STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034016	A. BUILDING _____ B. WING _____	C 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIENNA VILLAGE	6601 YADKINVILLE ROAD PFAFFTOWN, NC 27040

(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 survey and a complaint investigation on March 14-15, 2018. The complaint investigation was initiated by the Forsyth County Department of Social Services on March 9, 2018.	D 000	**Plan of Correction for D270/D912**	
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 B VIOLATION Based on observations, interviews and record reviews the facility failed to provide supervision for 1 of 5 sampled residents (#5) who had exhibited exit seeking behaviors and eloped from the facility. The findings are Review of Resident #5's current FL-2 dated 01/24/18 revealed: -Diagnoses included, other specified anxiety disorders, iron deficiency anemia, unspecified dementia with behavioral disturbance, essential primary hypertension, benign prostatic hyperplasia, hx of traumatic fracture, dependence on wheelchair, pulmonary hypertension, non-rheumatic aortic valve insufficiency, difficulty in walking not elsewhere classified, and history of nicotine dependency.	D 270	❖ Measures put in place to correct: Both our ***Policy for Identification and Supervision of Residents Who Wander*** and our ***Resident Assessment Tool for Wandering/Elopement*** have been revised. We have reassessed our residents based upon them exhibiting any of the following behaviors: • talking anxiously about "going home" while packing belongings • frequently opening exit doors to look outside • while walking outside, leaving hard surface area and wandering near to street • attempting to get into cars in parking lot • leaving premises without signing out nor informing staff We have taken measures to provide additional supervision to residents who were showing any of these type of behaviors or gave us other reasons to be concerned about their safety. We involved resident's family and physician in the process. After this process, six additional residents were given a wander bracelet. We have also encouraged these residents to participate in as many activities as possible since they will be under direct supervision during that time. Staff have also been individually trained about the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chris Parker — TITLE: ADMINISTRATOR — (X6) DATE: 4-17-2018

Received + accepted. AJS 4/23/18

Division of Health Service Regulation

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D 270	Continued From page 1 -Resident #5 was intermittently disoriented. Review of Resident #5's Resident Register revealed. -The resident was admitted to the facility on 01/22/18. -There was no documentation the resident was at risk for elopement. Review of Resident #5's Resident Notes revealed: -On 02/11/18 the resident went out of the front porch door. Staff redirected the resident back inside. The resident stated, "I told you I wasn't staying here". -On 02/14/18 the resident went into two different residents' rooms. Staff redirected resident to his room. -On 02/18/18 the resident went out the door at the end of the front hall. The resident was somewhat argumentative with staff but they were able to redirect him back into the facility. Facility staff called the residents daughter. Review of Resident #5's Primary Physician's Discharge order dated 02/21/18 revealed: -This was the form to discharge the resident from the facility to a locked unit. -An entry that noted several attempts to leave the facility since being admitted. -An entry that noted the resident was likely to attempt elopement again in the future. Review of Resident #5's Care Plan dated 01/23/18 revealed: -The resident was somewhat confused. -The resident was ambulatory with aide or device. -The resident used a walker with limited staff assist. -The resident was forgetful and needed	D 270	importance of re-directing residents. Staff have also been advised about quickly reporting any of the above behaviors to their supervisor. Staff are frequently reminded about the importance of quickly responding to any door alarms. Additional measures which have been utilized are listed in our assessment tool. ❖ <u>In order to prevent such an event from occurring again</u>: As mentioned above, we have updated both our ***Policy for Identification and Supervision of Residents Who Wander*** and our ***Resident Assessment Tool for Wandering/Elopement*** and are using the revised assessment tool prior to admission to determine if a potential resident has a history or propensity toward elopement. Input will be gathered from both the family, physician, and facility (if they currently reside in another facility) to determine if a potential resident has exhibited traits suggesting their likeliness to elope. During interviews with families of prospective residents, we emphasize strongly and clearly that our facility is <u>not</u> appropriate for residents who present confirmed evidence of elopement. If a prospective resident is denied admission due to elopement risk concerns, we recommend a facility with a locked unit where the individual can be supervised more safely. After admission, each resident will be monitored for development of behavior that is suggestive of elopement. For example, such behavior may include talking anxiously about "going home"	

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D 270	Continued From page 2 reminders. Observations on 03/14/18 at 8:45 am of the facility revealed the side exit door and was able to be opened and no sound was heard. Observation of the facility's front entry/exit door on 03/15/18 at 10:00 am revealed that it could be opened for exit from the facility with no sound heard. Observation of the area where Resident #5 was found was approximately 150 ft in front of the facility and several cars passed by the facility during a five minute timeframe. Interview with a first shift personal care aide on 03/14/18 at 10:15 am revealed: -Every resident that was known to wander was given a body alarm. -The doors would open without alarming unless a resident with a body alarm approached the door. -If a resident with a body alarm approached the door, the door would lock and the staff were notified. Interview with Resident #5's family member on 03/15/18 at 9:55 am revealed: -She was upset the physician had documented the resident had made several attempts to leave the facility prior to the incident on 02/19/18. -The facility never let her know the resident had attempted to leave the facility. -It was the facility's decision not to place a body alarm on the resident upon admission to the facility to allow as much independence and freedom as possible. -She was notified by the facility staff on 02/19/18 that a passerby called the facility and reported the resident was in the road in front of the facility.	D 270	while packing belongings; frequently opening exit doors to look outside; while walking outside, leaving hard surface area and wandering near to street; attempting to get into cars in the parking lot; or leaving premises without signing out nor informing staff. If any concerns arise, interventions will be enacted including (but not limited to) wander tag placement, medication review, increased focus on recreational activities, staff awareness and re-direction training, and potentially transfer to a secure/locked facility. Families and resident's physician are included in this process. We acquaint families regarding the dangers involved in elopement. Family members are also apprised that they need to immediately report any changes in mental status or behavior that they notice to staff. As mentioned above, staff have been individually trained about the importance of re-directing residents. Staff have also been advised about quickly reporting any of the above behaviors to their supervisor. Staff are frequently reminded about the importance of quickly responding to any door alarms. Elopement drills are conducted on a quarterly basis. Additional measures which have been utilized are listed in our assessment tool. In our April newsletter which is distributed to families and residents, the following reminder was included: *"If a resident leaves the facility, they or their family needs to sign them out on the sign out sheets we have located near most exit doors. This ensures that we know if any of our residents have*	

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D 270	Continued From page 3 -She was never given a timeframe from which the resident was gone from the facility. -She was informed by staff the resident was found without his walker. -Immediately after the incident the facility discussed discharge. -She was told the resident needed to be in a locked unit. -She had let the facility know the resident's attempts to wander at a previous facility out of state prior to admission. -After the incident on 02/19/18, the facility staff placed a body alarm on the resident and the resident cut the alarm off on 02/20/18. -The facility staff placed another body alarm on the resident on 02/20/18. -The three Administrators were working as well as the facility Social Worker but she was unable to recall any other staff that worked the day of the incident. Interview with an Administrator/Human Resources Director on 03/15/18 at 11:10 am revealed: -On 02/19/18 at 8:15 am the resident was seen leaving the dining room after breakfast. -On 02/19/18 around 15 minutes after the resident was seen leaving the dining room after breakfast, the facility staff received a call from a passerby stating an elderly gentleman was in the road in front of the facility. -The maintenance supervisor went to the road to assist the resident back to the facility, but the resident was uncooperative and would not return to the facility. The resident refused to return to the facility. -The facility Social Worker blocked traffic in the lane of traffic in which the resident was standing in an attempt to keep him safe. -The Administrator/Owner arrived at the facility in	D 270	*left the building and approximately what time they will be returning."* ❖ Who will monitor the situation: Administrator with assistance from all shift Supervisors and involvement from staff will provide supervision and assessment of residents to ensure their safety. Those with wander tags will also be monitored by the wander system if they open any exit doors. ❖ How will monitoring take place: Monitoring and potential re-assessment will occur on a daily basis. The wander system will monitor those with a wander tag at all times. ❖ Completion date: All of the above measures are currently in place.	

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an attempt to redirect the resident back to the facility.
-The resident continued to be uncooperative and would not return to facility.
-The Administrator asked the facility Social Worker to call 911 and the resident's family member.
-Staff were able to convince the resident to get into the facility Social Worker's vehicle and the resident was taken back to the facility.
-Once the resident was safely in his room a body alarm was placed on his ankle on 02/19/18.
-On 02/20/18 the resident used nail clippers to cut it off.
-Facility staff placed a second body alarm on the resident and on his walker on 02/20/18.
-Once the resident's family member arrived at the facility, the facility Administrators and Social Worker discussed discharge due to safety concerns and need for a locked unit.
-When the resident was admitted to the facility, the family member told the Administrator/Owner and Social Worker she did not want the resident contained and wanted him to be able to enjoy the gardens.
-If the resident had a body alarm he would not been able to go outside and enjoy the gardens.
-"We did not consider him an elopement risk."
-The facility tried to stay on the side of caution while still allowing the resident freedom.
-He had not attempted to leave the facility premises prior to 02/19/18.
-The body alarm system was updated in January 2018.
-When a resident with a body alarm approached the doors, the door would automatically lock, alarm and page the facility staff and supervisor.
-The Primary Care Provider was notified on 02/19/18 of the elopement.

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Interview with an Administrator/Owner on 03/15/18 at 11:20 am revealed.
-On 02/19/18 at 8:15 am the resident was seen leaving the dining room after breakfast.
-On 02/19/18 around 15 minutes after the resident was seen leaving the dining room after breakfast, the facility received a call from a passerby stating an elderly gentleman was in the road in front of the facility.
-She went down to the road to assist the resident back to the facility and he was uncooperative.
-She, along with the maintenance supervisor and the facility Social Worker stayed in the road with the resident because they could not get him to come back to the facility due to his uncooperative behavior.
-Together they persuaded the resident to get into the facility Social Worker's vehicle and managed to get him back to the facility and into his room
-The facility had never admitted a resident without seeing the resident face to face first.
-The facility admitted the resident by a phone skype interview.
-The resident's family member informed the facility staff prior to admission to the facility that the resident would attempt to get on the 3rd floor elevator and leave the previous facility
-The resident's family blamed it on the staff not understanding how to manage him.
-The resident's family member informed the facility staff that the resident would have bruises on his arms from the staff having to redirect him from attempts to get on the elevator and leave the previous facility.
-The resident's family member requested the facility not place a body alarm on the resident initially upon admission.
-The facility was unable to provide documentation of the family member's request.
-The resident's family member wanted him to be

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able to enjoy the gardens at the facility.
-She felt in hindsight the facility made a mistake by not placing a body alarm on the resident when initially admitted to the facility.
-She knew the resident had been redirected back inside by the facility staff prior (02/11/18 and 02/18/18) to the elopement on 02/19/18.

Interview with the primary care physician on 03/15/18 at 4:17 pm revealed:
-She was told by the facility staff that the resident was in the road on 02/19/18.
-It was a very dangerous situation with the resident in the road and cars driving by.
-She saw the resident later on 02/19/18 and the resident was "delusional".
-The resident was talking about going to get a haircut.
-She knew the resident had a history of dementia.
-The resident was a "new patient" to her.
-She was unable to recall if the facility had notified her of the resident attempting to elope from the facility prior to 02/19/18.
-She felt the resident would be safer in a locked unit.
-She could not say if a body alarm would have prevented the incident on 02/19/18.

Interview with the maintenance supervisor on 03/15/18 at 4:30 pm revealed:
-At about 8:45 am a passerby called and informed the facility staff an elderly man was in the middle of the road in front of the facility.
-He went down to the road to try and convince the resident to come back into the facility
-The resident stated he was going to get a haircut.
-The resident started cursing and swinging his arms.
-The Administrator/Owner came to the road to try

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and calm the resident down and attempted to get him back to the facility safely.
-The resident continued to be uncooperative and cursing.
-The facility Social Worker showed up and was able to calm the resident down and get him into her vehicle and back to the facility safely.
-The resident did not have his walker with him on 02/19/18.

Interview with a second shift personal care aide (PCA) on 03/15/18 at 4:40 pm revealed:
-The resident was intermittently confused.
-He would often wander into other residents' rooms.
-Staff would redirect the resident back to the correct room.
-Supervision was not increased until after the elopement on 02/19/18, and staff initiated 30 minute safety checks on 02/21/18.
-He would wander to the doors and needed to be redirected.
-The resident became irritated when staff would redirect the resident away from the doors.
-Staff checked on all residents at least every 2 hours and more often as needed.

Attempted interview with first shift PCA on 03/15/18 at 4:50 pm was unsuccessful.

Attempted interview with the facility Social Worker on 03/15/18 at 4:55 pm was unsuccessful.

The facility failed to assure supervision was provided for Resident #5, who had exhibited exit seeking behaviors and was known to wander, which resulted in Resident #5 eloping from the facility and found by a passerby on a busy road. This failure was detrimental to the resident's safety and welfare and constitutes a Type B

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D 270	Continued From page 8 Violation. Review of the Plan of Protection provided by facility on 03/15/18 revealed: -The facility will evaluate residents for the need of increased supervision. -The facility will put a plan in place for increased supervision. -The Administrator/Owner will train staff for increased supervision. -Wanderguard system has been in place since 2005 but upgraded the system with the latest technology in January 2018. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, MAY 1, 2018	D 270		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights. 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision. The findings are Based on observations, interviews and record	D912		

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reviews the facility failed to provide supervision for 1 of 5 sampled residents (#5), who had a diagnosis of dementia, exhibited exit seeking behaviors and elopec from the facility. [Refer to Tag 270. 10 NCAC 13F .0901(b) (Type B Violation).]