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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, follow-up survey and complaint investigation onsite on May 11 through May 13, 2022, and desk review on May 16 and May 17, 2022 with an exit conference via telephone on May 17, 2022.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure there were no substantial findings listed on the North Carolina Health Care Personnel Registry (HCPR) for 1 of 3 sampled staff (Staff A). The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 10/28/19. -There was a HCPR check completed on 10/22/19 and 11/24/21. -Staff A had one substantiated finding entered 03/20/12 for misappropriation of resident property while employed in an Adult Care Facility. Telephone interview with Staff A on 05/16/22 at 10:49am revealed: -The incident that initiated the findings on her	D 137		

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HCPR verification was an incident 9-years ago involving a missing watch that belonged to a resident.
-The watch was found, and it was all documented in the report.
-She had filed the appropriate paperwork to have the finding removed from her HCPR verification.
-She did not know if the finding had been removed from the HCPR because she moved and did not receive anything related to it.
-She had been questioned about the incident before when applying for another job, but the facility staff contacted the HCPR and were told the same story she had reported about the incident and she was allowed to work.
-She had worked at six different facilities since the incident occurred in 2012 so she thought it had been cleared up.

Telephone interview with the Administrator on 05/16/22 at 10:35am revealed:
-The Business Office Manager (BOM) was responsible for completing HCPR checks on all new staff.
-The BOM was no longer an employee of the facility, and she did not have a contact telephone number for the BOM.
-She was not aware Staff A had a substantiated finding listed on her HCPR verification.
-She would have expected the BOM to notify her if Staff A had a substantiated finding.
-If she had known Staff A had a substantiated finding, she would have talked to Staff A about the finding and then called to HCPR to verify.
-She had talked to Staff A after this was brought to her attention on 05/13/22 and Staff A thought the finding had been removed from the HCPR because the incident had been resolved.
-Staff A went through the process to have the finding resolved and did not know it was still on

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D 137	Continued From page 2 her HCPR checks. -Staff A had worked at other facilities and thought the issue had been resolved since no one had question Staff A about it in a while.	D 137		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter. Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator/SIC In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 51-60 Aide 24 24 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 61-70 Aide 28 28 24 Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately	D 219		

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available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48
Supervisor 16 16 8

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Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
191-200 Aide 80 80 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
221-230 Aide 92 92 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
231-240 Aide 96 96 64
Supervisor 24 24 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure required staffing hours

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were met on second and third shifts shifts based on a census of 53 for 3 of 24 sampled shifts between 04/16/22-05/08/22.

The findings are:

Review of the facility census record between 04/16/22-05/08/22 revealed there was a census of 53 residents in the assisted living which required 24 staff hours on 1st and 2nd shifts.

Review of the staff time records on 05/01/22 and 05/08/22 revealed:
-On 05/01/22, on 1st shift there was a total of 21 hours of aide coverage with a shortage of 3 hours.
-On 05/01/22, on 2nd shift there was a total of 20 hours of aide coverage with a shortage of 4 hours.
-On 05/08/22, on 1st shift there was a total of 19 hours of aide coverage with a shortage of 5 hours.

Interview with a personal care aide (PCA) on 05/11/22 at 11:23am revealed:
-She had been working at the facility for 25 years.
-When she worked 1st shift there were usually 3 PCAs working.
-She worked 1st shift on 05/08/22 and there were 3 PCAs; she did not know about staffing for 2nd shift on 05/08/22.
-She tried to keep an eye on all of her residents, but it was hard, because she had other responsibilities, like snacks, setting up the dining room and passing meals.
-She did the best she could.

Interview with the Medication Aide (MA) on 05/13/22 at 4:56pm revealed:
-She was responsible for administering

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medications and overseeing resident care.
-She did rounds on all the residents throughout the day.
-When she worked 2nd shift, she made rounds at 3:00pm, 4:00pm, 9:00pm, and 11:00pm.
-She administered medications between 5:00pm-6:00pm, 7:00pm-9:00pm.
-She was responsible for the B hall "sometimes."
-She thought the responsibilities were manageable when she was responsible for the B hall with the current needs of the residents.
-No one needed toileting on the B hall, but one resident had an occasional incontinence episode.
-When there was another PCA, "there was too much time on your hands."

Interview with a second shift PCA on 05/13/22 at 5:07pm revealed:
-Most of the residents were "pretty independent" and she just had to make sure everyone was okay.
-On the A hall, there was one resident who needed toileting reminders.
-On the B hall, the residents were mostly independent, and just needed to be checked on.
-On the C hall, there were four residents who needed toileting reminders.
-The staff assigned to the B hall usually was responsible for snacks and setting up the dining room.
-If the MA was assigned the B hall, the PCAs from the A and C halls did the snacks and dining room.
-She usually worked 2nd shift and 3rd if needed.
-There were usually 3 PCAs and a MA when she worked on 2nd shift.
-It was a "really light load at the facility" so everyone pitched in where they were needed.

Interview with another PCA on 05/13/12 at

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D 219	Continued From page 7 5:12pm revealed: -There were usually three PCAs and a MA working at the facility. -Everyone pitched in and assisted each other to make sure the residents were cared for. -He did not think the shifts he had worked were ever short staffed. -He thought the workload was manageable. Interview with the Administrator on 05/13/22 at 5:17pm revealed: -On 1st and 2nd shift she scheduled 1 MA and 3 PCAs. -On 3rd shift she scheduled 2 staff and another staff was within 500 feet of the facility. -On 05/01/22, there was an emergency with one of the scheduled staff who was not able to come into the facility later than expected. She tried to find another staff to cover those hours and had not found anyone before the staff member reported to work. -She did not know she did not have enough staff scheduled for 2nd shift on 05/01/22. -No one had reported any issues to her during the 2nd shift on 05/01/22. -Most of the residents went to bed after dinner. -On 05/08/22, she did not know 2nd shift was short. -On 05/08/22, she had an emergency with a family member, and another family member who worked as a PCA and was at the facility working, offered to work but she told them they did not need to because she did not know the facility was short 5 aide hours.	D 219		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and	D 270		

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D 270	Continued From page 8 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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled resident (Resident #1), who was adjudicated incompetent and had a history of elopement and wandering behaviors, was supervised according to his assessed needs and the facility's established procedure resulting in the resident leaving the facility unsupervised and without staff knowledge and his whereabouts being unknown until the resident was identified as a fatality at an accident scene. The findings are: Review of Resident #1's current FL-2 dated 04/07/22 revealed: -Diagnoses included schizophrenia and gastroesophageal reflux disease. -Resident #1 had intermittent confusion. -Resident #1 had wandering behavior. Review of Resident #1's care plan dated 12/14/21 revealed: -Resident #1 required staff supervision with toileting, eating, and ambulation. -Resident #1 required limited assistance from staff with bathing, dressing, and personal hygiene/grooming. -Resident #1 was sometimes disoriented. -Resident #1 was forgetful and needed	D 270		

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reminders.

Review of Resident #1's legal documents dated 10/04/19 revealed:
-Resident #1 was adjudicated incompetent and established a limited guardianship.
-Resident #1 retained the following legal rights and privileges: determine his degree of participation in interpersonal relations and social, religious, and community activities, assist in decisions regarding living arrangements, and handle amounts of money to be determined by the guardian and consult with the guardian regarding financial decisions.

Review of an electronic email from the Administrator dated 04/16/22 at 4:16pm revealed:
-She was working on locating written policies and directions to employees regarding supervision.
-The policy was to provide supervision in accordance with the resident's needs.
-Employees were required to conduct hourly rounds and verify the presence of all residents on the facility property or determine whether a resident signed out, and then document the verification by initialing a round sheet.

Review of a round sheet revealed:
-The heading on the sheet was documented as Hourly Rounds.
-There was documentation that all residents must be rounded on hourly.
-The sheet had a listing of all the residents and was assigned by hall identifiers, A, B, and C.
-The times were listed hourly from 7:00am-10:00pm.
-There was documentation which read, by signing this form the staff acknowledged that all facts were true.
-There was a place for each staff to sign the hall

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they were assigned to verify rounds were made hourly.

Review of Resident #1's primary care provider's (PCP) progress note dated 11/11/21 at 2:39pm revealed:
-Resident #1 was incapable of living on his own due to his mental illness.
-Resident #1 did not consistently take medications which resulted in emergency room visits for his complaints.
-Resident #1 had a cognitive impairment, difficulty in his speech pattern, and expressing his needs.
-Placing Resident #1 in an independent living situation would be detrimental for Resident #1.

Review of Resident #1's charting note dated 12/13/20 at 2:33pm revealed:
-Resident #1 was last seen by staff around 11:30am when staff was completing rounds.
-Staff drove around to look for Resident #1.
-Administration and police were notified and a missing person report was filed.

Review of Resident #1's local law enforcement event report dated 12/13/20 revealed:
-A missing person report was filed by staff at the facility for Resident #1 at 1:22pm.
-Resident #1 was last seen sitting outside the facility around 11:30am.
-Resident #1 was located at the bus station with a bus ticket to another city within the state.

Review of Resident #1's charting note dated 12/22/20 at 1:34pm revealed:
-At 10:00am, Resident #1 walked away from the facility and law enforcement was notified.
-Resident #1 was returned to the facility by law enforcement.
-The Administrator was aware of the incident and

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Resident #1 was being monitored closely.

Review of Resident #1's charting note dated 12/22/20 at 10:48pm revealed:
-Resident #1 tried to leave the facility around dinner time.
-When Resident #1 was asked to "come back" the resident took off running around the building.
-Staff went after him to ensure his safety.
-When Resident #1 got tired, he returned to the building.
-Resident #1 stated he was going to get out of this place.

Review of Resident #1's local law enforcement event report dated 12/22/20 revealed:
-A missing person report was filed by staff at the facility for Resident #1 at 11:05am.
-Staff reported Resident #1 was last seen outside the facility about an hour ago.
-Resident #1 was located on foot at the east bound interstate 40 and US highway 52 exchange and reported he was in route to another city within the state.

Review of Resident #1's charting note dated 02/22/21 at 9:00pm revealed:
-Around 3:30pm, Resident #1 left the facility.
-A search was conducted and after about 30 minutes Resident #1 could not be found.
-The police were notified and found Resident #1 on a nearby street.
-Resident #1 was returned to the facility unharmed.
-Resident #1 refused his medications.

Review of Resident #1's local law enforcement event report dated 02/22/21 revealed:
-A missing person report was filed by staff at the facility for Resident #1 at 4:13pm.

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D 270	Continued From page 12 -Resident #1 was last seen sitting outside the facility with another resident at 3:25pm. -Resident #1 was located walking towards the downtown area and was returned to the facility. Review of Resident #1's charting note dated 06/06/21 at 3:49pm revealed: -The Supervisor was notified by the personal care aide (PCA) Resident #1 was missing. -The facility was searched, and law enforcement was notified. -At 5:32pm, Resident #1 was found by the police and returned to the facility. -Thirty-minute checks were being completed on Resident #1. Review of Resident #1's local law enforcement event report dated 06/06/21 revealed: -A missing person report was filed by staff at the facility for Resident #1 at 3:45pm. -The first shift staff did not know Resident #1 was missing. -Review of the facility's security camera revealed Resident #1 was last seen in the backyard at the facility around 1:30pm. -Resident #1 was located approximately 3.5-4.0 miles away from the facility by another law enforcement agency. Review of Resident #1's charting note dated 10/24/21 at 1:26pm revealed: -Resident #1 walked out of the facility and was found walking on a nearby street. -Staff brought the resident back to the facility. Review of Resident #1's charting note dated 11/18/21 at 10:13am revealed: -Resident #1 tried to leave and staff had to get the resident from "up the street." -Resident #1 was trying to fight staff.	D 270		

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Review of Resident #1's charting note dated 11/22/21 at 1:21pm revealed Resident #1 was complaining of stomach pain and was sent to the emergency department to be evaluated.

Review of Resident #1's hospital visit summary dated 12/13/21 revealed:
-Resident #1's reason for admission on 11/22/21 was medication non-compliance resulting in agitation.
-New medications prescribed included Haldol 10mg (an antipsychotic medication) at bedtime and Haldol 50mg injection every 28-days.
-During the hospital admission, Resident #1 was evaluated by psychiatry on 11/25/21.
-Resident #1 was hospitalized from 11/22/21-12/13/21.

Review of Resident #1's charting note dated 05/08/22 at 7:08pm revealed:
-Resident #1 left the facility and a silver alert was done.
-When the Supervisor was completing the medication pass at dinner time, she noted Resident #1 was not in the facility.
-The facility was checked by all staff and the police were notified.

Review of Resident #1's local law enforcement event report dated 05/08/22 revealed:
-A missing person report was filed by staff at the facility for Resident #1 at 6:27pm.
-Resident #1 was reported to have been seen by facility staff in his room at 3:40pm.
-At 5:15pm, facility staff could not locate Resident #1 and the facility was checked prior to notifying law enforcement.
-Staff at the facility reported they had checked a nearby gas station prior to calling the police

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because Resident #1 frequented the location to get coffee.
-Multiple area locations were checked, bloodhounds were brought in, and a silver alert was issued.

Telephone interview with a representative of the local police department on 05/13/22 at 9:12am revealed:
-A call came into the police department on 05/08/22 at 6:27pm.
-The bloodhounds were taken to the facility to aid in the search for the resident at 7:05pm.
-She was not sure of the exact time of the silver alert, but she was notified of the silver alert at 8:49pm.
-A responding officer had documented checking local stores, shopping centers, and neighborhoods.
-The county sheriff's department was notified as well and the bus stations were checked.
-Immediately hospitals were checked to make sure Resident #1 was not there.

Review of Resident #1's round sheet dated 05/08/22 revealed:
-Resident #1 was assigned to C hall.
-A named PCA documented a checkmark each hour between 7:00am-2:00pm.
-A named PCA documented out of facility (OOF) for each hour between 3:00pm-10:00pm.

Interview with a personal care aide (PCA) on 05/11/22 at 11:23am revealed:
-She worked the C hall on first shift on 05/08/22.
-She had seen Resident #1 at lunch on 05/08/22.
-She did not recall if Resident #1 had left the facility before, but the Administrator had told staff to keep an eye on Resident #1.
-Keep an eye out meant to know where Resident

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#1 was at all times.
-She did not recall when the Administrator told the staff to keep an eye on Resident #1.
-Rounds were made on all residents every hour.
-She tried to keep an eye on all the residents, but it was hard.
-The PCAs also assisted with meals and snacks.
-Resident #1 liked to be outside.
-She saw Resident #1 outside on 05/08/22 but she did not recall what time.
-There were 3 PCAs and 1 medication aide (MA) working on Sunday, 05/08/22, during first shift.
-There were a lot of residents who went outside "on their own."
- She would check on the residents who were outside during her rounds, but she did not have to stay outside with the residents.
-When she came back to work on 05/10/22, the rules had changed, and staff had to stay outside with the residents.

Interview with the Supervisor on 05/11/22 at 4:55pm revealed:
-She worked as the MA on 05/08/22.
-There were two or three PCAs working on 05/08/22.
-Two PCAs were "plenty" for the needs of the residents.
-In the past, Resident #1 would say, "I am leaving" and they would know to keep a closer eye on him.
-She last saw Resident #1 sometime around 12:00pm, Resident #1 stopped by the medication cart, got his nutritional supplement, and walked down the hall toward his room.
-She did not think Resident #1 ate lunch in the dining room on 05/08/22, but that was not unusual since he had snacks in his room and would usually eat in his room.

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Telephone interview with a second PCA on 05/13/22 at 1:42pm revealed:
-She sometimes worked as a PCA at the facility; her primary job was to do activities.
-PCAs were supposed to do rounds on the residents every hour.
-Each PCA was assigned a hall.
-If there were only 2 PCAs on duty, the MA was assigned the B hall to complete rounds.
-The PCAs documented rounds on the facility's "rounds sheet."
-She always made rounds at the start of the shift and then throughout the shift.
-Resident #1's room was located on the C hall.
-She was assigned the C hall on second shift on 05/08/22 when Resident #1 was reported missing.
-When she worked on 05/08/22, she came in at 3:00pm, and made her rounds.
-After her rounds, she started passing snacks to the residents.
-She was supposed to document her rounds on the residents every hour, but she got busy and did not document her rounds until after Resident #1 was reported missing.
-She documented Resident #1 was out of the facility (OOF) at 3:00pm, 4:00pm, and the remainder of her shift because she did not recall seeing the resident.
-She thought Resident #1 was outside when he was not in his room when she made her rounds.
-She did not recall seeing Resident #1 outside on 05/08/22.
-The MA told her she did not see Resident #1 and that was when they started looking for the resident.

Second telephone interview with this PCA on 05/16/22 at 1:02pm revealed:
-She had been told to keep an eye on Resident

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#1 "last year" because he would walk away but "he had been doing so good."
-Keep an eye on meant to make sure Resident #1 was at the facility and check on him periodically.
-She looked outside on the patio on 05/08/22 when she did her 3:00pm rounds but did not see Resident #1.
-She thought Resident #1 must be on the other end of the facility, but she did not check the other end of the facility for Resident #1.
-When she did her hourly rounds on 05/08/22, she did not see Resident #1 and she did not look for him, because she thought he was outside.
-No one had told her they could stop keeping an eye on Resident #1, but he had been doing so good she did not think she had to.
-She was in the middle of serving meals to the residents on 05/08/22 when the MA told her she could not find Resident #1.

Telephone interview with a MA on 05/16/22 at 10:49am revealed:
-PCAs were responsible for rounding on the residents at the facility.
-The MA was responsible for making sure the PCAs were "laying eyes on all the residents."
-The round sheet was kept on the medication cart and she was usually at the cart when the PCAs documented their rounds.
-She asked the PCAs, "did you lay eyes on the residents."
-She also did rounds as she did her medication pass.
-Residents were supposed to be checked on every hour.
-The PCAs were assigned a hall and every resident on that hall was their responsibility to check.
-Resident #1 was the main resident staff needed to keep an eye on at all times because the

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resident had walked off before.
-The PCAs should do rounds on Resident #1 in between the hourly rounds to make sure they had laid eyes on him.
-Everyone pitched in to make sure eyes were laid on Resident #1.
-Resident #1 walked the halls a lot and would stop by the medication cart to get his nutritional supplement or ask for a canned drink.
-All staff had a meeting about Resident #1 and were told to keep any eye on the resident at all times (she did not recall when the meeting was).

Review of the sign-in and sign-out log on 05/11/22 at 10:00am revealed Resident #1 had not signed out of the facility on any date between 04/01/22 and 05/09/22.

Interview with Resident #1's roommate on 05/11/22 at 9:31am revealed:
-Resident #1 was his roommate "for a while."
-Resident #1 had moved to a room in front of the doctor's office, but he did not know why.
-He did not recall how long it had been since Resident #1 had been his roommate.
-When Resident #1 was his roommate, the resident would holler at himself in the mirror.
-He could not understand what Resident #1 was hollering about, but it had to do with his family.
-He had talked to Resident #1 about it and the resident stopped doing it.
-Resident #1 had sat on his bed and was visiting on 05/08/22 before lunch.

Review of an electronic email correspondence from Resident #1's court-appointed guardian dated 05/09/22 revealed:
-She had received a call from the local police department about a crash involving Resident #1.
-The police department responded to a crash at

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here."
-When Resident #1 first moved to the facility, he was delusional, and everything was a conspiracy and he would refuse medications.
-When Resident #1 was compliant with his medications, he was fine.
-If Resident #1 was not taking his medications, he would need to be monitored by staff more closely.

Second telephone interview with Resident #1's court-appointed guardian on 05/13/22 at 8:17am revealed in February 2021, the facility had been asked to please monitor Resident #1 when he went outside by the court appointed guardian, because of his history of elopement.

Telephone interview with the Owner of the Court Appointed Guardian program on 05/16/22 at 1:52pm revealed:
-The agency was the guardian of Resident #1 and a staff member was specifically assigned to work with Resident #1.
-Resident #1 was not encouraged to walk away from the facility.
-Resident #1 could walk away because the facility was not locked.
-The facility staff was asked by the guardian program to monitor Resident #1 using what was their monitoring, "however/often they did a headcount."
-Everyone had told Resident #1 to stay at the facility and he was educated on this but at the end of the day, Resident #1 had a right to be free.
-Just because Resident #1 was declared incompetent, he still had rights.
-Safety was their priority for Resident #1, but he could even have refused placement if he wanted to.
-Resident #1 could sign in and out of the facility and go anywhere he wanted to, but this would be

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discouraged.

Telephone interview with the Ombudsman on 05/17/22 at 10:20am revealed:
-Resident #1 was someone whom there were concerns with him related to elopement and the guardian had concerns about him being outside without staff because the resident was an elopement risk.
-The way the facility was laid out, it was easy for a resident to walk away at any time.
-Residents had rights to be able to go outside, but if they had a guardian, the guardian was responsible for making decisions.
-Resident #1's guardian was responsible for making decisions about what needed to be done to keep him safe.

Review of Resident #1's Licensed Clinical Social Worker (LCSW) psychotherapy progress noted dated 04/26/22 revealed:
-Review of symptoms included wandering, chronic pain, helplessness, sadness, and ruminating thoughts.
-Treatment goals were to increase compliance with the treatment plan by 25%, decrease mood symptoms by 25%, and decrease inappropriate behavior by 25%.
-Barriers to treatment were cognitive impairment and motivation.

Review of Resident #1's LCSW psychotherapy progress noted dated 05/01/22 revealed:
-Review of symptoms included appetite decrease, disorganized behavior, chronic pain, helplessness, initiative decrease, and ruminating thoughts.
-Treatment goals were to increase compliance with the treatment plan by 25%, decrease mood symptoms by 25%, and decrease inappropriate

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behavior by 25%.
-Barriers to treatment were cognitive impairment and motivation.

Telephone interview with Resident #1's LCSW on 05/13/22 at 9:27am revealed:
-Resident #1 had a history of exit seeking behavior.
-She assessed Resident #1 for exit-seeking behavior during each of her visits.
-Resident #1 had medication changes and was doing well.
-There had been no indication Resident #1 needed additional supervision.
-A year ago, she would have said Resident #1 needed additional supervision but not now.

Second telephone interview with Resident #1's LCSW on 05/17/22 at 9:29am revealed:
-She had never thought about Resident #1 signing himself in and out of the facility because he had never brought it up that he wanted to.
-If anyone had asked her if Resident #1 could sign himself out to leave the premises, she would have needed to ask some questions before making that decision.
-She would want to know where Resident #1 was going and what he was going to do.
-She would want to see if logistically, Resident #1 would know how to return to the facility if he was not with anyone.
-She did not think Resident #1 would have been able to manage time and geographically find his way back to the facility.
-She would have expected staff to have eyes on Resident #1 at meals and medication times, if not sooner.
-As a therapist, Resident #1 should be checked on every 2 hours, which would be ideal, but it was not alarming Resident #1 was only seen at

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mealtime.

Telephone interview with Resident #1's mental health nurse practitioner (NP) on 05/11/22 at 3:20pm revealed:
-Resident #1 mumbled a lot and was hard to understand.
-Resident #1 was very forgetful.
-Resident #1 seemed to be at his baseline when she saw him last on 05/06/22.
-She was not aware that Resident #1 had previous elopements.
-If Resident #1 had a history of elopement and since he was known to have confusion, she would expect the facility to know when Resident #1 went outside.
-She would expect the facility to have watched Resident #1.
-Resident #1's whereabouts should have been monitored by staff.

Telephone interview with Resident #1's PCP on 05/16/22 at 4:57pm revealed:
-She did not think Resident #1 could sign himself in and out of the facility.
-She did not think mentally Resident #1 could have or would have wanted to sign in and out of the facility to go to the store.
-No one had asked her if Resident #1 would be allowed to leave the facility alone and walk to the store or other locations.
-If a staff member had asked her if Resident #1 could have permission to leave the facility to go to the store, she would have said no and consulted with the behavioral health team for their input.

Interview with a resident on 05/11/22 at 9:10am revealed "since the man left and was hit by a truck" the staff had to let the residents go outside but before that, they could go outside any time

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D 270	Continued From page 24 they wanted without staff. Interview with another resident on 05/12/22 from 8:49am revealed: -Residents used to be able to stay outside all day if they wanted to but now, they could only stay outside for 30 minutes. -Staff would come outside and check on the residents but the staff did not stay outside. -Ever since Resident #1 walked off, the rules had changed, and staff sat outside with the residents for each smoke break, which was 30 minutes. Interview with a third resident on 05/12/22 at 8:56am revealed: -The rules for going outside had changed since Resident #1 had walked off. -Staff would let them outside, but the residents would prop the door open and leave it cracked, so the door did not shut and lock. -Now staff stayed with the residents on the smoking porch, but the staff did not stay with them before. -Resident #1 had walked off before. Interview with the Administrator on 05/13/22 at 8:42am revealed: -She was contacted by the Supervisor on 05/08/22 around 6:00pm, Resident #1 could not be located. -The Supervisor reported the PCA had not seen Resident #1 since 3:00pm. -She immediately started looking at the facility's security camera footage. -The Supervisor reported she could not find Resident #1 between 5:30pm-5:45pm. -When the Supervisor questioned the PCA, the PCA said she assumed Resident #1 was outside but had not told anyone. Interview with the Administrator on 05/12/22 at	D 270		

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D 270	Continued From page 25 3:44pm revealed: -Before Resident #1 left the facility, the door to the smoking area was supposed to be locked. -Residents could ask a PCA/MA to unlock the door so they could go outside, but the door was supposed to remain locked. -It was a challenge because the residents would not allow the door to close completely behind them, which left the door unlocked. -All the residents at the facility were allowed to go outside at any time. -Resident #1 did not have restrictions and could go outside anytime he wanted to. -At first Resident #1's guardian had said the resident could not go outside at all because he had left the facility, but the Ombudsman told him facility staff could not do that, that it was his right. -She thought it was about a year ago when that happened. -Resident #1 was then allowed to go outside but the facility staff would watch him discreetly because he would get mad if he thought he was being watched. -During that time, she expected the staff to check on Resident #1 every 15-20 minutes, but they had loosened up on watching Resident #1 because he was doing so well. -Resident #1 went to the hospital in November 2021 for stomach pains and she requested a psychiatric evaluation while he was at the hospital. -Resident #1 returned to the facility in December 2021 and he was a totally different person, and at that point, she did not worry about Resident #1 walking off. -She thought the medication changes made at the hospital really helped Resident #1. -When she reviewed the security camera footage on 05/08/22 after the Supervisor notified her Resident #1 could not be located, he was seen	D 270		

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D 270	Continued From page 26 walking toward the school behind the facility at 1:50pm. -She did not know if Resident #1 would know how to get back to the facility if he left but she would like to think he could. -She completed Resident #1's current FL-2 but she did not know why the block beside wandered had been checked because Resident #1 was not considered a wanderer. -She had meant to check the box below the wanderer box which was labeled verbally abusive because Resident #1 had been verbally abusive before. -She expected staff to check on Resident #1 every hour. _____ The facility failed to provide supervision for Resident #1 who was adjudicated incompetent, had a diagnosis of schizophrenia, was intermittently disoriented, and had a history of exit-seeking behaviors and multiple previous elopements. The staff did not complete the established hourly rounds on Resident #1 on 05/08/22 resulting in the resident exiting the facility without supervision and staff knowledge. The resident was last seen by staff at 1:50pm and was not discovered to be missing from the facility until sometime between 5:30pm-5:45pm on 05/08/22. Resident #1 was found by law enforcement with fatal injuries sustained when hit by a tractor trailer. The facility's failure resulted in serious neglect and death which constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 05/17/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 16,	D 270		

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D 270	Continued From page 27 2022.	D 270		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations and staff and resident interviews, the facility failed to serve milk at least twice daily for 51 of 51 residents. The findings are: Review of the facility's Week-At-A-Glance menu for 05/11/22 and 05/12/22 revealed 8 ounces of milk was to be served at breakfast, lunch and dinner on both days. Observation of the facility's refrigerator in the kitchen on 05/11/22 at 10:05 am revealed there was 1 gallon of 2% milk which contained one-fourth of a gallon of milk available to be served to the residents. Observation of the lunch meal on 05/11/22 from 12:30 pm to 1:05 pm revealed:	D 299		

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D 299	Continued From page 28 -There were 51 residents seated in the dining room. -There was a service cart in the dining room with a pitcher of water, grape flavored drink and tea on the cart, but no milk was on the service cart. -No milk was offered or served to any of the residents. -No residents requested milk. Observation of the dinner meal on 05/11/22 from 5:30 pm to 5:45 pm revealed: -There were 51 residents seated in the dining room. -No milk was offered or served to any of the residents. Interview with the Administrator on 5/11/22 at 5:50 pm revealed: -She was the cook for the day because the cook had called out of work. -The facility was out of milk and the food supply would be delivered on 5/12/22 which included a delivery of milk. Observation of the facility's refrigerator in the kitchen on 05/12/22 at 8:45 am revealed: -There were 6 gallons of 2% milk available to serve to residents. -There were 5 of 6 gallons of milk which were full and 1 gallon of milk was less than half full. Interview with a resident on 05/12/09 at 8:25 am revealed: -He was served milk at breakfast and that was the only meal when milk was served. -He was served milk at breakfast when cereal was served. -He would be served milk if he requested milk. Interview with a second resident on 05/12/22 at	D 299		

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8:35 am revealed:
-He was served milk twice a day because he liked milk.
-If he wanted milk, he would be served milk anytime he wanted milk because all he had to do was asked for milk.

Interview with a third resident on 05/12/22 at 8:40 am revealed:
-He was served milk twice a day at breakfast and dinner.
-He was not sure why there was no milk available on 05/11/22.
-If he wanted milk, he would ask for milk and staff served him milk.

Interview with a fourth resident on 05/12/22 at 8:55 am revealed:
-Milk was served at breakfast.
-He did not like milk so he did not drink milk but would get milk served with cereal.
-If he wanted milk, he could ask for it and staff would serve milk to him.

Interview with a fifth resident on 05/12/22 at 9:18am revealed:
-The residents were told they would get milk when they moved to the facility.
-Once they moved into the facility, they had to beg to get milk.
-They were provided milk for their cereal, but not to drink.
-They would like to drink milk every day.

Interview with a medication aide (MA)/personal care aide (PCA) on 5/13/22 at 2:30 pm revealed:
-She assisted in the dining room at mealtimes.
-She routinely prepared the place settings and poured milk for specific residents who liked milk.
-There were 5 residents who were routinely

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D 299	Continued From page 30 served milk. -Milk was not offered to the residents and was only served if requested. Interview with the Administrator on 05/12/22 at 3:40 pm revealed: -She did not know the facility was out of milk until yesterday afternoon (05/11/22). -Staff knew which residents liked milk and would routinely serve milk to those residents. -Staff did not offer milk to the residents, but if a resident wanted milk staff would give residents milk if they asked for milk. Interview with the cook on 05/13/22 at 9:00 am revealed: -He was aware of a regulation regarding service of milk. -Staff knew which residents drank milk and would serve milk to those residents at mealtimes. -Milk was not offered to the residents because milk was always available, and the residents could have milk if they asked for it. -He had been trained when hired on the proper procedures for food service.	D 299		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 31 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medications were administered and documented as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #4) related to Novolog insulin. The findings are: Review of Resident #4's record revealed a current FL-2 dated 07/15/22 revealed diagnoses included diabetes. Review of Resident #4's physician's orders sheet dated 01/27/22 revealed an order for check finger stick blood sugar (FSBS) before breakfast and supper; inject 8 units of Novolog for FSBS over 250. (Novolog is a rapid-acting injectable insulin used to treat elevated blood sugar levels). Review of Resident #4's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for check FSBS before breakfast and supper; inject 8 units of Novolog for FSBS over 250. -There were 4 of 56 opportunities where Novolog was not documented as administered as ordered. -On 02/14/22 at 5:00 pm, FSBS was not documented as obtained and no Novolog insulin was documented as administered with the reason documented as refused. -On 02/19/22 at 5:00 pm, FSBS-202 and 8 units of Novolog insulin was documented as administered and should have given no insulin. -On 02/27/22 and 02/28/22 at 7:00 am, FSBS was not documented as obtained and no Novolog insulin was documented as administered with no reason documented.	D 358		

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D 358	Continued From page 32 -FSBS ranged from 147 to 342. Review of Resident #4's March 2022 eMAR revealed: -There was an entry for check FSBS before breakfast and supper; inject 8 units of Novolog for FSBS over 250. -There were 3 of 62 opportunities where Novolog was not documented as administered as ordered. -On 03/24/22 at 7:00 am, FSBS-166 and 8 units of Novolog insulin was documented as administered and should have given no insulin. -On 03/26/22 at 7:00 am, FSBS was not documented as obtained and no Novolog insulin was documented as administered with the reason documented s refused. -On 03/30/22 at 7:00 am, FSBS-202 and 8 units of Novolog insulin was documented as administered and should have given no insulin. -FSBS ranged from 140 to 278. Review of Resident #4's April 2022 eMAR revealed: -There was an entry for check FSBS before breakfast and supper; inject 8 units of Novolog for FSBS over 250. -There were 16 of 60 opportunities where Novolog was not documented as administered as ordered with examples as follows: -On 04/01 at 7:00 am, FSBS-196 and 8 units of Novolog insulin was documented as administered and should have given no insulin. -On 04/10/22 at 7:00 at, FSBS-193 and 8 units of Novolog insulin was documented as administered and should have given no insulin. -On 04/14/22 at 7:00 am, FSBS-184 and 8 units of Novolog insulin was documented as administered and should have given no insulin. -On 04/20/22 at 7:00 am, FSBS-159 and 8 units of Novolog insulin was documented as	D 358		

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administered and should have given no insulin.
-On 04/21/22 at 7:00 am, FSBS-179 and 8 units of Novolog insulin was documented as administered and should have given no insulin.
-On 04/26/22 at 5:00 pm, FSBS-381 and no Novolog insulin was documented as administered and should have given 8 units.
-On 04/28/22 at 5:00 pm, FSBS-334 and no Novolog insulin was documented as administered and should have given 8 units.
-FSBS ranged from 159 to 515.

Review of Resident #4's May 2022 eMAR revealed:
-There was an entry for check FSBS before breakfast and supper; inject 8 units of Novolog for FSBS over 250.
-There were 2 of 21 opportunities where Novolog was not documented as administered as ordered.
-On 05/03/22 at 7:00 am, FSBS-232 and 8 units of Novolog insulin was documented as administered and should have given no insulin with the reason documented as refused.
-On 05/03/22 at 5:00 pm, FSBS-413 and no Novolog insulin was documented as administered and should have given 8 units with the reason documented as refused.
-FSBS ranged from 132 to 551.

Observation of Resident #4's medication on hand on 05/13/22 at 3:45 pm revealed:
-There was 1 Novolog insulin flex pen pre-filled syringe that was dispensed on 05/05/22 for a quantity of 300 units..
-There were 250 units remaining.

Interview with a representative from the facility's contracted pharmacy on 05/12/22 at 12:10 pm revealed:
-Resident #4 had an active order for Novolog 8

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units with FSBS at breakfast and supper if FSBS was above 250.
-One Novolog 300 units flex pen was dispensed to the facility on 05/05/22.

Interview with a medication aide (MA) on 05/13/22 at 10:17 am revealed:
-She checked Resident #4's FSBS and administered insulin to her.
-She worked in the mornings and would check Resident #4's FSBS and her FSBS were usually "good".
-Most of the time, Resident #4 did not require any insulin coverage in the mornings.

Interview with a second MA on 05/13/22 at 10:57 am revealed:
-She checked the FSBS and administered insulin to Resident#4.
-If Novolog insulin was not administered to Resident #4, "NA" was entered on the eMAR in the space for injection site.
-When the Novolog insulin was administered, the MAs enter "L" or "R" in the space for injection site to document 8 units of Novolog was administered.
-She was not sure why there would be documentation that Novolog was administered when Resident #4 did not need Novolog.
-MAs could have clicked on the eMAR in error for the entry for "L" or "R" instead of "N/A" when Novolog should not have been administered.

Interview with Resident #4 on 05/13/22 at 12:00 pm revealed:
-She was a diabetic had FSBS checks 2 times a day along with insulin injections.
-She did not recall refusing her FSBS or insulin injections.

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D 358	Continued From page 35 Interview with Resident #4's primary care provider (PCP) revealed; -She had written the orders for Resident #4 to receive FSBS checks twice daily along with Novolog insulin coverage. -She expected the Novolog orders to be followed. Interview with the Administrator on 05/13/22 at 3:40 pm revealed: -She was not aware Resident #4's Novolog insulin was not documented as administered as ordered. -The previous Resident Care Coordinator (RCC) was responsible for eMAR audits, but the audits had not been done since the RCC left in April 2022.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances was maintained for 2 of 5 sampled residents related to pain medication (#5) and anti-anxiety medication (#4).	D 392		

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The findings are:

1. Review of Resident #5's current FL2 dated 08/04/21 revealed diagnoses that included schizoaffective disorder, diabetes mellitus, hypothyroidism, and GERD.

Review of a signed physician's order for Resident #5 dated 04/21/22 revealed an order for oxycodone-APAP 5/325mg two tablets every 6 hours as needed (prn) for pain for up to five days.

Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for oxycodone-APAP 5/325mg two tablets every 6 hours as needed (prn) for severe pain (7-10) for up to five days.
-There was documentation oxycodone-APAP was administered eight times from 04/21/22 through 04/25/22.
-There was no documentation oxycodone-APAP was administered on 04/21/22 at 12:32am and at 7:34am.

Review of Resident #5's Controlled Substance Count Sheet (CSCS) dated 04/21/22 revealed:
-There were 20 tablets of oxycodone-APAP dispensed from the pharmacy on 04/21/22.
-The first tablet was signed out on 04/21/22 and the last tablet was signed out on 04/25/22 leaving a balance of 0.
-There was documentation oxycodone-APAP was signed out a total of ten times from 04/21/22 through 04/25/22.
-There was documentation of oxycodone-APAP being signed out on 04/21/22 at 12:32am and at 7:34am.

Attempted telephone interview with a

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representative from the facility's backup pharmacy on 05/16/22 at 3:38pm unsuccessful.

Interview with Resident #5 on 05/11/22 at 9:50am revealed that she did not have any problems with her medications.

Interview with a second shift medication aide (MA) on 05/13/22 at 4:10pm revealed:
-Her process for administering controlled substances was to pull the medication from the medication cart, sign it out on the CSCS, take the medication to the resident, watch the resident take the medication, then document administration on the eMAR.
-She did not know how oxycodone-APAP was signed out on the CSCS twice but was not documented on the eMAR.
-She thought that some of the other MAs forgot to document medication administration on the eMAR.

Interview with the Administrator on 05/13/22 at 6:10pm revealed:
-She was not aware that oxycodone-APAP administration was not documented on the eMAR twice on 04/21/22.
-She expected MAs to sign the CSCS as soon as they administered controlled substances.
-She expected MAs to count the controlled substances each shift.
-She expected the eMAR documentation to match the CSCS documentation.
-MAs were responsible for making sure the eMAR and CSCS matched.

2. Review of Resident #4's current FL2 dated 07/15/21 revealed diagnoses included schizophrenia disorder, severe chronic paranoid and diabetes.

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D 392	Continued From page 38 Review of Resident #4's physician's order sheets dated 07/15/21 and 01/27/22 revealed an order for lorazepam 2 mg take 1 tablet every 8 hours as needed (prn) for psychosis. Review of Resident #4's physician's orders dated 03/25/22 revealed an order to change lorazepam from 2 mg to 1 mg every 8 hours prn for agitation/anxiety. Review of Resident #4's March 2022 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1 mg one tablet every 8 hours prn for agitation/anxiety. -Lorazepam 1 mg was not documented as administered from 03/01/22 to 03/31/22. Review of Resident #4's Controlled Substance Count Sheet (CSCS) revealed: -There was a beginning balance of 30 lorazepam 1 mg tablets. -There was 1 tablet of lorazepam 1 mg signed out on 03/26/22 at 12:45 pm leaving a balance of 29 tablets. Review of Resident #4's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1 mg one tablet every 8 hours prn for agitation/anxiety. -Lorazepam 1 mg was documented as administered on 05/11/22. Review of Resident #4's Controlled Substance Count Sheet (CSCS) revealed: -There was a beginning balance of 26 lorazepam 1 mg tablets. -There was 1 tablet of lorazepam 1 mg signed out	D 392		

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on 05/03/22 at 10:00 am, on 05/11/22 at 2:00 am and on 05/12/22 at 7:03 pm leaving a balance of 22 tablets.

Interview with a pharmacist from the facility's contracted pharmacy on 05/13/22 at 11:45 am revealed:
-Lorazepam 1 mg was dispensed to the facility on 03/25/22 for a quantity of 30 tablets.
-The pharmacy only sent 1 bingo card with 30 tablets of lorazepam 1 mg because the resident did not take the medication very often.
-The pharmacy received 22 tablets of lorazepam 2 mg tablet which were returned to the pharmacy from the facility on 04/05/22.

Interview with a medication aide (MA) on 05/13/22 at 4:25 pm revealed:
Resident #4 was ordered a prn medication which meant she had to ask for the medication in order for the MAs to give her the medication.
-It was possible she may have become distracted and just forgot to go back and document the lorazepam on the eMAR or the CSCS.
-The process she used was she would pop the tablet out of the bingo card and sign it out on the CSCS and then administer the medication and would document administration on the eMAR.

Interview with Resident #4 on 05/12/22 at 12:00 pm revealed:
-She did not know the name of her as needed medication.
-She had medication for anxiety available if she needed it and staff administered her medications when she asked for the medication.
-She did not take the as needed anxiety medication very often.

Interview with the Administrator on 05/13/22 at

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D 392	Continued From page 40 5:15 pm revealed: -She was not aware there were issues with documentation on the CSCS. -She knew Resident #4 had an order for lorazepam 1 mg but she did not request it very often. -She expected the eMAR documentation to match the CSCS documentation. -The RCC was responsible for eMAR audits and CSCS audits but the RCC no longer worked at the facility. -Audits had not been done since the RCC left in April 2022.	D 392		
D 443	10A NCAC 13F .1208 (c) Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (c) A written notice containing the information under Paragraph (d) of this Rule shall be made within three days of any death resulting from violence, accident, suicide or homicide. (d) Written notice may be submitted in person or by telefacsimile or electronic mail. If the reporting facility does not have the capacity or capability to submit a written notice immediately, the information contained in the notice may be reported by telephone following the same time requirements under Subparagraphs (b) and (c) of this Rule until such time the written notice may be submitted. The notice shall include at least the following information: (1) Reporting facility: Name, address, county, license number (if applicable), Medicare/Medicaid provider number (if applicable), facility administrator and telephone number, name and title of person preparing report, first person to	D 443		

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learn of death and first staff to receive report of death, and date and time report prepared;
(2) Resident information: Name, Medicaid number (if applicable), date of birth, age, sex, race, primary admitting diagnoses, and date of most recent admission to an acute care hospital.
(3) Circumstances of death: place and address where resident died, date and time death was discovered, physical location decedent was found, cause of death (if known), whether or not decedent was restrained at the time of death or within 7 days of death and if so, a description of the type of restraint and its usage, and a description of events surrounding the death; and
(4) Other information: list of other authorities such as law enforcement or the County Department of Social Services that have been notified, have investigated or are in the process of investigating the death or events related to the death.
(e) The facility shall submit a written report, using a form pursuant to G.S. 131D-34.1(e). The facility shall provide, fully and accurately, all information sought on the form. If the facility is unable to obtain any information sought on the form, or if any such information is not yet available, the facility shall so explain on the form.
(f) In addition, the facility shall:
(1) Notify the Division of Facility Services immediately whenever it has reason to believe that information provided may be erroneous, misleading, or otherwise unreliable;
(2) Submit to the Division of Facility Services, immediately after it becomes available, any information required by this rule that was previously unavailable; and
(3) Provide, upon request by the Division of Facility Services, other information the facility obtains regarding the death, including, but not

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D 443	Continued From page 42 limited to, death certificates, autopsy reports, and reports by other authorities. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide a written death notification for 1 of 1 resident (#1) who died within 24 hours of an elopement from the facility. The findings are: Review of Resident #1's current FL-2 dated 04/07/22 revealed diagnoses schizophrenia, gastroesophageal reflux disease (GERD) and glaucoma. Review of Resident #1's Accident/Incident Report dated 05/08/22 revealed Resident #1 could not be located at the facility and a silver alert was initiated. Telephone interview with the Administration on 05/16/22 at 8:42am revealed: -She did not complete the written death report because the death did not occur at the facility. -She did not know a written death report was required within 3 days after the facility was notified of Resident #1's death.	D 443		
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	D 612		

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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.

This Rule is not met as evidenced by:
Based on 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 (NC DHHS) were implemented and maintained to protect 53 residents in the facility during the global coronavirus (COVID-19) pandemic as related to the screening of residents.

The findings are:

Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for healthcare personnel during the coronavirus disease 2019 (COVID-19) pandemic dated 02/02/22 revealed:
-Facilities should establish a process to identify anyone entering the facility, regardless of vaccination status, who has any one of the following three criteria so that they can be managed: a positive viral test for COVID-19, symptoms of COVID-19, or close contact with someone with COVID-19 infection.
-The options could include (but were not limited to): individual screening upon arrival to the facility

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or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.

Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARs-CoV-2 spread in Nursing Homes dated 02/22/22 revealed residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever.

Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021 revealed the staff and residents should be actively screened daily for fever, signs, and symptoms of COVID-19.

Review of the facility's COVID-19 policies revealed:
-There was an Infection Control with COVID-19 policy that was dated November 19, 2021.
-Screaming for signs and symptoms included all staff should be screened for symptoms prior to every shift; all residents should be screened for symptoms daily, and all visitors should be screened for symptoms prior to entering the facility.
-There was documentation on the screening log for family, visitors, and health care personnel for temperature and Covid-19 screening questions.
-There was documentation facility staff were screening at the beginning of every shift in the screening log.

Review of five residents' March 2022, April 2022 and May 2022 electronic medication administration records (eMARs) revealed there was no documentation of daily temperatures.

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D 612	Continued From page 45 Review of vital signs information documented for 5 sampled residents revealed there was documentation for monthly temperatures but no documentation for daily temperatures for the residents. Interviews with four residents on 05/11/22 between 9:10am-9:53am revealed: -One resident had their temperature checked when she recently requested it be checked because she did not feel well. -Another resident had not had their temperature checked daily (they did not recall the last time their temperature was checked). -A third resident had their temperature checked a lot when they had COVID-19 (did not recall when) but seldom checked their temperature now. -A fourth resident had not had her temperature checked but if a resident felt sick staff would check their temperature. Interview with a medication aide (MA) on 05/13/22 at 10:10am revealed: -Resident's temperatures were routinely checked monthly when vital were taken. -They would check a resident's temperature if the resident was showing signs of COVID-19. -The MAs was routinely checking residents' temperature daily during the facility's COVID-19 outbreak a few months ago. -There was a separate temperature log sheet for each resident kept on the medication cart when the facility had been taking residents' temperature daily. -Residents temperatures had not been taken daily for at least 3 months as far as she could remember. -She did not know why they stopped checking the residents' temperatures more often than monthly.	D 612		

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D 612	Continued From page 46 Interview with a resident on 05/12/22 at 8:25 am revealed staff used to check his temperature every day at 11:30 am, but staff had not check his temperature daily for a couple of months. Interview with a second resident on 05/12/22 at 8:35 am revealed staff did not check his temperature daily. Interview with a third resident who resided on the front hall of the building on 05/13/22 at 9:00am revealed: -He did not receive daily temperature checks. -He received monthly temperature checks. Interview with a fourth resident on 05/13/22 at 9:15am revealed: -The facility staff do not take her temperature daily. -They were taking residents' temperature daily a few months back when the facility had residents that were sick with COVID-19. -The facility staff take weights, temperature, blood pressure and pulse once a month on the residents. Interview with the Administrator on 05/13/22 at 10:45am revealed: -She relied on the web sites of the CDC, NCDHHS, and long-term care association, as well as information received from the local health department for updates to COVID-19 recommendations. -Residents' temperatures were only checked if they exhibited signs and symptoms of COVID-19; unusual coughing, appeared to not feel well, or any changes noted by staff. -She did not know exactly when the resident's daily temperature checks were stopped.	D 612		

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D 612	Continued From page 47 -She did not know the current guidelines included to check the residents' temperatures daily as part of COVID-19 screening in long term care facilities without an active outbreak of COVID-19. -Some residents were scheduled to see the facility's contracted primary care provider (PCP) every 2 weeks, some monthly, and some as needed. -The residents' vital signs, including temperatures were taken prior to seeing the PCP, but not daily.	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. This Rule is not met as evidenced by: Based on observations, 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 as related to supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled resident (Resident #1), who was adjudicated incompetent and had a history of elopement and wandering behaviors, was supervised according to his assessed needs and the facility's established procedure resulting in the resident leaving the facility unsupervised and	D912		

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D912	Continued From page 48 without staff knowledge and his whereabouts being unknown until the resident was identified as a fatality at an accident scene. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D912		