STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092180	A. BUILDING. _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA GLEN	3215 CREEDMOOR ROAD RALEIGH, NC 27612

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 16, 2022 to March 17, 2022.	D 000	On March 16th, temporary audible alarms were placed on each point of entry/exit in Assisted Living. An urgent work order was placed with 3rd party vendor on 3/16 to repair and reactivate the Wanderguard system. Vendor was onsite completing work on 3/18 and 3/21 and Wanderguard System was fully operational on 3/21. Each point of entry/exit from Assisted Living is now equipped with Wanderguard sensors. EVS team member will check wanderguard sensors weekly during routine rounds moving forward.	
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 6 of 7 exit doors accessible to residents' use were equipped with a sounding device that activated for the safety of 3 sampled residents who were documented as disoriented and a resident who eloped from the facility (#2). The findings are: Observations upon entrance to the facility on 03/16/22 at 8:15am and intermittently throughout	D 067	On 3/16, the first floor stairwell door alarm was activated. Going forward, Maintenance/EVS will check all stairwell exit doors weekly as part of their routine maintenance check. In addition to the Maintenance weekly check, these doors will be checked by the third shift security team member during nightly rounds. Resident #2 had 24 hour 1:1 companion care in place immediately following elopment on 3/14/2022 for his safety. In addition to 1:1 companion care implemented on 3/14/2022, a Wanderguard bracelet was placed on his person until his relocation/discharge to a memory care community on 3/30/2022. On 3/17/2022, an audit of all resident FL2's was conducted by the RCC. Any resident identified as having disorientation will wear a wanderguard bracelet and will be reassessed by our care management team and their physician for appropriate level of care Administrator and/or designee will audit FL2's annually per policy. On 3/17/2022, an audit of all resident assessments for orientation and ambulatory status was completed by the ALD/RCC. These assessments will be updated by the administrator and/or designee every 6 months or with any significant change in condition per our policy. On 3/17/2022, the ALD and RCC began re-training all care staff on the missing resident policy and procedure. Training on this policy will occur monthly for the next 3 months. Missing Resident Training/ Elopement Drills will be conducted by the EVS team, administrator, and/or designee every 6 months per policy. Administrator and/or designee will retrain all care staff on Residents' Rights. Residents' Rights training will occur annually for current associates and at new hire for all new associates on-boarding. Completion date: May 1st, 2022	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Mary L Ong TITLE Executive Director (X6) DATE 4/10/202

Reviewed and acknowledged on 4/22/22. S. Knapp

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D 067	Continued From page 1 the day until 4:00pm revealed: -The facility had three levels and a basement; the left end of the building was for Assisting Living (AL) and the middle and right ends of the building were for Independent Living (IL). -There were no sound alarming devices on the front entrance/exit door to the facility when opened. -There were no sound alarming devices on the back-courtyard door when opened. -The courtyard was fenced with an unlocked gate that led to a service road which led to a path in the woods or a main 4-lane road observed to have heavy traffic at 7:30am, 11:45am, 12:45pm, and 4:30pm that day (03/16/22). -There was a set of double doors propped open on the first, second, and third floors that did not have a sound alarming device when opened; the double doors on each floor led to the independent living facility that did not have sounding devices on any of the exit doors leading to the outside. Observation of a stairwell door on the first floor leading to the outside on 03/16/22 at 2:26pm revealed: -The door had a sounding device that was not activated when the door was opened. -The door led to a path that led to either the main parking lot or a service road which both led to a main main 4-lane road observed to have heavy traffic at 7:30am, 11:45am, 12:45pm, and 4:30pm that day (03/16/22). Review of the 5 sampled residents' FL-2's revealed: -There were 3 of 5 residents assessed as intermittently disoriented. -There were 2 of 5 residents with a diagnosis of dementia. -There was 1 of 5 residents with a diagnosis of	D 067		

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D 067	Continued From page 2 mild cognitive impairment. -Of the 3 of 5 residents who were assessed as intermittently disoriented, 2 were assessed as ambulatory (able to walk) and 1 did not have an ambulation assessment. -There were 2 of 5 residents who did not have an orientation assessment, one of those residents was semi-ambulatory and the other did not have a ambulatory assessment status. Review of the facility's Wandering/Missing Resident policy revealed: -All residents' cognitive abilities were to be evaluated for risk of wandering upon admission and during the standard quarterly reassessment process. -Residents at risk for wandering could have interventions including but not limited to a personal sitter 24/7 and monitoring of the resident's whereabouts. -The facility was to ensure door alarm checks and courtyard security/safety checks; the policy did not indicated how often door alarm and security/safety checks were to be done or whom was responsible. Review of Resident #2's FL-2 dated 10/07/21 revealed: -Diagnoses included dementia. -The resident was intermittently confused. -The resident was not assessed as being either ambulatory or non-ambulatory. Review of Resident #2's Resident Register dated 10/29/20 revealed: -The resident was admitted to the facility on 10/29/20. -The resident was identified as ambulatory. -The resident was forgetful and required reminders.	D 067		

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D 067	Continued From page 3 Review of Resident #2's care plan dated 02/10/22 revealed: -The resident was assessed as being able to ambulate and transfer independently. -The resident was to receive 8 safety checks per 24-hour period and regularly throughout the day to ensure his whereabouts and safety by facility staff. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluations revealed: -On 05/17/21 the resident was occasionally confused, required staff redirection, and ambulated independently without an assistive device. -On 08/12/21, the resident showed some confusion and ambulated independently without the use of an assistive device; the staff were to monitor the resident because he had wandered off from the facility approximately one month prior. -On 11/15/21, the resident was "alert confused", had a walker to assist him in ambulation but refused to use it, required ques and assistance with his activities of daily living (ADLs), and required assistance to and from the dining room for meals. -On 02/15/22, the resident was very confused at times, had a recent fall without injury, and required ques and assistance with ADLs and meals. Review of Resident #2's progress note dated 02/12/21 revealed: -The resident came to the medication room during third shift (11:00pm - 7:00am) confused and told the medication aide (MA) he was not okay with growing old asking if he should lock his	D 067		

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D 067	Continued From page 4 door. -He was reassured and redirected back to his room. Review of Resident #2's progress note dated 03/24/21 revealed: -The resident was confused on first shift (7:00am - 3:00pm). -The resident slammed his door a few times. Review of Resident #2's progress note dated 11/29/21 revealed: -The resident was confused on first shift (7:00am-3:00pm) coming out of his room in only a t-shirt at 8:15am and urinated on the medication room floor. -The resident had to be redirected back to his bathroom in his room. Review of Resident #2's progress note dated 01/28/22 revealed the resident exited his room on third shift (11:00pm-7:00am) disoriented and urinated on the laundry room floor. Review of Resident #2's progress note dated 03/14/22 at 11:00pm revealed: -When the MA attempted to administer the resident's medications at 7:45pm on that evening (03/14/22), she was unable to find the resident. -All staff were alerted to look for the resident upon identifying his missing status. -The resident was found behind a nearby elementary school. Review of Resident #2's charting note dated 03/14/22 revealed: -The resident was found to be missing that night (03/14/22) by an MA when she attempted to administer his medications and perform a safety check at 7:45pm.	D 067		

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D 067	Continued From page 5 -All on-site staff began a coordinated search for the resident upon identifying his missing status. -Family and management staff were called and responded to the facility to assist. -The resident was found at 8:45pm at a nearby elementary school by a school custodian. -The school custodian called the facility and a family member responded to the school to pick the resident up and bring him back to the facility. Review of a Supervisor in Charge (SIC) communication form dated 03/14/22 for second shift (3:00pm-11:00pm) revealed: -Resident #2 was identified as missing from the facility on second shift. -Resident #2 was found after at least 3 hours of searching. Review of Resident #2's Incident/Accident (I/A) Report dated 03/14/22 revealed: -The resident was determined missing at 7:45pm by a MA who could not find him to administer his medications. -The resident was found behind a nearby elementary school and provided with 1:1 supervision by a private certified nursing assistant (CAN) upon his return. -The resident was assessed for injury and then administered his nightly medications upon return. -The resident's family member and primary care provider (PCP) were notified of the incident at 7:55pm and 11:20pm respectively. Interview with a MA on 03/16/22 at 10:12am revealed: -There were at least four residents that she could recall as being disoriented to include Resident #2. -Of the disoriented residents she could recall, Resident #2 and another resident were also known to wander.	D 067		

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D 067	Continued From page 6 -She was not present when Resident #2 eloped on 03/14/22 and did not know any details about the incident. Interview with a lead MA on 03/17/22 at 11:00am revealed: -Resident #2 was confused and had wandering behaviors but she had never seen the resident try to leave the facility before and was not present when he eloped on 03/14/22. -There were some residents who had memory issues and trouble finding their rooms but she had never seen any other resident try to leave the facility before and was not aware of any elopements in the 14 years she had been working at the facility prior to Resident #2's elopement on 03/14/22. -The facility did not have any alarms on the doors, but she did not know why. -There was no process in place to check doors because they did not lock the doors from the inside, and they were not alarmed. Interview with the Resident Care Coordinator (RCC) on 03/17/22 at 10:36am revealed: -She was not present when Resident #2 eloped and did not think he had ever left the facility before. -There had been reports from staff that Resident #2 had some confusion over the last year such as not being able to find his room and she encouraged the family to have the resident evaluated by his PCP. -It was difficult to get Resident #2 evaluated and receive orders from his PCP because the PCP was not contracted with the facility. -There were several residents in the facility who were assessed as intermittently disoriented on their FL-2s. -Per her knowledge and observations, there were	D 067		

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D 067	Continued From page 7 some residents who were confused and exhibited wandering behaviors which was concerning because they could elope. -There were no alarms on the doors to the facility and she was not aware there was a rule requiring audible alarms on the doors for disoriented or wandering residents. -If there had been alarms on the doors the night that Resident #2 eloped, it may have alerted staff and prevented the resident from getting out of the facility and protected his safety. Interview with the Assisted Living Director (ALD) on 03/16/22 at 1:25pm and 3:49pm revealed: -Resident #2 had never left the facility property before his elopement on 03/14/22 but did have an incident on 02/14/22 when the resident "got turned around" and ended up on the third floor. -When the MA went to administer Resident #2's medications and perform a safety check on 03/14/22 after dinner at 7:00pm, the resident was identified as missing and the missing resident response was activated. -All staff were gathered to plan a search for the resident. -The resident was found by a custodian at a nearby elementary school at 8:45pm and called the facility. -The facility did not have any sounding alarms on doors because she did not think they were required to; the doors did lock from the outside after 8:00pm. -Residents at the facility could go outside to walk and were able to exit the courtyard to the road because the gate was only locked from the outside of the courtyard. -Residents were only able to re-enter the Assisted Living (AL) facility from the Independent Living (IL) facility's main entrance which was connected to the AL facility.	D 067		

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D 067	Continued From page 8 -The facility would conduct missing resident drills every two years and had not had a resident elopement for approximately 10 years prior. -Every resident received 2-hour safety checks meaning the staff would "lay eyes" on the residents and ensure they were present and safe. -If the facility had sounding devices on the doors, it would have likely prevented Resident #2 from eloping from the facility on 03/14/22. Interview with the maintenance supervisor on 03/17/22 at 12:03pm revealed: -All stairways were supposed to be activated to alarm if the door was opened to the outside and he was not aware that the stairwell door was not alarming. -The front and courtyard entrance were set to silently alarm to the main desk that was staffed 24/7 after 8:00pm if the doors opened. -If the doors to the front entrance for the courtyard opened after 8:00pm, the main desk staff were supposed to alert the facility staff to further investigate. -It was the main desk staff's responsibility to walk the perimeter of the facility each night after 8:00pm to ensure all doors were locked from the outside and this was last documented as completed on 03/14/22 at 8:21am. -None of the other doors in the facility were set to audibly alarm because he was not aware there was a rule that the doors were supposed to alarm. -It was his responsibility to ensure maintenance staff were ensuring the doors worked properly and maintained twice per year and he was unsure when that was last performed. -It was the maintenance staff's responsibility to ensure the stairwell exits alarmed as expected weekly which was last completed the previous week.	D 067		

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D 067	Continued From page 9 -If there had been a system in place with sounding alarms to alert staff that a door was opening it might have prevented Resident #2 from eloping from the facility. Interview with the Executive Director (ED) on 03/17/22 at 11:43am revealed: -She expected the gate to be secured and stairwell alarms to be activated and checked daily to ensure they were working properly. -She was not sure why the stairwell alarm was not working or if they had been checked as expected. Interview with the ED on 03/16/22 at 3:49pm revealed: -She was not aware that the facility was required to have sounding devices on the doors for disoriented or confused residents and the facility did not normally accept residents who had wandering behaviors. -There was a system that the facility could implement that would require a resident to wear a bracelet that would trigger an alarm if the resident crossed the threshold of a door they should not enter/exit through, but the system was not activated because she did not think they needed it. -She was not aware that Resident #2's confusion had been increasing and did not think the resident had ever left the facility before. -If the facility had sounding alarms on the doors it would have likely prevented the resident's elopement on 03/14/22. -She was not aware that the gate did not lock going out of the courtyard or that the sounding device on the stairwell door was not activated which would prevent residents from exiting through those doors unnoticed. -She thought the rule for sounding devices only	D 067		

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D 067	Continued From page 10	D 067		

applied to residents with exit seeking behaviors and not to residents with disorientation, so the facility did not have sounding devices on any of the other doors.

Interview with the facility's contracted PCP on 03/17/22 at 12:18pm revealed:
-He expected the facility to have sounding devices on doors if any residents resided in the facility who had disorientation or wandering behaviors for the safety of the residents.
-Having sounding alarms in place on doors at the facility might have prevented Resident #2 from eloping the facility on 03/14/22.
-Any resident who was disoriented or had wandering behaviors was an elopement risk.
-Residents as risk of elopement should be communicated as being a high alert risk to staff, the PCP, and the resident's family and have interventions in place such as door alarms to prevent them from exiting the facility.

Attempted interviews with Resident #2's family members on 03/16/22 at 3:30pm and 03/17/22 at 10:24am and 12:00pm were unsuccessful.

Attempted interview on 03/16/22 at 10:21am and 11:55am with the MA present during Resident #2's elopement was unsuccessful.

Attempted interview with Resident #2's PCP on 03/16/22 at 9:46am was unsuccessful.

The facility failed to ensure 6 of 7 exit doors were equipped with a sounding alarm device that activated when doors were opened for 3 residents who resided at the facility and were assessed as having intermittent disorientation and 1 of those residents who was assessed to have dementia and be ambulatory which resulted

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D 067	Continued From page 11 in the resident eloping from the facility on 03/14/22 (Resident #2). This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/16/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2022.	D 067		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Physical Environment. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure 6 of 7 exit doors accessible to residents' use were equipped with a sounding device that activated for the safety of 3 sampled residents who were documented as disoriented and a resident who	D912		

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D912	Continued From page 12 eloped from the facility (#2). This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. [Refer to Tag 67, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)].	D912		