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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on May 11, 2022 through May 13, 2022.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide ensure 2 of 2 sounding exit door alarms and locks accessible to residents' were in place and properly working, at sufficient volume for staff to hear, in the Special Care Unit (SCU) in which 1 of 7 sampled residents (#6) was able to elope. The findings are: Review of the facility's Elopement Management Program dated December 2021 revealed:	D 067		

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D 067	Continued From page 1 -Elopement was devastating and could result in fractures or death. -The facility was responsible to ensure residents were able to maintain being mobile in their community while having identified risks of elopement mitigated with team member response upon resident elopement. -Residents at risk of elopement were identified via diagnoses such as being cognitively impaired, with limited decision making skills, inability to demonstrate safety awareness, inability to return to the community independently, having a history of leaving without the necessary supervision outlined in the care plan, having a history of leaving a secured area regardless of whether they exited the building, and wandering or exit seeking behaviors. -Interventions could include having a resident wear a monitoring device, being provided cues, engagement, and redirection, and having someone escort the resident as needed. -Mitigating factors included camouflaging doors, use of door alarms, automatic door locks, specialized door handles, locks at the bottom of doors, increased supervision, and physical barriers. -Residents at risk of elopement were to be communicated through staff alerts, meetings, and resident care plans. -Performance tests of secure exits to confirm functionality were to be performed per facility policy. -It was every staff member's responsibility to assist in the management of reducing elopement risk, communicate resident behaviors, and promote a safe environment for residents. Review of Resident #6's current FL-2 dated 07/19/21 revealed: -The resident's level of care was in the Special	D 067		

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Care Unit (SCU).
-Diagnoses included dementia with agitation and frequent urinary tract infections.
-The resident was constantly disoriented and had wandering behaviors.
-The resident was ambulatory without any assistive devices or aides.

Review of Resident #6's Resident Register dated 07/15/21 revealed:
-He was admitted to the facility's SCU on 07/27/21.
-He was disoriented to time and place with significant memory loss requiring redirection.

Review of Resident #6's Resident Profile dated 07/15/21 revealed the resident had wandering behaviors and would try to get outside but was usually easily redirected.

Review of Resident #6's Dementia Care Disclosure Statement revealed:
-The facility would provide a safe and secure environment employing wander guard systems (devices available to be worn as bracelets that would alert a staff member if a resident attempted to exit) and delayed egresses.
-If a resident attempted to leave the SCU, a staff member would attempt to redirect or accompany the resident to ensure their safety and well-being.
-All possibilities were to be exhausted in meeting resident's needs with priority ensuring a safe environment.

Review of Resident #6's current care plan dated 03/08/22 revealed:
-The resident was non-verbal and required cueing and redirection.
-The resident's hobbies and interests included listening to music, being outside, and walking.

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-The resident did not prefer group activities and his favorite activity was exploring his neighborhood.
-The resident was identified as being likely to walk into other resident's rooms to look out the window.
-Staff were to provide a consistent routine to provide him with a sense of security and minimize confusion or uncertainty.
-He was to be provided with cues, reorientation, supervision, and assisted as needed.
-He was to be given simple cues, prompts, and step by step direction to assist him in decision making.
-He was to be provided with supervision as needed to ensure that he did not compromise his safety.
-He was a fall risk due to confusion and poor safety awareness due to his dementia.
-He was to have received guidance and support and be observed throughout the day to ensure the safety of himself and others.
-He was able to walk independently without the assistance of any durable medical equipment.
-Staff were to ensure all hazardous materials were kept secured and out of harm's way.

Review of Resident #6's Accident/Incident Report (I/A) dated 03/20/22 revealed:
-The resident was missing at 10:30am after a stairwell door alarm was found alarming by a staff member and a resident head count was performed.
-The SCU was immediately searched and police were notified.
-The resident was found by police and returned to the SCU without injury.
-Upon investigation it was found that the cover/alarm to the emergency release override button battery was dead and the resident was

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able to push the override button and exit the SCU.

Observation of the road the resdient was found on 05/13/22 from 10:25am to 10:45am revealed:
-The road the resident was found on is a busy eight lane highway and ran parallel with the front of the facility building approximately 50 yards from the front door of the facility.
-The posted speed limit on the road from the facility to the next intersection was 45 miles per hour.
-The distance from the facility to the intersection the resident was found was 1.4 miles.
-There were 5 intersections with stop lights from the exit of the facility on the road he was found until the intersection.
-At 10:30am, there were 36 cars that crossed the intersection over the period of one minute (60 seconds).
-There were at least 4 sections of the route from the facility to the intersection of where there was no sidewalk on the right side of the road, where the facility was located.

Observation of the exit doors on each end of the hall in the SCU on 05/11/22 at 8:55am revealed:
-They were locked and unable to be pushed open until a staff member entered a pin on a keypad to unlock the door and pass through it.
-When the pin was entered on the keypad and the door opened, there was no sounding alarm on the door that led into a stairwell from the hallway in the SCU.
-In the stairwell, there was a door that led outside to an open, un-gated area.
-The exterior door was was not locked but did have a sounding alarm.
-Outside of the exterior doors were sidewalks that led around the facility building and anyone could

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easily access the parking lot or a busy 8-lane highway the facility was located on.
-There was a green panel to the left of the door with a clear cover over an override button.
-When the clear cover was lifted, an audible alarm sounded.

Review of the facility's maintenance logbook report for doors, locks, and alarms of perimeter security revealed:
-All doors were secured and working properly when assessed on 01/31/22, 02/28/22, and 03/31/22.
-The battery to the clear door covering the override button was assessed as not working on 03/20/22 after the resident eloped.
-There was no documentation that the battery to the cover of the override was button was checked and working properly other than on 03/20/22.

Interview with a personal care aide (PCA) on 05/11/22 at 8:55am revealed:
-Resident #6 eloped about 1.5 months ago around 10:30am.
-Somehow the doors were unlocked, and he was able to leave through the hallway door that led into a stairwell with another door leading outside.
-The alarm on the stairwell door worked, but staff were not able to hear it from the common area where they were with other residents.
-There was no process in place at that time to check that doors were working properly on each shift, but maintenance was been responsible for checking the doors once per month.
-She was unsure when the doors had been last checked.

Second interview with a PCA on 05/13/22 at 10:15am revealed:
-She was working and served as team lead on

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the SCU the day Resident #6 eloped on 03/20/22.
-All staff were in the common area with most of the residents finishing up an activity after breakfast around 10:30am.
-The Special Care Director (SCD) heard the door alarm down the hallway (none of the staff in the common area were able to hear it) and came into the common area instructing them to perform a resident head count.
-Only the door in the stairwell that led to the outside was alarming, not the door in the hallway leading into the stairwell because it did not have an alarm.
-There was no process in place to ensure doors and alarms were working daily each shift prior to Resident #6's elopement.
-Staff were unable to hear the door alarm in the common area the day Resident #6 eloped because she did not want any harm to come to the residents.
-If staff had been able to hear the door alarm the day Resident #6 eloped, staff would have been able to respond sooner and prevent the resident from leaving the building and the property.

Interview with a second PCA on 05/13/22 at 11:05am revealed:
-She was working the day Resident #6 eloped on 03/20/22.
-When the resident eloped, she was in another resident room providing care and was unable to hear the door alarming.

Interview with the SCD on 05/11/22 at 2:08pm revealed:
-She was new in the SCD role and was not present when Resident #6 eloped but was told the door was unlocked.
-She was unsure if there was a working door alarm.

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D 067	Continued From page 7 -There was no process in place for staff to ensure door alarms were working properly each shift prior to Resident #6's elopement. Interview with the previous SCD on 05/12/22 at 2:56pm revealed: -She was present and serving as the manager on duty on 03/20/22, the day Resident #6 eloped from the SCU. -It was a weekend and she had been working in her office, she stepped out for approximately 5-10 minutes and when she returned, she heard a door alarm going off down the hall. -She followed the sound of the alarm realizing the door leading to the stairwell from the hallway was unlocked instead of being locked (it did not have an alarm) and the door leading outside from the stairwell was alarming. -She realized all the doors in the facility were unlocked and immediately assigned staff to supervise all residents. -Maintenance was responsible to ensure all doors were locked and working properly once monthly. -Prior to Resident #6's elopement on 03/20/22, there was no process in place to ensure doors were locked and working properly each shift and supervision safety checks were provided to all residents in the SCU every two hours. -Checking doors daily each shift had not been on her mind prior to Resident #6's elopement on 03/20/22 because the facility had never had a resident successfully leave the facility prior. -It was her responsibility to ensure resident safety at that time and it was important to ensure doors worked properly to provide a safe and secure environment. Interview with the Maintenance Coordinator on 05/12/22 at 3:55pm revealed: -He began working at the facility in February 2022	D 067		

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and was responsible to check door locks and alarms monthly.
-He was not present when Resident #6 eloped on 03/20/22 but was called in afterward to investigate how the resident was able to exit the SCU and to re-secure the unit.
-Upon his investigation, he realized the batteries to the door lock and alarm system override button were dead, which allowed the resident was able to open the door to the override system and push the button to unlock all the doors in the SCU.
-He was not sure how often the batteries to the override system were checked or changed, but when he replaced the dead battery it was dated November 2020.
-The doors in the SCU hallway leading into the stairwells on the SCU which lead outside never had alarms on them.
-Only the doors in the stairwell leading outside had alarms.
-He was not aware that all exit doors within the SCU were required to have alarms on them until being made aware, he thought the doors only had to remain locked.
-He had brought previous concerns about the security of the doors and the integrity of the system to prevent residents from exiting to the attention of the previous Administrator after Resident #6's elopement who told him to call the facility's corporate Information Technology (IT) department.
-When he called the corporate IT department after the elopement, they decided to upgrade the door system, but that had not been implemented yet and they were waiting on parts to arrive to complete the project.

Interview with the Administrator on 05/13/22 at 3:27pm revealed:
-He just started at the facility that week and was

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not present the day that Resident #6 eloped.
-He expected staff to check door locks and alarms daily and to ensure frequent battery checks to ensure door alarms sounded properly.
-If door alarms and locks had been working properly it would have prevented Resident #6 from eloping from the locked SCU on 03/20/22.
-There was no process in place to check door alarms and locks daily prior to Resident #6's elopement because the facility had never had a resident elope before.
-There should have been an alarm on the hallway doors leading from the SCU to the stairwell which led outside for resident safety per rules and regulations.
-He was not aware there was not alarm on the doors and he did not know why one had never been installed.
-It was all staff's responsibility to ensure door alarms and locks were working properly to protect resident safety.

Interview with the Resident #6's primary care provider (PCP) on 05/13/22 at 2:17pm revealed:
-She was notified that Resident #6 had eloped on 03/20/22 and he was assessed on 03/21/22.
-The resident had a history of wandering behaviors and she expected the facility to ensure door locks and alarms were always in proper working condition per rules and regulations for resident safety.
-She expected alarm batteries to be changed frequently to ensure they did not die preventing alarms from sounding which could affect resident safety.
-It was disturbing that the resident was able to elope from the locked SCU and it was important to maintain integrity of door locks and alarms to prevent elopement.
-Residents in the SCU were cognitively impaired,

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D 067	Continued From page 10 unable to make safe decisions for themselves, and had impaired judgement. -Residents who were able to leave the SCU unsupervised were at risk for injury by walking out into traffic or having someone take advantage of them. -She always expected facility staff to ensure resident safety and ensure exit doors were secured properly to prevent elopement. _____ The facility failed to ensure 2 of 2 exit doors on the Special Care Unit (SCU) were locked and equipped with a sounding device loud enough to alert staff when activated as well as ensure the batteries worked in the sounding alarm cover for the override button that unlocked all doors within the SCU resulting in Resident #6, known to be constantly disoriented, with wandering and exit seeking behaviors eloping from the SCU and walked 1.4 miles along a busy 8-lane highway through five intersections in which most of the route did not have a sidewalk. The resident was found by police and brought back to the facility. This failure resulted in substantial risk of death or serious injury from neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/12/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 12, 2022	D 067		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and	D 079		

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D 079	Continued From page 11 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 toiletry hazards left accessible to 23 residents including several hazardous items in 8 resident rooms and 1 community shower room 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 115 residents with a Special Care Unit (SCU) capacity of 25 residents. The facility's census in the SCU was 23 residents. Review of the facility's Chemical Safety Resident Risk Reduction Policy dated 11/11/05 revealed: -The facility was to take the appropriate precautions to minimize resident's risk of injury from chemical and other hazardous materials through a combination of diligent monitoring, safe dispensing, and proper usage with restricted access. -Personal care products/toiletries would be secured in a locked drawer in the resident's suite. -Key access to secured items would be limited to authorized staff members and family/friends. -Shared supplies would be locked in a cabinet in a central location. -Personal care aides (PCAs) would ensure that	D 079		

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all secured items are properly stored in locked drawers in the resident suites as they provide care throughout the day.
-All staff members were responsible to ensure all cabinets are locked before leaving the area.
-All staff members were responsible to immediately notify the Maintenance Coordinator of any damaged locks and were not to leave an un-lockable cabinet unattended if stocked with supplies.

Observation of resident room 187 on 05/11/22 at 9:23am revealed:
-There was a tube of toothpaste, a bottle of shampoo, a deodorant, a large bottle of body wash, a large bottle that was half full of mouth wash, a bottle of lotion, and a can of aerosol hair spray on the bathroom counter unsecured and accessible to anyone who entered the bathroom.
-There was a bottle of body splash perfume on the dresser in the resident's room.

Observation of resident room 186 on 05/11/22 at 9:26am revealed there was tube of deodorant, a tube of toothpaste, and a half full bottle of mouth was on the bathroom counter unsecured and accessible to anyone who entered the bathroom.

Observation of resident room 181 on 05/11/22 at 9:28am revealed there was a bottle of shampoo, a bottle of lotion, a pump bottle of mouth wash, a bottle of hand soap, and an aerosol can of shaving cream on the bathroom counter unsecured and accessible to anyone who entered the bathroom.

Observation of a common bathroom on 05/11/22 at 9:31am revealed there was an unlocked cabinet with an 8 ounce bottle of wound cleanser, an 8 ounce bottle of lotion, three tubes of 20%

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zinc oxide cream, and a 4 ounce bottle of skin protectant cream unsecured and accessible to anyone who opened the lockable cabinet.

Observation of resident room 162 on 05/11/22 at 9:32am revealed:
-There was a half full bottle of lotion, a half full bottle of hand sanitizer, and a half full bottle of hairspray on the resident's dresser unsecured and accessible to anyone who entered the room.
-There was a pump bottle of body wash, a half full bottle of lotion, and a tube of tooth paste on the bathroom counter.

Observation of resident room 164 on 05/11/22 at 9:35am revealed:
-There was a bottle of hand sanitizer and a container of lubricant on the resident's dresser unsecured and accessible to anyone who entered the room.
-There was a bottle of body wash and toothpaste on the bathroom counter.

Observation of resident room 166 on 05/11/22 at 9:38am revealed there was a bottle of body wash, lip balm, body lotion, and toothpaste on the bathroom counter unsecured and accessible to anyone who entered the room.

Observation of resident room 168 on 05/11/22 at 9:42 revealed there was a bottle of hand soap on the bathroom counter unsecured and accessible to anyone who entered the room.

Observation of resident room 169 on 05/11/22 at 9:47am revealed:
-There was a bottle of deodorant, hand soap, lotion, body wash, mouth wash, hand wash, body wash, skin barrier cream, powder, aerosol disinfecting spray, and disinfectant wipes on the

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bathroom counter unsecured and accessible to anyone who entered the room.
-There was a three tier shelf with drawers in the corner of the bathroom with each drawer full of copious amounts of toiletries to include body wash, shampoo, lotion, toothpaste, floss picks, petroleum jelly, antibiotic ointment, hydrocortisone cream, antifungal powder, and a hair dryer. .
-There were laundry powder pods and lotion on a shelf in the closet.

Observation of warning labels on toiletries and hazardous products on the SCU unit on 05/11/22 from 9:23am to 9:47am revealed the warning labels on the products included the contents could be harmful or fatal if inhaled or swallowed, to avoid contact with the eyes, to get help or contact poison control right away, and to keep out of reach of children.

Interview with a PCA on 05/11/22 at 9:45am revealed:
-There were 2-3 residents who were confused and had wandering behaviors with one of those residents who routinely wandered the unit and would enter any unlocked door he came upon.
-Toiletries in the SCU were to be locked up under resident's sinks in their bathrooms after supervised use.
-Confused residents could ingest or misuse toiletries accessible to them without supervision.
-She recently had one resident attempt to use her toothbrush to clean her under her armpits.
-She was not sure why toiletries had not been locked up as expected but knew there were several staff members who did not have keys to lock them up.

Interview with a second PCA on 05/11/22 at

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D 079	Continued From page 15 10:30am revealed all toiletries were expected to be locked up in resident rooms under the bathroom sink to keep out of reach of confused residents who might ingest them. Intermittent observations of resident bathrooms on the SCU unit on 05/11/22 from 9:23am to 9:47am revealed there were locks on all the cabinets under all the bathroom sinks. Interview with the Special Care Director (SCD) on 05/11/22 at 2:08pm revealed: -All toiletries were expected to be locked up and out of reach of residents' access only to be used by residents under direct supervision. -She was not aware that toiletries had been left out and unlocked in resident's reach. -She was not aware that all staff in the SCU did not have a key to lock the toiletries up. -Staff were aware of expectations to lock toiletries up upon hire and routinely thereafter and there was no excuse for toiletries to be out. -It was important to lock up toiletries and other chemical for resident safety because residents on the SCU were confused, unaware of their surroundings, and may not understand how to use the products safely. -It was her responsibility to ensure toiletries were locked up as expected and ensure all her staff had keys to lock them up to keep residents safe. Interview with the previous SCD on 05/12/22 at 2:56pm revealed: -She was the SCD until about two weeks ago when she was promoted. -Any substance or chemical that could be harmful to a resident when used improperly was expected to be locked up and out of reach from the residents. -She was aware that toiletries were out and	D 079		

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unlocked due to not having enough keys for staff and broken locks.
-She placed a maintenance work order approximately one month ago to have it fixed but it had not been completed yet.
-She followed up on the work order weekly in stand-up meetings and was told it would get done but it had not been completed yet and she did not know why.
-There were several residents who had wandering behaviors and go in and out of other resident rooms and might be too confused to know not to ingest the toiletries.
-It was her or the current SCD's responsibility to ensure the toiletries were kept locked up for resident safety.

Interview with the Maintenance Coordinator on 05/12/22 at 3:55pm revealed:
-He began working at the facility in February 2022 and had never received a work order to fix locks or provide staff keys to lock up toiletries.
-He was unaware toiletries had to be locked up and that there were any issues with any locks or unavailability of keys to staff.
-He attended the stand-up meetings regularly and the issue had never been brought to his attention regarding the issue.
-He was not aware locks needed to be fixed and keys needed to be provided to staff until he had been made aware that day, 05/12/22.

Interview with the Administrator on 05/13/22 at 3:27pm revealed:
-He was not aware that toiletries had been left unattended and unlocked within reach of residents until being made aware the previous day, 05/12/22.
-He had no knowledge of an existing work order to fix locks in resident rooms and provide keys to

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D 079	Continued From page 17 staff but expected work orders to be entered and completed immediately or as soon as possible pending needed supplies. -He expected all toiletries, chemicals, and hazards to be locked up and secured so that confused residents were kept safe from ingesting them. Interview with the facility's contracted primary care provider (PCP) on 05/13/22 at 2:17pm revealed: -All chemicals and toiletries in the SCU should always be locked away and secured from residents because resident could drink them or possibly cause injury to themselves from improper use. -Residents in the SCU were demented, unable to make safe decisions for themselves, had diminished cognitive abilities, and had impaired judgement and could not discern between food and chemicals/toiletries. -She expected all locks to be in proper working condition, for all staff to have keys to the locks, and for all staff to lock all chemicals and toiletries us after supervised use every time. -She expected the facility to implement and complete work orders immediately after identifying safety concerns to protect resident's safety.	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.	D 270		

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D 270	Continued From page 18 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 7 sampled residents (#6) based on the resident's assessed needs resulting in the resident eloping from the Special Care Unit (SCU). The findings are: Review of the facility's Elopement Management Program dated December 2021 revealed: -Elopement was devastating and could result in fractures or death. -The facility was responsible to ensure residents were able to maintain being mobile in their community while having identified risks of elopement mitigated with team member response upon resident elopement. -Residents at risk of elopement were identified via diagnoses such as being cognitively impaired, with limited decision making skills, inability to demonstrate safety awareness, inability to return to the community independently, having a history of leaving without the necessary supervision outlined in the care plan, having a history of leaving a secured area regardless of whether they exited the building, and wandering or exit seeking behaviors. -Interventions could include having a resident wear a monitoring device, being provided cues, engagement, and redirection, and having someone escort the resident as needed. -Mitigating factors included camouflaging doors, use of door alarms, automatic door locks, specialized door handles, locks at the bottom of	D 270		

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doors, increased supervision, and physical barriers.
-Residents at risk of elopement were to be communicated through staff alerts, meetings, and resident care plans.
-Performance tests of secure exits to confirm functionality were to be performed per facility policy.
-It was every staff member's responsibility to assist in the management of reducing elopement risk, communicate resident behaviors, and promote a safe environment for residents.

Review of Resident #6's current FL-2 dated 07/19/21 revealed:
-Diagnoses included dementia with agitation and frequent urinary tract infections.
-The resident was constantly disoriented and had wandering behaviors.
-The resident was ambulatory without any assistive devices or aides.

Review of Resident #6's Resident Register dated 07/15/21 revealed:
-He was admitted to the facility's SCU on 07/27/21.
-He was disoriented to time and place with significant memory loss requiring redirection.

Review of Resident #6's Resident Profile dated 07/15/21 revealed the resident had wandering behaviors and would try to get outside but was usually easily redirected.

Review of Resident #6's Dementia Care Disclosure Statement revealed:
-The facility would provide the resident a comfortable and secure home-like environment.
-Behaviors that could be appropriately monitored in the SCU included wandering, risk of

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elopement, and those with moderate to severe memory loss needing constant redirection with individualized attention.
-Each resident's care plan would include individualized services to meet the needs of the resident.
-Each staff member in the SCU would receive specialized training to include dementia, behaviors, and wandering.
-The facility would provide a safe and secure environment employing wander guard systems (devices available to be worn as bracelets that would alert a staff member if a resident attempted to exit) and delayed egresses.
-If a resident attempted to leave the SCU, a staff member would attempt to redirect or accompany the resident to ensure their safety and well-being.
-All possibilities were to be exhausted in meeting resident's needs with priority ensuring a safe environment.

Review of Resident #6's current care plan dated 03/08/22 revealed:
-The resident was non-verbal and required cueing and redirection.
-The resident's hobbies and interests included listening to music, being outside, and walking.
-The resident did not prefer group activities and his favorite activity was exploring his neighborhood.
-The resident was identified as being likely to walk into other resident's rooms to look out the window.
-Staff were to provide a consistent routine to provide his with a sense of security and minimize confusion or uncertainty.
-He was to be provided with cues, reorientation, supervision, and assisted as needed.
-He was to be given simple cues, prompts, and step by step direction to assist him in decision

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making.
-He was to be provided with supervision as needed to ensure that he did not compromise his safety.
-He was a fall risk due to confusion and poor safety awareness due to his dementia.
-He was to be received guidance and support and be observed throughout the day to ensure the safety of himself and others.
-He was able to walk independently without the assistance of any durable medical equipment.

Intermittent observations of Resident #6 from 05/11/22 to 05/13/22 revealed the resident was independently ambulatory, would walk up and down the halls attempting to open any door that was unlocked, and would routinely be observed standing at a window looking outside.

Review of an incident recall report from the local police department dated 03/20/22 revealed:
-A staff person from the facility contacted 911 on 03/20/22 at 10:31am to report a resident with dementia had been missing for 30 minutes.
-The staff person reported the resident was an older white male wearing a baseball cap, plaid shirt and jeans or khakis; he was non-verbal and normally kept his hands in his pockets.
-At 10:36am, the staff person reported that the resident did not have a vehicle and walked without any issues.
-At 10:37am, the staff person reported she was unaware of where the resident may have walked, and he was not allowed to leave the facility.
-Resident #6 was located by local police on 03/20/22 at 10:44am and returned to the facility.

Telephone interview with the local police department communications division on 05/13/22 at 10:19am revealed:

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-The facility contacted 911 at 10:31am on 03/20/22 to report a male resident had eloped.
-The lead personal care aide (PCA) reported that Resident #6 had dementia and had been missing for 30 minutes.
-Resident #6 was found at 10:44am approximately one and a quarter mile away from the facility.

Telephone interview with an officer with the local police department on 05/13/22 at 11:19am revealed:
-He responded to a dispatch call that a male resident had eloped from the facility on 03/20/22.
-He observed Resident #6 walking south approximately one and a quarter mile from the facility.
-Resident #6 was walking on the sidewalk and on portions of the grass beside the sidewalk.
-He assisted Resident #6 into the police vehicle and transported him back to the facility at 10:44am.

Review of Resident #6's Accident/Incident Report (I/A) dated 03/20/22 revealed:
-The resident was missing at 10:30am after a stairwell door alarm was found alarming by a staff member and a resident head count was performed.
-The SCU was immediately searched and police were notified.
-The resident was found by police and returned to the SCU without injury.
-Upon investigation it was found that the cover/alarm to the emergency release override button battery was dead and the resident was able to push the override button and exit the SCU.

Review of Resident #6's facility progress notes

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D 270	Continued From page 23 revealed: -On 03/20/22, the resident eloped from the SCU by pushing open a stairwell door and walking through a door in the stairwell leading outside. -The resident was found 20 minutes later and brought back to the SCU. -The resident would go through any door that was open and measures were taken to secure all SCU doors after the incident. -Staff were asked to monitor the resident for a few days to ensure safety and to check the integrity of the doors working properly at the beginning and end of each shift. -On 03/21/22, the resident was observed post elopement day one in the common area with no signs or symptoms of discomfort. -On 03/22/22, the resident was observed post elopement day two engaged in a 1:1 activity in his room with no further incidents or episodes. -On 03/23/22, the resident was observed post elopement day three as calm and cooperative, eating well with no report of insomnia. Observation of the road the resident was found on 05/13/22 from 10:25am to 10:45am revealed: -The road the resident was found on is a busy eight lane highway and ran parallel with the front of the facility building approximately 50 yards from the front door of the facility. -The posted speed limit on the road from the facility to the next intersection was 45 miles per hour. -The distance from the facility to the intersection the resident was found was 1.4 miles. -There were 5 intersections with stop lights from the exit of the facility on the road he was found until the intersection. -At 10:30am, there were 36 cars that crossed the intersection over the period of one minute (60 seconds).	D 270		

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D 270	Continued From page 24 -There were at least 4 sections of the route from the facility to the intersection of where there was no sidewalk on the right side of the road, where the facility was located. Review of Resident #6's primary care provider (PCP) note dated 03/21/22 revealed: -The resident had a history of dementia and resided in the SCU and ambulated unassisted. -The facility reported the resident's elopement on the previous day, 03/20/22. -The resident was able to exit unnoticed through an unsecured door and police found him and escorted him back to the facility. -The resident did not suffer any falls during the episode and the facility staff had not noticed any mood or behavior changes before or since the incident. -Facility staff were to monitor the resident for behavior and mental status changes and notify the PCP if any unexpected observation occurred. Interview with a PCA on 05/11/22 at 8:55am revealed: -Supervision safety checks for residents residing on the Special Care Unit (SCU) were provided every two hours per facility procedure but there was no documentation of it. -Resident #6 eloped about 1.5 months ago around 10:30am and thought he was gone approximately 30 minutes. -She could not recall how it was identified that Resident #6 was missing. -Somehow the doors were unlocked, and he was able to leave through the hallway door that led into a stairwell with another door leading outside. -She had never been instructed to provide Resident #6 with increased supervision more than every 2 hours.	D 270		

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D 270	Continued From page 25 Second interview with a PCA on 05/13/22 at 10:15am revealed: -Resident #6 had wandering behaviors and would open any unlocked door and enter that he could. -He was very curious, non-verbal, and a steady walker. -She was working and served as team lead on SCU the day Resident #6 eloped on 03/20/22. -All staff were in the common area with most of the residents finishing up an activity after breakfast round 10:30am. -The Special Care Director (SCD) heard the door alarm down the hallway, (none of the staff in the common area were able to hear it) and found all the doors were unlocked. -She then went into the common area instructed staff to perform a resident head count. -Only the door in the stairwell that lead to the outside was alarming, not the door in the hallway leading into the stairwell. -Staff identified that Resident #6 was missing after performing the head count. -One person was assigned to supervise the residents while the rest of the staff began looking for Resident #6. -Resident #6 was assigned to an agency staff PCA that day, and upon identifying that Resident #6 was missing, staff realized the agency PCA was also unaccounted for. -She immediately called the agency PCA who told her she was at a gas station getting a snack and would be back shortly, but that Resident #6 was not with her. -She did not give the agency staff member permission to leave the facility at that time and was unaware that the unit was short a staff member during the time frame of Resident #6's elopement. -She had last seen Resident #6 at breakfast approximately an hour earlier at 9:30am.	D 270		

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-She called 911 after 15 minutes of looking for the resident and the local police department found and returned the resident approximately 30 minutes after that.
-There was one other time Resident #6 had eloped, she could not recall when, but the resident was out to eat with the previous activity director and walked away from the restaurant.
-She thought 911 had been called and local police returned the resident on that occasion as well.
-Staff were aware that Resident #6 had wandering and elopement behaviors upon admission, but she did not know any further details.
-All residents on the SCU were provided with supervision safety checks every two hours per the facility's normal expectation.
-Other than providing increased supervision every hour for one week to all residents after Resident #6's elopement, she had never been instructed to provide increased supervision to Resident #6 despite his behaviors.
-Staff tried to keep all residents, especially residents with wandering behaviors, engaged in group activities in the common area, but Resident #6 liked to be alone and did not enjoy group activities.

Interview with a second PCA on 05/11/22 at 9:45am revealed Resident #6 had wandering behaviors and would open any door he came upon.

Interview with a third PCA on 05/13/22 at 11:05am revealed:
-Resident #6 had wandering behaviors and was always going to doors trying to open them.
-She was working the day Resident #6 eloped on 03/20/22.
-When the resident eloped, she was in another

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resident's room providing care and was unable to hear the door alarming.
-Another staff member came in and notified her that Resident #6 was missing and that she needed to help look for him around 10:30am.
-She had last seen Resident #6 that morning around 9:00am at breakfast.
-All SCU residents received supervision safety checks every two hours and she had never been instructed to provide Resident #6 with any increased supervision.

Interview with the agency PCA on 05/13/22 at 1:46pm revealed:
-Resident #6 had wandering behaviors and would go into other resident rooms.
-She was working on 03/20/22 when Resident #6 eloped, but she was on break when he had been identified as missing.
-She had last seen Resident #6 in his bedroom around 10:00am just before she took her break.
-The staff called her while on her break to notify her Resident #6 was missing and to come back to help look for him.
-She did not recall how long the resident was gone prior to being returned by the police and was unaware he had eloped before.
-She had never been instructed to provide Resident #6 increased supervision more than the standard 2 hours provided all SCU residents.

Interview with the Special Care Director SCD on 05/11/22 at 2:08pm revealed:
-She was new in the SCD role and was not present when Resident #6 eloped.
-She was told the door was unlocked and she was unsure if there was a working door alarm.
-Supervision safety checks were provided to all SCU resident every two hours; there was no documentation of safety checks, it was a verbal

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expectation.
-She was not sure how long Resident #6 was gone before staff identified he had been missing.
-Resident #6 did not enjoy group activities and preferred to walk and wander the halls alone most of the day.

Interview with the previous SCD on 05/12/22 at 2:56pm revealed:
-She was present and serving as the manager on duty on 03/20/22, the day Resident #6 eloped from the SCU.
-It was a weekend and she had been working in her office, she stepped out for approximately 5-10 minutes and when she returned, she heard a door alarm going off down the hall.
-She followed the sound of the alarm realizing the door leading to the stairwell from the hallway was unlocked and the door leading outside from the stairwell was alarming.
-She realized all the doors in the facility were unlocked and immediately assigned staff to supervise all residents.
-She immediately came back inside to alert staff and initiated a head count of all the residents and realized Resident #6 was unaccounted for.
-She assigned some staff to search for the resident, and she and another manager on duty immediately got in their vehicles and started driving around looking for the resident in neighboring areas.
-After about 15 minutes of looking for the resident, she called the facility and told them to call 911 to report the resident missing.
-Approximately 15-20 minutes after her return to the facility, the local police department had found Resident #6 and returned him to the facility unharmed.
-Resident #6 was found by police approximately 1 mile away walking down the road.

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D 270	Continued From page 29 -Upon her return, she also called the Maintenance Coordinator to come in and fix the doors to relock and alarm. -Prior to Resident #6's elopement on 03/20/22, there was no process in place to ensure doors were locked and working properly each shift and supervision safety checks were provided to all residents in the SCU every two hours. -Increased supervision each hour was provided to all residents in the SCU for one week following the elopement until staff were sure the doors continued to lock properly every shift for several days. -After one week, supervision for all residents returned to every two hours, even for Resident #6. -Resident #6 had previously eloped from the SCU approximately one month after admission in August 2021 by following a visitor out of the locked doors. -Resident #6 did was not able to leave the facility during that attempted elopement because the receptionist at the front desk identified him as a resident and returned him to the SCU. -Staff did not provide Resident #6 with any increased supervision. -Providing increased supervision and checking doors daily each shift had not been on her mind prior to Resident #6's elopement on 03/20/22 because the facility had never had a resident successfully leave the facility prior to her knowledge. -It was her responsibility to ensure resident safety at that time and it was important to ensure doors worked properly to provide a safe and secure environment. Interview with the Maintenance Coordinator on 05/12/22 at 3:55pm revealed: -He began working at the facility in February 2022	D 270		

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and was responsible to check door locks and alarms monthly.
-He was not present when Resident #6 eloped on 03/20/22 but was called in afterward to investigate how the resident was able to exit the SCU and to re-secure the unit.
-Upon his investigation, he realized the batteries to the door lock and alarm system override button were dead, meaning the resident was able to open the door to the override system and push the button to unlock all the doors in the SCU.
-He was not aware that all exit doors within the SCU were required to have alarms on them.
-He thought they only had to remain locked.
-He ran monthly elopement drills for staff on each shift to practice this scenario and had brought concerns to the previous administration regarding staff's delayed participation.
-He felt that staff had alarm fatigue to alarm doors and would often not respond to door alarms in a timely manner if at all.
-During one drill, a single staff member looked out the door that was alarming but did not go outside to check for the person that left and just re-shut the door behind them.
-During another drill, the door alarm or concern of elopement was never communicated over staff radios to ensure all staff were aware and alert of the situation.
-He was responsible to check the integrity of the door system once monthly but was the only person in the maintenance department and was unable to check every door every day.
-It was disturbing to him that another resident might be able to elope due to lack of staff participation in responding to door locks and alarms or checking the integrity of door locks and alarms.
-He expected staff to immediately respond to door alarms and communicate clearly any

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concerns of doors not working properly or possible residents being unaccounted for.

Interview with the Administrator on 05/13/22 at 3:27pm revealed:
-He just started at the facility that week and was not present the day that Resident #6 eloped.
-He was not aware of Resident #6's history of elopements and the facility should have had clear documentation of those elopements as well as increased supervision every hour due to his history.
-He also expected facility staff to perform door and alarm checks daily for resident safety as well as frequent battery checks to prevent alarms not working.
-After Resident #6's first elopement, he would have expected supervision to be provided at least every 30-minutes which should have mitigated a second or third elopement in which he should have had supervision every 15 minutes or a private sitter.
-He expected staff to communicate when they were leaving the facility and to hand off any instructions for resident supervision to ensure resident safety.
-It was staff's responsibility to ensure residents were supervised and accounted for to maintain resident safety and he expected staff to be engaged in responding to door alarms immediately.

Interview with the Resident #6's primary care provider (PCP) on 05/13/22 at 2:17pm revealed:
-She was notified that Resident #6 had eloped on 03/20/22 and he was assessed on 03/21/22 afterward.
-The resident had a history of wandering behaviors and she expected the facility to have provided the resident increased supervision of at

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D 270	Continued From page 32 least every 30-60 minutes to prevent exit seeking behaviors. -She expected other staff to supervise residents when responsible staff members were on break. -She expected all staff to be aware of residents with wandering and exit seeking behaviors to ensure safety. -Residents who were able to leave the SCU unsupervised were at risk for injury by walking out into traffic or having someone take advantage of them. -She expected facility staff to ensure resident safety at all times. _____ The failure of the facility to provide supervision to Resident #6, a resident with dementia and known wandering and exit seeking behaviors, resulting in the resident exiting the secure Special Care Unit (SCU) without the knowledge of staff after being able to press the override button unlocking all the locked doors within the SCU. The resident walked 1.4 miles along a busy 8-lane highway through five intersections in which most of the route did not have a sidewalk. The resident was found by police and brought back to the facility. This failure resulted in substantial risk of death or serious injury and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/13/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 12, 2022	D 270		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 33 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#9, #10) during the morning medication pass including errors involving insulin administration (#9) and antibiotic eye drops (#10), and for 1 of 7 residents sampled for record review including a vitamin supplement ordered for a resident to receive after dialysis treatment (#2). The findings are: 1. The medication error rate was 6% as evidenced by the observation of 2 errors with 29 opportunities during the morning medication pass on 05/12/22. a. Review of Resident #9's current FL-2 dated 02/24/22 revealed diagnoses included diabetes mellitus. Observation of the morning medication pass on 05/12/22 revealed: -Resident #9's fingerstick blood sugar was 76 at 7:41am. -The medication aide (MA) administered 6 units of Novolog insulin to Resident #9 in her right upper arm at 7:43am (Novolog is a fast-acting insulin used to lower blood sugar).	D 358		

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-The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle so that the resident received the full dose of insulin.

Review of the manufacturer's prescribing information for Novolog insulin pen revealed:
-After the needle was attached, a safety test should have been performed.
-The safety test is performed by dialing a test dose of 2 units and pressing the injection button and check to see that insulin comes out of the needle.

Observation of the assisted living dining room on 05/12/22 revealed:
-Resident #9 was brought to the dining room in her wheelchair by a personal care aide (PCA) at 9:25am.
-Resident #9 was served breakfast of coffee and oatmeal at 9:30am.

Review of Resident #9's physician orders dated 04/29/22 revealed there was an order for Novolog 6 units subcutaneously to be administered 15-20 minutes prior to meals.

Review of Resident #9's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog insulin inject 6 units subcutaneously before meals with instructions to administer 15-20 minutes prior to meals, scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-Novolog insulin 6 units was documented as administered on 05/12/22 at 7:30am.

Interview with Resident #9 on 05/12/22 at 9:00am

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revealed:
-Staff took her to the dining room for meals.
-She did not remember how long it was normally before she ate after receiving her insulin.
-She requested orange juice after her medications to "hold her over" until breakfast.

Interview with the MA on 05/12/22 at 10:40am revealed:
-She remembered being trained to prime the insulin pens with two units prior to dialing the resident's ordered dose for administration but forgot to do it this morning when she administered Resident #9's insulin.
-The PCAs transported Resident #9 downstairs to the dining room in the morning after she received her medication.
-She was not aware that the resident did not go to the dining room until 9:25am, which was concerning to her because she received insulin; but the resident received an orange juice after her medications.

Interview with the Resident Care Director (RCD) on 05/12/22 at 10:55am revealed:
-Staff was trained to prime the insulin pens prior to administration to ensure that the resident received the full dose of insulin.
-If the resident did not receive the full dose of insulin, there was a chance that the resident's blood sugar could remain elevated.
-She was not aware that Resident #9 did not eat until over 90 minutes after receiving her fast-acting insulin and would expect her to eat within 30 minutes so that her blood sugar would not drop to low.

Interview with the Administrator on 05/12/22 at 11:10am revealed he expected Resident #9 to receive her medication as ordered and in

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accordance with manufacturer's recommendations.

Attempted telephone interview with Resident #9's endocrinologist 05/12/22 at 2:42pm and 05/13/22 at 9:05am were unsuccessful.

b. Review of Resident #10's current FL-2 dated 12/01/21 revealed diagnoses included dehydration, hypertension, and atrial fibrillation (irregular heart rate).

Observation of the morning medication pass on 05/12/22 revealed:
-The medication aide (MA) placed one drop of Moxifloxacin into Resident #10's right eye at 8:19am (Moxifloxacin is an antibiotic used to treat infection).
-The MA placed one drop of Moxifloxacin into Resident #10's left eye at 8:20am.

Review of Resident #10's physician order sheet dated 03/10/22 revealed there was an order for Moxifloxacin 0.5% solution, instill 1 drop in left eye two times a day for eye condition.

Review of Resident #10's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Moxifloxacin solution, instill 1 drop in left eye two times a day, scheduled for administration at 8:00am and 8:00pm.
-Moxifloxacin solution, 1 drop in left eye was documented as administered on 05/12/22 at 8:00am.

Observation of Resident #10's Moxifloxacin eye drop vial on 05/12/22 revealed a printed label that read Moxifloxacin .5% drops, with instructions to

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D 358	Continued From page 37 instill 1 drop into left eye twice daily. Interview with the MA on 05/12/22 at 10:47am revealed: -She confused Resident #10's Moxifloxacin 0.5% eye drops with another eye drop that Resident #10 received later in the day that was ordered for both eyes. -She did not refer to the eMAR or medication label when administering Resident #10's Moxifloxacin which caused her to confuse the medications. -She should have looked at the eMAR and medication label prior to administering Resident #10's Moxifloxacin in order to ensure she gave the resident the right medication according to the order. Interview with the Resident Care Director (RCD) on 05/12/22 at 10:55am revealed: -She expected the MA to administer Resident #10's Moxifloxacin eye drops as ordered. -She expected the MA to compare the eMAR to the medication label, and administer the medication as written on the eMAR. Interview with the Administrator on 05/12/22 at 11:10am revealed he expected Resident #10 to receive her medication as ordered by the primary care provider (PCP). Telephone interview with Resident #10's PCP on 05/13/22 at 2:05pm revealed: -She expected Resident #10 to receive her Moxifloxacin eye drops as ordered. -The resident would not suffer any adverse effects from receiving a drop of Moxifloxacin into her right eye because the medication was absorbed intraocularly.	D 358		

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D 358	Continued From page 38 Based on observations, interviews, and record reviews it was determined Resident #10 was not interviewable. 2. Review with Resident #2's current FL-2 dated 12/24/21 revealed diagnoses included stage 4 kidney disease. Review of Resident #2's nephrologist orders dated 01/24/22 revealed there was an order to change Vitamin D3 to three times a week on Tuesday, Thursday, and Saturday (Vitamin D3 is a supplement used to prevent Vitamin D3 deficiencies in dialysis patients). Review of Resident #2's subsequent physician orders dated 05/05/22 revealed there was an order for Vitamin D3 50mcg, give 1 capsule by mouth in the evening every Tuesday, Thursday and Saturday with instructions to give after dialysis. Review of Resident #2's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3 50 mcg, give 1 capsule in the evening every Tuesday, Thursday, and Saturday after dialysis, scheduled for administration at 5:00pm. -Vitamin D3 50 mcg was documented as administered on 04/02/22 at 5:00pm, 04/05/22 at 5:00pm, 04/07/22 at 5:00pm, 04/14/22 at 5:00pm, 04/16/22 at 5:00pm, 04/19/22 at 5:00pm, 04/23/22 at 5:00pm, 04/26/22 at 5:00pm, 04/28/22 at 5:00pm, and 04/30/22 at 5:00pm. -Vitamin D3 50 mcg was documented as not administered on 04/09/22 at 5:00pm, 04/12/22 at 5:00pm, and 04/21/22 at 5:00pm with reason for not administered documented as 'leave of absence'.	D 358		

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-According to the April 2022 eMAR, Resident #2 did not receive 3 of the 13 ordered doses of Vitamin D3.

Review of Resident #2's May 2022 eMAR revealed:
-There was an entry for Vitamin D3 50 mcg, give 1 capsule in the evening every Tuesday, Thursday, and Saturday after dialysis, scheduled for administration at 5:00pm.
-Vitamin D3 50 mcg was documented as administered on 05/05/22 at 5:00pm.
-Vitamin D3 50 mcg was documented as not administered on 05/03/22 at 5:00pm, 05/07/22 at 5:00pm, and 05/10/22 at 5:00pm with reason for not administered documented as 'leave of absence'.
-According to the May 2022 eMAR, Resident #2 did not receive 3 of the 4 ordered doses of Vitamin D3.

Interview with Resident #2 on 05/12/22 at 9:20am revealed:
-He received dialysis treatment on Tuesday, Thursday, and Saturday.
-He returned to the facility after his dialysis treatments around 4:00pm.
-He normally received his medication after eating supper on his dialysis treatment days.
-He did not remember if he received his Vitamin D3 with his evening medications on dialysis treatment days.

Interview with a medication aide (MA) on 05/12/22 at 2:45pm revealed:
-If Resident #2 was not in the building when the medication 'popped up' on the eMAR to be administered, he documented that the resident was out of the facility on leave.
-Resident #2 was not receiving his Vitamin D3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092024	A. BUILDING: _____ B. WING _____	R 05/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF RALEIGH	3101 DURALEIGH 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 358	Continued From page 40 after dialysis because he was not back in the building from dialysis at the time the medication was scheduled. -Resident #2 sometimes did not return from dialysis treatment until after the medication was due. Interview with the RCD on 05/13/22 at 9:30am revealed: -She was not aware that staff was not administering Resident #2's Vitamin D3 after his dialysis treatment because of the time scheduled on the eMAR. -She expected staff to notify her that he was not back until after it was due to be given, so that she could work with the pharmacy to adjust the scheduled time. -It was important for Resident #2 to receive his Vitamin D3 as ordered because he was a dialysis patient. Interview with the Administrator on 05/13/22 at 4:00pm revealed he expected Resident #2 to receive his medications as ordered. Telephone interview with Resident #2's nephrologist on 05/13/22 at 10:59am revealed: -She wrote the order on 01/24/22 for the resident to receive his Vitamin D3 after his dialysis treatment on Tuesday, Thursday, and Saturday. -She expected the facility to administer the medication as ordered to Resident #2. -She expected the facility to have the medication scheduled at a time that Resident #2 would be in the building back from dialysis.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF RALEIGH	3101 DURALEIGH 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
D912	Continued From page 41 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 physical environment, and supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide ensure 2 of 2 sounding exit door alarms and locks accessible to residents' were in place and properly working in the Special Care Unit (SCU) in which 1 of 7 sampled residents (#6) was able to elope. [Refer to Tag 067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type A2 Violation)]. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 7 sampled residents (#6) based on the resident's assessed needs resulting in the resident eloping from the Special Care Unit (SCU). [Refer to Tag 270, 10A NCAC 13F .0901(b) Supervision (Type A2 Violation)].	D912		