STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063007	A. BUILDING: ______ B. WING ______	C 09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GARDENS	594 MURRAY HILL ROAD SOUTHERN PINES, NC 28387

(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 Moore County Department of Social Services conducted an annual survey and complaint investigation on 09/22/21-09/23/21. The complaint was initiated by Moore County Department of Social Services on 09/18/21.	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 reviews, the facility failed to ensure wander protection bracelets and exit doors equipped with a sounding device activated when the door was opened and in proper working order for residents (using the wander protection bracelets) who were diagnosed with dementia or Alzheimer's disease. The findings are:	D 067		

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Observation of the facility's main entrance/exit door of the Assisted Living unit (AL) on 09/22/21 at 7:45am revealed:
-The main entrance/exit door opened to the front grounds of the facility.
-The facility's front grounds were not gated and lead to the facility parking lot.

Observation of the facility's main entrance/exit door of the AL unit intermittently on 09/22/21 from 7:45am - 4:45 pm revealed there was an audible alarm sound when the door was opened, and the door was locked.

Observation of an exit door on the Special Care Unit (SCU) hallway on 09/22/21 at 8:18am revealed:
-There was a red octagon shaped alarm on the door in the upper left hand corner that read "STOP EMERGENCY EXIT ONLY, "ALARM SOUNDS WHEN DOOR IS OPENED."
-The alarm had a silver round metal base for a key insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical.
-The alarm's key insert was in horizontal position (indicating the alarm was positioned off).
-There was no audible sound when the unlocked exit door was opened.
-The door opened into an outside fenced in area.

Observation of an exit door on the front west wing of the facility on 09/23/21 at 9:28am revealed:
-There was a red colored octagon shaped alarm positioned in the upper left hand corner of the door.
-There was written on the alarm "STOP EMERGENCY EXIT ONLY, "ALARM SOUNDS

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D 067	Continued From page 2 WHEN DOOR IS OPENED." -The alarm had a silver round metal base for a key insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical. -The alarm's key insert was in vertical position (indicating the alarm was positioned on). -There was an audible sound when the unlocked exit door was opened. -Staff responded and disarmed the alarm after confirming no resident had exited. -The exit door opened to the ungated front grounds of the facility which could allow residents to leave the facility without staff knowledge. -The facility parking lot was to the right of the exit and a paved road to the right of the parking lot that was accessible to a heavily trafficked four-lane highway. -To the left of the parking lot was a gravel road and a wooded area was to the immediate left of the exit door. -There was a concrete table and bench seats outside the exit door with a stainless steel ashtray on top. Observation of a resident residing on the AL unit on 09/23/21 at 9:01am revealed: -The resident stood in front of the wander protection sensors with her wander protection bracelet on her wrist without the sensor alarm being set off. -The medication aide (MA) assisted the resident to place her wander protection bracelet directly on to the sensor without the sensor alarm being set off. -The MA was able to manually set off the alarm to reveal a "chirping" sound. -The MA was able to disarm the wander protection sensor.	D 067		

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D 067	Continued From page 3 Interview with the MA on 09/23/21 at 9:02am revealed: -She thought the business office manager (BOM) changed the bracelets when needed. -She would notify the BOM of the resident's bracelet not working. Interview with a second resident on 09/23/21 at 9:14am revealed: -The bracelet was "a reminder not to go places she should not go". -She had Alzheimer's disease. -She had never had the bracelet "go off" (alarm). Observation of a second resident residing on the assisted living unit on 09/23/21 at 9:15am revealed: -She walked down the 400-hall through the wander protection sensors without the sensor alarming. -She walked back by the wander protection sensors and the sensor alarmed. -The MA came out of a resident's room and reset the sensor alarm. -The MA had the resident walk back by the wander protection sensors again and the sensor alarm did not alarm. -Upon another walk past the wander protection sensors, the sensor was set off another time. Interview with the Maintenance Director on 09/23/21 at 10:10am revealed: -He was responsible for checking the wander protection bracelets. -He had checked them on Monday, 09/20/21, and all of them worked. -He did not keep a record of the testing that he did weekly.	D 067		

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Interview with the Executive Director (ED) on 09/23/21 at 9:50am revealed:
-"All wanderers go on the special care unit".
-The wander protection bracelets were not a "safeguard".
-They were used as an assistance to help staff to alert them if a resident wearing the bracelet was too close to an exit.
-They did not always work.
-Our Maintenance Director checked all the bracelets on Monday 09/20/21 and they all worked.
-The wander protection bracelets did not have to work.
-They were not used to keep the residents from going outside.
-They were to assist the staff as an alert if the resident was too close to an exit.
-The facility did not promote nor advertise the wander protection bracelet.
-The facility did not have policies on the use of the wander protection bracelet.
-She did not say how long the wander protection system had not been working.
-She did not say if anything had been done to correct the problem with the system not working.

Observations of the process to check the wander protection bracelets on 09/23/21 at 10:10am revealed:
-The Maintenance Director used a tester to test the bracelets and the wall sensors.
-The tester indicated the bracelet tested and wall sensor tested were in proper working order.

Review of the manufacturer's information regarding the use of and testing of the wander protection devices revealed:
-The bracelet was designed to protect special care residents against elopement risk.

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-The bracelet should be tested before putting it into use and daily thereafter.
-Failure to do so could result in injury to or death to a person being cared for.
-The tester would indicate when the bracelet was reaching the replace bracelet date.
-The tester had a non-replaceable battery.
-The tester battery was expected to last 2 years under typical use.

Observation of the AL 200 hall on 09/22/21 at 8:08am revealed a minor aged child disabled the exit door alarm from a wall security panel.

Observation of 200 hall exit door on 09/22/21 from 10:29am to 10:31am revealed:
-The exit door alarm sounded when opened.
-There were 4 residents seated in the foyer area of the 200-hall.
-The door alarm was disabled by one of the residents seated in the 200 hall foyer area.
-The resident disabled the exit door alarm by pressing a button on the wall control panel.
-Staff did not come to the 200-hall to disable the alarm or to see if a resident had exited through that door.

Interview with the resident on 09/22/21 at 10:31am revealed:
-She had disabled the alarm when other residents went out to smoke.
-Staff had shown her how to disable the exit door alarm from the wall control panel.
-She did say which staff had shown her how to disable the alarm nor when she had been shown.

A second interview with ED on 09/23/21 at 3:55pm revealed:
-The AL unit of the facility was not a locked unit and the door alarms were not always alarmed.

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D 067	Continued From page 6 -She was not aware that visitors had been disarming the door alarms. -She was aware that one resident on AL would disarm the door alarms. -The staff would lock and alarm the doors around 6:00pm - 7:00pm each evening. -The doors would remain locked until around 8:00am when the front office staff would arrive. -The resident was instructed numerous times not to disarm the door alarms but with her cognition, she was unable to understand. -The resident felt she was helping by disarming the alarm. -No visitor nor resident should disarm the alarms, only staff should disarm the alarms. Telephone interview with the BOM on 09/20/21 at 9:40am revealed: -If a resident had their wander protection bracelet on when they got within a certain distance from the door, the door would alarm notifying the staff that a resident with a wander protection bracelet was near an exit. -Some residents knew how to prevent the detection of the wander protection bracelet when nearing a door. -She was not sure if this was done by covering the wander protection bracelet or another way. Interview with the BOM via email on 09/21/21 revealed: -The wander protection bracelet was not to prevent residents from going outside and all families were aware that the wander protection bracelet did not always sound. -Any item, including a long sleeve shirt, could have covered the wander protection bracelet and the alarm would not have gone off. -There were five residents that had a wander protection bracelet.	D 067		

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-There were no residents on increased checks.
-Management informed the supervisors when a resident was to be on increased checks and how often they were to be checked.
-Anyone involved in a residents' care who felt that a resident needed increased checks was able to authorize that resident to be on increased checks.
-Because the wander protection bracelet was able to be deactivated, in addition to the wander protection bracelet, residents were placed on increased checks based on needs.

Observation of the SCU on 09/22/21 at 7:48am revealed:
-The two doors entering/exiting the SCU into the AL dining area were both locked and required a key code to enter/exit.
-The two doors exiting to the outside of the facility both had alarms that were turned off.
-Upon opening both doors, no alarm sounded.
-There was a screened in porch outside of one door at the end of the hallway that had a door to the outside with alarms that did not sound when the screen door was opened.
-While outside there were two gates exiting the secured outdoor area that were both locked and required a key code to exit.

Telephone interview with a MA on 09/23/21 at 3:52pm revealed:
-She was not able to indicate what had been done with the alarms when she was not working but when she was working the staff absolutely did not turn off the door alarms for any reason.
-During her shift this past weekend, she recalled the door alarms going off twice.
-She did not recall the exact times but knew that one time was before dinner and the second was after dinner.
-She only responded to one instance of the alarm

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going off.
-When the door alarm went off before dinner, she checked it and another resident turned the alarm off when she arrived at the alarm panel that indicated which door was alarming.
-This resident had been asked on this and numerous occasions not to turn the alarm off but continued to do so.
-Other than asking the resident to stop turning the alarms off, she did not know what else was done to stop the residents from deactivating the door alarms.
-She was not sure how this resident learned how to turn the alarm off but felt that they learned from watching the staff turn the alarm off.
-She, again, asked this resident not to turn the alarm off so that she was able to know who was going in and out of the facility.
-She walked to the door to see who was outside and found it was a resident who smoked.
-The residents knew that they were not supposed to use the east side door to go out to smoke, but they did it anyway when it was raining outside, and it was raining on the night of 09/18/21.
-The second alarm was on the opposite side of the building and she was not on that hall.
-It was that team's responsibility to answer that alarm, so she did not answer it and did not know who answered the alarm.
-Because she was not on that hallway and did not respond to the second alarm, she was not sure if it was a staff who checked the door and turned the alarm off or if a staff member or resident just turned the alarm off without checking the door.

Attempted Telephone Interview with a second MA on 09/23/21 at 4:09pm was unsuccessful.

Attempted Telephone Interview with a Personal Care Aide 09/23/21 at 4:11pm was unsuccessful.

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____
The facility failed to ensure all exit doors were alarmed and all wander protection bracelets were in proper working order and staff responded to all alarms when there was at least one identified resident who wandered or was disoriented resulting in a resident eloping from the facility without staff's knowledge. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

____
The facility provided a plan of protection in accordance with G. S. 131D-34 on 10/07/21 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2020.

D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision | D 270

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 (#2) who left the facility by walking out of the facility at night, unsupervised and eloped from the facility without staff knowledge.

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The findings are:

Review of Resident #2's current FL-2 dated 04/20/21 revealed:
-Diagnoses included Alzheimer's disease, hypertension, and diabetes.
-The resident was constantly disoriented and wandered.
-The resident was ambulatory.
-The resident's current level of care was domiciliary/other - assisted living (AL).

Review of Resident #2's admission FL-2 dated 08/14/19 revealed:
-Diagnoses included Alzheimer's disease, hypertension, and diabetes.
-The resident was intermittently disoriented and wandered.
-The resident was ambulatory.
-The resident's level of care was other, special care unit (SCU).

Review of Resident #2's care plan dated 08/04/20 revealed:
-The resident wandered.
-The resident was sometimes disoriented and required reminders.

Review of Resident #2's care plan dated 07/27/21, but not signed by the primary care provider (PCP) revealed:
-The resident wandered and had disruptive behavior.
-The resident was sometimes disoriented and required reminders.

The facility accident/incident report for Resident #2 was requested 09/22/21 at 11:06am, but the document was not provided by exit.

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Review of the Incident/Investigation report dated 09/18/21 from the local police department revealed:
-At 7:00pm, Resident #2 was last seen in the dining area.
-The staff searched for the resident and at 8:00pm, they contacted the local police department to notify them of the missing resident.
-She had wandered away from the facility, was found and sent to the emergency room (ER) for evaluation due to dementia, confusing behavior.

Review of updated Police Report dated 09/18/21 revealed:
-This report was for a missing/runaway person.
-This incident was called in on 09/18/21 at 7:57pm.
-Law Enforcement responded on 09/18/21 at 7:59pm.
-Resident #2 was listed as the victim.
-The reporting person was documented to be the Supervisor.
-An Officer responded to the facility where Resident #2 walked off an hour following the time Resident #2 went missing.
-Resident #2 was last seen by staff in the dining hall.
-When staff rounded all of the residents up, Resident #2 could not be seen.
-Another resident witnessed Resident #2 going outside to the smoking area.
-Resident #2 was determined to be missing at 9:00pm and the family was notified.
-Multiple K-9 tracks were run and unsuccessful at locating Resident #2 as K-9 continuously went to the hallway and to a window.
-Police advised that it was possible that Resident #2 was still inside of the facility.
-Additional K-9 tracks were run with a different

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K-9 team and these too were unsuccessful.
-Firefighters along with additional first responders searched the building with undisclosed results.
-An Officer completed a search of the woods behind the facility with no success.
-A helicopter was called in.
-The Detective was called away from the scene and was advised that Resident #2 had been located upon their return (did not state the time).
-Resident #2 was located at the end of a dirt road in the wooded area.
-Resident #2 was transported via EMS to the local hospital for evaluation.
-The Detective arrived on 09/18/21 at 8:30pm.
-The Detective had history with Resident #2 from a previous case from 08/05/21.
-Resident #2 was last seen by facility staff in the dining hall around 7:00pm.
-Staff were gathering the residents from outside at around 8:00pm when they found that Resident #2 was missing.
-Upon the arrival of Resident #2's family two K-9 units, drones, law enforcement officers, and fire rescue were on scene and aided in the search for Resident #2.
-The Detective and Resident #2's family first spoke with staff regarding notification of the family prior to searching the facility once more for Resident #2 who was not located.
-The drone spotted a heat signature at a dog park located behind the facility where he began searching for Resident #2 and did not locate her or any other persons.
-A nearby auto dealership was then approached to view surveillance.
-While viewing the surveillance, he received a call at which time it was shared that Resident #2 was located at the end of a gravel road.
-Resident #2 was sitting down and playing with pine straw and was in good health.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 -Resident #2 was transported to the local hospital via EMS for evaluation. Interview with the Local Detective on 09/22/21 at 11:47am revealed: -He was called to the facility when Resident #2 eloped from the building. -He was not the person who found Resident #2 on 09/18/21. -One of his coworkers found Resident #2 sitting on the ground playing with pine straw on 09/18/21 about 70 yards from the facility. -Resident #2 was found down a dirt road near the facility. -The dirt road that Resident #2 was located on ended at a gated community that had several ponds on the property. -The wooded area that Resident #2 was found in had several washed-out areas, by washed out areas he meant a large ditch that drained large amounts of water. -There were many washed out areas that could have fit and submerged two sport utility vehicles. -If Resident #2 had gone a short distance in any direction of where she was found, she could have fallen into one of these ditches and gotten seriously hurt or died. -He did not recall times of notification by the facility nor when Resident #2 was found. -The road the resident was found on also led to the shopping center and a major roadway, both areas heavy with vehicle traffic. Review of the ER provider notes dated 09/18/21 revealed: -At 11:52 pm, emergency medical services (EMS) transported Resident #2 to the hospital. -Resident #2 had no complaints as well as no complaints reported by EMS. -Resident #2 was brought in for evaluation after "wandering away from her 'locked facility' and	D 270		

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was found sitting outside in the woods and playing in pine straw".
-Resident #2 had "no obvious injuries or complaints".
-Resident #2 was discharged on 09/19/21 at 12:17am.

Interview with Resident #2's family member on 09/24/21 at 8:13am revealed:
-She had visited with Resident #2 earlier in the day on 09/18/21.
-The facility had not contacted the primary power of attorney (POA) regarding the elopement of Resident #2.
-The facility had contacted her (the secondary POA) around 8:15pm on 09/18/21.
-She was concerned that the facility was going to "evict" her family member now.
-She had received an email with "the eviction notice" on 09/22/21.
-She and her other family members were reviewing other facilities to choose one to meet the needs of her family member.
-She was not sure if she wanted to move her family member over to the SCU at the facility.
-Her family member was wearing a wander protection bracelet at the time of the elopement.
-She was not sure why the family was paying for it when it apparently did not work.

Interview with a medication aide (MA) on 09/23/21 at 10:20am revealed:
-Resident #2 was admitted to the SCU on 09/19/21 after she had eloped from the facility on 09/18/21.
-She was not working when the elopement occurred.
-Resident #2 had on a wander protection bracelet before the elopement but it was removed when she was admitted to the SCU.

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-Resident #2's family brought in an electronic global positioning system tag (used for tracking luggage when traveling) after her elopement and placed it on Resident #2's ankle.
-Resident #2 removed it from her ankle yesterday and lost the tag (09/22/21).
-Resident #2's family came yesterday (09/22/21) and finally found the tag.
-The family decided not to place the tag back on Resident #2 while she was in the SCU.

Review of the local online weather report revealed the outside temperature on 09/18/21 at the time of Resident #2's elopement was 68 degrees Fahrenheit.

Interview with the Executive Director (ED) on 09/23/21 at 3:55pm revealed:
-She was aware staff checked on residents at least every two hours and more often if the resident's needs required it.
-Checks were done more frequently with residents in the SCU.
-The AL side of the facility was not a locked unit and the door alarms were not always alarmed.
-Resident #2 wandered but the ED was not aware of any exit seeking behaviors.

Review of Resident #2's progress notes dated from 01/18/20 to 06/03/20 revealed:
-On 01/18/20, Resident #2 went out the west side front door and stated she was going home, and the MA brought her back inside the facility.
-On 01/20/20, the resident tried to walk out of the facility all night.
-On 01/21/20, Resident #2 was found in another resident's room in his bed.
-On 01/23/20, Resident #2 had to be redirected three times after setting off the door alarms.
-On 01/29/20, Resident #2 set off the door

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alarms.
-On 02/03/20, Resident #2 tried to go into other residents' rooms.
-On 02/09/20, Resident #2 set off the door alarms and stated she wanted to go home, and the MA and personal care aide (PCA) brought the resident back inside the facility.
-On 03/10/20, Resident #2 attempted to leave the facility and was brought back inside by the PCA and housekeeping staff.
-On 03/13/20, Resident #2 had set off the door alarms and roamed in and out of other residents' rooms and disrobed in the TV room.
-On 03/28/20, Resident #2 was found in another resident's room in their bed.
-On 04/15/20, Resident #2 wandered outside looking for her bedroom.
-On 05/05/20, Resident #2 attempted to leave the facility 'to go home'.
-On 05/21/20, Resident #2 was found in another resident's room.
-On 06/03/20, Resident #2 wandered outside and was brought back into the facility by the MAs.

Review of Resident #2's progress notes revealed no other notes were documented in the residents record until the elopement on 09/18/21.

Telephone interview with Resident #2's Primary Care Provider (PCP) on 09/23/21 3:09pm revealed:
-He was aware of one time, in addition to the elopement on 09/18/21, that Resident #2 eloped from the facility.
-He did not have concerns for the past elopement because Resident #2 did not get far before she was returned to the facility.
-Had he been made aware that Resident #2 had several elopement episodes from 01/18/20 to 06/03/20 and had exit seeking behaviors, he

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D 270	Continued From page 17 would have made alternate arrangement for Resident #2. -Prior to this elopement, the facility had already begun the process of trying to have Resident #2 placed in SCU. -Resident #2's family resisted this course of action because they did not want Resident #2 to lose her private room. -Resident #2's family suggested getting a tracker for Resident #2 and he felt this was a good way of tracking Resident #2, in the event she returned to assisted living. -Since Resident #2 learned how to remove the device, an alternate plan needed to be made. -He was aware that Resident #2 was currently in the SCU and preferred that she stayed there, but was going to give the family a chance to make alternate arrangements to return Resident #2 to assisted living. -The alternate option to the tracking device that was being considered was the family getting 24/7 sitters either to go to the assisted living or with Resident #2 at home. -He was going to give the family a chance to think this option over otherwise the SCU was the safest option for Resident #2. -Resident #2's family had historically ensured that she had the care that she needed even when she was still at home. -Resident #2's family hired some care in the home but then provided the remaining care and supervision themselves to ensure 24/7 care at home. -He believed that if needed and possible, the family would have hired a private sitter again but, in the facility setting. -Resident #2's family told him that they were getting sitters to come to the facility to provide someone to provide one on one care 24 hours a day.	D 270		

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D 270	Continued From page 18 -If the family was unable to provide sitters and continued to refuse placement into the SCU, then he would continue to work with the family to find the safest option for Resident #2. Telephone Interview with the ED on 09/18/21 at 10:44pm revealed: -She was five hours away in another state at the time of the elopement but was made aware of the situation by the Business Office Manager (BOM). -Resident #2 was found very close to the facility on a dirt road and returned to the facility. -As of 09/18/21, Resident #2 was going to be placed in the SCU for her safety. -Resident #2 had a history of wandering into other residents' rooms and would lay in their beds but did not wander outside. -This behavior was normal for Resident #2 and one reason why she had a wander protection bracelet. -She was unsure if Resident #2 had her wander protection bracelet on as she was not present at the time of the elopement or when Resident #2 was found. -Resident #2 was last seen by facility staff at about 7:15pm on 09/18/21 and staff realized Resident #2 was missing at around 7:30pm on 09/18/21. -She thought Resident #2 was found around 10:30pm. -She completed a full investigation upon her return to the facility on 09/21/21. -The Assistant Administrator and BOM immediately went to the facility once it was discovered that Resident #2 was not able to be found. The county Department of Social Security was made aware of the elopement of Resident #2 via local news articles and videos posted to a social	D 270		

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media website.

Telephone interview with the BOM on 09/20/21 at 9:40am revealed:
-Resident #2 had her wander protection bracelet on when she eloped, and it was still on her when she was found.
-If a resident had their wander protection bracelet on when they got within a certain distance from the door, the door would alarm notifying the staff that a resident with a wander protection bracelet was near an exit.
-Some residents knew how to prevent the detection of the wander protection bracelet when nearing a door but she was unsure if Resident #2 was included in these residents.
-She was not sure if this was done by covering the wander protection bracelet or another way.

Telephone interview with the ED on 09/21/21 at 10:20am revealed:
-The facility staff tried to notify the responsible party for Resident #2 on 9/18/2021 to inform her of the elopement but she did not answer which caused the staff to contact the secondary contact for Resident #2.
-She was not aware of the times of notification.
-The BOM called the local department of social services after hours phone number and notified them of the elopement.
-At 11:28am, ED was informed that Resident #2's family was with her until about 6:45pm on 9/18/21.
-During the visit Resident #2's family had been taking Resident #2 in and out of the facility all day to an unsecure area outside of the building that the facility did not normally allow her to go.
-It was believed that Resident #2's family members left around 6:45pm and Resident #2 went missing around 7:08pm.

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Resident #2 outside so often during the day then leaving while she was in the dining room.
-Resident #2 only went outside because she was looking for her family members.
-Resident #2 did not normally have exit seeking behaviors.
-At 11:45am, ED found that the family was at the facility at lunch time not dinner time and left between 3:00pm-4:00pm.

Attempted telephone interview on 09/23/21 at 10:49am with Resident #2's family member was unsuccessful.

A second interview with the ED on 09/23/21 at 11:22am revealed:
-Resident #2's FL2, dated 04/20/21, documented that she was to be in assisted living.
-Resident #2 was originally admitted to the facility on 08/26/19 at which time she had an FL2, dated 08/14/19, documenting that she was to be in SCU.
-Resident #2 was first in the SCU for memory support.
-Resident #2's PCP changed her level of care, to assisted living, and she was moved to assisted living around September or October 2020.
-Due to the change in the level of care, recommended by the PCP, Resident #2 was an assisted living resident on 09/18/21 when she eloped from the facility and was unable to find her way back.

Telephone interview with a MA on 09/23/21 at 3:52pm revealed:
-She was not working on Resident #2's hallway on the night of 9/18/21 but was working on another hall in assisted living.
-On 9/18/21, she was feeding residents in the dining room at dinner time while Resident #2 was

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getting up and down from her seat while she was supposed to be eating.
-The last time she remembered seeing Resident #2 was around 6:45pm on 09/18/21 walking around on the west side of the building.
-She did not see Resident #2 at any time after 6:45pm prior to her eloping.
-She was not able to indicate what had been done with the alarms when she was not working but when she was working the staff absolutely did not turn off the door alarms for any reason.
-During her shift, she recalled the door alarms going off twice.
-She did not recall the exact times but knew that one time was before dinner and the second was after dinner.
-She only responded to one instance of the alarm going off.
-She walked to the door to see who was outside and found it was a resident who smoked.
-The residents knew that they were not supposed to use the east side door to go out and smoke but they did it anyway when it was raining outside and it was raining on the night of 09/18/21.
-The second alarm was on the opposite side of the building and she was not on that hall.
-It was that team's responsibility to answer that alarm so she did not answer it and did not know who did answer the alarm.
-Because she was not on that hallway and did not respond to the second alarm, she was not sure if it was a staff member that checked the door and turned the alarm off or if a staff member or resident just turned the alarm off without checking the door.
-She was not sure what time it was but stated "a lady" called and told her that Resident #2 was missing.
-All staff that were present in the building, except the SCU staff who remained in the SCU and

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checked that area, checked the entire building.
-The dietary staff were also present and assisted with the search of the building.
-The staff had begun searching at about 7:10pm-7:15pm.
-The staff started with residents' rooms because it was normal behavior for Resident #2 to go into other residents' rooms and lay in their beds.
-When Resident #2 was not found in the building, the MA that was responsible for Resident #2 on 09/18/21 attempted to contact her family listed on her resident registry but the number for the responsible party was incorrect as it was the family member's work number.
-When Resident #2's responsible party did not answer, she called the Assistant Administrator and the BOM, while Resident #2's MA called 911.
-When law enforcement arrived at the facility, all staff and residents including the BOM and Assistant Administrator, who came in to assist, were put on lock down in the facility and were not able to leave for any reason or assist with the search.
-She was not sure when and/or where Resident #2 was found.
-Resident #2 was sent to the local hospital after being found.
-Resident #2 returned from the local hospital on the same night with no new orders and no changes to her current orders but was placed in the SCU.

Attempted Telephone Interview with a second MA on 09/23/21 at 4:09pm was unsuccessful.

Attempted Telephone Interview with a Personal Care Aide 09/23/21 at 4:11pm was unsuccessful.

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The facility failed to provide adequate supervision for 1 out of 5 sampled residents who had

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D 270	Continued From page 23 wandering behaviors which resulted in the elopement of Resident #2 on 09/18/21 and found 70 yards from the facility down a dirt road, off of the gravel road, in a wooded area at night. This failure was detrimental to the health, safety, and welfare of the residents constitutes a Type B Violation. ________________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/23/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 7, 2021.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, facility failed to ensure physician notification for 1 of 5 sampled residents (#2) with of wandering and exit seeking behaviors and who had exited from the Assisted Living (AL) unit and had to be brought back in to the facility by staff. The findings are: Review of Resident #2's current FL-2 dated 04/20/21 revealed: -Diagnoses included Alzheimer's, hypertension, and diabetes. -The resident was constantly disoriented and wandered.	D 273		

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D 273	Continued From page 24 -The resident was ambulatory. -The resident's current level of care was domiciliary/other. -The other was documented as assisted living (AL). Review of Resident #2's initial FL-2 dated 08/14/19 revealed: -Diagnoses included Alzheimer's, hypertension, and diabetes. -The resident was intermittently disoriented and wandered. -The resident was ambulatory. -The resident's level of care was other. -The other was documented as special care unit (SCU). Review of Resident #2's care plan dated 08/04/20 revealed: -The resident wandered. -The resident was sometimes disoriented and required reminders. Review of Resident #2's care plan dated 07/27/21 revealed: -It was not signed by the primary care provider, -The resident wandered and had disruptive behavior. -The resident was sometimes disoriented and required reminders. Interview with Resident #2's family member on 09/24/21 at 8:13am revealed: -She was not aware that her family member had previous episodes of leaving or trying to leave the facility. -She thought the wander protection bracelet was supposed to alert the staff that Resident #2 was too close to an exit.	D 273		

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D 273	Continued From page 25 Review of Resident #2's nurse's notes revealed: -On 01/18/20, Resident #2 went out the west side front door and stated she was going home, and the MA brought her back inside the facility. -On 01/20/20, the resident tried to walk out of the facility all night. -On 01/21/20, Resident #2 was found in another resident's room in his bed. -On 01/23/20, Resident #2 had to be redirected 3 times after setting off the door alarms. -On 01/29/20, Resident #2 had set off the door alarms by opening the doors. -On 02/03/20, Resident #2 tried to go into other residents' rooms. -On 02/09/20, Resident #2 set off the door alarms and stated she wanted to go home; and the MA and personal care aide (PCA) brought the resident back inside the facility. -On 03/10/20, Resident #2 attempted to leave the facility and was brought back inside by the PCA and housekeeping staff. -On 03/13/20, Resident #2 set off the door alarms and roamed in and out of other residents' rooms and disrobed in the TV room. -On 03/28/20, Resident #2 was found in another resident's room in their bed. -On 04/15/20, Resident #2 wandered outside looking for her bedroom. -On 05/05/20, Resident #2 attempted to leave the facility 'to go home'. -On 05/21/20, Resident #2 was found in another resident's room. -On 06/03/20, Resident #2 wandered outside and was brought back into the facility by the MA's. -There was not documentation that the Primary Care Provider (PCP) was notified of any of these behaviors. Interview with the Executive Director on 09/23/21 at 9:50am revealed:	D 273		

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D 273	Continued From page 26 -"All wanderers go on the memory care unit". -She was not aware of Resident #2 having left the facility prior to this elopement on 09/18/21. -She knew Resident #2 wandered but did not know she had been "exit seeking". -She expected to be notified of "exit seeking" behaviors by the Resident Care Coordinator (RCC). -The staff who noticed the behaviors should have reported to the RCC. -The MA on duty should notify the PCP when an elopement occured. -The RCC should notify the PCP of "exit seeking" behaviors. Telephone interview with Resident #2's Primary Care Provider (PCP) on 09/23/21 3:09pm revealed: -He was aware of one time prior to the elopement on 09/18/21, that Resident #2 eloped from the facility. -He could not recall the date of the prior elopement. -He did not have concerns for the past elopement because Resident #2 did not get far before she was returned to the facility. -Had he been made aware that Resident #2 had several elopement episodes in the last year he would have made alternate arrangement for Resident #2. -Prior to this elopement, the facility had already begun the process of trying to have Resident #2 placed in memory care.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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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 2 of 6 residents (#6, #7) observed during the medication pass including errors with a medication for acid reflux and a topical cream (#7) and a thyroid medication (#6).

The findings are:

The medication error rate was 10% as evidenced by the observation of 3 errors out of 29 opportunities during the 8:00am/9:00am medication pass on 09/22/21.

1a. Review of Resident #7's current FL-2 dated 03/12/21 revealed diagnoses included cancer associated pain, carcinoma of the right fallopian tube, drug induced constipation, hypokalemia, rheumatoid arthritis involving both hands, essential hypertension (HTN), gastroesophageal reflux disease (GERD) without esophagitis, depression, diverticulitis, epigastric pain and neuropathy.

Review of Resident #7's physician's orders dated 08/05/21 revealed there was an order for Hydrocortisone Cream 1% topically to arms and shoulders where there was pruitis (itching) twice a day. (Hydrocortisone Cream is used to treat itching.)

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D 358	Continued From page 28 Observation of the 8:00am/9:00am medication pass on 09/22/21 at 9:04am revealed: -The medication aide (MA) prepared Resident #7's routine medications for administration. -The MA administered Resident #7's medications and did not administer or offer the Hydrocortisone Cream. Review of Resident #7's September 2021 (electronic medication administration record (eMAR) revealed: -There was an entry for Hydrocortisone Cream 1% topically to arms and shoulders where there was pruritis twice a day scheduled at 8:00am and 8:00pm. -Hydrocortisone Cream was documented as administered on 09/22/21 at 8:00am. Interview with Resident #7 on 09/22/21 at 4:10pm revealed: -She did not receive her Hydrocortisone Cream on 09/22/21 when she received her morning medications and was not offered the cream by the MA. -She did not keep the Hydrocortisone Cream at bedside. -She was having some pruritis to her arms and shoulders and was going to speak with her primary care provider (PCP) about trying a different type of medication because the Hydrocortisone Cream did not help. Telephone interview with the MA on 09/22/21 at 2:50pm revealed: -Resident #7 kept the Hydrocortisone Cream in her room at bedside. -She could not remember if she had applied Resident #7's Hydrocortisone Cream. -She accidentally documented the Hydrocortisone	D 358		

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Cream as administered on 09/22/21 at 8:00am.

Interview with the Administrator on 09/22/21 at 3:10pm revealed it was the responsibility of the MA to document on the resident's eMAR after medications were administered.

Attempted telephone interview with Resident #7's PCP on 09/22/21 at 9:31am was unsuccessful.

b. Review of Resident #7's physician's orders dated 08/05/21 revealed there was an order for Protonix 40mg 1 tablet every 12hrs. (Protonix is a medication used to decrease the amount of acid produced in the stomach.)

Observation of the 8:00am/9:00am medication pass on 09/22/21 at 9:04am revealed the medication aide (MA) administered Resident #7's routine medications that included the Protonix.

Review of Resident #7's September 2021 (electronic medication administration record (eMAR) revealed:
-There was an order for Protonix 40mg every 12hrs scheduled at 7:00am and 7:00pm.
-Protonix was documented as administered on 09/22/21 for 7:00am.

Telephone interview with the MA on 09/22/21 at 2:50pm revealed:
-She did not administer Resident #7's Protonix 40mg as ordered on 09/22/21 at 7:00am because it was an oversight.
-She administered Resident #7's Protonix with her morning medications on 09/22/21 at 9:04am.
Refer to interview with the Administrator on 09/22/21 at 3:10pm.

Attempted telephone interview with Resident #7's

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PCP on 09/22/21 at 9:31am was unsuccessful.

2. Review of Resident #6's current FL-2 dated 06/04/21 revealed diagnoses included atrial fibrillation, Alzheimer's Disease, dementia, dilated cardiomyopathy, chronic bronchitis and anemia.

Review of Resident #6's physician's orders dated 06/04/21 revealed there was an order for Levothyroxine 112mcg once daily. (Levothyroxine is used to treat an underactive thyroid gland.)

Observation of the 8:00am/9:00am medication pass on 09/22/21 at 9:13am revealed the medication aide (MA) administered Resident #6's routine medications that included the Levothyroxine.

Review of Resident #6's September 2021 (electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 112mcg once daily scheduled at 7:30am.
-Levothyroxine 112mcg was documented as administered on 09/22/21.

Telephone interview with the MA on 09/22/21 at 2:50pm revealed:
-She did not administer Resident #6's Levothyroxine as ordered at 7:30am because it was an oversight.
-She administered Resident #6's Levothyroxine with his morning medications on 09/22/21 at 9:13am.

Refer to interview with the Administrator on 09/22/21 at 3:10pm.

Based on observations and interviews, it was determined that Resident #6 was not

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D 358	Continued From page 31 interviewable. Attempted telephone interview with Resident #6's PCP on 09/22/21 at 9:33am was unsuccessful. ______________________ Interview with the Administrator on 09/22/21 at 3:10pm revealed: -It was the responsibility of the MA to administer medications at least 1hr before or 1hr after the scheduled administration times. -It was the responsibility of the MA to notify the resident's primary care provider (PCP) when medications were not administered as ordered.	D 358		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that a medication cart on the Assisted Living (AL) unit was locked when not under the direct supervision of staff in charge of medication administration. The findings are: Observation of the 8:00am/9:00am medication pass on 09/22/21 at 9:04am revealed: -The medication aide (MA) prepared a resident's	D 378		

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D 378	Continued From page 32 medications at the medication cart and then entered in the resident's room to administer the medications. -The medication cart was positioned beside the resident's room door, was left unlocked, and was not visible by the MA while in the resident's room. -The MA was in the resident's room for approximately 1 minute administering medications. -There was not another MA monitoring the medication cart while she was in a resident's room. -There were no residents visible near the medication cart. Interview with the Administrator on 09/22/21 at 3:10pm revealed: -She walked on the hall and observed the medication cart was unlocked. -The MA was in a resident's room at the time administering medications and could not visibly see the medication cart. -It was the responsibility of the MA to ensure that the medication cart was locked when medications were not being directly supervised by the MA. Attempted telephone interview with the MA on 09/22/21 at 2:50pm was unsuccessful.	D 378		
D 389	10A NCAC 13F .1007 (d) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (d) All medications destroyed at the facility shall be destroyed by the administrator or the administrator's designee and witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted	D 389		

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so that no person can use, administer, sell or give away the medication.

This Rule is not met as evidenced by:
Based on observation, record review, and interviews, the facility failed to assure medications that were disposed of in the facility were witnessed by a licensed pharmacist or designee of a licensed pharmacist.

The findings are:

Review of Resident #7's current FL-2 dated 03/12/21 revealed:
-Diagnoses included cancer associated pain, carcinoma of the right fallopian tube, drug induced constipation, hypokalemia, rheumatoid arthritis involving both hands, essential hypertension (HTN), gastroesophageal reflux disease (GERD) without esophagitis, depression, diverticulitis, epigastric pain and neuropathy.
-There was an order for Senna-Plus 8.6-50mg 3 tablets twice a day. (Senna-Plus is a combination of a stool softener and a laxative used to treat constipation.)

Observation of the 8:00am/9:00am medication pass on 09/22/21 at 9:04am revealed:
-Resident #7's Senna-Plus 8.6-50mg was on a medication card with 3 Senna-Plus tablets in 1 bubble.
-The medication aide (MA) prepared Resident #7's medication from her medication card and dropped 1 tablet of the 3 Senna-Plus tablets onto the floor.
-The MA picked the tablet of Senna-Plus off the floor and placed it in the regular trash can on the medication cart that was easily accessible to other staff and residents.

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D 389	Continued From page 34 -The MA prepared another dose of Senna-Plus from Resident #7's medication card and disposed of 2 of the 3 Senna-Plus tablets into the regular trash can on the medication cart that was easily accessible to other staff and residents. -The MA did not have a witness for the disposal of the 3 Senna-Plus tablets. Interview with the Administrator on 09/22/21 at 3:10pm revealed: -It was the responsibility of the MA to have second MA or the Administrator to witness the disposal of all medication. -It was the responsibility of the MA to dispose of medications in the sharps' container. Attempted telephone interview with the MA on 09/22/21 at 2:50pm and was unsuccessful.	D 389		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.	D 612		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to appropriate screening of visitors.

The findings are:

Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of COVID-19 in long term care (LTC) facilities, updated 09/10/21, revealed all visitors should be screened for the presence of fever and symptoms of the virus when entering the building.

Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of COVID-19 in LTC facilities revealed all visitors should be screened for signs and symptoms of COVID-19 before entering the building.

Review of the facility's COVID-19 Screening Sign In Sheets on 09/23/21 revealed:
-All visitors were normally screened at the front door.
-The screening sign in sheets located at the front door did not have either of the visitors listed on the sheets as being screened in to the facility.
-Employees used the entrance at the east wing door where they were screened in upon arrival to work.
-The employee (the family member of the visitors) had screened in and signed in on 09/22/21.

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D 612	Continued From page 36 -The 12-year-old and 10-year-old visitors names were not signed in on any of the sheets located at the east wing door. -There was no documentation of the visitors being screened in by having their temperatures checked nor the questions answered as related to COVID-19 on 09/22/21 when the visitors had been observed in the facility in common areas. Observation of foyer area on 09/22/21 at 8:01am revealed: -There was a blind resident seated in the foyer area. -There was a minor aged child that lead the blind resident to the dining room. -The child was wearing a face mask. Observation of the assisted living 200 hall on 09/22/21 at 8:08am revealed the minor aged child disabled the exit door alarm from a wall security panel. Interview with the minor age child on 09/22/21 at 8:08 am revealed: -The resident she had escorted was not a relative. -She was 10 years old. -The child had come to work with her mother sometimes when there was no school. Observation of room 109 on the assisted living hall on 09/22/21 at 8:10am revealed: -The room had not been assigned to a resident and it had been unoccupied. -There were two minor aged children seated in the room. -The children were watching TV. Interview with a second minor aged child on 09/22/21 at 8:10 am revealed: -She was 12 years old.	D 612		

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D 612	Continued From page 37 -She and her sister had come to work with their family member because there was no school on 09/22/21. Interview with a Medication Aide (MA) on 09/22/21 at 8:27am revealed: -She had brought her two children to work on 09/22/21 because school was closed. -Her children had engaged with the residents in some resident activities. -Her children had helped with passing out snacks to the residents and had help with escorting residents around the facility. -Her children had mostly stay in an unoccupied resident room and watch TV. -She monitored her daughters while at work. Interview with the Administrator on 09/23/21 at 3:55pm revealed: -She was not aware the children were on site until 2:00pm on 09/22/21. -The children had engaged with the residents when resident activities were offered. -The children were required to sign in and be screened by staff each time they would come to the facility. -The children were required to wear masks at all times when inside of the facility. -The family member would obtain permission to bring the children to work when she needed to.	D 612		
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.	D912		

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D912	Continued From page 38 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure every resident had the right to receive care and services, which are adequate, appropriate, and in compliance with rules and regulations as related to supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) based on assessed needs, resulting in a resident eloping from the facility without staff knowledge. [Refer to Tag 270, 10A NCAC 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D912		