STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075010	A. BUILDING: _____ B. WING _____	R-C 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

(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 and the Polk County Department of Social Services conducted annual and follow-up survey and complaint investigation on 09/04/19 to 09/05/19 with an exit conference via telephone on 09/06/19. The complaint investigation was initiated by the Polk County Department of Social Services on 08/12/19.	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 B VIOLATION Based on observations, interviews, and record review, the facility failed to ensure 1 of 7 exit doors accessible to residents in the Special Care Unit (SCU) had an alarm that was of sufficient volume that it could be heard by staff and 2 of 4 exit doors accessible to assisted living residents that when activated was responded to for the	D 067	See Attached	

Reviewed and Accepted
Date: 10/11/19 cs

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D 067	Continued From page 1 safety of residents. The findings are: 1. Observation on the SCU on 08/12/19 at 3:25pm revealed the alarm panel in the medication aide office was hanging off the wall with the wires exposed. Interview with a medication aide (MA) on 08/12/19 at 3:30pm revealed: -Since the storm on 07/04/19 the alarm just "clicks" in the medication room. -"It does not go off." Observation of the door at the time clock of the SCU on 08/12/19 at 3:35pm revealed: -When the door was opened the alarm was not of sufficient volume that it could be heard by staff. -No staff came to check the door. -The alarm panel in the medication room made a clicking noise. Review of the Memory Care Door Alarm Test logs dated 07/05/19 to 08/12/19 revealed: -On 07/05/19, 1 of 8 doors failed the alarm test due to "storm damage" with a note "fixed" on 07/10/19 Administrator "aware system down." -On 07/10/19, 3 of 8 doors failed the alarm test due to "storm damage" with a note Administrator "aware." -On 07/12/19, 3 of 8 doors failed the alarm test due to "storm damage" with a note Administrator "aware again company working on doors and alarm system." -On 07/19/19, 2 of 8 doors failed the alarm test due to "storm damage" with a note Administrator "aware all alarms not working" and "company aware and has been coming out working on it." -On 07/26/19, 2 of 8 doors failed the alarm test	D 067		

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D 067	Continued From page 2 due to "storm damage" with a note "doors been worked on by [name of alarm panel company]" since 07/04/19 "new parts being ordered." -On 08/05/19, 1 of 8 doors failed the alarm test due to "storm damage"with a note "doors been worked on by [name of alarm panel company]" since 07/04/19 "new parts being ordered." -On 08/12/19, 1 of 8 doors failed the alarm test due to "storm damage" with a note "doors been worked on by [name of alarm panel company]" since 07/04/19 "new parts being ordered." Review of Resident #3's current FL2 dated 05/07/19 revealed: -Diagnoses included dementia. -Special Care Unit (SCU) was documented as Resident #3's level of care. -Resident #3 was ambulatory. Review of Resident #3's current Care Plan dated 06/04/19 revealed: -The resident had occasional disorientation to person, place, time or situation even in familiar surroundings and required frequent direction and reminders. -The resident had current wandering behaviors and moved with intentional destination and needed direction or occasional reminders. -The resident required frequent staff monitoring as an intervention to prevent or limit elopements. -The resident communicated verbally with the assistance of an electrolarynx. -The resident had mild visual impairment, but could see adequately with devices. -The resident had mild hearing impairment, but could hear adequately with devices. Review of Resident #3 Incident/Accident Report dated 08/09/19 at 6:50pm revealed: -Staff heard the door alarm where the time clock	D 067		

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D 067	Continued From page 3	D 067		

was located.
-Staff performed a head count of all residents in the SCU and discovered Resident #3 was missing.
-Staff searched "the whole building."
-A call was received by the facility from a neighboring house informing the facility staff Resident #3 was there.

Interview with a MA on 09/05/19 at 4:55pm revealed:
-The MA went in the medication room and heard the clicking noise the alarm system was making.
-MA ran to the time clock door and the SCC was already outside.
-Staff came inside and did a head count and realized Resident #3 was not there.

Interview with a personal care aide (PCA) on 09/06/19 at 8:44am revealed:
-The PCA was walking with a resident to the library when she heard a clicking sound in the SCU medication room.
-The PCA went to the back door and went outside and saw the SCC outside checking the area.

Interview with a MA on 09/06/19 at 10:10am revealed:
-Resident #3 had eloped through door near the time clock.
-The MA had been coming into work just as Resident #3 had eloped.
-The MA had seen the SCC in the parking lot looking for Resident #3.

Interview with Maintenance Director (MD) on 09/05/19 at 3:08pm revealed:
-A storm on 07/04/19 had affected the exit door alarms and the alarm panel.
-The alarm panel was replaced.

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D 067	Continued From page 4	D 067		

-The new door alarms were "too low toned" to be heard.
-Additional higher volume alarms were purchased and installed for the two time clock entrances interior and exterior doors two days after Resident #3 eloped.
-"We put loud alarms on all the exits."
-The MD checked the alarms on the secured unit exits weekly.
-A log was maintained with the results of those weekly checks.

Interview with the Administrator on 09/05/19 at 3:50pm revealed:
-The new alarm panel they installed in the SCU after the lightening strike on 07/04/19 were "not as loud or audible as the previous panel."
-The alarm panel was replaced "right away on 07/05/19."

2. Review of Resident #1's current FL2 dated 05/10/19 revealed:
-Diagnoses included dementia, hypothyroidism, and vitamin B12 deficiency.
-Resident #1 was ambulatory and intermittently disoriented.

Observation of Resident #1 on 09/04/19 at 9:00am revealed:
-The resident was seated on a bench outside the hospitality room in the front entrance of the facility.
-The resident was dressed and appeared to be waiting for someone.

Observation of Resident #1 on 09/04/19 at 9:07am revealed:
-Resident #1 walked up the 100 hall hallway.
-Resident #1 had a purse on her arm.
-She stood in the doorway of a resident room for

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D 067	Continued From page 5 a moment and then turned and walked towards the front entrance of the facility. Observation of Resident #1 on 09/04/19 at 9:16am revealed: -Resident #1 walked up the 100 hallway. -She walked over to the 100 hall front exit door and looked out. Observation of the 100 hall front exit on 09/04/19 at 9:10am revealed: -The door was unlocked. -The door opened onto a covered porch which was approximately 50 ft. from a busy two lane highway. -When the door was closed it automatically locked and could not be opened from the outside. -There was no alarm when the door was opened or when the door was closed. -There was a door bell mechanism affixed to the window of the door. -When the door bell mechanism was pressed, there was no sound. -No staff came to check the door. Review of the call signal report dated 09/04/19 for the 100 hall door bell mechanism revealed: -On 09/04/19 at 9:10am, a signal was received from the 100 hall door bell mechanism. -An immediate page was sent to all staff who carried a pager. -Thirty seconds after the page was sent to all staff who carried a pager the incident message concerning the 100 hall door bell being activated was canceled by falling off the end of messaging chain. Observation of the 100 hall front exit on 09/04/19 at 3:27pm revealed: -The door was unlocked.	D 067		

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D 067	Continued From page 6 -When the door closed it automatically locked and could not be opened from the outside. -There was no alarm when the door was opened or when the door was closed. -There was a door bell mechanism affixed to the window of the door. -When the door bell mechanism was pressed, there was no sound. -No staff came to check the door. Observation of all the exit doors on the 100 and 200 halls with the Resident Care Coordinator (RCC) on 09/04/19 at 3:47pm revealed: -The front 200 hall exit door was unlocked, automatically locked and could not be opened from the outside, did not alarm or page when opened. -The front 100 hall exit door was unlocked, automatically locked and could not be opened from the outside, paged when opened, and the door bell mechanism paged when pressed. Observation of the 100 hall front exit on 09/05/19 at 10:41am to 10:47am revealed: -At 10:41am, the door was unlocked. -When the door was closed it automatically locked and could not be opened from the outside. -There was no alarm when the door was opened or when the door was closed. -When the door bell mechanism was pressed, there was no sound. -At 10:47am, no staff who wore pagers had checked the door. Interview with a personal care aide on 09/05/19 at 10:52am revealed: -She had a pager and she had not received a page in regards to the 100 hall front exit being opened at 10:41am. -"It usually doesn't stop beeping until I	D 067		

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D 067	Continued From page 7 acknowledge it." Interview with a dietary staff on 09/04/19 at 3:25pm revealed: -Resident #1 had lived in the facility for 6 months. -She had been moved from the independent living facility up the hill. -Resident #1 liked to walk up and down the halls. -Resident #1 would go out on the front porch at the front entrance, but she "only stays a few minutes." Interview with the Special Care Coordinator (SCC) on 09/04/19 at 3:35pm revealed: - Resident #1 walked through the building, but had not ever tried to leave. -If two pages were received "back to back" a page could be pushed off the main screen into memory making it harder for staff to see unless they paged through the messages. Interview with the RCC on 09/04/19 at 3:46pm revealed: -The exit doors were connected to the paging system. -When a door opened, a page automatically went out to all the staff who wore pagers which included the SCC, RCC, medication aides, and the personal care aides. -When a door bell mechanism was pressed, a page automatically when out to all staff who wore pagers. Interview with a personal care aide on 09/04/19 at 4:55pm revealed: -When the exit doors were opened, the pager "goes off." -The pages tell us which door alarm was activated. -"We have to check the door."	D 067		

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D 067	Continued From page 8 -The doors automatically lock when they shut. -If outside and one wanted back in, then one would have to press the door bell or walk around the facility to the front entrance which was unlocked. -Resident #1 was confused. -Resident #1 was starting to get her days and nights "mixed up." -Resident #1 walked around during the night. -She had only seen Resident #1 go to the front lobby door "once" and she was easily redirected. -The personal care aides and the medication aides "tag team the door checks" and their response time to check an alarm were "quick." Interview with the SCC on 09/05/19 at 11:02am revealed: -Resident care took precedence over checking the door alarms. -Staff performed "safety rounds" every 2 hours on all residents. -"You learn your residents and the ones you really need to keep your eye on." Interview with the RCC on 09/05/19 at 11:10am revealed: -The personal care aide assigned to that hall was supposed to check the door that alarmed as quickly as possible. -Staff had been trained that they had 6 minutes to respond and check the door alarms. -If the personal care aide was busy with a resident, they would walkie talkie the medication aide assigned to the hall and ask them to check the door alarm. -If both staff were busy with resident care, they were expected to check the door alarm as soon as they could. Interview with Maintenance on 09/05/19 at	D 067		

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D 067	Continued From page 9 3:05pm revealed: -He had worked at the facility for 4 weeks. -The door sensors at the 100 and 200 hall exits were connected to the paging system. Interview with the Administrator on 09/05/19 at 3:50pm revealed: -The residents on the assisted living side were allowed to go out the exit doors. -The residents enjoyed going out to sit on the porches. -Resident #1 had not been assessed as an elopement risk or exit seeking or she would have already been moved to the memory care unit. -Resident #1 was moved from independent living to assisted living due to "cognitive decline." -Personal care aides and medication aides work well as a team and communicate when they caring for residents and unable to check a door alarm. -All staff have walkie talkies and can check doors. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. --- The facility failed to ensure all exit doors had an alarm that was of sufficient volume that it could be heard by staff when there was at least one resident (Resident #3) who exhibited exit seeking behaviors and wandering behaviors which resulted in Resident #3 eloping from the facility without staff knowledge. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/12/19.	D 067		

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D 067	Continued From page 10 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 20, 2019.	D 067		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure one of three Medication Aides sampled (Staff E) who	D 164		

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D 164	Continued From page 11 administered insulin to residents completed training on the care of diabetic residents prior to the administration of insulin. The findings are: Review of Staff E's personnel record revealed: -Staff E was hired as a Medication Aide (MA) on 08/08/19. -There was no documentation that Staff E had received training on the care of a diabetic resident. Review of the Medication Administration Record (MAR) for August 2019 revealed Staff E had documented she had administered insulin for residents on 08/08/19 at 8:00am and 5:00pm, 08/09 at 8:00am and 5:00pm, 08/20/19 8:00am, 5:00pm, 6:00pm, and 8:00pm, 08/23/19 at 8:00am, 5:00pm and 6:00pm, 08/26/19 at 5:00pm, 6:00pm and 8:00pm, and 08/27/19 at 8:00am, 11:30am, 5:00pm, and 6:00pm. Review of the MAR for September 2019 revealed Staff E had documented she administered insulin for residents on 09/02/19 at 5:00pm and 6:00pm, 09/03/19 at 8:00am, 11:30am, 5:00pm and 6:00pm, and 09/04/19 at 8:00am, 11:30am, 5:00pm and 6:00pm. Interview with the Special Care Coordinator on 09/05/19 at 12:09pm revealed: -She knew all MA's had to have a diabetic class. -She was not aware the class had to be completed prior to the administration of insulin. Interview with Staff E on 09/05/19 at 12:54pm revealed: -She had been administering insulin to residents while another trained medication aide was	D 164		

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D 164	Continued From page 12 present. -She was scheduled to take the diabetic training in September. -She had not had a diabetic class prior to administering insulin. Interview with the Administrator on 09/05/19 at 3:20pm revealed: -Training on the care of diabetic residents was an area that was missed. -They have diabetic training for the MA's once every three months. -The MA had not been by herself when she gave insulin. -She was unaware the diabetic training had to be completed prior to administering insulin if a trained staff member was present with the MA.	D 164		
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 A2 VIOLATION Based on observations, interviews, and record review, the facility failed to provide supervision for	D 270		

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D 270	Continued From page 13 1 of 2 sampled residents (Resident #3) with a diagnosis of dementia who exhibited wandering and exit seeking behaviors, and eloped from the Special Care Unit (SCU) without staff knowledge. The findings are: Review of Resident #3's current FL2 dated 05/07/19 revealed: -Diagnoses included dementia. -Special Care Unit (SCU) was documented as Resident #3's level of care. -Resident #3 was ambulatory. Review of Resident #3's current Care Plan dated 06/04/19 revealed: -The resident had occasional disorientation to person, place, time or situation even in familiar surroundings and required frequent direction and reminders. -The resident had current wandering behaviors and moved with intentional destination and needed direction or occasional reminders. -The resident required frequent staff monitoring as an intervention to prevent or limit elopements. -The resident communicated verbally with the assistance of an electrolarynx. -The resident had mild visual impairment, but could see adequately with devices. -The resident had mild hearing impairment, but could hear adequately with devices. Review of Resident #3 progress report notes dated 06/16/19 revealed: -Resident #3 was going in and out doors more. -Resident #3 was setting off alarm and trying to watch staff put in code. Review of Resident #3 progress report notes dated 06/21/19 revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075010	A. BUILDING: _____ B. WING _____	R-C 09/06/2019

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D 270	Continued From page 14 -Resident #3 was attempting to exit through the door near the time clock by pushing it. -A medication aide (MA) and a personal care aide (PCA) tried to get Resident #3 away from the door and Resident #3 hit the PCA in the face. -Resident 3# left then came back to door and started back pushing door. Review of Resident #3 progress report notes dated 06/23/19 revealed Resident #3 was more anxious and trying to get out the doors. Review of Resident #3 progress report notes dated 06/25/19 revealed Resident #3's primary care provider was notified about the residents increased behaviors and anxiety and an order was received for labs, a psychiatric consult, and an as needed order for lorazepam (a medication used to treat anxiety). Review of Resident #3 progress report notes dated 07/07/19 revealed resident tried to go out time clock door several times and was trying to hit the MA. Review of the facility census for 08/09/19 revealed there were 15 residents residing in the SCU. Review of the SCU staffing schedule for 08/09/19 revealed there was one personal care aide and one medication aide who worked second shift. Review of Resident #3 progress notes dated 08/09/19 revealed: -At 6:50pm, a medication aide entering the medication room heard an alarm coming from the door located at the time clock. -Staff performed a count of all residents on the SCU and discovered Resident #3 was missing.	D 270		

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D 270	Continued From page 15 -Staff checked the entire SCU and assisted living areas of the facility, but could not find Resident #3. -Staff checked all outside areas around the facility, but could not find Resident #3. -Two staff got in their personal vehicles and drove on the highway in front of the facility to look for Resident #3, but they could not find Resident #3. -A call was received "from next door" and Resident #3 had been found by a neighbor and was sitting on the neighboring house's front porch. Review of Resident #3 Incident/Accident Report dated 08/09/19 at 6:50pm revealed: -Staff heard the door alarm where the time clock was located. -Staff performed a head count of all residents in the SCU and discovered Resident #3 was missing. -Staff searched "the whole building." -A call was received from a neighboring house informing the facility staff Resident #3 was there. Observation on the SCU on 08/12/19 at 3:25pm revealed the alarm panel in the medication aide office was hanging off the wall with the wires exposed. Interview with a medication aide on 08/12/19 at 3:30pm revealed: -Since the storm on 07/04/19, the alarm just "clicks" in the medication room. -"It does not go off." Observation of the door of the SCU near the time clock on 08/12/19 at 3:35pm revealed: -When the door was opened, the alarm was not of sufficient volume that it could be heard by staff. -No staff came to check the door.	D 270		

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D 270	Continued From page 16 -The alarm panel in the medication room made a clicking noise. Interview with SCC on 09/05/19 at 8:55am revealed: -The SCC heard the alarm when she came in the door from the assisted living area of the facility. -The SCC went outside and looked around the parking lot but did not see anyone. -Staff did a head count and could not find Resident #3. -The SCC went back to the parking lot as another MA was coming in the parking lot to work. -The other MA had not seen Resident #3 on the road. -The SCC called the independent living facility which was located on the same campus and asked them to check the area for Resident #3. -The SCC and MA on duty drove their cars in separate directions on the highway in front of the facility to look for Resident #3. -The SCC and MA were pulling back in the parking lot and received a call that Resident #3 was found next door at a neighbor's house. -The SCC and MA went to the house and picked up Resident #3 and returned him to the facility. -Resident #3 had been missing about 20 minutes. Interview with a MA on 09/05/19 at 4:55pm revealed: -There was a birthday party in the dining hall in the SCU that night (08/09/19) around 6:30pm. -The MA went in the medication room and heard the clicking noise the alarm system was making. -MA ran to the time clock door and the SCC was already outside. -Staff came inside and did a head count and realized Resident #3 was not there. -Staff started searching the rooms. -The SCC and a MA got in their cars and	D 270		

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D 270	Continued From page 17	D 270		

searched the road.
-The SCC and the MA came back in the parking lot and received a call that the neighbor had called to report Resident #3 was at their house.
-The SCC and a MA went to the house and brought Resident #3 back to the facility.

Interview with a PCA on 09/06/19 at 8:44am revealed:
-The PCA was walking with a resident to the library when she heard a clicking sound in the SCU medication room.
-The PCA went to the back door and went outside and saw the SCC outside checking the area.
-The PCA went to provide incontinent care to a resident and then got a call that Resident #3 had gone to a house next door.

Interview with the relief MA on 09/06/19 at 10:10am revealed:
-She was coming in to work to relieve the day shift medication aide.
-She worked 7:00pm to 7:00am.
-Resident #3 had gotten out of the time clock door.
-The MA had seen the SCC in the parking lot looking for Resident #3.
-The MA had not seen Resident #3 on the road.

Interview with the neighbor on 09/05/19 at 5:10pm revealed:
-Resident #3 was seen in their back yard "walking around."
-The neighbor talked with Resident #3 and ask him if he wanted to sit on the porch and offered the resident a beverage.
-Resident #3 was unable to speak, but wrote his name on a piece of paper for the neighbor.
-The neighbor called a friend that knew the resident's family and was told Resident #3 lived at

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D 270	Continued From page 18 the facility next door. -The neighbor contacted the facility. -Two staff from the facility came and picked up Resident #3. -From the time Resident #3 was seen and picked up was about 20 minutes. Interview with Maintenance Director (MD) on 09/05/19 at 3:08pm revealed: -A storm on 07/04/19 had affected the exit door alarms and the alarm panel. -The alarm panel was replaced. -The new door alarms were too "low toned" to be heard. -Additional higher volume alarms were purchased and installed for the two time clock entrances interior and exterior doors two days after Resident #3 eloped. The facility failed to provide supervision for 1 of 2 sampled residents (Resident #3) with a diagnosis of dementia who exhibited wandering and exit seeking behaviors, and eloped from the facility without staff's knowledge from the Special Care Unit (SCU) . This failure put Resident #2 at substantial risk for serious harm which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/23/19. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 6, 2019.	D 270		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service	D 283		

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D 283	Continued From page 19 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the reach-in ice machine in the kitchen was clean and free of contamination related to the build-up of a black residue located inside the ice machine. The findings are: Review of the local Environmental Health sanitation report dated 01/15/19 revealed: -The inspection score was 96.5. -A demerit of 1.0 was taken due to "Ice protected, dispensed, equipment clean, in good repair." Observation of the ice machine located in the kitchen on 09/04/19 at 11:50am revealed: -Black residue located in the interior of the reach-in ice machine. -The Dietary Manager (DM) used a gloved finger to easily remove some of the black residue. Interview with the DM on 09/04/19 at 11:52am revealed: -The ice machine was used last for resident beverages at the evening meal on 09/03/19. -The ice machine received a system flush about 2 weeks ago. -He was responsible to make sure it is clean. -He cleaned the interior of the ice machine 2 weeks ago. -He was not aware of the black residue located	D 283		

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D 283	Continued From page 20 inside the ice machine. Interview with the Administrator on 09/05/19 at 3:20pm revealed: -She was not aware the ice machine in the kitchen had a black residue on the interior. -She was not sure why the issue with the ice machine had occurred. -It is the DM's responsibility to assure this was being done weekly. -It was her understanding the ice machine was being cleaned weekly.	D 283		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents residing in the Special Care Unit (SCU) were provided a non-disposable place setting consisting of a knife, spoon, and fork at each meal. The findings are: Observation of the lunch meal on 09/04/19 at	D 287		

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D 287	Continued From page 21 12:18pm revealed: -There were sixteen residents in the SCU dining room. -All place settings included a non-disposable fork and spoon. -No place settings had knives. -The lunch meal served was chopped ham, green beans, dressing and a biscuit. -None of the staff was observed to offer any of the residents a knife. Interview with the Personal Care Aide on 09/04/19 at 12:40pm revealed the dietary staff always set up the tables in the SCU dining room for meals. Interview with the Dietary Aide on 09/04/19 at 12:44pm revealed: -She had set up the place settings on the tables for the noon meal in the SCU on 09/04/19. -There was a list on the refrigerator in the kitchen area of the SCU of six residents who did not receive knives at meals. -She was aware all residents were supposed to have a non-disposable knife, fork and spoon other than the six on the posted list. -She forgot to put the knives out for the other ten residents on 09/04/19 at the noon meal but she should have. Interview with the Special Care Coordinator (SCC) on 09/04/19 at 12:55pm revealed: -Dietary staff set up the table for meal times. -They always had enough utensils, plates and cups for a full place setting. -She was not aware that no residents received a knife at the noon meal on 09/04/19. -She presented documentation of physician's orders for nine of the sixteen residents on the SCU who were not supposed to have knives due	D 287		

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D 287	Continued From page 22 to using the knives inappropriately and safety concerns. -The other seven residents should have had knives at the noon meal. Interview with the Dietary Manager on 09/04/19 at 3:20pm revealed: -There were enough utensils for all residents in the SCU to have a knife, fork and spoon at each meal time. -He kept extra utensils to replace one if needed. -The dietary staff was aware that all residents should have a full place setting unless there was a physician's order that stated otherwise. -He gave the dietary aide ten knives on 09/04/19 to set the table for the noon meal in the SCU. Observation in the kitchen on 09/04/19 at 3:23pm revealed a count of 54 knives for the SCU. Interview with the Administrator on 09/05/19 at 3:20pm revealed: -All residents on the SCU should have had a full place setting at each meal unless they had a physician's order. -They had enough knives, forks, and spoons to ensure the residents had a full place setting at each meal. -She was not aware all residents were not receiving a full place setting at meal times. -The dietary aide knew she was supposed to set out a full place setting at each meal for all residents in the SCU unless there was a physician's order that a resident could not have a knife.	D 287		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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	HAL075910	A. BUILDING: _____ B. WING _____	R-C 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 23 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #2) related to medications to treat infection. The findings are: Review of Resident #2's current FL2 dated 10/18/18 revealed diagnoses included bilateral macular degeneration, hypertension, mild cognitive impairment, and hypercholesterolemia. Review of Resident #2's incident report dated 07/30/19 revealed: -The resident was found sitting on her bottom outside on the sidewalk with a bloody face. -The resident was "weeding" and lost her balance.	D 358		

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	HAL075010	A. BUILDING: _____ B. WING _____	R-C 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 24 -The resident was sent to the emergency department for evaluation via emergency medical service. Review of Resident #2's local emergency department after visit summary dated 07/30/19 revealed: -The reason for the visit had been for facial injury and insect bite. -Resident #2 was diagnosed with fall, open nasal fracture, and nasal laceration, initial encounter. -Resident #2 received a laceration repair. a. Review of Resident #2's physician order dated 07/31/19 revealed: -Augmentin (used to treat infection) 500mg/125mg two times a day for 7 days. -One facility staff indicated on the order they had faxed the Augmentin order to the contracted pharmacy on 07/31/19 by stamping the order "Faxed" and initialed and dated 07/31/19. Review of Resident #2's July, August, and September 2019 electronic Medication Administration Records (eMARs) revealed: -There were no entries for Augmentin 500mg/125mg two times a day for 7 days. -There were no documented administrations of Augmentin 500mg/125mg. Observation of Resident #2's medications on hand on 09/05/19 at 12:03pm revealed there was no Augmentin available in the resident's medications. Telephone interview with the local pharmacy on 09/05/19 at 12:15pm revealed: -They had filled a prescription for Resident #2 for Augmentin 500mg/125mg two times a day for 7 days on 07/31/19.	D 358		

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	HAL075019	A. BUILDING: _____ B. WING _____	R-C 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

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D 358	Continued From page 25 -The Augmentin had been picked up on 07/31/19 at 5:00pm. Review of Resident #2's progress notes dated 07/31/19 to 08/04/19 revealed: -On 07/31/19, resident was taken to see the primary care provider and "received some new orders to keep away infection." -On 08/03/19 7p-7a, resident was "about halfway" through "antibiotic and showed no signs of any side effects." -On 08/04/19 7a-7p, resident "showing no signs of reaction to antibiotic.." -On 08/04/19 7a-7p weekly summary, Resident #2 had a fall on 07/30/19 and received "stitches to her nose for a cut" and was on antibiotic -On 08/07/19 7a-7p, Resident #2 had "3 doses of antibiotic left" and has shown no side effects. Interview with the SCC on 09/05/19 at 3:24pm revealed: -Medications from the facility's contracted pharmacy were delivered in bubble packs. -The Augmentin picked up from the local pharmacy would have come in a bottle. -Staff should have stored the bottle in with the Resident #2's other bubble packed medications. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/19 at 12:07pm. Refer to the telephone interview with the facility's contracted pharmacy on 09/05/19 at 12:19pm. Refer to the interview with the Special Care Coordinator (SCC) on 09/05/19 at 12:45pm.	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 26 Refer to the interview with Resident #2's family member on 09/05/19 at 3:00pm. Refer to the interview with the SCC on 09/05/19 at 3:25pm. Refer to the interview with the Administrator on 09/05/19 at 3:50pm. b. Review of Resident #2's physician order dated 07/31/19 revealed Bacitracin ointment (used to treat infection) to laceration two times a day for 7 days. Review of Resident #2's July, August, and September 2019 electronic Medication Administration Records (eMARs) revealed: -There were no entries for Bacitracin ointment two times a day to laceration for 7 days. -There were no documented administrations of Bacitracin ointment. Observation of Resident #2's medications on hand on 09/05/19 at 12:03pm revealed there was no Bacitracin ointment available in the resident's medications. Interview with the Special Care Coordinator (SCC) on 09/05/19 at 3:24pm revealed: -Resident #2's Bacitracin order should have been sent over to the facility's contracted pharmacy. -She could find no proof in the eMAR system that Bacitracin had been administered. -A paper MAR could have been completed for Resident #2's Bacitracin, but she had been unable to find one. Based on observations, interviews, and record reviews it was determined Resident #2 was not	D 358		

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LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

(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 358	Continued From page 27 interviewable. Refer to the interview with the Resident Care Coordinator on 09/05/19 at 12:07pm. Refer to the telephone interview with the facility's contracted pharmacy on 09/05/19 at 12:19pm. Refer to the interview with the Special Care Coordinator (SCC) on 09/05/19 at 12:45pm. Refer to the interview with Resident #2's family member on 09/05/19 at 3:00pm. Refer to the interview with the SCC on 09/05/19 at 3:25pm. Refer to the interview with the Administrator on 09/05/19 at 3:50pm. --- Interview with the Resident Care Coordinator (RCC) on 09/05/19 at 12:07pm revealed: -The medications had been ordered by the hospital for Resident #2. -Resident #2's family member must have picked it up the medications from a local pharmacy instead of getting it filled through the facility's contracted pharmacy. -"Even though our pharmacy didn't fill it," the pharmacy should have "profiled" the medications and added them to the electronic Medication Administration Record. Telephone interview with the facility's contracted pharmacy on 09/05/19 at 12:19pm revealed: -They had not received an order dated 07/31/19 for Resident #2. -The facility staff were supposed to fax new orders to the pharmacy and let the contracted	D 358		

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D 358	Continued From page 28 pharmacy know the medication would be obtained from another pharmacy and to only add the medication to the eMAR system. -If the medications had been entered into the eMAR system, they would have showed up under the discontinued orders. Interview with the Special Care Coordinator (SCC) on 09/05/19 at 12:45pm revealed: -Resident #2's medication order should have been sent over to the facility's contracted pharmacy. -She could find no proof in the eMAR system that the medications had been administered. -"I don't remember her getting antibiotic." Interview with Resident #2's family member on 09/05/19 at 3:00pm revealed: -She did not know if Resident #2 had received the medications ordered on 07/31/19 as it was ordered or not, but Resident #2's face had healed up and there did not seem to be any signs of infection. -Another family member usually was the one who oversaw Resident #2's care, but that family member was currently on vacation and could not be reached. Interview with the SCC on 09/05/19 at 3:25pm revealed: -"The medication aides should have brought it to our attention, it was not on the eMAR." -She could not explain what happened. -She did not know why the medication aides had not faxed the order to the contracted pharmacy so it could be put on the eMAR. -She could not see the medication aides giving a medication that was not on the eMAR because they were "not supposed to." -She nor the medication aides could add	D 358		

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D 358	Continued From page 29 medications to the eMAR without going through the contracted pharmacy. -A paper MAR could have been completed for Resident #2's Augmentin, but she had been unable to find one. Interview with the Administrator on 09/05/19 at 3:50pm revealed; -When a new order was received from a phyisican, the order was faxed to the facility's contracted pharmacy. -The contracted pharmacy was responsible for entering the new order into the eMAR system. -The medication aides, RCC, and SCC were all responsible for ensuring new orders were sent to the contracted pharmacy.	D 358		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to	D 454		

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D 454	Continued From page 30 be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the local county department of social services, local law enforcement, and the guardian were immediately notified of the elopement of a special care unit resident (Resident #3). The findings are: Review of Resident #3's current FL2 dated 05/07/19 revealed: -Diagnoses included dementia. -Special Care Unit (SCU) was documented as Resident #3's level of care. -Resident #3 was ambulatory. -There was an admission date of 05/25/18. Review of Resident #3's Resident Register revealed the resident had a guardian. Review of Resident #3's current Care Plan dated 06/04/19 revealed: -The resident had occasional disorientation to person, place, time or situation even in familiar surroundings and required frequent direction and reminders. -The resident had current wandering behaviors and moved with intentional destination and needed direction or occasional reminders. -The resident required frequent staff monitoring as an intervention to prevent or limit elopements.	D 454		

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D 454	Continued From page 31 -The resident communicated verbally with the assistance of an electrolarynx. -The resident had mild visual impairment, but could see adequately with devices. -The resident had mild hearing impairment, but could hear adequately with devices. Review of Resident #3 Incident/Accident Report dated 08/09/19 at 6:50pm revealed: -Staff heard the door alarm where the time clock was located. -Staff performed a head count of all residents in the SCU and discovered Resident #3 was missing. -Staff searched "the whole building." -A call was received by the facility from a neighboring house informing the facility staff Resident #3 was there. -Resident #3's physician was notified of the incident on 08/09/19 at 8:30pm. -Resident #3's guardian was notified of the incident on 08/09/19 at 8:00pm and responded to the notification at 8:00pm. Review of Resident #3 progress notes dated 08/09/19 revealed: -At 6:50pm, a medication aide entering the medication room heard an alarm coming from the door located at the time clock. -Staff performed a count of all residents on the SCU and discovered Resident #3 was missing. -Staff checked the entire SCU and assisted living areas of the facility, but could not find Resident #3. -Staff checked all outside areas around the facility, but could not find Resident #3. -Two staff got in their personal vehicles on the highway in front of the facility to look for Resident #3, but they could not find Resident #3. -A call was received "from next door" and	D 454		

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D 454	Continued From page 32 Resident #3 had been found sitting on the neighboring house's front porch. Interview with Special Care Coordinator (SCC) on 09/05/19 at 8:55am revealed: -On 08/09/19, Resident #3 eloped from the SCU and walked to a nearby house. -The resident was missing from the facility for "about 20 minutes." Interview with the neighbor on 09/05/19 at 5:10pm revealed: -Resident #3 was seen in their back yard "walking around." -The neighbor talked with Resident #3 and ask him if he wanted to sit on the porch and offered the resident a beverage. -Resident #3 was unable to speak, but wrote his name on a piece of paper for the neighbor. -The neighbor called a friend that knew the resident's family and was told Resident #3 lived at the facility next door. -The neighbor contacted the facility. -Two staff from the facility came and picked up Resident #3. -From the time Resident #3 was seen and picked up was about 20 minutes. a. Review of an email dated 08/12/19 at 12:27pm revealed: -The message was addressed to the Adult Services Supervisor of the local Department of Social Services (DSS) office. -The message was sent by the SCC at the facility to notify the local DSS office of the elopement incident on 08/09/19 which involved Resident #3 . -A copy of Resident #3's incident report dated 08/09/19 was attached to the email. Review of Resident #3's record revealed there	D 454		

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D 454	Continued From page 33 was a delay of two and a half days from when Resident #3 eloped and the local department of social services was notified. Interview with the Administrator on 09/05/19 at 4:29pm revealed: -It was the facility's policy to have staff immediately search the interior and exterior of the facility. -Staff were expected to notify the SCC and Administrator immediately when a resident was discovered to be missing. -Staff were expected to search for the missing resident for 30 minutes. -In the case of an elopement, the county DSS would be notified immediately if the resident was not found. -If the resident was found, the county DSS would be notified per incident and accident reporting guidelines. b. Telephone interview with a medication aide on 09/05/19 at 4:55pm revealed: -The facility's policy on missing residents was to contact the Supervisor to notify them when a resident was missing. -It was the Supervisor's responsibility to notify the Administrator. -After staff had checked "everywhere possible" for the missing resident, the Administrator would advise them as to when to notify local law enforcement. Interview with the Administrator on 09/05/19 at 4:29pm revealed: -It was the facility's policy to have staff immediately search the interior and exterior of the facility when a resident was found to be missing. -Staff were expected to notify the SCC and Administrator immediately when a resident was	D 454		

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D 454	Continued From page 34 discovered to be missing. -Staff were expected to search for the missing resident for 30 minutes. -If the resident was not found after 30 minutes, staff were expected to notify local law enforcement. c. Telephone interview with Resident #3's Guardian on 09/05/19 at 9:35am revealed: -They received a call on 08/09/19 "around 8:45pm" from a medication aide. -The medication aide notified the Guardian Resident #3 had eloped from the facility and walked to a house beside the facility. -The Guardian was told the resident had only been missing from the facilty for about 20 minutes before being found and returned to the facility. Review of Resident #3's record revealed there was a delay of one hour and 55 minutes from when Resident #3 eloped and his Guardian was notified. Interview with the Administrator on 09/05/19 at 4:29pm revealed: -It was the facility's policy to have staff immediately search the interior and exterior of the facility when a resident was found to be missing. -Staff were expected to notify the SCC and Administrator immediately when a resident was discovered to be missing. -Staff were expected to search for the missing resident for 30 minutes. -If the resident was not found after 30 minutes, staff were expected to notify the responsible person.	D 454		

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D 464	Continued From page 35	D 464		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to complete quarterly care plans for 2 of 2 sampled residents (Resident #3 and #4) in the Special Care Unit (SCU). The findings are: 1. Review of Resident #4's current FL-2 dated 05/28/19 revealed: -Diagnoses included Alzheimer's dementia. -SCU was documented as Resident #4's level of care. -There was documentation that Resident #4 was	D 464		

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D 464	Continued From page 36 intermittently disoriented. Review of Resident #4's medical record revealed: -There were resident care plans completed on 12/11/18 and 05/01/19. -The care plan updates on 12/11/18, 03/06/19, 05/19/19 and 08/11/19 did not include a comprehensive revision of environmental, social and health care strategies to assist Resident #4 to maintain the maximum level of functioning possible and compensate for lost abilities. Refer to the interview with the Special Care Coordinator on 09/05/19 at 12:15pm. Refer to the interview with the Administrator on 09/05/19 at 3:20pm. 2. Review of Resident #3's current FL2 dated 05/07/19 revealed: -Diagnoses included dementia. -SCU was documented as Resident #3's level of care. -The resident was admitted to the facility on 05/25/18. Review of Resident #3's record revealed: -There was a resident care plan completed on 05/19/19 and signed by the primary care provider on 06/04/19. -The care plan updates on 06/13/18, 09/10/18, 12/11/18, and 03/06/19 did not include a comprehensive revision of environmental, social and health care strategies to assist Resident #3 to maintain the maximum level of functioning possible and compensate for lost abilities. Refer to the interview with the Special Care Coordinator on 09/05/19 at 12:15pm. Refer to the interview with the Administrator on	D 464		

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D 464	Continued From page 37 09/05/19 at 3:20pm. _____ Interview with the Special Care Coordinator (SCC) on 09/05/19 at 12:15pm revealed: -The Care Plan update form was developed "last year." -We thought it was comprehensive. -There was quarterly documentation for all residents in the Special Care Unit. -She recognized based on the regulation the quarterly documentation was not comprehensive. -She was responsible to update the Care Plans. Interview with the Administrator on 09/05/19 at 3:20pm revealed: -She was aware there was a quarterly Care Plan update for residents in the Special Care Unit. -She was not aware the quarterly Care Plan update for residents in the Special Care Unit were not comprehensive. -The SCC was responsible to update the Care Plans.	D 464		
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:	D912		

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D912	Continued From page 38 Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to door alarms and supervision. The findings are: 1. Based on observations, interviews, and record review, the facility failed to ensure 1 of 7 exit doors accessible to residents in the Special Care Unit (SCU) had an alarm that was of sufficient volume that it could be heard by staff and 2 of 4 exit doors accessible to assisted living residents that when activated was responded to for the safety of residents.[Refer to Tag 067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 2. Based on observations, interviews, and record review, the facility failed to provide supervision for 1 of 2 sampled residents (Resident #3) with a diagnosis of dementia who exhibited wandering and exit seeking behaviors, and eloped from the Special Care Unit (SCU) without staff knowledge. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D912		

This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Laurelwoods as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Tag: D 067

1. The Community has purchased and installed magnetic latch alarms as an additional method of auditory alert. Additionally, the Community utilizes pager system and walkie talkies to communicate door alarms throughout the entire community, including Assisted Living.
2. Community will continue to utilize pager system and walkie talkie system to communicate when doors are opened to alert other staff in the area to check doors. On or before October 20, 2019, staff will be in-serviced on the door check policy and on continuing hallway rounds in SCU.
3. The SCC, Floor Manager, Executive Director or designee will be responsible for monitoring.
4. SCC, Floor Manager, Executive Director or designee will conduct weekly monitoring of electronic alert system via Internet program to check. Additionally, the Maintenance Director or designee will conduct weekly monitoring of the exit door alarm functionality
5. Completion: ~~September 6~~, 2019
   October 18, 2019

Tag: D 164

1. Employee E will complete training for care of diabetic residents.
2. The Community obtained a comprehensive training document for care of diabetic residents to supplement training already in place. The Community will conduct an in-service in October to ensure current Med Aides have received the necessary training. Additionally, comprehensive training guide will be added to Med Aide training prior to insulin administration.
3. The SCC (Wellness Director) or designee will be responsible for monitoring to ensure training has been completed prior to checking off Med Aides.
4. Monitoring will occur as Medication Aides are checked off prior to administering insulin.
5. Completion: October 31, 2019

Tag: D 270

1. Resident 3 is being appropriately supervised. Resident 3 has the following interventions in place to prevent elopement: frequent staff reminders and redirection, encourage verbalization, and identify and recognize feelings. If any mechanical systems are known to be non-functioning, back up methods include but not limited to continuous staff presence at exit doors will be utilized.
2. Community continues to utilize audible alarms on exit doors, including implementation of additional audible magnetic latch alarms on exit doors. Exit doors are also electronically tied into nurse call/paging system. Residents in SCU are on 2 hour checks or as indicated by their Plan of Care.
3. SCC (Wellness Director), Executive Director or designee will monitor staff rounds weekly; Maintenance Director or designee monitors exit door functionality weekly.
4. Door alarm functionality will be checked weekly by Maintenance Director or designee.
5. Completion: September 6, 2019 ~~7~~ no

Tag D 283

1. The ice machine was thoroughly cleaned by Food Service Director at the time of discovery.
2. The ice machine will be audited and cleaned weekly or more often if needed
3. The Food Service Director will be responsible for monitoring to ensure the ice machine is clean.
4. The Food Service Director, Executive Director or designee will monitor weekly.
5. Completion: October 31, 2019

Tag D 287

1. Memory Care residents have access to knives during meals.
2. In October and upon hire Wait staff will in-serviced on of place setting requirements .
3. Food Service Director, Executive Director or designee will be responsible for monitoring the place settings.
4. Food Service Director, Executive Director or designee will be responsible for monitoring place settings.
5. Food Service Director, Executive Director or designee will monitor at least weekly.
6. Completion: October 31, 2019

Tag D 358

1. Resident 2 MAR's accurately reflects administration of medications.
2. The Community provided the Med Aides with paper MARs to utilize in the event the pharmacy fails to input orders timely into QuickMAR. In addition, Med Aides will be in-serviced on scanning medications prior to administration. If unable to scan, they will check orders against medication label to find any discrepancy and alert the Floor Manager or SCC (Wellness Director).
3. SCC (Wellness Director), Floor Manager, Executive Director or designee will monitor medication orders
4. Auditing and monitoring will occur monthly
5. Completion: October 31, 2019

Tag D 454

1. The incident involving Resident 3 was reported timely to law enforcement and guardian per 10A NCAC 13F .1212(e)(2).
2. Med Aides will be in-serviced on completing DSS incident report and faxing to DSS office after hours and on weekends in the absence of SCC or Floor Manager.
3. SCC (Wellness Director), Executive Director or designee will monitor after each reportable incident.
4. Monitoring will occur as needed after each reportable incident.
5. Completion: October 31, 2019

Tag D 464

1. Residents 3 and 4 care plans were updated.
2. SCC will utilize the same comprehensive care plan form/assessment on a quarterly basis as she uses for 6 month updates rather than the quarterly form that she has been using. For those residents that she has previously used the quarterly form she will redo using the comprehensive assessment.
3. SCC will destroy current form but will continue using same method of tracking due dates and will utilize comprehensive care plan assessment for quarterly updates as well as 6 month updates.
4. SCC (Wellness Director), Executive Director or designee will monitor monthly
5. Completion: October 31, 2019

Tag D 912

1. Resident 3 is being appropriately supervised.
2. The Community added additional audible devices to exit doors in SCU. For Assisted Living doors, Community continues to utilize a nurse call system to verbally check when doors in Assisted Living are opened and utilize a walkie talkie system to communicate if staff are unable to check the door themselves. Staff will be in-serviced on reporting defective door alarms . In addition, staff will be in-serviced on the door check policy. SCU were in-serviced on continuous rounding.
3. Wellness Director, Floor Manager, Executive Director or designee will be responsible for weekly monitoring.
4. Wellness Director, Floor Manager, Executive Director or designee will monitor nurse call logs weekly for timely compliance.
5. Completion: ~~October 31~~, 2019
   September 7, 2019