STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 and the Mecklenburg County Department of Social Services conducted a complaint investigation and a COVID-19 Infection Control Survey with an onsite visit on 08/12/20, a desk review survey on 08/03/20, 08/04/20, 08/05/20 08/06/20, 08/07/20, 08/10/20, 08/11/20 and a telephone exit on 08/13/20. The Mecklenburg County Department of Social Services initiated the Complaint Investigation on 08/03/20.	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 A2 VIOLATION Based on interviews, observations and record reviews the facility failed to provide supervision to 1 of 5 sampled residents (Resident #1) who had a diagnosis of dementia and a history of elopement, which resulted in Resident #1 eloping from a locked special care unit (SCU). The findings are: Review of Resident #1's FL-2 dated 08/13/19 revealed: -Diagnoses included dementia, open reduction and internal fixation of left hip. -A recommended level of care listed Special Care	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 1 Unit (SCU). -Resident #1 was constantly disoriented. -There was no documentation for wandering or exit seeking behavior. Review of Resident #1's Resident Register revealed Resident #1 was admitted to the SCU on 03/27/18. Review of Resident #1's Care Plan dated 08/24/19 revealed: -Resident #1 was independent with ambulation and transferring. -Resident #1 required supervision with toileting and grooming/personal hygiene. -There was no additional information regarding Resident #1's supervision needs. Review of the facility's Elopement/Unauthorized Absence Policy dated 10/03/19 revealed: -The facility will identify residents with potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement the facility will implement its policies and procedures promptly to locate the resident in a timely manner. -Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervisions to do so. -All residents will be assessed for the risk of elopement using the Elopement Assessment on admission, quarterly, and as needed. -When the Elopement Assessment score is 4 or higher, the resident is identified as "at risk for elopement". -Residents identified at risk will have interventions promptly implemented to reduce the risk of elopement.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 2	D 270		

-The resident's physician will be notified of risk and recommended interventions.
-The resident's responsible party will be informed of potential risk and interventions being implemented to provide for the resident's safety.
-Residents identified at risk will have their picture and face sheet placed in a binder that is kept in an area accessible by staff.

Review of Resident #1's Wandering/Elopement Risk Review Form dated 07/31/19 revealed:
-Resident #1 scored a 12, at risk for elopement.
-Resident #1 had attempted to leave or had successfully left environment, exhibits exit seeking behaviors.
-Resident #1 was placed on a wander guard system with increased supervision.
-A urinalysis was obtained.

Review of Resident #1's Wandering/Elopement Risk Review Form dated 08/13/19 revealed:
-Resident #1 scored a 12, at risk for elopement.
-Resident #1 for had attempted to leave or had successfully left environment, exhibits exit seeking behaviors.
-Resident #1 was moved to the SCU to prevent another elopement.

Review of Resident #1's Wandering/Elopement Risk Review Form dated 08/03/20 revealed:
-Resident #1 scored a 12, at risk for elopement.
-Resident #1 had attempted to leave or had successfully left environment, exhibits exit seeking behaviors.
-There were no interventions documented on the form.
-There was no documentation Resident #1 was wearing a wander guard in the SCU.

Review of Resident #1's incident report dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 3	D 270		

08/03/20 revealed:
-Resident #1 had eloped from the SCU on 08/01/20.
-Resident #1 was found outside the front door by Emergency Medical Services (EMS) around 3:00am.
-Resident #1's responsible party was notified.
-Resident #1's physician was notified.
-Follow-up intervention included increased supervision and to monitor Resident #1 for increased wandering.

Observation on 08/12/20 at 11:55am revealed:
-The SCU required entrance via code entry through a keypad at each exit door.
-There were 2 corridors with the resident bedrooms on each side.
-The SCU consisted of a kitchen and dining area and adjoining living room with 2 magnetically locked exit doors to the outside area.
-Adjacent to each exit door was an override switch with a clear plastic cover affixed with a red pull tab to prevent residents' access to the switch.
-On the outside of the exit door there was a six to eight inch drop off from the sidewalk.
-Near the sidewalk was a hill leading to a wooded area and a paved parking lot.
-A four lane business street was located approximately 30 feet from the front door of the facility.

Review of Resident #1's progress note dated 08/01/20 revealed:
-Resident #1 was found outside the front door by EMS at 3:00am.
-Resident stated, "I don't know."
-The medication aide brought her back to her room.
-There was documentation, "No injuries."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 4	D 270		

Telephone interview with an EMS paramedic on 08/10/20 at 4:35pm revealed:
-They arrived at the facility on 08/01/20 at approximately 2:53am to return a different resident from the hospital.
-While waiting for staff to answer the doorbell, a paramedic observed a female resident (Resident #1) sitting on a bench outside in front of the building.
-Resident #1 was wearing a pink night gown that reached below the knee with no shoes or socks on her feet.
-She asked Resident #1 what she was doing, Resident #1 responded, "Just chilling."
-The facility staff did not answer the door bell, so she had to contact the EMS office to call the facility to get someone to open the facility's door and to make them aware Resident #1 was sitting outside in her pajamas.
-When staff opened the door, the paramedic pointed to Resident #1 and informed the staff, "assume she was one of yours."
-The staff member gasped, put her hands over her chest, and went back inside the building leaving Resident #1 outside.
-The paramedic attempted to guide Resident #1 back into the facility while holding the door, but Resident #1 refused.
-Another facility staff member came and assisted Resident #1 back into the SCU in the facility.

Interview with Resident #1's responsible party on 08/12/2020 at 6:38pm revealed:
-Resident #1 was admitted to the facility's assisted living unit in March of 2018.
-Resident #1 had been in the SCU for about a year to a year and half.
-Resident #1 was ambulatory.
-On 08/01/20 at approximately 5:30am, she received a call from staff informing her that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 5	D 270		

Resident #1 had eloped from the SCU.
-Resident #1 was found sitting in front of the building by EMS and Resident #1 was unharmed.
-Resident #1 was in the SCU because Resident #1 had previously eloped when she lived on the assisted living side of the building.
-She was not aware of any interventions the facility had put in place to address Resident #1's behaviors or increased supervision after the elopement on 08/01/20 from the SCU.
-It was her understanding the SCU exit doors were locked and equipped with alarms.
-She discussed with the Administrator why staff had not heard the alarm sounding when Resident #1 eloped.
-The Administrator told her he would see if it was possible to make the door alarm sound until the staff person physically turned the alarm off by the keypad or by a key.

Telephone interview with a personal care aide (PCA) on 08/10/20 at 1:29pm revealed:
-She had worked on the SCU the night Resident #1 eloped.
-She was assisting another staff member on assisted living side when a staff member informed her, she had heard an alarm.
-Resident #1 resided on the 400 hall in the SCU.
-Two staff completed a head count of the residents on the 300 hall.
-She had completed a head count on the end of the 400 hall while another staff conducted the head count on the top of the 400 hall.
-The facility had lost power for about three hours a couple days before the elopement.
-There were problems with the facility's alarm system after the facility lost power a couple days before the elopement.
-Management was aware of the problems with exit door alarm system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 6	D 270		

-The red tab for the clear cover for the override switch was broken on the 400 hall, and the switch was turned off.
-Staff notified the Resident Care Director, RCD on 08/01/20, who advised them what steps to take to ensure all residents were accounted for.
-Emergency Medical Service discovered Resident #1 outside on 08/01/20 around 3:00am.
-Resident #1 was moved to SCU after her elopement from the assisted living, but she did not recall when that elopement occurred.
-She was aware of the facility had an elopement policy.
-The facility had conducted an elopement training on 08/06/20.

Telephone interview with a second PCA on 08/10/20 at 2:10pm and on 08/11/2020 at 1:26pm revealed:
-Resident #1 was known for walking around the facility at night, "that's what she does."
-She recalled Resident #1 wandering around the SCU on 08/01/20 around 1:00am.
-She checked on her assigned residents every 2-hours.
-When staff informed her about hearing the alarm, she immediately checked on the residents, but she did not check the side where Resident #1 resided.
-She was not aware that she was assigned to Resident #1.
-She did not hear the alarm sounding on 08/01/20.
-The sound of the alarm was typically loud enough to hear in the building.
-She did not take another PCA seriously about hearing the alarm on 08/01/20, because that PCA was known to "joke a lot in the facility."
-The exit door on the 400 hall was the only door in the SCU where the emergency override switch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 7	D 270		

was in the off position to open the exit door without a code.
-EMS alerted staff on 08/01/20 that Resident #1 was sitting in front of the building.

Telephone interview with a third PCA on 08/11/2020 at 12:34pm revealed:
-She worked on 08/01/20 on the assisted living side of the facility.
-On the evening when Resident #1 eloped, a SCU staff came to her and asked if she heard the alarm.
-She had not heard an alarm; the alarm could not be heard on the assisted living side of the building.
-Staff checked the fire emergency panel to determine if the panel showed where an alarm may have sounded.
-There were no alerts on the panel.
-She checked fire emergency panel on the assisted living side of the building, and there was an alert on the 300 hall.
-She went to the SCU to check the residents on the 300 hall; all residents were accounted for.
-She did not check the residents on the 400 hall.
-EMS returned another resident to the facility on 08/01/20 and found Resident #1 outside in front of the building.
-She was told by the MA to contact the RCD on 08/01/20 in regard to resident 31 and the elopement.
-The RCD informed to tell the MA to complete a body audit on Resident #1 after she returned to the SCU.
-There was an issue with the power going out in the facility a couple days before the elopement.
-The Maintenance Director could not get the monitor to come back on and called to get the sound system connected to the alarm system back up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 8 -On 08/01/20 when Resident #1 eloped out of the SCU, the emergency panel did not show that the exit door to the 400 hall was opened. -Resident #1 had previously eloped from the assisted living side of the building last year and was moved to the SCU after that elopement. Telephone interview with the Maintenance Director on 08/10/20 at 3:01pm revealed: -The safety tab was broken on the clear protective cover for the override switch on the 400 hall. -With the safety tab broken, anyone could lift the box and turn the emergency override switch off to exit out the emergency exit door. -There was nothing wrong with the alarm system. -The override switch to the emergency exit door to the 400 hall was turned off. -No one knew who turned the emergency override switch off. -If the cover was lifted, an alarm would sound until the clear cover was closed. -The switch to the maglock was turned off when the switch was in the down (off) position. -The keypad beside the override switch worked as a bypass to unlock the emergency exit door. -The code was not needed to open the exit door if the emergency override switch was turned down in the off position. -There was a second alarm that would sound the emergency exit door was physically opened. -The door alarm was supposed to sound for approximately 1-2 minutes when the door was opened. -It was mostly unlikely to hear the alarm sound on the assisted living side because of the fire doors. -Once the exit door was closed, the alarm would reset and stop alarming. -On the outside of the exit door here was a small concrete drop-off that went around the front	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 9	D 270		

entrance of the building.
-If Resident #1 had stepped off the concrete drop-off, there was a possibility that she could had fallen because there was a 6-8 inch drop off on the concrete.
-There was a hill off the concrete pad that lead to a wooded area and a paved parking lot.
-There was lighting in the back of the building, but there was no fence just a wooded area.
-There had been a power outage a few days before Resident #1 elopement from the SCU which affected the alarm panel system.
-The alarm panel system outage had been restored and was fully functional on the night Resident #1 eloped from the SCU on 08/01/20.

Interview with the Resident Care Director (RCD) on 08/12/20 at 11:55am revealed:
-On the evening Resident #1 eloped from the SCU she received a call from a PCA who informed her the MA reported hearing an alarm inside of the facility between 2:00am to 2:30am.
-The PCA was working on the assisted living side of the building.
-The PCA told her staff working in the SCU "were not moving" when informed about the alarm.
-A PCA on the SCU had "half checked on her residents.
-Resident #1 "probably got out of the building" on 08/01/20 between 2:00 or 2:30am because she received a telephone from the hospital around 1:50am that another resident was returning to the facility.
-She expected staff to follow the policy and procedures for elopement when staff reported hearing the alarm.

Telephone interview with the medication aide who worked the night of the elopement on 08/10/20 at 1:55pm was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 10 Telephone interview with a fourth PCA who worked the night of the elopement on 08/10/20 at 3:00pm was unsuccessful. Telephone interview with Resident #1's primary care physician on 08/23/20 at 8:00am revealed: -Resident #1 was admitted to the SCU for increased supervision due to her wandering behavior. -He expected staff to supervise all residents in the SCU. -The facility notified his office on 08/01/20 that Resident #1 had eloped and was returned to the SCU without injury. -He was not aware of any documented attempts of Resident #1 trying to exit from the SCU. Interview with the Administrator on 08/12/20 at 12:45pm revealed: -Staff made him aware on 08/01/20 Resident #1 had eloped from the SCU on 08/01/20. -The staff were not aware how Resident #1 eloped from the SCU. -He was aware EMS found Resident #1 outside near the front entrance to the facility around 3:00am on 08/01/20. -He and the RCD conducted an internal investigation to find out how Resident #1 had eloped from the SCU and reported the incident to the Health Care Personal Registry. -His expected staff to check all the residents in the SCU when the alarm sounded on 08/01/20. -The exit alarm was fully functional on 08/01/20. _____ The facility staff failed to provide increased supervision to Resident #1 diagnosed with dementia and a history of elopement, who resided in the locked SCU. Resident #1 was found outside the facility near the front entrance	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 270	Continued From page 11 by EMS at 3:00am. The facility is located near a business 4 lane street with a wooded area in the back of the facility. Staff were unaware Resident #1 had eloped from the SCU and failed to respond to the alarm system identifying the door leading outside of the SCU had been opened. This failure of the facility staff resulted in substantial neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/10/ 20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 13, 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 observation, interview and record review, the facility failed to ensure residents were free of neglect related to health care. The findings are: Based on interviews, observations and record reviews the facility failed to provide supervision to 1 of 5 sampled residents (Resident #1) who had a diagnosis of dementia and a history of elopement, which resulted in Resident #1 eloping from a	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R 08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
D914	Continued From page 12 locked special care unit (SCU). [Refer to Tag 271 10A NCAC 13F .0901 (b) Personal Care and Supervision (Type A2 Violation)].	D914		