying. -She had witnessed Resident #2 in the past trying to punch the code on the keypad. -She would redirect Resident #2 when she observed this behavior. Interview with the RDO on 07/25/25 at 9:40 am revealed: -She conducted an intensive interview regarding Resident #2 and the other resident. -Resident #2 got the code to the door. -The alarm was not activated. -Resident #2 had a diagnosis of dementia, but he was cognitively intact "in a lot of ways." -Resident #2 was nonverbal; however, he could say yes or no. -The POA was not surprised that Resident #2 was able to get out of the facility. -The POA advised that Resident #2 would watch and plan. -The POA believed Resident #2 was capable of remembering the code to enter on the keypad to exit the SCU. -The resident got out the front door. -The BOM saw the resident when she was sitting in car getting ready to leave for the evening.		

-The AED completed the incident report on the evening of 07/18/25.
-A regional meeting was held on 07/19/25 to discuss the incident.
-She interviewed all staff that worked that evening.
-One on one supervision was put in place for Resident #2 until discharge or until a safer plan for Resident #2 was devised.
-Staff was instructed to block the keypad when entering the code.

Telephone interview with the HWD 09/10/25 at 12:18 pm revealed:
-He was aware Resident #2 had eloped in June of 2025 and made it to the nearby preschool.
-The facility interventions for Resident #2 included one on one supervision after the second elopement, hot box charting, and referred to psych services.
-All the elopements occurred on second shift.
-The doors were checked, and the codes were changed.
-The facility did not have cameras to monitor the exit doors.

Refer to telephone interview with the Assistant Executive Director on 09/11/25 at 10:00 am.

3. Review of Resident #3's current FL-2 dated 03/11/25 revealed:
-Diagnoses included dementia; hypertension; pre-diabetes; vitamin D deficiency; hypercholesterolemia; chronic renal disease; and obesity.
-Resident #3 was intermittently disoriented.
-She was ambulatory and continent of the bowel and bladder.
-Resident #3 's recommended level of care was SCU.

Review of Resident #3's Face Sheet revealed an admission date to the facility as 03/10/25.

Review of Resident #3's Special Care Unit Profile dated 06/07/25 revealed:
-The HWD completed the assessment.
-Resident #3's identified behaviors included wandering and agitation/aggression.
-She had cognitive impairments with lack of orientation to place; lack of orientation to time; impaired short-term memory; and impaired long-term memory.
-She required partial assistance with dressing, grooming, and bathing.
-Resident #3 required cuing and redirection for toileting and eating.

-She was independent with ambulation and transfers.
-Resident #3 was able to help with dressing; grooming; bathing; toileting; eating; and ambulation.
-She used a walker for mobility assistance.

Review of Resident #3's Service Plan Report dated 07/01/25 revealed:
-Resident #3 ambulated using a walker.
-Resident #3's Focus for Supervision of Needs goal was to be provided supervision at her need level to keep her safe.
-Resident #3 needed moderate supervision to ensure she did not get outside of the SCU due to her wandering behaviors.
-Resident #3's Focus for Evacuation needs had a goal of was to be evacuated safely in an emergency situation."
-She required one person assist for evacuation in emergency situations that included prompting or ongoing cueing to safely evacuate in an emergency.
-Resident #3 had wandering behaviors that required supervision, redirection due to exit seeking behaviors, cognitive deficits, and confusion.
-She had a history of verbal/physically aggressive behaviors.
-The Health and Wellness Director (HWD) signed the Service Plan Report on 07/01/25.
-The Physician Assistant (PA) signed the Service Report on 07/01/25.

Review of Resident #3's Elopement Risk Screening completed on 03/10/25 revealed.
-The document was completed by the RCCA.
-Resident #1 scored a 10, ("If the total score was 10 or greater; the resident should be considered to be at risk for elopement. Prevention protocols should be followed and documented in the service plan."
-Her mobility was documented as fully ambulatory with a mental status of disoriented, with no wandering behaviors.
-Resident #3's history of elopement was no attempts.
-Her behavior management documented no behaviors noted.
-She was taking one medication that was considered antipsychotic or mood altering.
-Resident #3's diagnosis included dementia.

Review of Resident #3's Elopement Risk Screening completed on 07/19/25 revealed:
-The document was e-signed by the HWD.
-Resident #3 scored a 34, and the document, "If the total score was 10 or greater; the resident should be considered to be at risk for elopement. Prevention protocols should be followed and documented in the service plan."

-Her mobility was fully ambulatory with a mental status of "wandering aimlessly." -The emotional status was documented as "voices desire to leave." -Resident #3's history of elopement attempts documented she had 1 plus attempts. -Her behavior management stated she was difficult to redirect. -She was taking "two or more" medications that were considered antipsychotic or mood altering. -She had two or more diagnoses present of dementia and/or any type of mental health. -Goals for wandering and/or elopement behaviors and "her safety will be maintained." -The task will address wandering and elopement behaviors. -The intervention included staff would observe her within her location in the community. Review of Resident #3's accident/incident report dated 07/18/25 revealed: -The report was completed by the AED. -At 7:29 pm, Resident was observed by the BOM exiting the main entrance of the facility with another resident. -The BOM escorted both residents back in the secured area of the community. -The assistant ED was notified. -The assistant ED notified the regional operational specialist who notified the regional leadership team. -All secured doors and gates were checked to ensure all were secured. -All doors and gates were properly secured. -The BOM interviewed all staff. -The Staff on the neighborhood were providing personal care for the two other residents on the SCU. -There were no alarms that sounded. -There were no staff that left the community proceeding the incident. -"Based off of operation specialist discussion with family, interviews with staff, and observations of all secured doors, it was determined that another resident acquired the code to the secured doors." Review of Review #3's progress notes revealed: -On 04/29/25, Resident #3 was exhibiting "exit-seeking behaviors and wandering." She became upset when redirected. -There were no interventions documented after the incident on 04/29/25.		

-On 06/26/25, Resident #3 stated, "she needed to get out." She was administered a PRN (as needed) medication to help with anxiety. -There were no interventions documented after the incident on 06/26/25. -On 06/30/25, Resident #3 was awake around 2:00 am and called the police twice. -There were no interventions documented after the incident on 06/30/25. -On 07/04/25, Resident #3 was exhibiting exit seeking behaviors and resisted redirection. -There were no interventions documented after the incident on 07/04/25. -On 07/10/25, Resident #3 was up at 12:30 am looking for her family member and banging on doors with her cane. She was yelling throughout the shift. It took multiple attempts to administer a PRN. -There were no interventions documented after the incident on 07/10/25. -On 07/15/25, Resident #3 had "behaviors" and refused to go to bed. She was in the TV room. Resident #3 was administered a PRN medication. -There were no interventions documented after the incident on 07/15/25. -On 07/18/25, Resident #3 was observed at 7:29 pm walking out of the front door of the community with another resident. She was seen by the Business Office Manager (BOM), and both residents were immediately escorted back to the secure unit of the community. The POA was notified at 11:00 pm. -The POA was relieved no one was injured. The POA questioned "how the alarms on the doors worked and was curious about the other resident involved." The POA was informed she was unable to share the identity of the other resident and was informed of the safety measures that were immediately taken. -There were no interventions documented after the incident on 07/15/25. -On 07/22/25, Staff tired to redirect Resident #3 multiple times but were unsuccessful. She was given a PRN. -There were no interventions documented after the incident on 07/22/25. Telephone interview with Resident #3's POA on 09/08/25 at 9:15 am revealed: -She received a telephone call from the RDO on 07/18/25 at 10:00 pm that Resident #3 had eloped with another resident.		

-The RDO would not tell her who Resident #3 was with, and she did not know how the residents were able to get out of the SCU. -She was told the resident with Resident #3 knew the code to get out of the facility. -The information about a resident with dementia entering a code to get off the SCU did not make sense. -She was assured that measures were being put in place to ensure this incident would not happen again. Telephone interview with Resident #3's PCP on 09/08/25 at 1:08 pm revealed: -He was made aware that Resident #3 was able to leave the SCU with another resident. -Resident #3 was unable to retain or enter a code to open the secure doors. -He expected Resident #3 to be monitored to ensure she was supervised and safe in the SCU. Interview with the BOM on 07/25/25 at 2:05pm revealed: -On 07/18/25, she was sitting in her car waiting for the car to cool down before she left for the evening between 7:00 am to 7:45 pm on. -She observed Resident #3 walk out of the building to the parking lot. -She called caregivers to come outside to assist with getting both residents back in the secured unit. -Resident #3 sat on the bench outside. -Staff offered the resident ice cream to get them back in the facility. -A MA opened the gate and helped her get the resident back inside the building. -She notified the Assistant Executive Director (AED) of the incident. -The AED notified the RDO of the incident. -She pulled the caregivers together and informed them that Resident #3 was observed outside in the parking lot. Interview with the RDO on 07/25/25 at 9:40 am revealed: -She conducted an intensive interview regarding Resident #3 and the other resident. -The alarm was not activated. -Resident #3 possibly got out with another resident. -The resident got out the front door. -The BOM saw Resident #3 when she was sitting in car getting ready to leave for the evening. -The AED completed the incident report on the evening of 07/18/25.		

-A regional meeting was held on 07/19/25 to discuss the incident.
-She interviewed all staff that worked that evening.
-Staff was instructed to block the keypad when entering the code.

Telephone interview with the HWD on 09/10/25 at 12:18 pm revealed:
-All the elopements occurred on second shift.
-The doors were checked, and the codes were changed.
-The facility did not have cameras to monitor the exit doors.

Telephone interview with the Assistant Executive Director on 09/11/25 at 11:10 am revealed:
-She was unsure how Resident #2 and Resident #3 eloped from the facility.
-She was unaware regarding the details of Resident #1's elopement because she was in training at a sister facility.
-She was told that Resident #2 would watch staff enter the code on the keypad and that he remembered the code to unlock the doors.
-The facility invested in covers to place over all the keypads.
-Staff was trained to block the keypad when entering the code to exit/enter the secured unit.
-All codes were changes, and staff was told not to share the code with family members.

The facility failed to provide supervision for 3 residents who resided in the SCU with a diagnosis of dementia and history of exit seeking behaviors resulting in Resident #1 leaving and returning without staff knowledge and two residents (#2 & #3) eloping the SCU and found in the parking lot. This failure resulted in serious neglect which constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G. S. 131D-34 for this violation on 07/18/25 and on 07/25/25.

THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 17, 2025.

Rule/Statute Number: 10A NCAC 13F .1307 (2) Special Care Unit Resident Profile and Care Plan	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: In addition to the requirements in Rules .0801 and .0802 of this Subchapter, the facility shall: (2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.		
Level of Non-Compliance: Citation		
Findings: Based on observation, record review, and interviews, the facility failed to ensure 3 of 5 sampled residents had a care plan that was signed by a physician or a physician's extender within 15-days of the resident being assessed (Resident #1, #2, and #5). 1. Review of Resident #1's FL-2 dated 09/15/24 revealed: -Diagnoses included dementia, vitamin B-12 deficiency, and anemia. -Resident #1 was ambulatory, intermittently disoriented, and continent of bowel and bladder. -Resident recommended level of care was a special care unit (SCU). Review of Resident #1's Resident Registry revealed that the document was signed on 08/04/22 with the move-in date blank. Review of Resident #1's Face Sheet documented a move-in date of 08/06/22. Review of Resident #1's Special Care Unit Resident Profile date 07/01/25 revealed. -Resident #1's profile was completed by the Resident Care Coordinator Assistant (RCCA). -Resident #1 presented behaviors included wandering, paranoid/delusions, and sundowning. -Resident #1 required cueing/redirection for dressing; grooming; toileting; and eating. -She required partial assistance with bathing.		

-She was independent with ambulation and transferring. -Resident #1 could assist with dressing, grooming, bathing; toileting; eating; and ambulation. Review of Resident #1's undated Service Plan Report with a print date of 07/18/25 revealed: -She had wondering behaviors and was easily redirected. -She was confused at times and exit seeking. -Staff were to document her wandering behaviors, engage her in activities, and redirect her. -She was ambulatory without assistive devices. -She required supervision due to wandering behaviors. -Staff will provide supervision at my need level to keep me safe and monitor for exit seeking behaviors. -Interventions are moderate and requires some supervision in home and needs attendance when outside of the because she tends to wander. 2. Review of Resident #2's FL-2 dated 05/20/25 revealed: -Diagnoses included dementia and vitamin D deficiency. -Resident #2 was constantly disoriented and was a wanderer. -He was ambulatory and incontinent of bowel and bladder. -Resident #2's recommended level of care was SCU. Review of Resident #2's Face Sheet documented a move-in date of 11/20/24. Review of Resident #2's Special Care Unit Resident Profile dated 04/30/25 revealed: -The document was completed by the RCCA. -The behaviors identified for Resident #2 included wandering and sundowning. -His degree of cognitive impairment included lack of orientation to place; lack of orientation to time; impaired short-term memory; and impaired long-term memory. -He was independent with ambulation and transfer. Review of Resident #2's undated Service Plan Report revealed: -Resident #2's Focus for Ambulation included a goal of maintaining his current level of function in ambulation. -The intervention was prompting/assistance to vacate the building in an emergency." -Resident #2's Focus for wandering and/or elopement behavior had a goal of "My safety will be maintained." -Resident #2 had a history of wandering into other resident's rooms inside the community and required redirection.		

-Resident #2's Focus for supervision needs had a goal of providing supervision at his need level to keep him safe. -Resident #2 required regular supervision in the home and could not leave home unattended due to Resident #2 being unaware of unsafe areas. 3. Review of Resident #5's current FL-2 dated 10/08/24 revealed: -Diagnoses included dementia with behaviors; chronic kidney disease; hypertension; Rhabdomyolyses; hypothyroidism; irritable bowel syndrome; and bilateral hearing loss. -She was constantly disoriented. -She was semi-ambulatory with a wheelchair. -The recommended level of care was SCU. Review of Resident #5's Face Sheet documented a move-in date of 12/03/16. Review of Resident #5's Special Care Unit Resident Profile date 06/11/25 revealed. -Resident #5's profile was completed by the Resident Care Coordinator Assistant (RCCA). -Resident #5 presented behaviors included wandering and sundowning. -Resident #5 required cueing/redirection for eating, ambulating, and transferring. -She required partial assistance with dressing, bathing, and toileting. -Resident #5 could assist with eating and ambulation. Review of Resident #5's undated Service Plan Report with a print date of 07/18/25 revealed: -She had no wondering behaviors or exhibited purposeless ambulation, but she was easily redirected. -She was confused at times and may be a potential for unintended exiting. -Staff were to document her wandering behaviors, engage her in activities, and redirect her. -She was ambulatory with a wheelchair to maximize her independence. -She needed physical assistance for transferring and dressing. -Resident #5 needed standby supervision, set up, verbal cues, and or reminders to complete bathing tasks and grooming. -She could eat independently or with set up. -Resident #5 required verbal cues/reminders to attend meals and assistance with menu selections.		

Interview with the Resident Care Coordinator Assistant (RCCA) on 09/17/25 at 1:45 pm revealed:
-The Health and Wellness Director (HWD) was responsible for completing the care plan.
-HWD was responsible for ensuring the care plans were signed.
-He was not responsible for completing the care plans.

Interview with the HWD on 09/17/25 at 2:15 pm revealed:
-Care plans were completed by him, the RCCA, or Operational Specialists on the regional level.
-Care plan meetings were held via phone or in-person to discuss with the responsible party.
-During the care plan meetings, the responsible party signed the document agreeing to the plan of care.
-If the responsible party was not present, a button was checked in the Point Click Care acknowledging a verbal agreement from the responsible party.
-Once the care plan was reviewed and approved by the responsible party, the care plan was placed in the physician mailbox for signature or faxed to the outside physicians for signature.
-He was unaware that Residents #1, #2, and #5 did not have a current care plan.
-He thought the RCCA was completing the care plan due to him working at the sister's facility next door.

Interview with the Assistant Executive Director on 09/17/25 at 1:40 pm revealed:
-She was hired in June as the Assistant Executive Director.
-She hung her Administrator's license around mid or late August.
-The HWD was responsible for ensuring care plans were completed accurately and signed by the primary care provider.
-She was unaware that the care plans were not being completed.

IV. Delivered Via:	Hand-delivered	Date: 9/23/25
DSS Signature:	Vida M. Sanders	Return to DSS By: 10/15/25

V. CAR Received by:	Administrator/Designee (print name): Tyvonder Jones	
	Signature: Tyvonder Jones	Date: 9/23/25
	Title: Assistant Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	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.*		