Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074033	A. BUILDING: ____ B. WING ____	R-C 04/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON HOUSE	**716 WALL STREET GRIFTON, NC 28530**

(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 an annual and follow-up survey and complaint investigation on April 4-6, 2017 and on April 10, 2017.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations and interviews, the facility failed to assure all exit door alarms were maintained in operational conditions and activated with a sounding device when opened, which resulted in 1 of 5 sampled residents (#2), who was disoriented, exited the building without staff knowledge and was located at a nearby home the next day. The findings are:	D 067		

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Observation on 4/4/17 at 1:00 p.m. revealed:
-A note on the front door asking all staff and visitors to use the back door as an entrance, because of construction in the living room.
-Upon entrance into the back of the facility, which was the smoking area, the door did not alarm.

Observation on 4/4/17 at 6:02 p.m. revealed the back door, which led to the smoking area, opened and the door did not alarm.

Review of Resident #2's current FL-2 dated 6/6/16 revealed:
-The resident had diagnoses of dementia, high blood pressure and hypothyroidism.
-The resident was constantly disoriented and was ambulatory with a walker.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 12/9/13.

Review of Resident #2's Care Plan dated 6/6/16 revealed:
-The resident was always disoriented.
-"No" was written in the area by wandering.
-"No" was checked-off at the question if the resident was receiving medications for mental illness/behavior.
-The resident was independent with transfers.

Confidential interview with a staff member revealed:
-When Resident #2 had eloped from the facility, it was reported by another staff member the alarms were cut by another resident one to two months ago.
-Since the alarms had been cut, nothing was put in place to monitor the exit doors.

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Confidential interview with a staff member revealed:
-When a company was doing construction at the facility, the construction workers turned off the door alarms.
-They were not aware the alarms were off until 4/1/17, when Resident #2 had eloped from the facility.
-Since they were not aware the alarms were off, nothing was put in place to make sure Resident #2 did not leave the building without staff knowledge.

Confidential interview with a second staff member revealed:
-The alarms were supposed to be on at all times.
-The staff person did not know if the front doors locked or alarmed.
-The exit door to the smoking area does not ever come on.
-The side exit door alarmed, if someone opened the doors.
-When a door alarmed, the staff person checked the doors.
-Doors lock at a certain time during the night. The staff person did not know the time.
-The back door the smoking are never was locked or alarmed.

Confidential interview with a third staff member revealed:
-All of the exit doors alarmed except the back door that led to the smoking area.
-The back door to the smoking area also did not lock.
-The back door had not locked or alarmed for at least 2 months, since construction had started at the facility.
-Nothing was put in place to make monitor the exit doors.

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Confidential interview with a fourth staff member revealed:
-The alarms on the side doors had never been broken.
-Sometimes residents put a piece of tape on the back door to keep it opened. When the residents put tape in the door, staff did not always remove the tape.

Confidential interview with a fifth staff member revealed:
-The alarms on all of the exit doors had not worked at least since January 2017.
-Staff did not monitor the doors to make sure residents who were disoriented did not get out of the facility.
-The door at the end of the women's hall had not alarmed since construction had been going on at the facility (at least January 2017).
-The AIT became aware the side door alarm on the women's hall had not worked when Resident #2 eloped from the facility (3/31/17).

The facility did not put anything in place when staff were aware the alarms were not on while construction was at the facility to make sure residents who were disoriented or wandered did not leave out of the facility without staff knowing.

Telephone interview with the Chief from the local Sheriff's Office on 4/5/17 at 12:14 p.m. revealed:
-The local Sheriff's office received a call from someone at the facility on 4/1/17 at 8:15 a.m. of a missing resident.
-A Sheriff Officer arrived at the facility at 8:17 a.m.
-The Sheriff Officer looked at the surveillance footage in the facility and documented the resident had left the facility on 3/31/17 at 6:18 p.m.

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-Staff reported to the Officer the door alarm, where Resident #2 had exited the building, was cut and not working. The alarms did not appear cut. He did not know who reported to the Officer the alarms were cut.
-He did not know if the alarms alarmed inside of the building when the Officer entered the building.
-The search team did two searches for the resident.
-A neighbor across the street reported to the search team there was someone behind her house.
-The resident was found on the back porch.
-The resident was transported to the local hospital by the Emergency Medical Services (EMS).

Interview with the RCC on 4/10/17 at 5:22 p.m. revealed:
-When the management team and the local Sheriff Officer reviewed the camera inside the facility, they observed that Resident #2 exited the door on the women's hall on 3/31/17 at 6:18 p.m. and the door did not alarm when the resident left the building.
-A Rescue Squad member checked the exit doors with management and observed 5 exit door alarms, including the door on the end of the women's hall Resident #2 used to elope, were not working because it was disconnected and the wires were cut on a 6th door, which was on the back of the women's hall. At least 5 of the exit doors, including the one the resident used to elope, were used by the construction workers.
-The Rescue Squad member reconnected all 5 of the exit door alarms.
-The wires on the door that was cut, was repaired on 4/1/17.
-He was not aware 5 door alarms had been disconnected and a 6th exit door wire had been

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D 067	Continued From page 5 cut. -Construction had been going on at the facility since September 2016 or October 2016 and staff had not been monitoring the exit doors until Resident #2 eloped. -The exit door the residents used to go smoking never locked, because the residents kept putting paper in the door to keep it unlocked. -Currently, staff monitor to make sure anything was not in the door to keep it unlocked. -Currently all exit doors are locked and alarmed. -The front door is alarmed and unlocked during the day. It is locked at night at 11:00 p.m. Interview with the AIT on 4/10/17 at 6:18 p.m. revealed: -After she was called by the Supervisor on 4/1/17 at 8:05 a.m. and was informed Resident #2 had eloped from the facility, she came to the facility. -She came to facility and she and staff searched the inside and outside of the facility. -She was not aware the door alarms were disconnected and there was an exit door where the wires on the alarms had been cut, until management was reviewing the facility's camera and a Rescue Squad member checked the alarms after they discovered Resident #2 had eloped from the facility on 3/31/17. -Staff had not monitored the exit doors until Resident #2 eloped from the facility on 3/31/17. Interview with the Administrator on 4/5/17 at 9:16 a.m. revealed: -He became the temporary Administrator at the facility December 2016. -On 3/31/17, Resident #2 had eloped from the facility at 6:15 p.m. -The door did not alarm after the resident had left the building. -A rescue team searched for the resident.	D 067		

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-He did not know who found the resident.
-When the resident was found, she was 100 yards from the building.
-He was unsure if EMS took the resident to the hospital.
-During the time the resident eloped, no one had gone to check on her.
-Staff did not hear the alarms.
-He was not aware the resident had eloped until 4/2/17 at 11:00 a.m.
-After he found out the resident had eloped, he sent two of his Administrators to investigate the elopement.
-Staff needed to be aware if construction was propping the doors open.
-The facility was in the process of many major repairs but staff should still pay attention to doors being propped open.
-Currently, he had a team at the facility replacing and repairing the alarms on the exit doors.

Observation on 4/5/17 at 9:16 p.m. revealed:
-Construction was at the facility working and had propped open the exit door to the left of the women's hall TV room.
-The Administrator instructed a staff to close the door and keep an eye on residents near the door.

Interview with the Administrator on 4/5/17 at 9:16 a.m. revealed he was not aware the construction crew was propping the exit door to the left of the women's hall TV room on 4/5/17.

Based on observation, interview and record review, Resident #2 was not interviewable.

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The facility neglected to assure exit door alarms were maintained in operational conditions and activated with a sounding device when opened with sufficient volume to alert staff, which resulted

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D 067	Continued From page 7 in 1 of 5 residents who had a diagnosis of dementia and was constantly disoriented, exiting from the facility without staff knowledge for 13 hours and was not found until 20 hours after cameras showed the resident had exited the facility. This constitutes an A2 Violation. ____________________ The facility submitted a Plan of Protection dated 4/5/17, as follows: -Immediately, the alarms will be repaired on the doors. -The Resident Care Coordinator (RCC) and the Administrator-in-Training (AIT) will provide training to the staff on the protocol to the exit door alarms. -All doors will be alarmed and locked. -The RCC will monitor the door alarms daily. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 10, 2017	D 067		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, floors and ceilings in the residents' bedrooms, and the East and West hallways in the facility were kept clean and in good repair.	D 074		

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The findings are:

Observation of Resident Room #103 on 4/4/17 at 1:33pm revealed:
-The 12-inch square glass ceiling light cover contained numerous dead bugs.
-The light switch by the entrance had a sticky brown grime.

Observation of the 5-foot long wooden hand rail in the hallway to the left of the entrance of Resident Room #103 on 4/4/17 at 1:38pm was loose.

Observation of Resident Room #107 on 4/4/17 at 1:55pm revealed:
-The wall to the left of the entrance door had 10 unpainted patched areas.
-The ceiling had 6 sections of unpainted patched areas between 2 to 4 feet in diameter.

Observation of Resident Room #109 on 4/4/17 at 1:59pm revealed the light switch by the entrance had a sticky brown grime.

Observation of Resident Room #111 on 4/4/17 at 2:02pm revealed the light switch by the entrance had a sticky brown grime.

Observation of the 5-foot long wooden hand rail in the hallway to the left of the entrance of Resident Room #113 on 4/4/17 at 2:14pm was loose.

Observation of Resident Room #113 on 4/4/17 at 2:16pm revealed:
-There was a 5-inch hole in the wall 1-foot below the outlet on the left wall.
-The 18-inch square ceiling ventilation grate was rusted, covered in dust and had remnants of gray

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duct tape on 3 sides.
-The light switch by the entrance had a sticky brown grime.

Confidential interviews with three residents revealed:
-The bedroom walls and ceilings needed paint.
-The facility did not have a maintenance person.
-Various facility staff, including medication aides and dietary aides, assisted in facility repairs when needed.

Confidential interview with a staff member revealed:
-The facility needed "a good paint job."
-The facility was old and needed a full-time maintenance person.
-The facility had no maintenance person on staff.
-The facility called outside contractors for repairs when needed.

Interview with the Resident Care Coordinator (RCC) and the Administrator in Training (AIT) on 4/5/17 at 3:45pm revealed:
-The facility did not have a maintenance person.
-Minor repairs were performed by housekeeping and dietary staff.
-Many of the walls had been patched and left unpainted for over a year.
-They had been behind schedule for all repairs in the facility.
-They had not walked thru the facility to determine areas in need of repair.
-They were aware of some of the repairs needing to be performed.
-There was a new building owner that would be taking responsibility for all repairs starting next month.

Interview with theAdministrator on 4/5/17 at

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D 074	Continued From page 10 10:45am revealed: -The building had not been maintained for well over a year. -The building did not have a maintenance person or contracted company. -The building had just been purchased this week and repairs would be performed beginning immediately. -He was responsible for overseeing the maintenance of the building. -The new building owner would be completely overhauling the entire facility. -There was no time-of-completion date for the repairs.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the resident bedroom nightstands and chairs were kept clean and in good repair. The findings are: Observation of Resident Room #103 on 4/4/17 at 1:33pm revealed: -The nightstand to the left of the window had a top wood surface with two 5-inch long worn unpainted areas on the top left and right edges. -Three of five knobs of the nightstand drawers were missing.	D 076		

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-The base of the night stand had scrape marks extending across the entire front.
-There was a metal-frame chair with a gray seat with multiple dark stains.

Observation of Resident Room #111 on 4/4/17 at 2:02pm revealed:
-The wooden nightstand to the right of the bed had worn unpainted top surface.
-There was a missing knob on the right side of the top drawer.
-There were multiple scrapes on all surfaces of the nightstand.
-The 2-foot by 3-foot white shelving unit had peeling paint and multiple round beige stains on all shelves.

Observation of Resident Room #113 on 4/4/17 at 2:16pm revealed there were 3 of 5 drawer knobs missing on the night stand next to the bed by the left wall.

Observation of Resident Room #116 on 4/4/17 at 2:16pm revealed:
-There were multiple scrapes on all surfaces of the nightstand.
-The top center surface of the brown-stained dresser was worn to the beige-colored wood and had 9-inch long dried paint spatter.

Confidential interviews with three residents revealed:
-The furniture in the facility was old and worn.
-The facility did not have a maintenance person to repair or clean any of the furniture.
-They did not mention any missing dresser knobs, ceiling lights or dirty chairs to the management because the management had said "they would get to it" in the past and never did.
-Various facility staff assisted in facility repairs

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D 076	Continued From page 12 when ordered by management. Confidential interview with a staff member revealed: -The facility needed new chairs, beds and nightstands. -The residents' room furniture was old and worn. -The facility called outside contractors for repairs to walls, ceiling and plumbing when needed, but they were not called in to repair furniture. -The staff member did not report or forward any furniture repair requests to management as they had too much on their plate running the facility's day-to-day operations already. Interview with Resident Care Coordinator (RCC) and the Administrator in Training (AIT) on 4/5/17 at 3:45pm revealed: -The facility did not have a maintenance person. -Minor repairs were performed by housekeeping and dietary staff. -Much of the furniture including nightstands and chairs were to be replaced sometime in the future and were too old to repair. -The Administrator had informed them that the building was sold and new upgrades to resident rooms including furniture would be addressed. -They did not do a daily walk through the facility to determine furniture in need of repair or cleaning. . -The had not received any resident complaints about the furniture. Interview with Administrator on 4/5/17 at 10:45am revealed: -The building had not been maintained for well over a year. -The building did not have a maintenance person or contracted company for needed furniture repairs or cleaning. -The building had just been purchased this week	D 076		

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D 076	Continued From page 13 and upgrades to the entire facility including furniture would be addressed as needed. -He was responsible for overseeing the maintenance of the building. -The new building owner would be completely overhauling the entire facility which would include new furniture. -There was no time-of-completion date for the repairs.	D 076		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the resident's bedroom baseboard heaters and wall cables, and the exit door alarm wiring on the building exit doors were maintained in a clean manner and free hazards. The findings are: Observation of Resident Room #103 on 4/4/17 at 1:33pm revealed: -There was a 3-inch diameter hole in the left wall approximately 1 foot to the left of the closet door with a thin black television signal cable hanging out of the hole.	D 079		

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-The baseboard heater unit beneath the window had a partially detached 6-inch metal plate sticking out to the left of the control knob.

Observation of Resident Room #107 on 4/4/17 at 1:55pm revealed:
-There was a 3-inch diameter hole in the left wall approximately 1 foot to the right of the closet door with a thin 18-inch black cable hanging out of the hole.
-There was a rusted metal face plate on the baseboard heater beneath the window with a 6-inch section sticking out on the left side.

Observation of Resident Room #113 on 4/4/17 at 2:16pm revealed there was a rusted metal face plate on the baseboard heater beneath the window with a 2-foot section sticking out on the right side.

Observation of Resident Room #116 on 4/4/17 at 2:19pm revealed there was a rusted metal face plate on the baseboard heater beneath the window that was detached.

Observation of Resident Room #119 on 4/4/17 at 2:21pm revealed there was a rusted metal face plate on the baseboard heater beneath the window that was detached, protruding outwards into pathway between the bed and the heater.

Observation of Resident Room #222 on 4/4/17 at 2:23pm revealed:
-There was a rusted metal face plate on the baseboard heater beneath the window that was detached.
-There was a 3-inch diameter hole in the left wall approximately 1 foot to the right of the closet door with a thin 2-foot long black cable sticking out into the room.

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D 079	Continued From page 15 Observation of the exit door at the end of the West Hall on 4/4/17 at 2:35pm revealed: -There was a 2-foot long unsecured hanging white wire which ran from a hole in the ceiling above the door hinge to a brown-colored door alarm contact with exposed metal wire ends attached to two screws in the contact. -There were 5 sections of cracked plastic wire cover that were broken exposing white and gray wire which was spliced in several areas by clear plastic tape. -The plastic wire cover sheaths were detached from the wall and loosely hanging from the ceiling. Observation of the rear building exit door to the left of the Business Office on 4/4/17 at 2:46pm revealed: -There was a disconnected 2-foot red and white wire dangling from the ceiling over the left upper corner of the door with two orange wire caps. Observation of the rear building exit door to the left of the East Hall television room on 4/4/17 at 2:54pm revealed: -There was an unsecured 2-foot red and white wire hanging from the ceiling connected to a brown-colored door alarm contact with exposed metal wire ends attached to two screws in the contact. Observation of the exit door at the end of the East Hall on 4/4/17 at 2:54pm revealed: -There was an unsecured 2-foot red and white wire hanging from the ceiling connected to a gray-colored door alarm contact with exposed inner black and red wire with stripped ends attached to two screws in the contact.	D 079		

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Confidential interview with a staff member revealed:
-The wires at the exit doors alarm wires had been "sticking out like that" for over a year.
-The facility was old and needed a full-time maintenance person.
-The facility had no maintenance person on staff.
-The facility called outside contractors for repairs when needed.
-The facility had not called a maintenance man or electrician to fix the appearance of exit door wires or the wires in the resident bedrooms.
-The residents had not complained about the wiring.
-The door alarms functioned but the loose wiring could easily be pulled by any resident.

Interview with Resident Care Coordinator (RCC) and the Administrator in Training (AIT) on 4/5/17 at 3:45pm revealed:
-The facility did not have a maintenance person.
-The loose wires by the exit doors and in resident rooms were functional but needed to be repaired.
-No residents had been injured by the exposed wiring.
-They had been behind schedule for all repairs in the facility.
-There was a new building owner that would be taking responsibility for all repairs starting next month.
-The new building owner would repair all the wiring in the facility.

Interview with Administrator on 4/5/17 at 10:45am revealed:
-The building had not been maintained for well over a year.
-The building did not have a maintenance person or contracted company.
-The building had just been purchased this week

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D 079	Continued From page 17 and repairs to the wiring by the exit doors and in resident rooms would be performed beginning immediately. -He was responsible for overseeing the maintenance of the building. -The new building owner would be completely overhauling the entire facility. -There was no time-of-completion date for the repairs.	D 079		
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 review, the facility failed to provide supervision for 3 of 3 sampled Residents (#4, #6, #7) who were known to smoke in the facility and did not follow the facility's anti-smoking policy and failed to provide supervision for 1 of 1 sampled Resident (#2) who had a diagnosis of dementia, constantly disoriented and was known to wander in the facility and who had eloped from the facility. The findings are: 1. Review of Resident #4's current FL-2 dated 9/7/16 revealed: - Diagnoses included cardiovascular accident,	D 270		

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hypertension, congestive heart failure, depression, gout, diabetes, hypokalemia, groin pain, hypernatremia, and hyperkalemia. .
- Resident #4 had no information on orientation.
- Resident #4 was listed as ambulatory with wheelchair as an assistive device.

Review of Resident #4's Resident Register revealed:
- Resident #4 was admitted to the facility on 6/30/10.
-The register's section describing "memory status if different from the FL-2 "indicated "forgetful, needs reminders."

Review of Resident #4's Personal Care Plan dated 8/11/16 revealed Resident #4 was a smoker and often used the designated smoking area at the facility.

Observation of Room #111 (Resident #4's room) on 4/3/17 at 1:05pm revealed:
-Resident #4 was laying on the bed.
-The room smelled of cigarette smoke.
-There were 3 partially extinguished cigarettes of varying lengths in the trashcan.
-There were multiple ashes on the 2nd shelf of the white shelving unit on the right wall.
-There were burn marks on the front edges of the 2nd and top shelf of the shelving unit on the right wall.
-There were ashes on the linoleum floor to the right of the bed.
-There were tiny pieces of brown-colored tobacco dispersed on the white 2-foot square disposable cotton bed liner in the center of the bed.

Observation of Resident #4's room on 4/5/17 at 7:52am revealed:
-There was a soda can on the second shelf of the

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white cabinet with cigarette ashes on top of the can and around the base of the can.
- The room had an odor of smoke.
- There were ashes on top of the nightstand in front of the digital clock.
- There were ashes on the white cotton disposable pad on the bedspread.
- There were 3 partially burned cigarettes in the plastic liner of the trashcan.

Observation of the housekeeper on 4/5/17 at 10:25am revealed she emptied the trashcan, swept the ashes from the floor, discarded the cotton disposable pad on the bed and sprayed disinfectant in the room.

Interview with a housekeeper on 4/5/17 at 10:20am revealed:
-She was unaware that Resident #4 smoked in his room.
-She had just began working at the facility 3 weeks ago.
-Residents were not allowed to smoke in their rooms.
-Any resident caught smoking in their rooms were to be instructed to smoke outside.
-She did not realize she had swept up cigarette ashes.

Interview with a second housekeeper on 4/6/17 at 10:20am revealed:
-Resident #4's room had been cleaned and disinfected daily, including 4/4/17, 4/5/17 and 4/6/17 which included replacing the trash can liners and disposable bed liners.
-He found cigarette butts and ashes in Resident #4's room on 4/6/17 and reported it to the Resident Care Coordinator (RCC) on 4/6/17.

Interview with the RCC on 4/5/17 at 10:52am

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revealed:
- All resident's signed a smoking policy upon admission to the facility as part of their admission packets.
- The smoking policy included a 3-strikes rule which Resident #4 had signed.
-Resident #4 was one of the three smoking offenders.
-Out of the three smoking offenders, Resident #4 was the worst.
-There were more than 3 incidences in the past where Resident #4 had smoked in his room but the policy went unenforced.
-Facility staff had told Resident #4 repeatedly not to smoke in his room, but he keeps smoking in his room.
- Staff frequently redirected Resident #4 from smoking in his room and encouraged him to go outside.
- Resident #4's family member would bring him cigarettes as well as another resident.
- The facility did not control or monitor Resident #4's smoking habits.

Interview with the RCC on 4/6/17 at 10:35am revealed:
-He had not been informed that Resident #4 had been smoking in his room on 4/4/17, 4/5/17 and 4/6/17 by the staff.
-He would contact Resident #4's family member and speak with staff to create a plan for monitoring on 4/6/17 to address the resident's lack of smoking compliance.

Interview with the RCC on 4/6/17 at 11:30am revealed he had instructed staff to tell him each time Resident #4 was smoking in the room and to pass on the information to others including the 2nd shift staff when they arrived to work to let him know when Resident #4 violated the smoking

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policy.

Confidential interviews with 5 staff revealed:
- Resident #4 was told many times not to smoke in his room.
- Resident #4, was known to smoke in the room.
- The RCC and Administrator were notified of Resident #4 in the past on each occasion when the resident had smoked in the room but there were no repercussions to the resident or changes in the resident's supervision.
- Resident #4 was the worst of the smoking offenders.
- The staff kept telling Resident #4 not to smoke in his room but it "fell on deaf ears."
- Staff got tired of telling management about Resident #4's smoking in the room because there were no consequences to the resident.
- Resident #4's family member and another resident purchased Resident #4's cigarettes which he kept in his room.
- Resident #4 was frequently redirected to smoke outside when caught smoking in his room.
- Staff were tired of telling Resident #4 not to smoke in his room so they stopped telling the resident.

Observation of the designated smoking area patio on 4/5/17 at 12:45pm revealed Resident #4 was smoking in the designated area.

Observation of Resident #4's room on 4/6/17 at 8:02am revealed:
-There were ashes on the floor to the right of the bed.
-There was one burnt cigarette in the plastic liner of the trash can.
-There was a burn hole on the seat cushion of the chair in the right corner.
-There were no ashes on the nightstand or the

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white book shelf from yesterday.

Interview with Resident #4 on 4/5/17 at 10:05am revealed:
-He lived in a private room.
-He never smoked in his room.
-He rarely smoked cigarettes.
-He remained silent when asked about the cigarettes currently in the trashcan, the ashes on the counter and the smell of smoke in the room.

Interview with the Administrator on 4/5/17 at 2:05pm revealed he was unfamiliar with Resident #4's smoking violations but would speak with the RCC to determine the proper steps including documentation of all violations as well as potential discharges.

Review of the facility's smoking policy, signed by Resident #4, included in all resident admission packets provided by the RCC revealed:
- The building is a "Smoke Free Facility."
- "Absolutely NO SMOKING is allowed in resident rooms, bathrooms and the like."
- Smoking is allowed in designated outside areas only.
- Staff are to direct any person who is smoking inside the facility to extinguish the lighted smoking product immediately.
- Residents will be monitored daily to ensure that residents are in compliance with this rule.
- Any resident that is noticed or caught smoking twice in the facility will have their smoking products restricted for two weeks.
- Cigarettes and lighter products will be monitored by staff.
- Staff will issue cigarettes to residents that need monitoring.
- If any resident is caught with a lit cigarette or tobacco product for the third time in the facility,

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the facility will control cigarette products by monitored staff.
- If the resident will not comply this policy, the resident will be given a 30-day notice or discharged immediately.

Refer to the interview with the Interim Administrator in Training on 4/6/17 at 10:08am.

Refer to interview with the RCC on 4/5/17 at 10:52am.

Refer to interview with the Administrator on 4/5/17 at 2:05pm.

2. Review of Resident #6's current FL-2 dated 8/30/16 revealed:
- Diagnoses included chronic obstructive pulmonary disease, Cardio vascular accident, hypertension, diabetes, depression, chronic pain, and left-sided hemiparesis.
- Resident #6 was intermittently oriented.
- Resident #6 was listed as semi-ambulatory.

Review of Resident #6's Resident Register revealed Resident #6 was admitted on 9/7/16.

Interview with Resident #6 on 4/5/17 at 12:45pm revealed:
- He had smoked for several years.
- He was aware of the facility's designated smoking areas.
- Sometimes during the colder months he had "smoked inside but we're not supposed to."
- The management had never reprimanded him for smoking in non-designated areas.
- He was aware of the designated smoking areas and posted no smoking area signs.
- He knew of other residents [unnamed] that smoked in their rooms but would never tell on

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another resident.
- He did not feel the facility should be concerned where anyone smokes "because it doesn't harm anyone."
- He denied ever having ever smoked in his room.

Confidential interviews with 5 staff revealed:
- Resident #6 was known to smoke in the bedroom.
- The Resident Care Coordinator (RCC) and Administrator were notified of Resident #6 in the past on each occasion when the resident had smoked in the room but there were no repercussions to the resident or changes in the resident's supervision.
- Staff got tired of telling management about Resident #6's smoking in the room because there were no consequences to the resident.

Observation of the designated smoking area patio on 4/5/17 at 12:45pm revealed Resident #6 was smoking in the designated area.

Confidential interview with staff revealed Resident #6 was always discreet about smoking in his room and was harder to catch the resident smoking in the room.

Interview with the RCC on 4/5/17 at 10:52am revealed:
- All resident's signed a smoking policy upon admission to the facility as part of their admission packets.
- The smoking policy included a 3-strikes rule which Resident #6 had signed.
-Resident #6 was one of the three smoking offenders.
-Out of the three smoking offenders, Resident #6 was the second worst.

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-There were more than 3 incidences in the past where Resident #6 had smoked in his room but the policy went unenforced.

Interview with the Administrator on 4/5/17 at 2:05pm revealed he was unfamiliar with Resident #6's smoking violations but would speak with the RCC to determine the proper steps including documentation of all violations as well as potential discharges.

Review of the facility's smoking policy, signed by Resident #6, included in all resident admission packets provided by the RCC revealed:
- The building is a "Smoke Free Facility."
- "Absolutely NO SMOKING is allowed in resident rooms, bathrooms and the like."
- Smoking is allowed in designated outside areas only.
- Staff are to direct any person who is smoking inside the facility to extinguish the lighted smoking product immediately.
- Residents will be monitored daily to ensure that residents are in compliance with this rule.
- Any resident that is noticed or caught smoking twice in the facility will have their smoking products restricted for two weeks.
- Cigarettes and lighter products will be monitored by staff.
- Staff will issue cigarettes to residents that need monitoring.
- If any resident is caught with a lit cigarette or tobacco product for the third time in the facility, the facility will control cigarette products by monitored staff.
- If the resident will not comply this policy, the resident will be given a 30-day notice or discharged immediately.

Refer to the interview with the Interim

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Administrator in Training on 4/6/17 at 10:08am.

Refer to interview with the RCC on 4/5/17 at 10:52am.

Refer to interview with the Administrator on 4/5/17 at 2:05pm.

3. Review of Resident #7's current FL-2 dated 8/11/16 revealed:
- Diagnoses included diabetes, hypertension, chronic renal failure stage 3, anemia, hyperlipidemia, intellectual mental retardation and peripheral artery disease.
- Resident #7 was intermittently oriented.
- Resident #7 was listed as ambulatory.

Review of Resident #7's Resident Register revealed the resident was admitted on 9/15/09.

Review of Resident #7's Personal Care Plan dated 9/13/16 revealed:
- Resident #7 indicated supervision was needed in the areas of eating, bathing, dressing and grooming.
- Resident #7 spent most of his day on the smoking area outside.

Interview with Resident #7 on 4/5/17 at 12:45pm revealed:
- Resident #7 often searched for "cigarette butts that weren't completely smoked."
- Resident #7 collected partially smoked cigarettes in the ashtrays and on the ground of the smoking area daily and brought them back to his room for later use.

Confidential interview with staff revealed Resident #7 picked up cigarette butts from outside on a daily basis and often took them to his room to

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smoke.

Observation of the designated smoking area patio on 4/5/17 at 12:45pm revealed Resident #7 was searching through the cigarette ashtrays and on the ground for partially used cigarettes.

Confidential interviews with 5 staff revealed:
- Resident #7 was known to smoke in the bedroom.
- The RCC and Administrator were notified of Resident #7 in the past on each occasion when the resident had smoked in the room but there were no repercussions to the resident or changes in the resident's supervision.
- Staff got tired of telling management about Resident #7's smoking in the room because there were no consequences to the resident smoking in the room.

Observation of the designated smoking area patio on 4/5/17 at 12:45pm revealed:
- Resident #7 was smoking in the designated smoking area..
- Resident #7 was searching through the cigarette ashtrays and on the ground for partially used cigarettes.

Interview with the RCC on 4/5/17 at 10:52am revealed:
- All resident's signed a smoking policy upon admission to the facility as part of their admission packets.
-The smoking policy included a 3-strikes rule which Resident #7 had signed.
-Resident #7 was one of the three smoking offenders.
-Out of the three smoking offenders, Resident #7 was the third worst.
-There were more than 3 incidences in the past

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where Resident #7 had smoked in his room but the policy went unenforced.

Interview with the Administrator on 4/5/17 at 2:05pm revealed he was unfamiliar with Resident #7's smoking violations but would speak with the RCC to determine the proper steps including documentation of all violations as well as potential discharges.

Review of the facility's smoking policy, signed by Resident #7, included in all resident admission packets provided by the RCC revealed:
- The building is a "Smoke Free Facility."
- "Absolutely NO SMOKING is allowed in resident rooms, bathrooms and the like."
- Smoking is allowed in designated outside areas only.
- Staff are to direct any person who is smoking inside the facility to extinguish the lighted smoking product immediately.
- Residents will be monitored daily to ensure that residents are in compliance with this rule.
- Any resident that is noticed or caught smoking twice in the facility will have their smoking products restricted for two weeks.
- Cigarettes and lighter products will be monitored by staff.
- Staff will issue cigarettes to residents that need monitoring.
- If any resident is caught with a lit cigarette or tobacco product for the third time in the facility, the facility will control cigarette products by monitored staff.
- If the resident will not comply this policy, the resident will be given a 30-day notice or discharged immediately.

Refer to the interview with the Interim Administrator in Training on 4/6/17 at 10:08am.

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D 270	Continued From page 29 Refer to interview with the RCC on 4/5/17 at 10:52am. Refer to interview with the Administrator on 4/5/17 at 2:05pm. ______________________________ Interview with the Interim Administrator in Training (IAT) on 4/6/17 at 10:08am revealed: - The facility had a smoking policy that was not adhered "for a while." - She had no explanation why the policy was not being followed. - She would begin to implement the existing smoking policy. - She was aware of Resident #4, #6 and #7 as being the "chronic violators" of the smoking policy. - All staff would immediately be reeducated on the protocol for smoking violations in the building. Interview with the Resident Care Coordinator (RCC) on 4/5/17 at 10:52am revealed: - The facility had a 3-strikes smoking policy that had not been enforced. - There was no reason given for the lack of enforcement of the facility's smoking policy. - He could not provide a reason for the smoking policy not being enforced. - He would begin to enforce the smoking policy by telling all staff to report each incident of smoking in the rooms to him immediately. Interview with the Administrator on 4/5/17 at 2:05pm revealed: - The facility was being completely revamped, including its enforcement related to smoking policies. - Many of the facility's rules were not enforced by the previous Administrator.	D 270		

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- He was taking charge of building improvements and addressing immediate needs, which included enforcement of all policies and reassessments of residents that the facility may not adequately be able to assist with their needs.
- Smoking should not be occurring in any of the resident rooms.
- Staff will immediately be retrained to enforce all policies including smoking and be instructed to inform management upon discovery of each incident.
-The smoking policies were in place for the safety of all residents.
- Addressing smoking issues were among the list of many items on a long list which he was addressing beginning with immediate potential hazards to residents.

4. Review of Resident #2's current FL-2 dated 6/6/16 revealed:
-The resident had diagnoses of dementia, high blood pressure and hypothyroidism.
-The resident was constantly disoriented and was ambulatory with a walker.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 12/9/13.

Review of Resident #2's Care Plan dated 6/6/16 revealed:
-The resident was always disoriented.
-"No" was written in the area by wandering.
-"No" was checked-off at the question if the resident was receiving medications for mental illness/behavior.
-The resident was independent with transfers.

Review of Resident #2's progress notes dated 4/1/17 signed by a Medication Aide (MA), and two

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Personal Care Aides (PCAs) revealed:
-When a first shift PCA came on duty (7:35 a.m.), she noticed Resident #2 was missing from her room.
-The two PCAs on duty, the MA and another staff searched the building to look for the resident.
-The MA called the Administrator-in-Training (AIT) to notify her the resident was missing.
-The local Sheriff' was called and arrived at the facility between 7:45 a.m. to 8:00 a.m.
-The Search and Rescue Team was called.
-The resident was found at 2:16 p.m. in a neighbor's back yard across the street.
-The resident was taken to the hospital for an evaluation.

Interview with the PCA on 4/4/17 at 5:17 p.m., who worked first shift on 4/1/17 and was assigned to Resident #2 on the women's hall, revealed:
-She worked at the facility as a PCA on first (7:00 a.m. to 3:00 p.m.) and second shift (3:00 p.m. to 11:00 p.m.).
-She had been working at the facility for the past 18 years.
-Resident #2 used a walker for ambulation and sometimes a wheel chair for transferring, because sometimes the resident's knees bothered her.
-The resident normally walked slowly and sometimes she walked fast. The resident walked in a fast if she was mad. She did not say how often the resident was mad.
-On 4/1/17, the PCA arrived at the facility to work at 7:00 a.m.
-When she arrived to work the morning of 4/1/17, she was told by third shift staff that there was no problems with the residents during third shift.
-She started getting her supplies together to give assigned residents' showers.
-Around 7:35 a.m., she went to go and look for

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Resident #2 to give her a shower, but she could not find the resident.
-The resident's wheel chair and walker were in her room.
-She searched every room to look for the resident, including the men's hall.
-She asked the PCA assigned to the men's hall, if she had seen Resident #2 and the PCA had not seen the resident.
-Between 7:35 a.m. and 8:00 a.m., a MA called the AIT and the AIT told the MA to call the police.
-After the police was called, she called the Resident Care Coordinator (RCC).
-The PCA was told by another staff member, the resident was found across the street on 4/1/17 at 2:16 p.m. at a neighbor's house in the back yard on a porch.
-After the resident was found, she went to the hospital.
-The PCA got off work at 3:00 p.m. on 4/1/17.
-She was not working when the resident returned back to the facility. She was told by another staff the resident arrived back to the facility at 6:00 p.m. on 4/1/17.
-Resident #2 had never gotten out of the facility until she was discovered missing on 4/1/17.
-Before Resident #2 eloped from the facility, staff monitored the resident every two hours. Staff did not document the monitoring.

Interview with a second PCA on 4/5/17 at 10:03 a.m. revealed:
-She worked as a PCA first and second shifts.
-She worked the men's hall and the women's hall.
-When she first got to work on first shift, she got the bath supplies together, gave resident's showers and then she checked on all of her assigned residents.
-Resident #2 wandered from resident's rooms to rooms.

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D 270	Continued From page 33 -She had been wandering from room to room within the past month. -When the resident wandered from room to room, staff redirected the resident , took the resident to her room and staff continued to monitor her every two hours. -On 4/1/17, the PCA worked from 7:00 a.m. to 3:00 p.m. on the men's hall. -Between 7:30 a.m. to 7:58 a.m. on 4/1/17, the PCA assigned to the women's hall came to her and asked her if she had seen Resident #2 and she told her she had not seen the resident. -Both PCA's began looking for Resident #2 under the beds and "everywhere" inside of the facility. -The MA called one of Resident #2's Power of Attorney's (POA). -When the Rescue Squad and one of the resident's POA arrived at the facility, they walked up and down the halls and checked on the outside of the facility. -The PCA assigned to Resident #2 asked the AIT to check the facility's cameras. -The assigned PCA told her the AIT reviewed the cameras and saw the resident had gone out the side door on the women's hall on 3/31/17 at 6:15 p.m. -The exit door on the women's hall was not alarmed the day the resident eloped from the facility. -The PCA assigned to the resident told her the resident was found on 4/1/17 at 2:10 p.m. across the street on the back porch at a neighbor's house. -When the resident was found, the resident went to the local hospital. -When the PCA got off work on 4/1/17 at 3:00 p.m., the resident had not returned from the hospital. -If a resident could not be found after staff had searched the building, staff reported it to the	D 270		

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D 270	Continued From page 34 MA/Supervisor. -Before Resident #2 had eloped on 4/1/17, staff monitored the resident every two hours. -Staff had never increased the monitoring for Resident #2 until after the resident had eloped from the facility. Interview on 4/5/17 at 11:40 a.m. with the MA/Supervisor, who worked first shift on 4/1/17, revealed: -She worked at the facility as a Supervisor/MA on first and second shifts. -Resident #2 wandered inside the facility, when she got agitated. The resident received medication to help with the agitation. -When the resident wandered, staff kept the resident in sight. -The resident was a slow walker. -When she came to work at 7:00 a.m. on 4/1/17, she was told by the third shift MA/Supervisor during shift report, who worked third shift (11:00 p.m. to 7:00 a.m.) on 3/31/17, all of the residents were fine. She was not informed of any residents out of the facility. -When she was in the dining room on 4/1/17 between 7:35 a.m. to 7:40 a.m., the PCA assigned to the women's hall came to her and asked if she had seen Resident #2. -She told her she had not seen the resident. -She and both PCAs started looking for the resident inside the building. They searched the building three times and the resident could not be found. -After they searched the building, she called the AIT and two of Resident #2's POA's to inform them of the elopement. -Between 7:50 a.m. to 8:00 a.m., she called the local Sheriff's office to inform them of the missing resident. -The Sheriff Officer arrived at the facility within 10	D 270		

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D 270	Continued From page 35 minutes and began talking to Resident #2's POA's. -The Rescue Squad was at the facility and began searching for the resident. -Resident #2 was found on 4/1/17 at 2:17 p.m. at a house across the street from the facility. -She did not see the resident when she was found, because the resident went straight to the hospital. -Before Resident #2 eloped from the facility, the resident had never eloped or attempted to elope from the facility and she monitored the resident every 30 minutes. She had been monitoring the resident every 30 minutes since she had been working at the facility (one year). -When she worked at the facility on 3/31/17 first shift, Resident #2 was at the facility. Telephone interview on 4/7/17 at 2:55 p.m. with the PCA, who was assigned to Resident #2 second shift on 3/31/17, revealed: -On 3/31/17, she worked at the facility from 3:00 p.m. to 11:00 p.m. -She no longer worked at the facility. She retired on 4/3/17. -She was the only person assigned to the women's hall on 3/31/17, which was where the resident's room was located. -On 3/31/17, she had checked on Resident #2 at dinner time (6:00 p.m.) to see if the resident wanted to come to dinner, the resident told her she was not coming to the dining room and was not hungry. -At 6:00 p.m., the PCA was in the dining room feeding a resident. The feeding lasted for 30 minutes. -After she had finished feeding a resident, she had taken another resident to the room to do personal care. -She did not know Resident #2 had eloped from	D 270		

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the facility until she was told by staff on 4/1/17.
-The phone hung up while interviewing the PCA.
-Further attempts were made to contact the PCA, but she could not be reached by the end of the survey.

Interview on 4/5/17 at 3:01 p.m. with a fourth PCA/Dietary Aide, who worked third shift on 3/31/17 and was assigned Resident #2, revealed:
-On 3/31/17, she worked third shift as a PCA.
-She arrived to work at 11:00 p.m. and was assigned Resident #2, who lived on the women's hall.
-She had been working as a Dietary Aide since 4/3/17.
-She had worked at the facility for the past 18 years as a PCA.
-On 3/31/17, the second shift PCA, who was assigned the women's hall, told her all of the resident's on the women's hall were in bed.
-After she was told by the PCA all of the residents were sleep on the women's hall, she never opened the door to see if Resident #2 was in her room for the rest of the shift.
-She did not see Resident #2 on 3/31/17 during third shift.
-She should have checked on Resident #2, when she got to work on 3/31/17, because it was her responsibility.
-The PCA, who was assigned to Resident #2 on second shift on 3/31/17, told her she had seen Resident #2 at 11:00 p.m., because she had checked on her.
-When she arrived at the facility, the PCA "usually" walked the halls and did hourly checks on all of her assigned residents.
-Resident #2 had never been known to wander in the facility or elope from the facility.
-Resident #2 never had increased supervision.
-On 4/1/17 at 5:00 a.m., she walked down the hall

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to check on the residents.
-On 4/1/17 at 6:00 a.m., she started getting some of the residents up to get dressed.
-On 4/1/17 at 7:30 a.m., when she found out Resident #2 had eloped from the facility, she came to the facility to help search for the resident.

Interview on 4/6/17 at 10:06 a.m. with a Supervisor/MA, who worked second shift on 3/31/17, revealed:
-A PCA, who no longer worked at the facility, was assigned to Resident #2 on second shift on 3/31/17.
-At 4:00 p.m. on 3/31/17, when she had gone to attempt to give Resident #2 her evening medications, the resident was agitated and told her she wanted to go home and cook for the resident's husband.
-The resident did not want to take her medications at 4:00 p.m. She went back to the resident at 4:30 p.m. to give the resident her medications and the resident took her medication.
-After Resident #2 had taken her medications at 4:30 p.m., she laid back down.
-At 5:30 p.m. on 3/31/17, which was the last time she had seen the resident on 3/31/17, she had gone to check on the resident to see if she wanted to eat dinner, but the resident said she did not want to eat dinner.
-At 10:00 p.m., the PCA assigned to Resident #2 had done her rounds.
-The PCA told her that Resident #2 was sleep, because she had just checked on her in her room.
-Second shift staff, checked on the residents every two hours.
-The PCA assigned to Resident #2 did not always do two hour checks and she had to remind her.
-At 10:30 p.m. on 3/31/17, she told the PCA

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assigned to Resident #2 to make sure she checked on Resident #2, because the resident was agitated earlier.
-She did not say if staff checked on the resident.

Observation on 4/4/17 at 12:00 p.m. of the area identified where Resident #2 was found revealed:
-The Resident was found behind a red-brick home, which was located approximately 200 feet from the front entrance of the facility.
-The red-brick home was across the street from the facility.
-The pathway between the facility entrance and the red-brick home involved crossing the facility's parking lot, a 15-foot wide grass median separating the road and the facility, crossing the approximately 20-foot wide 2-lane road with a posted 25 miles per hour speed limit, then to the red-bricked home's grass lawn where the property began.
-There were no cars at time of observation on the residential road.
-The red-brick home had a metal fence enclosure on the opposite side of the home away from the road.
-Within the fenced in area on the opposite side of the house from the view of the facility was a latched swing gate where the resident was discovered inside the property boundary.

Observation on 4/4/17 at 2:22 p.m. revealed:
-The exit door at the end of the women's hall was opened.
-The door alarmed from 2:22 p.m. to 2:23 p.m.
-No staff came to check on the door to see if a resident had exited the building.

Observation on 4/5/17 at 8:25 a.m. revealed:
-Staff told residents to use the exit door in the dining room versus the main exit door to the

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smoking area, because construction was making repairs by the exit door and residents would not be able to use the door.
-A construction worker had propped opened the side door to the dining room near the smoking area with a paint bucket.
-Resident #2 was in the dining room eating her breakfast meal.
-Cigarette smoke was coming in the dining room.
-The Business Manager was informed that the door was propped opened.

Interview with the Business Manager on 4/5/17 at 8:25 a.m. revealed the door should have been closed and not propped open.

Observation in the dining room on 4/5/17 at 8:48 a.m. revealed a resident had gone out of the exit door and the door alarmed.

Interview with one of Resident #2's POA on 4/5/17 at 3:27 p.m. revealed:
-She was one of Resident #2's POA's.
-The resident had dementia and vertigo. She had a walker. Her knees are weak at times. She was not supposed to go out of the facility without supervision.
-On 4/1/17 at 8:00 a.m., she was contacted by a Supervisor and was told when first shift came on duty, it was discovered Resident #2 was missing from the facility.
-Immediately, all three of Resident #2's POA's came to the facility and started searching in the building, woods and the neighborhood.
-The staff at the facility continued to search for the resident.
-While the POA's, staff and the Rescue Squad were searching the neighborhood, a neighbor who lived across the street from the facility, came and asked them if they were searching for

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D 270	Continued From page 40 someone. -The neighbor had just came home and found the resident on her back porch. -The neighbor told her theywere gone all night on 3/31/17 and had seen the resident on the back porch the afternoon of 4/1/17. The neighbor had seen that the Rescue Squad in the neighborhood appeared to be looking for someone and immediately informed them about the resident on her back porch. -The POA did not know the time the resident was found. She assumed it was at 2:30 p.m. -She went to the neighbor's house and saw Resident #2 sitting on the floor on the back porch in a dog bed, with her back against the wall. The residents' legs were slightly bent, her feet were crossed and the pole of a garden tool was under her knees. -EMS arrived at the facility to take the resident to the local hospital. -The resident was dehydrated. She received two IV fluids. Her hands were dirty. The resident said she was not hungry, but when she had gotten to the local hospital, she received a sub, chips, apple slices and a soda. The resident ate all of the meal except the chips. -She was told by staff, according to the cameras at the facility, the resident had left on 3/31/17 at 6:15 p.m. -The resident had been gone for over 12 hours until staff discovered she was missing. -She was missing from the facility for 21 hours. Review of the police report from the local Sheriff's Office dated 4/2/17 revealed: -On Saturday 4/1/17 at 8:15 a.m., a call was received at the local Sheriff's office about a missing resident at the facility. -The Sheriff Officer arrived at the facility at 8:17 a.m. with staff on site.	D 270		

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-The Officer contacted the local EMS to see if the resident had been picked up by EMS. The resident had not been picked up by EMS.
-The Officer contacted the local hospitals to see if the resident had been admitted. Neither hospitals had the patient.
-The police department in a nearby city had been called and they were not aware of the missing resident.
-A helicopter and search dogs came on sight to help search for the resident.
-"Around 2:43 p.m.," the resident was found.
-She was found in "the back yard under a shelter attached to the back side of the residence."
-The resident was transported to the local hospital by EMS and "appeared to be in good health."
-"She was checked out and released at about 5:00 p.m."

Telephone interview with the Chief from the local Sheriff's Office on 4/5/17 at 12:14 p.m. revealed:
-The local Sheriff's office received a call from someone at the facility on 4/1/17 at 8:15 a.m. of a missing resident.
-A Sheriff Officer arrived at the facility at 8:17 a.m.
-The Sheriff Officer looked at the surveillance footage in the facility and documented the resident had left the facility on 3/31/17 at 6:18 p.m.
-Staff reported to the Officer the door alarm, where Resident #2 had exited the building, was cut and not working. The alarms did not appear cut.
-He did not know if the alarms alarmed inside of the building when the Officer entered the building.
-The search team did two searches for the resident.
-A neighbor across the street told the search team there was someone behind her house.

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D 270	Continued From page 42 -The resident was found on the back porch. -The resident was transported to the local hospital by the Emergency Medical Services (EMS). Interview with the RCC on 4/10/17 at 5:22 p.m. revealed: -He received a phone call from staff at the facility on 4/1/17 at 8:00 a.m. that Resident #2 had eloped from the facility. -Immediately, he came to the facility and begin searching on the outside of the facility, the woods in the back and sides of the facility, the fields and a church to find the resident. -The local police and a search and rescue squad with dogs helped to search for Resident #2 in the neighborhood. -While everyone was outside of the facility searching for the resident, someone yelled they found the resident. -The resident was found after 2:00 p.m. on 4/1/17 across the street at a neighbor's house on the back of a porch. -The resident was sitting on the back of the porch calmed and confused. -The resident went to the hospital by EMS and returned on the same day after 7:00 p.m. -The resident did not have any injuries. -When the resident returned from the hospital, he told staff to monitor and document her every two hours, until an Interim Administrator from another facility recommended to monitor and document the resident every 15 minutes. -Before Resident #2 eloped from the facility, staff monitored the resident every two hours. -When Resident #2 had eloped from the facility, many of the staff were in the dining room assisting residents with the dinner meal (6:00 p.m.). -Staff did not check on the resident every two	D 270		

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hours like they were supposed to.
-She should not have been out of the building unsupervised.
-She was usually in her room with her door closed.
-The resident shut her room door when she left.
-The resident had never tried to elope from the facility.
-Every time the resident said she wanted to go out of town, staff redirected her. He did not say how often that occurred.

Interview with the AIT on 4/10/17 at 6:18 p.m. revealed:
-After she was called by the first shift Supervisor on 4/1/17 at 8:05 a.m. and was informed Resident #2 had eloped from the facility, she came to the facility.
-After she arrived to the facility she and staff searched the inside and outside of the facility.
-The resident was found on 4/1/17 between 2:30 p.m. and 3:30 p.m. across the street on a neighbor's back porch.
-Her expectation was for staff to monitor residents with dementia every two hours until 4/1/17. Staff were not required to document the two hour checks.

Interview with an Interim Administrator on 4/10/17 at 7:04 p.m. revealed:
-She worked at another facility as an Administrator.
-She was there to answer questions for the Administrator.
-After staff realized Resident #2 had eloped from the facility and the resident returned back to the facility, staff were monitoring the resident every two hours.
-On 4/3/17, she recommended staff to monitor the resident every 15 minutes and document.

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D 270	Continued From page 44 -The RCC should randomly check the monitoring. -The expectation was to make sure residents did not wander away from the facility. -The facility did not assure Resident #2 did not wander from the facility. Interview with the Administrator on 4/5/17 at 9:16 a.m. revealed: -He became the temporary Administrator at the facility December 2016. -On 3/31/17, Resident #2 had eloped from the facility at 6:15 p.m. -A rescue team searched for the resident. -He did not know who found the resident. -When the resident was found, she was 100 yards from the building. -He was unsure if EMS took the resident to the hospital. -Staff did not do two hour checks as they should have. -The two hour checks existed, but it was not enforced. -During the time the resident eloped, no one had gone to check on her. -He was not aware the resident had eloped until 4/2/17 at 11:00 a.m. -After he found out the resident had eloped, he sent two of his Administrators to investigate the elopement. Based on observation, interview and record review, Resident #2 was not interviewable. The Sheriff Officer, who arrived at the facility after Resident #2 had eloped, could not be reached by the end of the survey. The third shift Supervisor/MA, who worked at the facility on 3/31/17, could not be reached by the end of the survey.	D 270		

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The failure of the facility to enforce the smoking policy resulted in the lack of supervision which would prevent their facility's smoking residents #4, #6 and #7 from smoking in their rooms permitting a fire hazard. The failure of the facility to provide supervision in accordance with Resident #2's assessed care needs, care plan and history of wandering, resulted in Resident #2 eloping from the facility and being dehydrated due to neglect. The cameras showed the resident had been gone from the facility for over 13 hours until staff discovered she was missing. This non-compliance constitutes a Type A1 Violation for lack of supervision.

____

The facility submitted a Plan of Protection dated 4/4/17, as follows:
-Staff will begin to monitor residents who smoke to ensure they are not smoking in their rooms or other areas inside the facility.
-A resident caught smoking inside the facility will be reported to management staff for actions to be taken.
-A residents caught smoking inside the facility will have smoking products restricted for 2 weeks with staff giving out smoking products upon request for staff to monitor.
-A resident caught a 3rd time inside the facility will have their smoking products controlled by staff from now on.
-If resident does not want to follow [these restrictions and monitoring], a discharge will be given to the resident.

The facility submitted a Plan of Protection dated 4/5/17, as follows:
-Immediately, staff will do 15 minute checks for residents with a diagnosis of dementia,

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D 270	Continued From page 46 Alzheimer's who wandered and were disoriented. -Staff would be trained on resident rights, the missing resident policy and resident safety. -Any resident who goes outside of the building who has a diagnosis of dementia, Alzheimer's, who wandered and were disoriented, would have one on one supervision. -The residents Care Plans would be updated. -The Resident Care Coordinator (RCC) would make sure staff are documenting the 15 minute checks. -For residents who does not have a diagnosis of dementia, Alzheimer's, who wandered and were disoriented, would be placed on two hour checks. -Staff would document the checks. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 10, 2017	D 270		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have a matching therapeutic diet menus for 1 of 1 sampled residents (#7) on the No Added Salt (NAS)/No Concentrated Sweets (NCS) combination diet and 1 of 1 sampled residents (#9) on a Low Fat Low Cholesterol (LFLC)/NCS combination diet. The findings are:	D 296		

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1. Review of Resident #7's current FL-2 dated 8/11/16 revealed:
-The resident's diagnoses included diabetes, high blood pressure, hyperlipidemia, peripheral artery disease.
-The resident had a diet order for a NAS/NCS diet.

Review of Resident #7's Resident Register revealed the resident was admitted to the facility on 9/15/09.

Review of the diet list dated 3/30/17 revealed Resident #7 was to receive the NAS/NCS chopped food diet.

Review of the facility's menus revealed the facility did not have a menu for a NAS, NCS or a NAS/NCS diet.

Review of the Week 3 Wednesday 2016-2017 LCS breakfast menu revealed the resident was to be served 4 ounces (oz) juice, 1 serving of cereal, 1 slice of french toast, 1 breakfast meat, 1 margarine/sugar free syrup and 8 oz 2% milk.

Observation of Resident #7 on 4/5/17 at 7:35 a.m. during the breakfast meal revealed the resident was served 3/4 cup of corn flakes with milk, 3 oz scrambled eggs, 1 slice of bread, 1 link chopped sausage, 1 sugar-free jelly, 8 oz water and 8 oz milk

Observation of Resident #7 on 4/5/17 at 8:05 a.m. revealed the resident had eaten all of the meal and drank all of his beverages.

Review of the Week 3 Wednesday 2016-2017 LCS lunch menu revealed the resident was to be

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served 3 ounces (oz) meat loaf, 1 oz gravy, 4 oz garlic mashed potatoes, 4 oz green beans, ½ square of German chocolate cake and 1 white/wheat roll.

Observation of Resident #7 during the lunch meal on 4/6/17 at 11:45 a.m. revealed the resident received 3 oz meatloaf, 4 oz mashed potatoes, 4 oz green beans, 1 wheat roll, 4 oz fruit cocktail, 8 oz water, and 8 oz tea.

Observation of Resident #7 on 4/6/17 at 12:25 p.m. revealed the resident had eaten all of his meal and drank all of his beverages.

Interview with Resident #7 on 4/6/17 at 12:25 p.m. revealed he enjoyed his meal.

Interview with Resident #7 on 4/10/17 at 3:25 p.m. revealed:
-He had limited salt in his diet.
-He was not on a diet with limited amount of sweets.

Refer to interview with a Dietary Aide on 4/4/17 at 1:34 p.m.

Refer to interview with the Cook on 4/5/17 at 9:25 a.m.

Refer to interview with a Cook on 4/6/17 at 12:43 p.m.

Refer to interview with the Administrator-in-Training (AIT) on 4/6/17 at 12:22 p.m.

Refer to interview with the AIT on 4/6/17 at 12:45 p.m.

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D 296	Continued From page 49 Refer to interview with the AIT on 4/10/17 at 6:18 p.m. Refer to interview with the RCC on 4/10/17 at 5:22 p.m. Refer to interview with an Interim Administrator on 4/10/17 at 7:04 p.m. 2. Review of Resident #9's current FL-2 dated 1/6/17 revealed: -The resident's diagnoses included high blood pressure and diabetes mellitus. -The resident had a history of a myocardial infarction and a transient ischemic attack. -There was a diet order for a LFLC/NCS diet and one sugar free shake daily. The resident was only to receive juice once a week. Review of Resident #9's Resident Register revealed the resident was admitted to the facility on 9/1/09. Review of the diet list dated 3/30/17 revealed Resident #9's was to receive the LFLC/NCS diet and juice only once weekly. Review of the facility's menus revealed the facility did not have a menu for a LFLC/NCS diet. Review of the Week 3 Wednesday 2016-2017 LFLC breakfast menu revealed the resident was to be served 6 ounces (oz) juice, 1 serving cereal, 2 slices French toast, a breakfast meat 1 margarine/sugar free syrup and 8 oz 2% milk. Review of the Week 3 Wednesday 2016-2017 LCS breakfast menu revealed the resident was to be served 6 oz juice, 1 serving cereal, 2 slices French toast, a breakfast meat 1 margarine/syrup	D 296		

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and 8 oz skim milk.

Observation of Resident #9 during the breakfast meal on 4/5/17 at 8:00 a.m. revealed the resident's meal included ¾ cup cereal with milk, 1 sausage pattie, 2 french toast with sugar free syrup, 3 oz scrambled eggs, 8 oz coffee, 8 oz water and 1 sugar free mighty shake.

Observation of Resident #9 during the breakfast meal on 4/5/17 at 8:18 a.m. revealed the resident had finished his meal and had eaten all of the cereal with milk, the sausage pattie, french toasts and scrambled eggs and had drank all of the water and mighty shake and had drank 6 oz of the coffee.

Review of the Wednesday Week 3 2016-2017 LFLC lunch menu revealed the resident was to be served 3 oz meat loaf, 1 oz gravy, ½ cp garlic mashed potatoes, 4 oz green beans, ½ square of German chocolate cake and 1 white/wheat roll.

Review of the Wednesday Week 3 2016-2017 LCS lunch menu revealed the resident was to be served 3 oz meat loaf, 1 oz gravy, 4 oz garlic mashed potatoes, 4 oz cp green beans, ½ square of German chocolate cake and 1 white/wheat roll.

Observation of Resident #9 during the lunch meal on 4/5/17 at 11:58 a.m. revealed the resident received 3 oz meat loaf, 4 oz mashed potatoes, 4 oz green beans, 4 oz fruit cocktail, 1 wheat roll, 8 oz water and 8 oz tea.

Observation of Resident #9 during the lunch meal on 4/5/17 at 12:10 p.m. revealed:
-The resident had eaten all of the meat loaf and mashed potatoes and over ¾ of the green beans.
-The resident did not eat the roll of the fruit

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cocktail.
-The resident drank all of the beverages.

Interview with Resident #9 on 4/10/17 at 7:44 p.m. revealed:
-He was a diabetic.
-He did not receive sugar free dessert.
-He did not receive fried foods.

Resident #9's primary are physician could not be reached by the end of the survey.

Refer to interview with a Dietary Aide on 4/4/17 at 1:34 p.m.

Refer to interview with the Cook on 4/5/17 at 9:25 a.m.

Refer to interview with a Cook on 4/6/17 at 12:43 p.m.

Refer to interview with the Administrator-in-Training (AIT) on 4/6/17 at 12:22 p.m.

Refer to interview with the AIT on 4/6/17 at 12:45 p.m.

Refer to interview with the AIT on 4/10/17 at 6:18 p.m.

Refer to interview with the RCC on 4/10/17 at 5:22 p.m.

Refer to interview with an Interim Administrator on 4/10/17 at 7:04 p.m.

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Interview with a Dietary Aide on 4/4/17 at 1:34 p.m. revealed:
-The morning Cook had left for the day.

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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 296	Continued From page 52 -For residents on the No Added Salt (NAS) diet, salt was not added into the food. -For residents on the Low Fat Low Cholesterol (LFLC) diet, the food was not fried. -For residents on the No Concentrated Sweets (NCS) diet, the desserts and beverages were sugar free. -For Residents on the NCS/NAS diet, no salt was added to their meal and the desserts and beverages were sugar free. -For residents on the LFLC/NCS diet, the food was not fried and the desserts and beverages were sugar free. Interview with the Cook on 4/5/17 at 9:25 a.m. revealed: -The facility did not have a Dietary Supervisor. -For residents on the LFLC/NCS diet, they did not receive fried foods and the desserts were sugar free. -For residents on the NAS/NCS diet, salt was not added to the food and they received sugar free desserts. -The facility did not have a combined LFLC/NCS menu or a NAS/NCS menu. -The facility did not have combination diet menus. -The facility had been using combined diet orders for at least one year. Interview with the same Cook on 4/6/17 at 12:43 p.m. revealed she had been using the Low Concentrated Sweets (LCS) menu for the NCS menu, since the fall of 2016. Interview with the Administrator-in-Training (AIT) on 4/6/17 at 12:22 p.m. revealed: -For the NAS diet, the Cooks prepared the food without salt. -For the NCS diet, residents received sugar free desserts and beverages.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074033	A. BUILDING: ___ B. WING ___	R-C **04/10/2017**

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D 296	Continued From page 53	D 296		

-For the NCS diet, the Cook had been following the LCS menu. She thought it was the NCS menu. She told staff to follow the LCS menu.
-For the LFLC diet, the residents did not receive fried foods. The food was baked.
-The facility did not have combination menus.
-The facility had been using combination diet orders for the past 12 years.
-She was not aware a combination diet order required a combination diet menu.
-If a resident had a combination diet order, staff just followed both diet menus.

Interview with the AIT on 4/6/17 at 12:45 p.m. revealed:
-She had just received the facility's new menu cycle on 4/5/17.
-The new menu cycle had the NAS and NCS menus.
-The facility will start using the new cycle menus on 4/8/17.

Interview with the AIT on 4/10/17 at 6:18 p.m. revealed:
-She was responsible for dietary.
-She had been responsible for dietary since November 2016.
-She monitored meals in dietary once weekly.
-She last monitored the meals in the kitchen last week (between 4/2/17 and 4/8/17).
-Her expectation was for staff to prepare the diets as ordered by the resident's primary care physician.

Interview with the Resident Care Coordinator (RCC) on 4/10/17 at 5:22 p.m. revealed:
-The AIT was over dietary.
-The facility had residents on combination diet orders and had been offering the combination diet orders for the past 7 years.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074033	A. BUILDING: ______ B. WING ______	R-C **04/10/2017**

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D 296	Continued From page 54 -The facility did not have combination menus. -If a resident was on a NAS/NCS diet, the resident would not receive added salt with the meal and would receive fruit versus a cake. -If a resident was on a LFLC/NCS diet, he was not sure how to prepare it. -He was not aware the facility did not have a NCS menu. -If he was aware, he would have made sure staff had a menu. -Sometimes he monitored meals twice monthly. Interview with an Interim Administrator on 4/10/17 at 7:04 p.m. revealed: -She worked at another facility as an Administrator. -She was there to answer questions for the Administrator. -The facility Administrator's expectation was for the staff to follow the menu based upon the diet order. -The facility's Administrator was aware the facility had combination diet orders. The Administrator was not available for interview.	D 296		
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 assure residents were not neglected related to exit door alarms not being activated, a resident eloping from the facility and residents smoking inside the facility.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	Continued From page 55	D914		

The findings are:

Based on observations, interviews and record review, the facility failed to provide supervision for 3 of 3 sampled Residents (#4, #6, #7) who were known to smoke in the facility and did not follow the facility's anti-smoking policy and failed to provide supervision for 1 of 1 sampled Resident (#2) who had a diagnosis of dementia, constantly disoriented and was known to wander in the facility and who had eloped from the facility. [Refer to Tag D067, 10A NCAC 13F .0305(h)(4). (Type A1 Violation)]

2. Based on observations and interviews, the facility failed to assure all exit door alarms were maintained in operational conditions and activated with a sounding device when opened, which resulted in 1 of 5 sampled residents (#2), who was disoriented, exited the building without staff knowledge and was located at a nearby home the next day. [Refer to Tag D270, 10A NCAC 13F .0901(b). (Type A2 Violation)]