Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051041	A. BUILDING: ____ B. WING ____	R 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAYTON HOUSE	145 DAIRY ROAD CLAYTON, NC 27520

(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 a follow- up survey from 10/25/22 to 10/26/22.	{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: FOLLOW- UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations and interviews, the facility failed to provide supervision for a facility licensed as a Special Care Unit during a time when the front door was malfunctioning resulting in 1 of 5 sampled residents (#5) with a diagnosis of dementia and wandering behaviors eloping from the facility without staff knowledge. The findings are: Review of the facility ' s current 2022 license revealed the facility was licensed as a special care unit (SCU) with a 60-bed capacity. Review of Resident #5 ' s current FL-2 dated 04/19/22 revealed:	{D 270}		

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-Diagnoses included dementia, expressive aphasia, and anxiety.
-The recommended level of care was a SCU.
-He was ambulatory and had wandering behaviors.
-There was no documentation related his orientation status.

Observations on 10/25/22 at 8:45am revealed:
-The front door was locked and there was a doorbell at the door.
-The staff unlocked the front door from the inside of the building using a keypad.
-There was a sounding device that sounded while the door was opened, but immediately stopped sounding when the door was closed.
-The staff did not have to deactivate the sounding device.
-There were 4 other exit doors throughout the facility that had the same type of sounding device and keypad as the front door.
-The sounding devices were not controlled by the keypad and were not connected to a fire panel.

Observation of Resident #5 on 10/25/22 at 2:00pm revealed Resident #5 was at the 200 hall exit door attempting to push the door opened and pushing buttons on the key pad.

Review of an accident/incident report for Resident #5 dated 10/14/22 revealed:
-At approximately 6:15pm, Resident #5 eloped from the facility and returned with no injuries sustained.
-Resident #5 ' s primary care provider (PCP), family member and the adult home specialist were notified.
-Resident #5 was placed on increased supervision, the door codes were changed, and the contracted company was notified and

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{D 270}	Continued From page 2	{D 270}		

assessed the doors.

Interview with a medication aide (MA) on 10/26/22 at 9:20am revealed:
-On the evening of 10/14/22, she was in the dining room assisting residents with supper when the medical complex center across the street from the facility called and informed them Resident #5 was there.
-The staff got Resident #5 from across the street, he was assessed with no injuries noted, and placed on safety checks every 15 minutes.
-She had last seen Resident #5 in the dining room approximately 20 minutes prior to the medical complex center calling.
-The alarming device on the exit doors sound when the doors were opened, and automatically turned off when the doors were closed.
-She did not remember hearing the door alarm sounding on 10/14/22.
-She was informed earlier that date that the front door was not functioning properly, and the door had to be unlocked using the keypad on the inside of the building.
-The door was locked prior to supper.
-It was the responsibility of the MA to check all exit doors to ensure they were locked every hour and the personal care aides (PCA) to check the exit doors every 2 hours.
-The exit door safety checks were documented by the MA and the PCA in a binder at the nurses station.

Interview with the Maintenance Director on 10/26/22 at 9:48am revealed:
-On 10/14/22, at approximately 8:30am, he was alerted by staff that the front exit door was not functioning properly.
-He checked the door and noted the door would not unlock using the keypad on the outside of the

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building but would unlock if the keypad was used on the inside of the building.
-He removed the keypad on the outside of the building, tested it, but could not figure out what the problem was.
-He placed a note on the outside of the building notifying the staff to use the doorbell and wait to be let inside of the facility.
-He checked the door about 15 - 20 times throughout the day and there were times that the door was able to be pushed opened without having to use the keypad.
-He reset the keypad several times by putting the code in continuously, and the door would eventually lock.
-He notified his corporate point of contact and informed them of the door issue and was informed someone would be out to the facility on Monday, 10/17/22, to check the doors.
-He did not receive any guidance related to ensuring the doors were locked until the contracted company was able to come check the doors.
-There was no staff that sat at the door while the door was not functioning properly.
-He checked the exit doors before leaving for the day at approximately 3:00pm on 10/14/22, and the front door was still locked.
-He received a call from the facility on 10/14/22 at approximately 6:00pm - 6:30pm and was informed that Resident #5 got out of the facility.
-He returned to the facility, reset the keypad on the front door, and was able to get the front door to lock.
-He came to the facility on that 10/15/22 and 10/16/22 to check the exit doors and noted them to be locked.
-On 10/17/22, a contractor came to out to the facility and replaced the keypad on the outside of the front door and the staff were able to unlock

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{D 270}	Continued From page 4 the front door using the outside keypad. Interview with the Resident Care Director (RCD) on 10/26/22 at 12:30pm revealed it was the responsibility of the MA and the PCA to check the exit doors hourly to ensure they were locked and document the checks in a binder at the nurse ' s station. Interview with the Administrator on 10/26/22 at 8:45am revealed: -On the evening of 10/14/22, Resident #5 eloped from the facility and walked across the street to a medical complex. -Resident #5 was eating supper and after he finished, he left from the dining room. -The medical complex called the facility and informed them that Resident #5 was across the street. -The staff drove across the street and brought Resident #5 back to the facility and he was placed on safety checks every 15 minutes. -There were no injuries sustained. -Earlier that same date, she and the Maintenance Director was made aware by staff that the front door was not working properly. -The staff were trying to enter the front door using the keypad, but the door would not unlock. -The Maintenance Director worked on the doors, informed the Administrator and staff that the keypad on the outside of the door was inoperable so the staff inside the building had to let staff and visitors in. -The staff were to ring the doorbell outside to alert the staff inside for entry. -The Maintenance Director and staff checked the front exit door every 30 minutes that date to ensure that the door was locked. -The door was not unlocked during the 30 minutes checks they completed throughout the	{D 270}		

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day.
-It was the expectation that a staff member should be on the halls to monitor residents as they exited the dining room.

A third interview with the Administrator on 10/26/22 at 2:44pm revealed resident #5 could have fallen or gotten hit by a car when he eloped from the facility on 10/14/22.

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The facility failed to provide supervision of all residents residing in a licensed Special Care Unit when the front entrance door which all residents had access was malfunctioning. This resulted in Resident #5 eloping from the facility without staff ' s knowledge, traveling across the street and to another medical facility where she was found by a medical office staff. This failure resulted in substantial risk for harm and constitutes a Type A2 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/26/22 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED November 25, 2022.

{D912} G.S. 131D-21(2) Declaration of Residents' Rights {D912}

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.

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{D912}	Continued From page 6 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free from mental and physical abuse, neglect, and exploitation and in compliance with relevant federal and state laws and rules and regulations related to Personal Care and Supervision. The findings are: 1. Based on observations and interviews, the facility failed to provide supervision for a facility licensed as a Special Care Unit during a time when the front door was malfunctioning resulting in 1 of 5 sampled residents (#5) with a diagnosis of dementia and wandering behaviors eloping from the facility without staff knowledge.[Refer to Tag 270 10A NCAC 13F. 0901(b) Personal Care and Supervision (Type A2 Violation)]	{D912}		