STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 06/09/21 to 06/11/21.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision to 1 of 6 sampled residents (#2) resulting in the resident being hit by a car while trying to cross a busy four lane road and being hospitalized with multiple serious injuries. The findings are: Review of Resident #2's FL-2 dated 01/20/21 revealed: -Diagnoses of hypertension, left ventricular mural thrombis, diabetes mellitus type 2, and seizure disorder. -There was no documentation of the resident's orientation status. -The resident was ambulatory and required assistance with bathing and feeding. Review of Resident #2's current assessment and care plan dated 01/20/21 revealed: -The resident had a history of substance abuse.	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 270	Continued From page 1 -The resident was ambulatory with a cane. -The resident was sometimes disoriented and forgetful, needing reminders. -The resident required supervision with ambulation. -The resident required limited assistance with bathing, dressing, and grooming. Interview with a medication aide (MA) on 06/09/21 at 11:27am revealed: -Each hall was staffed with 1 MA and 2 personal care aides (PCA) each shift. -Supervision checks on all residents were performed by all staff every hour and consisted of ensuring each resident's presence in the facility and providing incontinence care as needed. Interview with a PCA on 06/10/21 at 9:55am revealed: -He usually worked on the men's hall and was very familiar with Resident #2. -Resident #2 was independent, happy, and easy to get along with. -Resident #2 never displayed any concerning behaviors or confusion. -Resident #2 usually left with his family member to go shopping or go out to eat, but he had left 1 or 2 times before by himself to go to the store to get cigarettes and snacks. -Resident #2 walked with a limp and a cane, but he was not concerned with the resident's ability to walk independently. -He was concerned that Resident #2 was walking on the busy road the facility was located on but if residents signed out of the facility per policy, it was their right to leave whenever they wanted to. -Sometimes residents would tell staff when they were leaving, but they did not have to. -Residents were expected to be back in the facility by 9:00pm when visiting hours ended.	D 270		

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	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

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D 270	Continued From page 2	D 270		

-The staff performed hourly resident checks every hour to ensure the residents were present and safe.
-If they could not find a resident, they would first check the sign-out book to see if the resident signed out and left the facility, then look for the resident if they had not signed out.
-If a resident was not present and had not signed out of the facility, he would report it to the medication aide/supervisor (MA/S) and go look for the resident.
-The MA/S would then contact the Resident Care Coordinator (RCC), the Administrator, and the family if they could still not find the resident.
-He was not sure how Resident #2 got out of the facility unsupervised on 05/28/21; "he must have just walked out".
-The facility had always done hourly resident checks on all residents, but the procedure and form were updated approximately one month ago.

Review of Resident #2's Supervision Monitoring Form dated 04/20/21 revealed the resident had problems with orientation, required personal care assistance, and had functional limitations.

Review of Resident #2's incident/accident report dated 05/28/21 revealed:
-The time the event took place was not documented.
-The event, location, type, and nature of injury were all documented as "other".
-The resident had been transported to the emergency department (ED) and was admitted to the hospital for surgery.
-The resident's family member was notified on 05/29/21 at 1:00am, the day after the incident, by the MA/S.
-The Department of Social Services (DSS) was notified on 05/29/21, the day after the incident, via

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 3	D 270		

fax by the Administrator.
-It was not documented that 911 was called on behalf of the resident.
-The MA/S documented she left a message for the resident's primary care provider (PCP) to call them back notifying him that the resident had been admitted to the hospital.

Review of a police report dated 05/28/21 at 10:28pm revealed:
-Resident #2 had been struck by a vehicle in a six-lane roadway while attempting to cross the road on foot where there was no cross walk.
-After impact, Resident #2 struck the windshield of the vehicle before being thrown into the next lane where the resident was found by law enforcement.
-The resident was transported to the hospital by emergency medical services (EMS).

Observation of the facility on 06/09/21 at 8:00am revealed the facility was located on a busy 4 lane road with heavy traffic.

Review of the facility's one-hour resident check sheets for Resident #2 dated 05/28/21 revealed:
-The resident was present in the facility at 8:00pm.
-The resident was out of the facility at 9:00pm, 10:00pm, and 11:00pm.
-The resident was in the hospital from 11:00pm forward.

Review of the facility's Visitation policy revealed:
-The facility provided care 24 hours per day, 7 days per week.
-The posted visitation hours were from 9:00am until 9:00pm.
-Before leaving the facility, residents were to notify staff that they were leaving, informing the

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	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 270	Continued From page 4	D 270		

staff of the resident's destination, with whom the resident would be accompanied by, and when the resident was expected to return.
-The resident was to sign in and out of the facility using the Visitation Sign-Out Register at the time of departure and time of return.

Review of Resident #2's Resident Sign Out Log revealed:
-Resident #2 had not signed out of the facility on 05/28/21.
-There was no documentation that the resident had ever signed out of the facility since his admission.

Review of the facility's Missing Resident Policy and Procedure revealed:
-All door alarms were to be checked every 24-hours and documented in the "alarm check book".
-The person in charge or MA would be responsible for documenting the incident in the resident's record to reflect actual facts relating to the incident to include times, person contacted, condition of resident upon return to the facility (or when found), physician notification, any orders or treatment indicated, and any other pertinent information.

Review of the facility's Alarm Door Check form dated May 2021 revealed the facility's door alarms had been documented as checked and in working order on all days in May 2021 from 05/01/21-05/31/21.

Observation of the facility's door alarms on 06/09/21 revealed the facility's door alarms were operational and in working order.

Review of Resident #2's Emergency Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 270	Continued From page 5 (ED) Care Timeline dated 05/28/21 to 05/29/21 revealed: -The resident arrived in the ED at 9:31pm on 05/28/21 and was immediately placed in a trauma bay for treatment. -His eyes opened to speech, but he had inappropriate words in response to questions and commands. -The ED physician noted that the resident had been a pedestrian on the road and was stuck by a vehicle which caused "starring" on the windshield and then was subsequently thrown 50 feet from the impact. -The resident was disoriented and verbally abusive. -The resident was immobilized and stabilized, then admitted as an in-patient for further treatment. Review of Resident #2's hospital Neurosurgery consult note dated 05/28/21 revealed: -The resident had a fracture of his C2 (second cervical/neck vertebrae) in his neck. -The resident had traumatic widening of the C6-C7 (sixth and seventh cervical/neck vertebrae) in his neck. -The resident had a fracture of his C6 in his neck. -The resident had possible injury to the vertebral artery. -The resident was to receive MAP push therapy (central line blood pressure monitoring to increase blood flow to the affected area to prevent further neurological damage). -The resident was to receive "spinal precautions", including to always remain in a cervical collar, and receive pre-operative treatment for surgery on the next day, 05/29/21, for open reduction internal fixation surgical procedure of the affected areas.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 270	Continued From page 6 Review of Resident #2's hospital Orthopedics consult note dated 05/29/21 revealed: -Multiple surgeries would have to be planned to address Resident #2's injuries. -The resident had deep abrasions (open wound/scratches) to the abdomen, knees, hands, forehead and nose. -The resident had lacerations (deep cuts) to the scalp and left forearm. -The resident had a left tibial plateau fracture (a break of the upper part of the tibia/shinbone involving the knee joint). -The resident had a fracture of the left femur (thigh bone). -The resident had a left clavicle fracture (bone located between the ribcage and shoulder blade). -The resident had a fracture to the L1 vertebrae (lumbar/lower back vertebrae). -The resident had injuries to the right knee that may require further surgery. -The resident had a possible left forearm fracture that required further evaluation. Review of Resident #2's Intensive Care Unit (ICU) Progress Notes revealed: -The resident had been intubated on a ventilator from 05/29/21 to 06/03/21, fed through a nasogastric tube, and remained in the surgical intensive care unit as of 06/09/21. -On 05/29/21, the resident underwent a procedure to repair the lacerations to his forehead and left elbow. -On 05/29/21, the resident underwent surgery to stabilize and repair the fracture in his neck from C2-C7. -On 05/30/21, the resident underwent surgery to stabilize and repair the fractures to his left tibia and femur. -On 06/01/21, the resident underwent surgery to revise the repair to the left tibia.	D 270		

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	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 7	D 270		

-On 06/08/21, the resident could follow commands to move his right side only, would have to consider placing a percutaneous endoscopic gastrostomy (PEG) tube (a tube passed through the abdominal wall into the stomach to feed someone who cannot eat by mouth) for a long term nutrition plan, and would need skilled nursing or long term acute care placement upon discharge.
-On 06/09/21, the resident underwent surgery to repair his right knee of multi-ligament tears.

Interview with the second PCA on 06/10/21 at 4:30pm revealed:
-She usually worked on the women's hall and was responsible for caring for residents and assisting them with anything they needed.
-Resident #2 had a limp and walked with a cane.
-PCAs were responsible for hourly resident supervision checks to ensure the residents were in the facility and their needs were met.
-She was working on 05/28/21 and had last seen Resident #2 around 7:30pm that evening walking toward the men's hall, talking to another resident.
-She did not know why Resident #2 left the facility or how he got out of the facility.

Interview with a third PCA on 06/10/21 at 3:45pm revealed:
-She had worked at the facility for 10 years, always worked the men's hall, and was responsible for carrying out the hourly resident supervision checks.
-She was working on 05/28/21 and had last seen Resident #2 at 8:00pm that evening; he appeared to be normal, not confused or upset.
-Around 8:05pm, she went to the laundry room to put clothes in the washer and dryer.
-When she came out of the laundry room around 8:30pm she learned from other staff members

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	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 8	D 270		

that Resident #2 was not in the facility and had been seen walking down the road.
-Resident #2's normal routine was to take his medications at 8:00pm and go to bed.
-Resident #2 would go out to smoke 1-2 times per day.
-She did not know why the resident left the facility or what door he went out of but thought someone from the kitchen had seen him in the front yard of the facility, but she did not know who.
-She did not think Resident #2 had left the facility before.
-Resident #2 walked with a cane but was fast when he walked.
-She had been worried about him walking on such a busy road and was upset that he did not tell anyone he was leaving the facility; she would have taken him where he needed to go safely.

Interview a fourth PCA on 06/10/21 at 11:27am revealed:
-It was the PCA's responsibility to perform hourly supervision checks on the residents.
-On 05/28/21, she was working the second shift on the women's hall.
-Resident #2 seemed to be acting normal that day and had not been confused or disoriented.
-At 7:00pm she had left the facility on her break to go to the gas station to buy Resident #2 a phone card.
-She returned to the facility at 7:30pm and gave Resident #2 his money back because she was unable to buy the phone card on his behalf.
-Around 8:30pm the Dietary Manager/Manager on Call notified her that Resident #2 was walking down the road.
-She checked the resident sign-out book to see if the resident had signed out of the facility; he had not.
-She let the MA/S know that Resident #2 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 9	D 270		

been seen walking down the road and had not signed out of the facility.
-The MA/S subsequently notified the Administrator that Resident #2 had left the building without signing out.
-She had not been too concerned about Resident #2 because residents had a right to sign out of the facility and leave when they wanted to; they did not have to say where they were going.
-She thought Resident #2 might have left to get the phone card he wanted for himself.
-She did not normally worry about residents being gone from the facility until 10:00pm, when residents were supposed to return to the facility if they were not staying overnight somewhere.
-At 10:00pm, the MA/S noticed that Resident #2 had still not returned to the facility.
-She, the MA/S, and one other PCA left the facility around 10:20pm to go look for Resident #2.
-The front door alarm and the back door alarm (where residents go outside to smoke) had the same alarm sounds.
-The door alarms were working on 05/28/21, but staff could not always check the doors when they heard the alarms because they may have been providing resident care.
-Another reason staff may not have responded to the door alarms when Resident #2 exited the facility may have been because it was a normal smoking time and staff expected to hear the door open when the residents went outside and came inside from smoking.

Interview with the MA/S on 06/10/21 at 2:48pm revealed:
-She oversaw the PCAs duties, ensured hourly supervision rounds were completed, and assisted the PCAs with resident care when she was not passing medications.
-She oversaw the entire facility when the

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	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 10 Administrator, RCC, or Manager on Call were not in the building. -If any incidents occurred while on her shift, she would call the Manager on Call to obtain guidance in handling the issue; sometimes they would come to the facility to assist. -At 8:00pm on 05/28/21, she administered Resident #2 his medications in his resident room. -Around 8:30pm, the Dietary Manager/Manager on Call notified the staff that she had seen Resident #2 walking down the road outside of the facility. -Upon learning that Resident #2 was not in the facility, she immediately left the facility around 8:40pm to go try and find Resident #2. -She did not find Resident #2 when looking for him and returned to the facility around 8:50pm. -When the next shift came in around 10:00pm, they notified her that there had been an accident near the facility. -She left the facility again to search for Resident #2 and spoke with a woman sitting on a curb where the accident had taken place and learned that a man had been hit by a vehicle and had been taken to the hospital. -She returned to the facility to get Resident #2's record and went to the hospital where she found Resident #2 around 10:30pm. -She spoke with the triage nurse at the hospital and provided Resident #2's information and family contact information. -If she had seen Resident #2 trying to leave, she would have stopped him and asked him where he was going and to sign out. -She did not know how or why Resident #2 left and thought maybe he followed another person out of the door. -She was concerned that Resident #2 left because he had never left the facility before and he ambulated with a cane.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 11 -The responsibility of enacting the facility's missing person policy fell on her and the Dietary Manager/Manager on Call and it should have been done. Interview with the Dietary Manager/Manager on Call on 06/10/21 at 10:12am revealed: -Resident #2 walked with a cane and was always kind and nice. -To her knowledge, Resident #2 had never left the facility alone before. -On 05/28/21, she was driving down the road near the facility because she lived nearby. -She saw Resident #2 crossing the street walking fast with his cane around 8:35pm; he did not appear distressed or confused, and she was not concerned he would not make it across the street. -She did not stop and speak to Resident #2 because it was quicker to come to the facility to see if he had signed out first. -Residents could leave and come back as they wanted and were encouraged to notify staff when they were leaving and sign out when doing so. -When she saw that Resident #2 had not signed out, she realized that no one knew where Resident #2 was, and she was unsure if that was out of character for his behavior. -When she saw that Resident #2 had not signed out, she left the facility and went to look for him from 8:50pm to 9:00pm. -When she did not find Resident #2, she went home. -She received a call from staff around 10:00pm that Resident #2 still had not returned to the facility. -She then went back to the facility and took staff with her again to look for Resident #2 around 10:15pm. -While they were looking for Resident #2, they	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 12	D 270		

learned there had been an accident nearby and someone had been taken to the hospital after being hit by a vehicle.
-They called the hospital and found out that Resident #2 was a patient there and had been the person hit by a vehicle.
-The door alarms were working properly on 05/28/21 and she was unsure how Resident #2 left the facility without anyone knowing.
-There was an unlocked gate in the smoking area he could have left through and staff would not have known if he had already been in the smoking area.
-Residents had been checked on every hour for supervision ever since she started at the facility.
-She thought that if communication had been better and staff had taken turns monitoring the hallways and exits in between resident care, it may have prevented Resident #2 from leaving the facility.
-Staff intermittently monitored the smoking area every 5-10 minutes, but the task was not assigned to just one staff member and it was expected that all staff members would check on the area as they were able in between their other responsibilities.
-All staff were able to hear facility door alarms and it was also all staff's responsibility to check the doors when they heard the alarms.

Second interview with the Dietary Manager/Manger on Call on 06/11/21 at 8:28am revealed:
-As the Dietary Manager, she did not routinely perform direct resident care.
-When acting as Manager on Call, it was her responsibility to spend 8 hours per day at the facility, then be available by phone to staff the rest of the time.
-While at the facility, she was responsible to walk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13	D 270		

through the facility and check in on residents, check the smoking area, check door alarms, address any staffing issues and find coverage when staff called out, and call the RCC or Administrator as needed to keep them updated when issues occurred.
-She tried to handle as many issues independently as possible to not bother the RCC and Administrator when they were off duty.
-She did not stop and talk to Resident #2 when she saw him crossing the street because he was on the other side of the street and it was easier to go to the facility first to see if the resident had signed out.
-She did not call the Administrator at that time and she was unsure why.
-She did not consider Resident #2 walking down the street alone to be an emergent situation.
-She did not consider Resident #2 a missing person because she had seen where was and just did not know what time he had planned to return to the facility.
-She expected Resident #2 to return by 9:00pm which was when visiting hours ended.
-She did not follow up to see if Resident #2 had returned to the facility but was notified by the Administrator around 10:00pm that he had not returned.
-She wished that the PCAs had communicated better and took turns monitoring the halls and exits which could have prevented Resident #2 from leaving the facility.
-She wished she would have turned her car around and talked to Resident #2 to see where he had been going.

Interview with the RCC on 06/11/21 at 8:12am revealed staff could have kept a closer eye on Resident #2 and monitored the exits to prevent him from leaving the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 14 Interview with the Administrator on 06/10/21 at 11:50am revealed: -No facility staff or residents at the facility saw Resident #2 leave the facility on 05/28/21. -Residents were expected to sign-out in the Resident Sign-Out log when leaving the facility and let facility staff know that they were leaving. -They did not worry about residents being out of the facility if the resident had signed out unless they did not return at the time the resident stated they would return. -If a resident did not return by the time stated on the sign-out log, they would begin to look for a resident and contact the resident's family member. -Residents were expected to return to the facility no later than 12:00am unless they were staying the night somewhere else. -The Dietary Manager/Manager on Call and the MA/S were responsible to carry out the facility's policy and to keep her informed when Resident #2 went missing on 05/28/21. -The Dietary Manager/Manager on Call should have stopped to talk to Resident #2 when she had seen him, called the facility, and taken him back to the facility; that may have prevented Resident #2 from getting hurt. -She had not been informed of Resident #2 being missing until the facility staff found the resident injured at the hospital. -The front door and back door (smoking door) alarms had been working properly on 05/28/21 per documentation. -All staff were responsible to monitor who was going in and out of those doors when they heard the alarms when the doors opened at all hours of the day and night, despite their responsibility to resident care. -Everyone in the facility had been trained to check	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 15	D 270		

who was coming in or leaving through the doors when they heard a door alarm.
-She was unsure what door the resident exited out of; he could have left through the back gate after going out of the back-smoking door, but the facility had never had a resident leave that way before.
-She arrived at the facility around 11:30pm or 12:00am (she lived 1 ½ hours away) upon learning of Resident #2 being injured.
-Resident #2's family and PCP were notified sometime on the night of 05/28/21 or early morning 05/29/21 of the resident's status and situation.
-She notified the Department of Social Services via fax of Resident #2's incident and situation on the next day, 05/29/21.

Interview with Resident #2's family member on 06/10/21 at 11:01am revealed:
-Resident #2 had a history of stroke that caused left sided weakness, but he had been doing well prior to the accident.
-She was not sure why or how Resident #2 left the facility and did not understand why he had been out that late at night.
-She was notified of Resident #2's accident via another family member on 05/29/21; the day after Resident #2's accident occurred.

Attempted telephone interviews with Resident #2's responsible party on 06/10/21 at 12:37pm and 06/11/21 at 9:40am were unsuccessful.

Interview with Resident #2's current PCP on 06/10/21 at 9:30am revealed:
-She just started as Resident #2's PCP 1 week ago and was unfamiliar with the resident's need for care and supervision.
-She was unaware Resident #2 had wandered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 16	D 270		

away from the facility on 05/28/21 and sustained injuries from being hit by a vehicle.
-Resident #2's previous PCP resigned last week, and she was unsure if he left any forwarding contact information.
-In general, she expected the facility to be as "locked down" as possible with supervised exits to prevent residents from wandering away.
-She expected staff to perform hourly checks on all residents to ensure safety and meet their needs.
-She would think that a resident's care plan would indicate if the provider was comfortable with a resident signing themselves out to leave the facility independently.

Telephone interview with a medical record specialist at Resident #2's previous PCP office on 06/11/21 at 9:42am revealed:
-There was no forwarding contact information for Resident #2's previous PCP on file.
-There was not any documentation regarding Resident#2's ability to be able to sign out of the facility independently.
-Resident #2 used a cane for ambulation and required assistance with his activities of daily living.

_____

The failure of the facility to provide supervision to Resident #2 resulted in the resident exiting the facility unbeknownst to the facility staff through an unknown door that was unsupervised; he walked along and crossed a busy 4-lane road, was then seen by a staff member and not brought back to the facility. Resident #2 was hit by a car and thrown 50 feet while trying to cross the road, resulting in multiple serious injuries to include deep abrasions, lacerations, and fractures to his cervical and lumbar vertebrae, femur, tibia, and clavicle requiring 5 surgical procedures, being on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 17 a ventilator for respiratory support for six days, not being able to eat or drink by mouth, and not being able to speak, communicate or move the left side of his body. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/10/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 10, 2021.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 6 residents sampled (#6) who had bed sores that were not reported to the Primary Care Physician and orders to take pictures of the bed sores were never obtained by the facility. The findings are:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 18	D 273		

Review of Resident #6's current FL-2 dated 09/29/20 revealed:
-Diagnoses included breast cancer, generalized arthritis, hypertension, anxiety, unspecified visual disturbance, and mental neurodevelopmental disorder.
-Resident #6 was non-ambulatory.
-Resident #6's skin was normal.

Review of Resident #6's care plan dated 09/29/20 revealed:
-Resident #6 was non-ambulatory and used a wheelchair to ambulate.
-Resident #6's skin had pressure areas.
-Resident #6 was sometimes disoriented and forgetful needed reminders.
-Resident #6 was vision was legally blind.
-Resident #6 required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of Resident #6's Resident Register revealed she had a Power of Attorney (POA).

Interview with the Resident Care Coordinator (RCC) on 06/10/21 at 2:27pm revealed:
-Resident #6 was discharged from the facility on 10/12/20 to the hospital.
-Resident #6 was discharged from the hospital to a skilled nursing facility on 11/13/20.

Review of Resident #6's care note dated 10/04/20 revealed:
-There was documentation that two personal care aides (PCA) found bedsore to Resident 6's right hip when they changed her soiled linen.
-The two PCA's reported a bedsore to the medication aide (MA) who worked at the time they found the sore.
-The MA informed the two PCA's to document the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 19	D 273		

incident.
-There was no documentation that Resident #6's Primary Care Physician (PCP) was notified.

Review of Resident #6's care notes revealed there was no care note documented from 10/05/20 to 10/09/20.

Review of Resident #6's care note dated 10/10/20 revealed:
-The MA documented that she saw two bedsores on Resident #6's left buttock and right buttock.
-The MA documented the bedsore to the left buttock looked healed.
-The MA documented the bedsore to the right buttock looked fresh because it was bleeding.
-The MA documented that she "cleaned up" Resident #6.
-There was no documentation that Resident #6's PCP was notified.

Review of Resident 6's visit note from her PCP on 10/09/20 revealed:
-Resident #6 was seen by her PCP for a pressure injury of the skin of the contiguous region involving the right buttock and hip, which had an unspecified injury stage.
-The PCP was unable to view the pressure areas of concern during her visit with Resident #6.
-The PCP ordered the facility to take pictures of the areas of concern on Resident #6 and send them to her.

Review of Resident #6's hospital record dated 10/12/20 revealed:
-On admission into the hospital Resident #6 required wound care consultation.
-Resident #6 had 3 approximately 1-inch pressure ulcers on bilateral hips and her right elbow.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 273	Continued From page 20 -Resident #6 had an unstageable pressure injury to the right side of her sacrum, an unstageable pressure injury to the left proximal trochanter, a deep tissue injury to the left distal trochanter, a deep tissue injury to her left heel, and a wound of unknown etiology to her left elbow. Interview with a PCA on 06/10/21 at 10:50am revealed: -Her job duties included bathing, feeding, and toileting residents. -She last worked with Resident #6 in October 2020. -Resident #6 was wheelchair-bound. -She repositioned Resident #6 in her wheelchair and bed every 2-hours. -She provided toileting, bathing, transferring, and feeding assistance to Resident #6. -She did not remember the exact date she last provided bathing assistance to Resident #6. -Resident #6 did not have any bedsores in October 2020. -If she had noticed a bedsore, she would have notified the MA. Interview with a MA on 06/10/21 at 11:16am revealed: -She wrote the care note that was dated 10/10/20. -She did not remember writing the care note dated 10/10/20. -She did remember the last time she worked with Resident #6. -She did not remember if a PCA notified her that Resident #6 had bed sores. -If she was notified, she would have notified Resident #6's PCP. Interview with the RCC on 06/10/21 at 2:27pm revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 21 -Resident #6 was total care and needed assistance with all activities of daily living. -MA's and PCA's were trained on wound care and skin assessments when they were first hired. -PCA's were required to complete skin assessments of residents when they provided baths. -The PCA was supposed to look for any change in the skin, rashes, bruises, and any open areas. -If the PCA noticed a change in the residents' skin they were supposed to notify the MA immediately and complete a skin assessment sheet. -Once notified, the MA was supposed to assess the resident and notify the RCC immediately or if the RCC was not available the MA should have notified the supervisor. -She was notified by a PCA that Resident #6 had a bedsore. -She did not remember when she was notified by the PCA. -She notified the previous Administrator immediately that Resident #6 had bed sores. -The previous Administrator notified Resident #6's PCP. -She did not have documentation that the previous Administrator notified the PCP immediately. -She did not have wound care orders from Resident #6's PCP. -She did not remember what wound care orders Resident #6's PCP ordered. -She was responsible to take pictures of Resident #6's bedsore that her PCP ordered on 10/09/20. -She did not take the pictures of Resident #6's bedsores because she forgot. -She did not have any skin assessment sheets that documented Resident #6's bedsores. -She was not notified by any PCA on 10/04/20 that Resident #6 had a bed sore. -She was not notified by the MA on 10/10/20 that	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 22 Resident #6 had a bedsore. -She should have been notified immediately on 10/04/20 and 10/10/20 that Resident #6 had a bedsore. -She did not know why the staff did not notify her. -If she was notified, she would have contacted the Administrator and notified Resident #6's PCP. Interview with the Administrator on 06/10/21 at 3:37pm revealed: -She became the Administrator in January 2021. -She was not familiar with Resident #6. -If a resident had a skin breakdown, the PCA, MA, or RCC were supposed to notify the resident's PCP immediately. -The PCA was supposed to report any changes in residents' skin to the MA that worked immediately. -The MA was supposed to notify the RCC or supervisor immediately. -The RCC was supposed to complete a skin assessment once she has been notified by the MA. -After the RCC completed her skin assessment, she was supposed to notify the resident's PCP immediately. -The RCC should have taken the pictures as ordered by Resident #6's PCP immediately and sent the PCP the pictures the same day. -She did not know why the RCC did not take Resident #6's pictures as ordered. -The MA that documented the care note on 10/10/20 should have notified the RCC immediately of the bedsores she observed. -She did not know why the MA did not notify the RCC. -She did not know why there were no wound care orders from the PCP for Resident #6. -She did not know why there were no skin assessments documented on Resident #6.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 23 Attempted telephone interview the PCA that wrote the care note dated 10/04/20 on 06/11/21 at 8:58am was unsuccessful. Attempted telephone interview with Resident #6's POA (Power of Attorney) on 06/10/21 at 9:24am was unsuccessful. Attempted telephone interview with Resident #6's PCP on 06/10/21 at 1:29pm and 06/11/21 at 9:56am was unsuccessful. _____ The facility failed to ensure a resident's (#6) PCP was notified immediately of bedsores that personal care aides observed on 10/04/20 and the facility failed to take pictures of the wounds as ordered by the (PCP) on 10/09/20. The facility's failure was detrimental to the residents' health, safety, and welfare which constitutes a Type Unabated B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/10/21 for this violation.	D 273		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.	D 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 24 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record review and interviews, the facility failed to immediately notify the resident's responsible party, law enforcement, and the county Department of Social Services (DSS) when the whereabouts were unknown for Resident #2, who walked out of the facility and was struck by a vehicle while trying to cross a busy 4-lane road. The findings are: Review of Resident #2's FL-2 dated 01/20/21 revealed: -Diagnoses of hypertension, left ventricular mural thrombis, diabetes mellitus type 2, and seizure disorder. -There was not orientation status documented for the resident. -The resident was documented as ambulatory and required assistance with bathing and feeding. Review of Resident #2's current assessment and care plan dated 01/20/21 revealed: -The resident had a history of substance abuse. -The resident was ambulatory with a cane. -The resident was sometimes disoriented and forgetful, needing reminders. -The resident required supervision with ambulation. -The resident required limited assistance with bathing, dressing, and grooming. Review of Resident #2's Supervision Monitoring Form dated 04/20/21 revealed the resident had	D 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 328	Continued From page 25	D 328		

problems with orientation, required personal care assistance, and had functional limitations.

Review of Resident #2's incident/accident report dated 05/28/21 revealed:
-The time the event took place was not documented.
-The event, location, type and nature of injury were all documented as "other".
-The resident had been transported to the emergency room and was admitted to the hospital for surgery.
-The resident's responsible party was notified the next day, on 05/29/21 at 1:00am, by the medication aide/supervisor (MA/S).
-The DSS was notified the next day, on 05/29/21, via fax by the Administrator.
-It was not documented that 911 was called on behalf of the resident.
-The MA/S documented she left a message for the resident's primary care provider (PCP) to call them back notifying him that the resident had been admitted to the hospital.

Review of a police report dated 05/28/21 at 10:28pm revealed:
-Resident #2 had been struck by a vehicle in a six-lane roadway while attempting to cross the road on foot where there was no cross walk.
-After impact, Resident #2 struck the windshield of the vehicle before being thrown into the next lane where the resident was found by law enforcement.
-The resident was transported to the hospital by emergency medical services (EMS).

Review of Resident #2's Emergency Department (ED) Care Timeline dated 05/28/21 to 05/29/21 revealed:
-The resident arrived in the ED at 9:31pm on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 26	D 328		

05/28/21 and was immediately placed in a trauma bay for treatment.
-His eyes opened to speech, but he had inappropriate words in response to questions and commands.
-The ED physician noted that the resident had been a pedestrian on the road and was stuck by a vehicle which caused "starring" on the windshield and then was subsequently thrown 50 feet from the impact.
-The resident was disoriented and verbally abusive.
-The resident was immobilized and stabilized, then admitted as an in-patient for further treatment.

Review of Resident #2's hospital Neurosurgery consult note dated 05/28/21 revealed:
-The resident had a fracture of his C2 (second cervical/neck vertebrae) in his neck.
-The resident had traumatic widening of the C6-C7 (sixth and seventh cervical/neck vertebrae) in his neck.
-The resident had a fracture of his C6 in his neck.
-The resident had possible injury to the vertebral artery.
-The resident was to receive MAP push therapy (central line blood pressure monitoring to increase blood flow to the affected area to prevent further neurological damage).
-The resident was to receive "spinal precautions", including to always remain in a cervical collar, and receive pre-operative treatment for surgery on the next day, 05/29/21, for open reduction internal fixation surgical procedure of the affected areas.

Review of Resident #2's hospital Orthopedics consult note dated 05/29/21 revealed:
-Multiple surgeries would have to be planned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 27	D 328		

address Resident #2's injuries.
-The resident had deep abrasions (open wound/scratches) to the abdomen, knees, hands, forehead and nose.
-The resident had lacerations (deep cuts) to the scalp and left forearm.
-The resident had a left tibial plateau fracture (a break of the upper part of the tibia/shinbone involving the knee joint).
-The resident had a fracture of the left femur (thigh bone).
-The resident had a left clavicle fracture (bone located between the ribcage and shoulder blade).
-The resident had a fracture to the L1 vertebrae (lumbar/lower back vertebrae).
-The resident had injuries to the right knee that may require further surgery.
-The resident had a possible left forearm fracture that required further evaluation.

Review of Resident #2's Intensive Care Unit (ICU) Progress Notes revealed:
-The resident had been intubated on a ventilator from 05/29/21 to 06/03/21, fed through a nasogastric tube, and remained in the surgical intensive care unit as of 06/09/21.
-On 05/29/21, the resident underwent a procedure to repair the lacerations to his forehead and left elbow.
-On 05/29/21, the resident underwent surgery to stabilize and repair the fracture in his neck from C2-C7.
-On 05/30/21, the resident underwent surgery to stabilize and repair the fractures to his left tibia and femur.
-On 06/01/21, the resident underwent surgery to revise the repair to the left tibia.
-On 06/08/21, the resident could follow commands to move his right side only, would have to consider placing a percutaneous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 28	D 328		

endoscopic gastrostomy (PEG) tube (a tube passed through the abdominal wall into the stomach to feed someone who cannot eat by mouth) for a long term nutrition plan, and would need skilled nursing or long term acute care placement upon discharge.
-On 06/09/21, the resident underwent surgery to repair his right knee of multi-ligament tears.

Review of the facility's Visitation policy revealed:
-The facility provided care 24 hours per day, 7 days per week.
-The posted visitation hours were from 9:00am until 9:00pm.
-Before leaving the facility, residents were to notify staff that they were leaving, informing the staff of the resident's destination, with whom the resident would be accompanied by, and when the resident was expected to return.
-The resident was to sign in and out of the facility using the Visitation Sign-Out Register at the time of departure and time of return.

Review of the facility's Missing Resident Policy and Procedure revealed:
-The purpose of the policy was to ensure all necessary steps were taken in the event a resident wandered away from the facility.
-When a resident was determined to be missing, all available staff would be directed by the person in charge to search the entirety of the facility premises both inside and outside.
-If a resident could not be found, the facility staff were to call 911 to report the resident missing and ask local law enforcement for assistance in locating the resident, notify the Administrator, notify the resident's family or responsible party, and notify the Department of Social Services (DSS) immediately.
-All door alarms were to be checked every

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 29	D 328		

24-hours and documented in the "alarm check book".
-The person in charge or MA would be responsible for documenting the incident in the resident's record to reflect actual facts relating to the incident to include times, person contacted, condition of resident upon return to the facility (or when found), physician notification, any orders or treatment indicated, and any other pertinent information.

Review of the facility's one-hour resident check sheets for Resident #2 dated 05/28/21 revealed:
-The resident was present in the facility at 8:00pm.
-The resident was out of the facility at 9:00pm, 10:00pm, and 11:00pm.
-The resident was in the hospital from 11:00pm forward.

Review of Resident #2's Resident Sign Out Log revealed:
-Resident #2 had not signed out of the facility on 05/28/21.
-There was no documentation that the resident had ever signed out of the facility since his admission.

Interview with a personal care aide (PCA) on 06/10/21 at 4:30pm revealed:
-Around 8:30pm, the Dietary Manager/Manager on Call came to the facility to notify the staff that she had seen Resident #2 walking down the road.
-She notified the MA/S of the information about Resident #2 walking down the road, then went back to the women's hall to continue providing care to her residents.

Interview with a second PCA on 06/10/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 30 3:45pm revealed: -She last saw Resident #2 at 8:00pm on 05/28/21 and he appeared to be normal, not confused or upset. -Around 8:05pm on 05/28/21, she went to the laundry room to put clothes in the washer and dryer. -When she came out of the laundry room around 8:30pm on 05/28/21 she learned from other staff members that Resident #2 was not in the facility and had been seen walking down the road. -She was aware of the facility's missing person policy and was unsure why the staff did not call 911, she assumed the steps of the policy had been followed, but it wasn't her responsibility to carry those steps out. Interview a third PCA on 06/10/21 at 11:27am revealed: -On 05/28/21, she was working the second shift on the women's hall. -Resident #2 seemed to be acting normal that day and had not been confused or disoriented. -At 7:00pm, she left the facility on her break to go to the gas station to buy Resident #2 a phone card. -She returned to the facility at 7:30pm and gave Resident #2 his money back because she was unable to buy the phone card on his behalf. -Around 8:30pm, the Dietary Manager/Manager on Call notified her that Resident #2 was walking down the road. -She checked the resident sign-out book to see if the resident had signed out of the facility; he had not. -She let the MA/S know that Resident #2 had been seen walking down the road and had not signed out of the facility. -She had not been too concerned about Resident #2 because residents had a right to sign out of	D 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 31	D 328		

the facility and leave when they wanted to; they did not have to say where they were going.
-She thought Resident #2 might have left to get the phone card he wanted for himself.
-She did not normally worry about residents being gone from the facility until 10:00pm, when residents were supposed to return to the facility if they were not staying overnight somewhere.
-At 10:00pm, the MA/S noticed that Resident #2 had still not returned to the facility.
-She, the MA/S, and one other PCA left the facility around 10:20pm to go look for Resident #2.
-While they were searching for Resident #2, she learned there had been an accident in the area.
-She called the police department to find out the details of the accident, but they would not give her any information; she did not report Resident #2 missing because she did not consider him to be missing.
-She then called the hospital where they learned Resident #2 was a patient due to being involved in the accident and had been hit by a vehicle.
-The MA/S went to the hospital to be with Resident #2 and she went back to the facility.
-Upon doing resident hourly supervision checks, if facility staff did not know where Resident #2 was, and he had not signed out, they should have looked for the resident and considered the resident missing.
-They did not call 911 to report the resident missing because they thought he had a right to be gone.

Interview with the MA/S on 06/10/21 at 2:48pm revealed:
-She oversaw the entire facility when the Administrator, Resident Care Coordinator (RCC), or Manager on Call were not in the building.
-If any incidents occurred while on her shift, she would call the Manager on Call to obtain guidance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 32	D 328		

in handling the issue; sometimes they would come to the facility to assist.
-At 8:00pm on 05/28/21, she administered Resident #2 his medications in his resident room.
-Around 8:30pm, the Dietary Manager/Manager on Call notified the staff that she had seen Resident #2 walking down the road outside of the facility.
-Upon learning that Resident #2 was not in the facility, she immediately left the facility around 8:40pm to go try and find Resident #2.
-She did not find Resident #2 when looking for him and returned to the facility around 8:50pm.
-When the next shift came in around 10:00pm, they notified her that there had been an accident near the facility.
-She left the facility again to search for Resident #2 and spoke with a woman sitting on a curb where the accident had taken place and learned that a man had been hit by a vehicle and had been taken to the hospital.
-She returned to the facility to get Resident #2's record and went to the hospital where she found Resident #2 around 10:30pm.
-She left a message for Resident #2's responsible party the next day after she returned to the facility to notify them of what happened to Resident #2 around 1:00am on 05/29/21.
-She was aware of the facility's missing person policy but thought she would have to wait for the resident to be missing for 24 hours before she reported the resident missing and asked law enforcement for help, which is why she did not call 911 to report the resident missing.
-She was not aware that she was supposed to report a missing resident to DSS.
-She did not "technically" consider the resident missing, even though he had not signed out, because they knew where he had been, and assumed he would return to the facility when he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 33 was ready. -She had been trained on the facility's missing person policy when she started at the facility one year ago. -She panicked on 05/28/21 when Resident #2 went missing and should have asked the Administrator for guidance in handling the situation, considered the resident a missing person, called 911 to report the resident missing and have them help try to find the resident, and called the resident's responsible party. -The responsibility of enacting the facility's missing person policy fell on her and the Dietary Manager/Manager on Call and it should have been done. Interview with the Dietary Manager/Manager on Call on 06/10/21 at 10:12am revealed: -On 05/28/21, she was driving down the road near the facility because she lived nearby. -She saw Resident #2 crossing the street walking fast with his cane around 8:35pm; he did not appear distressed or confused, and she was not concerned he would not make it across the street. -She did not stop and speak to Resident #2 because it was quicker to come to the facility to see if he had signed out first. -Residents could leave and come back as they wanted and were encouraged to notify staff when they were leaving and sign out when doing so. -When she saw that Resident #2 had not signed out, she realized that no one knew where Resident #2 was, and she was unsure if that was out of character for his behavior. -When she saw that Resident #2 had not signed out, she left the facility and went to look for him from 8:50pm to 9:00pm. -When she did not find Resident #2, she went home.	D 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 34 -She received a call from staff around 10:00pm that Resident #2 still had not returned to the facility. -She then went back to the facility and took staff with her again to look for Resident #2 around 10:15pm. -While they were looking for Resident #2, they learned there had been an accident nearby and someone had been taken to the hospital after being hit by a vehicle. -They called the hospital and found out that Resident #2 was a patient there and had been the person hit by a vehicle. -Staff should have notified the RCC, Administrator, and Resident #2's family of the incident. Interview with the Dietary Manager/Manger on Call on 06/11/21 at 8:28am revealed: -When acting as Manager on Call, it was her responsibility to spend 8 hours per day at the facility, then be available by phone to staff the rest of the time. -She did not stop and talk to Resident #2 when she saw him crossing the street because he was on the other side of the street and it was easier to go to the facility first to see if the resident had signed out. -She did not call the Administrator at that time and she was unsure why. -She did not consider Resident #2 walking down the street alone to be an emergency situation. -She did not consider Resident #2 a missing person because she had seen where was and just did not know what time he had planned to return to the facility. -She expected Resident #2 to return by 9:00pm which was when visiting hours ended. -She did not follow up to see if Resident #2 had returned to the facility but was notified by the	D 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 35	D 328		

Administrator around 10:00pm that he had not returned.
-She did not call 911 to report the Resident #2 missing because she thought a resident had to be missing for more than 24 hours first.
-The first time she had been educated on the facility's missing person policy was on 06/10/21.
-She did not call 911, Resident #2's family, or DSS because did not know she was supposed to and did not consider him to be a missing person.

Interview with the Administrator on 06/10/21 at 11:50am revealed:
-No staff or residents at the facility saw Resident #2 leave the facility on 05/28/21.
-Residents were expected to sign-out in the Resident Sign-Out log when leaving the facility and let facility staff know that they were leaving.
-They did not worry about residents being out of the facility if the resident had signed out unless they did not return at the time the resident stated they would return.
-If a resident left without signing out, the staff would look for the resident within the facility and on facility premises outside, call the resident's family, and call 911 to report the resident missing within 15-30 minutes of identifying that the resident was missing per the facility's missing person policy.
-After staff had searched for the resident and reported the resident missing to law enforcement, they were to call the Administrator and the RCC.
-Staff were trained upon hire to the facility's missing person's policy and how to respond when a resident went missing; she had never done a formal update or refresher training course.
-The staff did not follow the facility's missing person policy and procedure and should have treated Resident #2 as a missing person.
-She was disappointment that the facility staff did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 36	D 328		

not follow the facility's protocol to protect Resident #2 from harm.
-When Resident #2 went missing around 8:30pm, the facility staff should have called 911 for assistance in locating the resident no later than 9:00pm, then they should have notified the resident's responsible party.
-The Dietary Manager/Manager on Call and the MA/S were responsible to carry out the facility's policy and to keep her informed when Resident #2 went missing on 05/28/21.
-She arrived to the facility around 11:30pm or 12:00am (she lived 1 ½ hours away) upon learning of Resident #2 being injured.
-Resident #2's family and PCP were notified sometime on the night of 05/28/21 or early morning 05/29/21 of the resident's status and situation.
-She notified the Department of Social Services via fax of Resident #2's incident and situation on the next day, 05/29/21.

Interview with the Administrator on 06/11/21 at 9:05am revealed:
-The Manager on Call acted as the Administrator in the Administrator's absence.
-The Dietary Manager/Manager on Call called her on 05/28/21 around 9:00pm for the first time to notify her of Resident #2's situation.
-She instructed the Dietary Manager/Manager on Call to investigate the situation and search for Resident #2 and keep her informed.
-She thought that all available staff had been searching for Resident #2 the entire time between 8:30pm and 10:00pm and she was unaware that the Dietary Manager/Manager on Call had gone home after being unable to find Resident #2 at 9:00pm.
-When she spoke with the Dietary Manager/Manager on duty again on the phone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE ASSISTED LIVING OF GREENVILLE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 328	Continued From page 37 around 10:00pm, she was told that the facility staff were out looking for Resident #2 and had found him at the hospital. -The Dietary Manager/Manager on Call should have been aware of the facility's missing person policy and should have identified Resident #2 as a missing person enacting the procedures of the facility's missing person policy to try and keep Resident #2 safe. -Both the Dietary Manager/Manager on Call and the MA/S could have communicated better and should have enacted the facility's missing person policy when Resident #2 went missing. Attempted telephone interview with Resident #2's responsible party on 06/10/21 at 12:37pm and 06/11/21 at 9:40am was unsuccessful. Interview with Resident #2's current primary care provider (PCP) on 06/10/21 at 9:30am revealed: -She just started as Resident #2's PCP 1 week ago and was unfamiliar with the resident's need for care and supervision. -She was unaware Resident #2 had wandered away from the facility on 05/28/21 and sustained injuries from being hit by a vehicle. -Resident #2's previous PCP resigned last week, and she was unsure if he left any forwarding contact information. Telephone interview with a medical record specialist at Resident #2's previous PCP office on 06/11/21 at 9:42am revealed: -There was no forwarding contact information for Resident #2's previous PCP on file. -There was no documentation that the facility had notified the previous PCP of Resident #2's incident/accident and injuries. The facility failed to immediately notify law	D 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 328	Continued From page 38 enforcement that Resident #2 was missing on 05/28/21. Resident #2 was hit by a vehicle while walking down a busy 4-lane road and sustained serious injuries requiring multiple surgeries and the inability to move the left side of his body. This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/18/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 10, 2021.	D 328		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, personal care and supervision, and other resident care and services. The findings are: 1. Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 6 residents sampled (#6) who had bed sores that were not	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074044	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D914	Continued From page 39 reported to the Primary Care Physician and orders to take pictures of the bed sores were never obtained by the facility. [Refer to Tag 273, 10A NCAC 13F .0902(b) Healthcare (Type B Violation)]. 2.Based on observations, interviews, and record reviews, the facility failed to provide supervision to 1 of 6 sampled residents (#2) resulting in the resident being hit by a car while trying to cross a busy four lane road and being hospitalized with multiple serious injuries. [Refer to Tag 270, 10A NCAC 13F .0901(b) Supervision (Type A1 Violation)]. 3.Based on record review and interviews, the facility failed to immediately notify the resident's responsible party, law enforcement, and the county Department of Social Services (DSS) when the whereabouts were unknown for Resident #2, who walked out of the facility and was struck by a vehicle while trying to cross a busy 4-lane road. [Refer to Tag 328, 10A NCAC 13F .0904(f)(4) Other Resident Care and Services (Type A1 Violation)].	D914		