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CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 03/08/22- 03/10/22.	{D 000}		
{D 079}	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards left accessible to the 26 residents including a staple gun and wire cutters not monitored by staff. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed with a capacity of 96 residents with a Special Care Unit (SCU) capacity of 36 residents. The facility's policy for Storage of Hazardous Items on the SCU was requested on 03/08/22 at 4:02pm and was not provided prior to survey exit. Observation of the SCU common activity room on 03/08/22 at 9:29am revealed: -There was an unsecured gray tote box by the table. -Inside the tote box there was a staple gun, wire cutters, and decorating items.	{D 079}		

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{D 079}	Continued From page 1 -There was no door and the room was open and accessible to residents. -There was one resident in the open room next to the activity room. -There was no staff present in the activity room. Interview with a personal care aide (PCA) on 03/08/22 at 9:31am revealed: -She was leading activities with the residents in the room next to the common activity room. -The gray tote box held decorating supplies because she was decorating the room over the last couple of days.. -She was unsure how many days the gray tote box was stored in the activity room. -She would keep the tote box in the common activity room because residents would take down decorations and she would need to put them back up. -The gray tote box should have been stored in the locked activity closet but was taken out for decorating. -There were residents who would wander and rummage in containers and furniture. Interview with the Special Care Coordinator (SCC) on 03/08/22 at 4:02pm revealed: -She had been notified of the gray tote box and hazards that day. -The PCA was decorating that room in the morning and needed the supplies because residents would remove the decorations. -Hazardous supplies should be locked up. Interview with the Resident Care Director (RCD) on 03/10/22 at 4:37pm revealed: -She expected all hazardous items to be locked on the SCU. -The residents in the SCU that had memory issues and some had behaviors which may cause	{D 079}		

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{D 079}	Continued From page 2 problems with hazardous items. Interview with the Administrator on 03/08/22 at 2:00pm revealed sharp items must be kept out of reach from residents.	{D 079}		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure supervision for 1 of 6 sampled residents (#6) exited the special care unit (SCU) through a bedroom window following an altercation with another resident. The findings are: Review of the facility's policy for Community Rounds dated 06/08/21 revealed: -Resident whereabouts would be monitored to minimize potential for elopement from the special care unit (SCU).	{D 270}		

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{D 270}	Continued From page 3	{D 270}		

-Community rounds would be made every hour per staff assignments.
-Change of shift time would include an additional accounting of all residents.
-All residents would be visited to account for whereabouts.
-Any unsafe conditions would be corrected immediately and reported to the supervisor.

Review of the facility's policy for Missing Person Elopement dated 06/08/21 revealed:
-Staff would be routinely alerted to individual residents who had been identified to be at risk (of wandering) via their Service Plan, communication records and shift change reports.
-Routine rounds would be made by staff to account for resident whereabouts each hour during each shift and at each shift change.
-For residents returning from medical evaluation and remaining in the community:
Maintain 1 to 1 resident oversight until further evaluation and the resident was determined to be safe from repeated elopement.
-The Memory Care Director or designee would update the their Service Plan to reflect elopement risks and interventions.

Review of Resident #6's current FL-2 dated 03/31/21 revealed diagnoses included seizure disorder, anxiety, hypertension, depression and dementia.

Review of Resident #6's current care plan dated 01/31/22 revealed:
-She was ambulatory and had wandering behaviors.
-She was sometimes disoriented, forgetful and needed reminders.
-There was no documentation related to a history of elopement attempts and aggressive/assaultive

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{D 270}	Continued From page 4 behaviors towards other residents. Review of Resident #6's Service Plan dated 02/14/22 revealed: -She had occasional behavior issues including disruptive, aggressive or socially inappropriate behavior. -Actions included she might require special tolerance or staff training and might have behavior management in place. -She had moderate wandering issues including current or history of wandering within the facility and might wander outside the facility where health or safety might be jeopardized. -She was not combative about returning to the facility and did not require professional consultation or intervention. -She might also have behavior management (psychiatric services) in place. Interview with the Resident Care Director (RCD) on 03/10/22 at 12:43pm revealed: -Moderate wandering issues on the service plan meant a resident had current or a history of disorientation and wandering and required supervision for oversight and safety and might have behavioral management in place. -Residents with moderate wandering issues were placed on the SCU for supervision and oversight. -Staff knew of each residents' needs by the Monthly Task Log where they documented care provided each shift. Review of Resident #6's March 2022 Monthly Task Logs revealed: -There was no documentation of the resident's history of aggressive/assaultive behaviors or elopements. -There was no documentation of supervision needs for the resident.	{D 270}		

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{D 270}	Continued From page 5 a. Review of a progress note for Resident #6 dated 10/11/21 at 9:26pm revealed another resident went into Resident #6's room and was pushed out of the room by Resident #6 causing the resident to fall in the hallway. Review of a progress note for Resident #6 dated 01/17/22 at 1:36pm revealed the resident dragged another resident out of her room by her feet and was trying to kick the other resident when staff intervened. Review of an incident report for Resident #6 dated 01/17/22 at 1:30pm revealed: -The resident pulled another resident out of her room by the feet. -The primary care provider (PCP) and family member were notified. -Actions included alert charting, frequent checks for 72 hours and safety of the environment was reviewed. Interview with a medication aide (MA) on 03/10/22 at 9:53am revealed: -She documented the incident occurred on 01/17/22 involving Resident #6 and another resident. -Resident #6 pushed the other resident down in her room, dragged her out of the room by her feet and then started to kick the other resident. -Staff "kept a check" on Resident #6 the remainder of that shift on 01/17/22. -Staff did not document any checks on the resident. Review of an incident report for Resident #6 dated 03/05/22 at 1:30pm revealed: -The resident was "beating" up another resident when the other resident entered her room.	{D 270}		

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{D 270}	Continued From page 6 -The family member was notified. -Actions included alert charting and frequent checks for 72 hours. Review of Resident #6's progress notes dated 01/18/22 through 03/07/22 revealed there was no documentation of an altercation between Resident #6 and another resident. Interview with a personal care aide (PCA) on 03/09/22 at 11:01am revealed: -Prior to 03/05/22, staff did not have to keep an eye on Resident #6. -Before lunch on 03/05/22, Resident #6 had a "squirmish" with another resident. -She was folding laundry when another PCA called out to her that Resident #6 was hitting another resident. -The other PCA was standing with both residents in the hallway outside Resident #6's room. -She did not see anyone hitting anyone else when she got there. -The residents were separated, and Resident #6 went in her room. -When residents were in their rooms, she checked on them when she passed by their rooms. -She would enter their room and make sure they were okay. -She could not say how often she checked on residents who were not in sight in common the living room area. Interview with a second PCA on 03/09/22 at 3:26pm revealed: -Residents on the SCU were checked every 30 minutes. -In January 2022 Resident #6 dragged another resident out of her room and caused a skin tear on her hand that was only now starting to heal.	{D 270}		

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{D 270}	Continued From page 7 -She checked Resident #6 every 15-30 minutes prior to 03/05/22 because the resident liked to go and shake on the exit doors trying to open get the doors opened. -After lunch on 03/05/22 around 12:45pm - 1:00pm, she put a movie on in the living room which lasted approximately 30-45 minutes. -She was standing at the desk in the SCU when she heard someone say, "help me". -She went towards the call for help and found Resident #6 pulling another resident by her hair, dragging the other resident out of her room and punched her in the face and was holding her neck. -A second PCA tried to help separate the residents and Resident #6 started punching the PCA. -Resident #6 calmed down after 1-2 minutes of talking to her. -Staff exited the resident's room and the resident locked the door. -Following the resident to resident altercation in January 2022, if staff saw that a resident was walking down the hall towards Resident #6's room, they would watch to see where the resident was going. Interview with a medication aide (MA) on 03/09/22 at 10:29am revealed: -Resident #6 did not like other residents going into her room. -The resident would usually just push the other resident out of her room. -On 03/05/22, another resident went into Resident #6's room. -Resident #6 was hitting the other resident until they were separated by staff. -Staff were expected to separate residents when there was altercation between residents, notify the family member, administer as needed	{D 270}		

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{D 270}	Continued From page 8	{D 270}		

medication if available and complete documentation on an incident report, progress note and end of shift book.

Interview with the Special Care Coordinator (SCC) on 03/10/22 at 9:53am revealed:
-She did not remember the resident to resident altercation between Resident #6 and another resident on 01/17/22.
-Staff reported Resident #6 having an altercation with another resident prior to her elopement from the facility on 03/05/22.
-She did not know Resident #6 pulled the other resident out of the room by her hair, punched her on the face and grabbed her neck.
-When there was a resident to resident altercation, staff were expected to separate and redirect residents, call family members and/or her, check for as needed medications and document the incident on an incident report.
-Incident reports triggered alert charting and monitoring which was documented on the electronic medication record (eMAR) every shift for 72 hours.
-The RCD reviewed incident reports completed by MAs.
-Both residents should have monitored throughout the shift for 72 hours.
-Staff was expected to monitor the residents and there should have been alert charting on the eMAR for 72 hours.
-Staff would have checked on the resident more often after the incident on 01/17/22, but it would not have been documented.
-Rounds were done by staff every 2 hours on the SCU.
-The frequency of checks after an incident depended on the severity.
-She could not specify how often Resident #6 should have monitored following the incidents on

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{D 270}	Continued From page 9 01/17/22 and 03/05/22. Review of Resident #6's January, February and March 2022 electronic medication administration records (eMARs) revealed: -There was no entry for an as needed medication for agitation and/or anxiety. -There was no documentation of 72 hour monitoring and/or alert charting. Interview with the RCD on 03/10/22 at 2:00pm revealed 72 hour charting was not documented on the eMAR, it was documented in the progress notes as alert charting. Review of progress notes for Resident #6 dated 01/17/22 through 03/07/22 revealed there were no entries related to alert charting and/or 72 hour monitoring. Interview with the Administrator on 03/10/22 at 4:19pm revealed: -He was not made aware of the incident between Resident #6 and another resident on 03/05/22, he was told by the RCD on 03/07/22. -He did not immediately recall the incident between Resident #6 and another resident on 01/17/22. -Staff were expected to immediately separate residents, tend to any injuries and monitor the residents. -The frequency of monitoring depended on the circumstances of each situation. -If staff were not sure what to do, they were supposed to contact the SCC, RCD or him. b. Observations during the tour of the special care unit (SCU) on 03/08/22 from 8:56am to 9:00am revealed Resident #6 was walking in the hallway with another resident stopping frequently	{D 270}		

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{D 270}	Continued From page 10 to attempt opening doors. Observations on the SCU on 03/09/22 at 2:39pm revealed: -Resident #6 and her roommate were attempting to open the exit door near room C4. -Both residents left the door when it did not open immediately. Review of a progress note for Resident #6 dated 04/03/21 revealed: -At 11:40am, staff documented the resident was at the end of the hallway pulling at the fire alarm cover and was redirected by staff. -The resident returned to pulling the fire alarm cover and then pushed the (exit) door open and went out the door. -Staff was able to get the resident back inside the building; she was aggressive with staff. -The Special Care Coordinator (SCC) was aware and contacted the family member. Review of a progress note for Resident #6 dated 06/12/21 revealed: -At 7:25am, the resident was seen walking on the sidewalk outside the facility with her roommate walking towards the front of the building. -Staff attempted to redirect the residents back inside the facility, but Resident #6 got aggressive with staff and pulled her roommates arm and shirt. -Both residents hit and kicked staff requiring an additional staff member to help get the residents back inside the facility. -The Administrator intervened and talked to Resident #6 which calmed her down. -After seeing the residents outside, staff observed that the window in the residents' room was opened from the top allowing the residents to climb out of the window.	{D 270}		

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{D 270}	Continued From page 11 Review of a progress note for Resident #6 dated 06/18/21 at 5:26pm revealed the resident was moved to room C17 (on the SCU). Review of progress notes for Resident #6 dated 03/05/22 revealed: -At 3:01pm, a medication aide (MA) documented a call was received from staff on the assisted living (AL) side informing them that the resident had gotten out of the facility. -Staff searched the SCU to identify how the resident got out of the SCU and found the windowpane was out and the air conditioner unit cover was off in the resident's room. -At 7:30pm, the Special Care Coordinator (SCC) documented the resident was moved to a room with double security (secured window which opened to a fenced in area) and there would be extra room checks on the resident for the next few days. Review of an incident report for Resident #6 dated 03/05/22 at 2:15pm revealed: -The resident removed her bedroom window and eloped from the SCU. -Staff were alerted the resident was not in the facility by a call from the local law enforcement agency. -She was picked up by staff and did not sustain any injury. -The primary care provider (PCP) and family member were notified. -Actions included alert charting, frequent checks for 72 hours and safety of the environment was reviewed. Review of a local law enforcement event call record revealed a missing person report was reported to local law enforcement at 2:04pm on	{D 270}		

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{D 270}	Continued From page 12 03/05/22 at an address of an apartment complex near the facility. Observation of global positioning system (GPS) map on 03/09/22 at 10:19am revealed the driving distance between the facility and the location Resident #6 was found was 1.2 miles. Observations on 03/10/22 from 11:30am until 12:00pm revealed: -The wooded area outside the SCU had thick brush, heavy piles of branches to step over, vines, thorn bushes, an unavoidable 3 foot wide stream and a steep hill approximately 30 feet to the top. -The top of the hill opened to the rear of an apartment complex followed by several parking lots, grass field and a concrete structure. -At the rear of the concrete structure, there was a path through another wooded area leading to a train track and another wooded area on the other side with a steep hill down to get to the location where Resident #6 was found. Interview with a personal care aide (PCA) on 03/09/22 at 11:01am revealed: -Prior to 03/05/22, staff did not have to keep an eye on Resident #6. -She did not wander or try to leave the facility. -She usually walked the hall with her roommate or stayed in her room. -She was working on 03/05/22, when the resident got out of the facility. -She saw Resident #6 at lunch and again at 1:50pm just before she went on break. -She was still at work when the resident returned to the facility. -Staff had to check on Resident #6 more often on 03/05/22 after she returned to the facility. -She kept an eye on her the remainder of her shift	{D 270}		

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{D 270}	Continued From page 13 (first) on 03/05/22. -Every 15 minute checks on the residents started on Sunday 03/06/22. Interview with a second PCA on 03/09/22 at 3:26pm revealed: -Resident #6 was checked every 15-30 minutes prior to 03/05/22 because the resident liked to go and shake on the exit doors trying to open get the doors opened. -She was working on 03/05/22. -It was approximately 15-30 minutes later when she heard that the local law enforcement had called the facility about Resident #6 getting out of the facility. -She checked that all exit doors were secured and then went to the resident's room. -The cover to the air conditioning unit was on the floor, the window was out and down on the floor. -A staff went to get the resident and when she returned, she was terrified, panicked and shaking. -After the elopement, Resident #6 was changed to a room where the window faced a fenced in area. Interview with a medication aide (MA) on 03/09/22 at 10:29am revealed: -On 03/05/22, she was in the medication room when the MA/Supervisor on the assisted living (AL) side called and said local law enforcement had called the facility to notify them they had found Resident #6 and a nearby apartment complex. -She began asking staff how the resident got out of the SCU and the facility. -A personal care aide (PCA) reported the resident had "busted" the window out. -She went to look at the window in the resident's room and saw that the lower pane had been	{D 270}		

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	HAL092213	A. BUILDING: _____ B. WING _____	R 03/10/2022

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{D 270}	Continued From page 14	{D 270}		

taken out and not "busted".
-She did not know how long the resident had been out of the facility.
-None of the staff on the SCU knew the resident was gone before local law enforcement called the facility.
-Resident #6 was at lunch at around 12:30pm, back in her room at 1:00pm and it was 2:15pm when the MA/Supervisor called the SCU.
-When the resident returned to the facility, staff helped her to change her clothes and initiated every 15 minute checks.
-The resident was still being checked by staff every 15 minutes.
-The every 15 minute checks were documented on a piece of paper kept at the front desk of the SCU.
-The resident was moved from room C17 to room C12.
-Resident #6 had left the facility through a bedroom window once before with another resident.
-She did not remember if the resident's room was changed and if anything was done to secure the windows.

Interview with a second medication aide (MA) 03/10/22 at 1:30pm revealed:
-She was working as the MA/Supervisor on 03/05/22.
-She received a call at 2:28pm, from an officer of the local law enforcement who informed her that Resident #6 had been found at a nearby apartment complex.
-She then called the SCU and asked the staff who answered where the resident was; staff said she was in her room.
-She did not know who she spoke to in the SCU.
-She told the staff about the call from law enforcement.

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{D 270}	Continued From page 15 -A PCA on the SCU said she saw the resident before she went to lunch at 1:54pm on 03/05/22. -The Resident Care Director (RCD) and Administrator were contacted. -She went and picked the resident up from where she was found. -The only injury Resident #6 had was a scratch on her left hand which staff cleaned. -The officer told her the resident most likely went through the woods. -She did not think it was not possible for the resident to have left the facility, walked a "technical mile" through the woods in 19 minutes. -The resident would have gone up hills and through the woods; she would have been tired and short of breath. -The resident wanted comfort, security and to know she was not in trouble. -She did not know where she was or what she did to her room. -Seeing her family member calmed her down. -The citizen who called 911, said the resident came out of the woods behind an apartment complex with leaves and branches on her. Telephone interview with the responding local law enforcement officer on 03/11/22 at 8:42am revealed: -The citizen called 911 at 2:04pm as documented on the call report. -The citizen reported finding Resident #6 coming out of the woods with dirt and leaves all over her and in her hair. -She did not know her name, where she was or where she had come from. -He knew there was a facility nearby, the resident told him she worked there when he said the name of the facility. -He contacted the facility and told them he had one of their residents.	{D 270}		

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{D 270}	Continued From page 16 -The citizen called 911 quickly after seeing the resident come out of the woods. -It was not an easy walk for the resident from the facility to the apartment complex. -Through the woods there was a railroad track, a 30 foot drop on each side of the track and a fence. -She was feeble when he saw her. -He contacted emergency medical services (EMS) and they completed an assessment before she went back to the facility. -She left the apartment complex near 2:50pm; he left her with EMS and facility staff at 2:47pm. Telephone interview with Resident #6's PCP on 03/10/22 at 10:55am revealed she was aware of the resident's aggressive behaviors, the altercation on 01/17/22 and elopements and had made a psychiatric referral on 03/07/22. Interview with the Special Care Coordinator (SCC) on 03/10/22 at 9:53am revealed: -She was notified by staff on 03/05/22 that Resident #6 left the facility. -The resident reported she left the facility because she was looking for a family member. -The resident said she was cleaning her room and just started pulling things apart. -Once the window was out, she said she went out the window, down the hill and back up the hill through the wooded area to the side of the facility and then started running. -The resident was in good condition when she saw her. -Other than the resident's comments, she only knew that staff saw the resident after lunch. -The maintenance person put screws in windows on 03/05/22 and the resident was moved from C17 to C12 later that same day. -After Resident #6 went out the exit door on	{D 270}		

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{D 270}	Continued From page 17 04/03/21, SCU staff monitored the resident more and increased involvement in community and with activities. -After the elopement through her bedroom window on 06/12/21, the window was secured in her room and she was moved to room C17. -There were no further elopements from 06/12/21 until 03/05/22. -Rounds were done by staff every 2 hours on the SCU. -The frequency of checks after an incident depended on the severity. -Resident #6 was currently on every 15 minute checks until cleared by the primary care provider (PCP). -The needs of the residents would be on the activities of daily living (ADL) sheets which come from the service plan. -Additionally, outgoing staff were expected to communicate needs and any changes to oncoming staff each shift. Review of an untitled document for Resident #6 revealed there was documentation of 15 minute checks for the resident starting on 03/07/22 at 5:15pm through 03/09/22 at 1:45pm. Upon request on 03/09/22 at 12:24pm, 03/10/22 at 8:40am and 03/10/22 at 2:00pm, every 15 minute documentation for 03/05/22 through 03/06/22 was not available for review. Observations on the SCU on 03/09/22 from 11:58am until 12:06pm revealed rooms C15 and C17 opened to areas outside the facility that were not enclosed by secured fencing. Interview with the Administrator on 03/09/22 at 2:33pm revealed after Resident #6 got of her bedroom window in June 2021, she was moved	{D 270}		

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{D 270}	Continued From page 18 to another room and brackets were put in the window of the room she was moved to. Interview with the Administrator on 03/10/22 at 4:19pm revealed: -He received a call from the RCD the afternoon of 03/05/22 regarding Resident #6's elopement from the facility. -Staff reported last seeing the resident at 1:50pm. -He did not know at that time how far the resident had gotten from the facility. -He was not aware of the time the citizen called 911 regarding finding Resident #6 at 2:04pm on 03/05/22. -He did not have a response for discrepancies in the timeline of events on 03/05/22. -The resident was placed on every 15 minute checks and the PCP was notified. -The resident was placed on every 15 minute checks on 03/05/22 due to the circumstances. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable. The facility failed to provide supervision for Resident #6, who had a history of wandering behavior, previous elopement and aggressive behavior towards other residents. The facility's failure resulted in the resident exiting the special care unit (SCU) through a bedroom window following an altercation with another resident and being found with leaves, dirt and branches on her clothing and in her hair coming out of the woods behind an apartment complex approximately one mile of wooded areas from the facility. The failure to supervise Resident #6 resulted in substantial risk of serious injury and/or death and constitutes a Type A2 Violation.	{D 270}		

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{D 270}	Continued From page 19 The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/09/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 9, 2022.	{D 270}		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Personal Care and Supervision. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure supervision for 1 of 6 sampled residents (#6) exited the special care unit (SCU) through a bedroom window following an altercation with another resident. [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision. (Type A2 Violation)].	{D914}		