STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL004003	A. BUILDING: _____ B. WING _____	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW TERRACE OF WADESBORO	123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170

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D 000	Initial Comments The Adult Care Licensure Section conducted a Complaint Investigation via off-site desk review and no COVID-19 focused Infection Control survey on July 30-31, 2020 and August 3-7 and 10-11, 2020.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews, and interviews, the facility failed to ensure supervision for 1 of 5 (#1) sampled residents with a diagnosis of dementia who was left outside, unsupervised in the sun for 3 to 4 hours which resulted in a heat stroke. The findings are: Review of Resident #1's current FL-2 dated 01/08/20 revealed: -Diagnoses included post-traumatic stress disorder (PTSD), dementia, unilateral primary osteoarthritis, anxiety disorder, chronic kidney disease Stage 2 and secondary hypertension (HTN). -The resident was intermittently disoriented. -The resident was ambulatory. Review of Resident #1's Resident Register revealed he was admitted to the facility on	D 270		

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D 270	Continued From page 1 12/24/19. Review of Resident #1's assessment and care plan dated 01/20/20 revealed: -The resident was oriented, but he was forgetful and needed reminders. -The resident required supervision with ambulation. -The resident required limited assistance with transferring. Review of the Licensed Health Professional Support (LHPS) evaluation for Resident #1 dated 06/25/20 revealed: -The resident was alert to person only. -The resident ambulated with the use of a wheelchair. Review of Resident #1's accident/incident report dated 07/26/20 at 11:41 am revealed the resident was found on the facility's grounds unresponsive, and he was sent to the Emergency Department (ED). Review of the 911 Communication Notes dated 07/26/20 revealed: -Emergency Medical Services (EMS) staff were dispatched at 11:39 am. -EMS staff arrived on the scene at 11:46 am. -The resident was unresponsive. -EMS staff left the scene at 12:05 pm. Review of the ED visit note for Resident #1 dated 07/26/20 revealed: -The resident was cognitively impaired and oriented to his name. -The resident was assessed with hyperthermia and altered mental status (AMS). -The resident was left outside, and "he got significantly overheated today."	D 270		

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-The resident was unresponsive; and he had sat out in the sun for four hours.
-The resident was sitting outside at an assisted living facility and when the staff went to check on him, he was unresponsive.
-The resident had 2-3 blisters on his abdominal and sunburn of the abdominal wall.
-The resident's rectal temperature was 107 degrees F, and he had a heat stroke.
-"The family did not want Resident #1 to be sent back to the assisted living because they believe he was not cared for adequately there."
-The resident was in the process of being transferred to the hospice house.

Review of the Weather Channel Monthly report for July 2020 revealed on 07/26/20 the high temperature was 92 degrees F, and the low temperature was 70 degrees F.

Review of the hospice notes dated 07/27/20 revealed:
-Resident #1 had a terminal diagnosis of respiratory failure with hypoxia or hypercapnia.
-The resident had multiple blisters on the right side of his chest and right arm.

Telephone interview with Resident #1's family member on 08/10/20 at 1:51 pm revealed:
-The medication aide (MA) notified the family member on 07/26/20 between 12:00 pm and 12:30 pm that Resident #1 was found outside unresponsive, and he had already been sent to the ED.
-The MA did not offer any other information.
-The staff at the hospital reported Resident #1's temperature was 107 degrees F on 07/26/20.
-Resident #1 had blisters on his trunk, stomach, chest and arms, and he had a sunburn on the right side of his face.

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-Resident #1 went to the hospital on 07/26/20, and he was transferred to hospice on 07/27/20 and died on 7/28/20 at the hospice house..
-The resident used a wheelchair as a mode of ambulation, and he would not be able to push the wheelchair, to open the door to go outside.
-The staff would have had to push the wheelchair for the resident and to open the door for the resident to go outside.
-The family member did not see any way Resident #1 could have went outside by himself.

Telephone interview with a personal care aide (PCA) on 08/06/20 at 4:37 pm revealed:
-The MA found Resident #1 outside unresponsive on 07/26/20 around 11:30 am.
-The last time she checked Resident #1 for incontinent care was on 07/26/20 at 7:30 am.
-She did not know when Resident #1 went outside on 07/26/20, but the resident was able to propel his wheelchair and open the door.
-Resident #1 was allowed to go outside unsupervised.
-She went outside at 8:30 am, 10:00 am and 11:00 am on 07/26/20 and Resident #1 was sitting outside in the sun in his wheelchair.
-Resident #1 was rocking back and forth and slouched in his wheelchair and moving his legs as usually his eyes were fully open at 8:30 am and 10:00 am.
-Resident #1 was not rocking back and forth, but he was slouched in his wheelchair, and his legs were not moving, but his eyes were fully open at 11:00 am.
-There were no interactions between her and Resident #1 at 8:30 am, 10:00 am and 11:00 am on 07/26/20.
-Resident # 1 should have been brought back in the facility around 9:30 am for incontinent care.
-She thought Resident #1 was enjoying siting

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D 270	Continued From page 4	D 270		

outside, and she did not bother him.
-This was the first time Resident #1 stayed outside for a long time; usually the resident would go outside for a few minutes, and then come back in the facility.
-There was no policy for how long residents could stay outside.

Telephone interview with a MA on 8/10/20 at 11:52 am revealed:
-She found Resident #1 outside unresponsive on 07/26/20 at 11:20 am.
-Resident #1 was sitting in his wheelchair, and he had on a short sleeve shirt and jogging pants.
-Resident #1 had a pulse of 110 at 11:20 am, and he was breathing.
-She called Emergency Medical Services (EMS) on 07/26/20 at 11:30 am, and EMS staff arrived at the facility around 12:00 pm.
-She alerted the EMS staff that Resident #1 was found outside in the sun unresponsive, and she did not know how long he had been out there.
-The PCA did not know how long Resident #1 had been outside on 07/26/20.
-She notified the Administrator on 07/26/20 at 11:35 am about Resident #1 being found outside unresponsive.
-She notified Resident #1's family member on 07/26/20 at 12:30 pm about Resident #1 being found outside unresponsive.
-She called the ED nurse, and she stated Resident #1 had a heat stroke on 07/26/20.
-The last time she observed Resident #1 in the facility was around 8:00 am when she gave him his medications.
-She did not know when Resident #1 went outside on 07/26/20, but the resident was able to propel his wheelchair and to push the door open.
-Resident #1 was allowed to go outside unsupervised.

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-The PCA should have checked on Resident #1 every two hours.
-She did not know if the PCA checked on Resident #1 every two hours.
-The PCA did not report anything was wrong with Resident #1.
-There was no policy for how long residents could stay outside.

Telephone interview with Resident #1's primary care physician (PCP) on 08/07/20 at 4:17 pm revealed the staff should supervise Resident #1 when he was outside due to his confusion.

Telephone interview with the Administrator on 08/07/20 at 2:41 pm and 08/11/20 at 1:33 pm revealed:
-He was notified by the MA on 07/26/20 at 11:35 am that Resident #1 was found outside unresponsive and needed to be sent to the ED.
-He initially did not know how long Resident #1 had been left outside.
-Resident #1's family member notified him on 07/26/20 at 4:00 pm the resident had been left outside for a long time, based on the resident's diagnosis at the ED.
-On 07/26/20, the Administrator initiated an investigation.
- He interviewed the staff, but they did not know how long Resident #1 had been sitting outside.
-He observed the facility's video recording on 07/27/20 and determined Resident #1 was left outside for 3 hours and 26 minutes on 07/26/20.
-All of the direct staff were responsible for the care of Resident #1.
-The staff should have interacted with Resident #1 when he was sitting outside.
-Resident #1 should have been checked on every two hours.
-The staff responsible for the care of Resident #1

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D 270	Continued From page 6 no longer worked at the facility. -Resident #1 was alert with confusion, but he was allowed to go outside unsupervised. -There was no policy for how long residents could stay outside in the hot or cold weather prior to 07/26/20. -He was notified on 07/27/20 by Resident #1's family member the resident was transferred to hospice and on 07/28/20 the resident died at the hospice house. _____ The facility failed to provide supervision for 1 of 5 sampled residents (#1) who was left outside unsupervised in the sun which resulted in Resident #1 having blisters on the upper part of his body, being unresponsive and suffering a heat stroke with a body temperature of 107 degrees F. The facility's failure to supervise Resident #1 resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation for neglect. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/10/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED September 10, 2020.	D 270		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record reviews and interviews, the	D914		

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D914	Continued From page 7 facility failed to assure each resident was free of neglect related to supervision. The findings are: Based on record reviews, and interviews, the facility failed to ensure supervision for 1 of 5 (#1) sampled residents with a diagnosis of dementia who was left outside, unsupervised in the sun for 3 to 4 hours which resulted in a heat stroke. [Refer to Tag D 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]	D914		