STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
			7 56.25(6		R
		FCL008029	B. WING		12/29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
VIRGINIA'	S PLACE		VERNOR'S ROAI)	
			R, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 000	Initial Comments		C 000		
	_				
C 069	10A NCAC 13G .0312 Exits	2(g) Outside Entrance And	C 069		
	Exits (g) In homes with at I determined by a phys to be disoriented or a for resident use shall sounding device that opened. The sound sthat it can be heard by of remote sounding do control panel for the sthe bedroom of the peor in a location access by the administrator to This Rule is not met a TYPE B VIOLATION Based on observation reviews, the facility fadoors were equipped was audible througho was opened and access.	is activated when the door is shall be of sufficient volume by staff. If a central system evices is provided, the system shall be located in erson on call, the office area sible only to staff authorized to operate the control panel. as evidenced by: as, interviews and record iled to ensure 3 of 3 exit with a sounding device that the facility when the door essible to 1 of 3 sampled and a history of wandering in a increased paranoia,			
	The findings are:				
	Review of a facility po 04/01/20 revealed:	licy for door alarms dated			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		` '	(X3) DATE SURVEY COMPLETED	
					R		
		FCL008029	B. WING		12/29/2	2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
VIRGINIA'	S DI ACE	1517 GOV	/ERNOR'S ROA	D			
VIICOINIA	OT LAGE	WINDSOI	R, NC 27983				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE 0	(X5) COMPLETE DATE	
C 069	Continued From page	e 1	C 069				
	-Any employee who had proceed to the area at alarmThe staff member with alarm, look for reside have caused the door -The surrounding are checkedBefore deactivating at employee will identify rectify cause and/or the surrounding area of a be lost or eloping from -If an employee deact find cause, the employeit situation immediately -The employee will contain the staff of the s	alarm, the responding I the cause for alarm and horoughly check Ilarm for a resident who may In the facility. Itivates an alarm and did not byees must report the					
	12/01/22 revealed dia schizophrenia, interm anxiety, depression a disability. Review of Resident #	ittent explosive disorder, ind moderate intellectual 3's Resident Register dated					
	03/13/22 revealed the 04/07/22 and was for	e resident was admitted on getful.					
	12/01/22 revealed: -The resident had wa care and was verbally -The resident was for reminders and was so						

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05/04/22 revealed:

STATE FORM 6899 G30Z11 If continuation sheet 2 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
			A. BOILDING.			_
		FCL008029	B. WING		12	R / 29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
		1517 GO	VERNOR'S ROAD			
VIRGINIA	S PLACE	WINDSO	R, NC 27983			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETE DATE
C 069	Continued From page	2	C 069			
	-The resident had wa	ndering behaviors, resisted				
	care and was verbally					
	-The resident was for					
	reminders and was so	ometimes disoriented.				
	Observation of the tw	o-lane highway in front of				
		2 at 9:20am revealed the				
	speed limit was 55 m					
	Observation of the ex	it doors on 12/29/22 at				
	8:10am revealed:					
		arm on the front door which				
	led into a bedroom fo	r Resident #3 and his				
	roommate.	0. 19.1				
		arm on the kitchen door				
	turned off position and	the backyard, but it was				
	opened.	d did flot alaim when				
	-	arm on the side door which				
		out it was turned off and did				
	not alarm when open					
	a. Review of Residen	t #3's discharge summary				
	from an inpatient psyd 06/17/22 revealed:	chiatric hospital dated				
	-The resident was ad	mitted to an inpatient				
	psychiatric hospital ui	nder involuntary status and				
		ntary status from 05/29/22 to				
	06/17/22 with a disch					
		oderate intellectual disability.				
		mitted due to paranoia,				
	_	away from the facility on				
		g to return to the facility.				
		d additional information from				
	the facility Administra	or. ported that Resident #3				
		used to come back to the				
	home or to get in the					
		id to contact the local police				
		was wandering down the				

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STATE FORM 6899 G30Z11 If continuation sheet 3 of 16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_	
		FCL008029	B. WING		R 12/29/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
VIRGINIA'	S PLACE	1517 GOVE WINDSOR,	RNOR'S ROA	D		
0/0.15	SHMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 069	Continued From page	3	C 069			
	road and refused to c	ome back to the facility. ported that the resident				
	b. Review of a discha #3 from an inpatient po 09/07/22 revealed: -The resident was ad inpatient hospital und 08/30/22 to 09/07/22 of schizophrenia and disabilityThe resident was ad-The Administrator ob commitment due to the and walking in the mi 08/30/22The Administrator rechange in his behavioration and in the minus medications were the Administrator rechange in his behavioration and and refused to greturn to the facilityShe notified local law the local hospital inparamount of the property would stand for long property in the standard	mitted due to paranoia. Intained an involuntary The resident acting recklessly ddle of the road on Interpret that she noticed a The row weeks ago. Interpret that she did not think Interpret that the resident had Interpret that the middle of the Interpret the car with her and Interpret that the resident to the car with her and Interpret that the resident that the resident Interpret that th				
	him a chair so he cou was outside between Interview with a medi 12/29/22 at 8:20am re -She did not know wh in the kitchen was tur	evealed: ny the alarm on the exit door ned off.				
		y it did not alarm when she ly needed new batteries or				

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STATE FORM 6899 G30Z11 If continuation sheet 4 of 16

Division of Health Service Regulation						
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					1 _	
					R	
		FCL008029	B. WING	· · · · · · · · · · · · · · · · · · ·	12/2	9/2022
		07055740	DD500 01TV 0T4	TE 710 000E		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ALE, ZIP CODE		
VIRGINIA	S DI ACE	1517 GOV	'ERNOR'S ROA	D		
VIICOINIA	3 FLAGE	WINDSOF	R, NC 27983			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	<u></u>	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	≀IATE	DATE
				DEFICIENCY)		
0.000			0.000			
C 069	Continued From page	2 4	C 069		ļ	
	needed to be replace	d			ļ	
					ľ	
		trator checked all door			ľ	
	alarms yesterday.				ļ	
	_	ninistrator removed the exit			ļ	
	door alarm sounding	device from the front door			ļ	
	yesterday when they	realized it was not attached			ľ	
	correctly and did not	work.			ļ	
	-The alarm on the fro	nt door was not attached			ļ	
		ing down from the door.			ļ	
		w long the alarm on the front			ļ	
		ng down and not attached			ľ	
	_	ig down and not attached			ļ	
	correctly.	1.0.00			ļ	
		oor alarms on at 9:00pm			ļ	
	each evening and tur	ned them off at 6:00am.				
					ļ	
	Interview with the Adr	ninistrator on 12/29/22 at			ļ	
	11:24am revealed:				ļ	
	-She removed the do	or alarm device from the			ļ	
	front door on 12/28/22	2 at approximately 8:00pm			ľ	
		on aide (MA) informed her			ļ	
		nanging off the front door.			ľ	
		nt door alarm checks but			ļ	
	were expected to test				ļ	
		o monitor the door alarms to			ļ	
	·				ļ	
	ensure they worked o	,			ļ	
		rned on each evening at			ļ	
		f each morning at 6:30am.			ľ	
		(MA) did not sleep at night.			ļ	
	-All exit doors should	have been alarmed from			ļ	
	7:30pm to 6:30am to	ensure resident safety.			ļ	
					ļ	
	Telephone interview v	vith a licensed practical				
		ent #3's psychiatrist's office			ĺ	
	on 12/29/22 at 11:50a	· ·				
		om should not be located				
		the front porch that led to a				
	two-lane highway.					
		about his safety when he				
		oia, agitation and wandered				
	away from the facility					

Division of Health Service Regulation

STATE FORM 6899 G30Z11 If continuation sheet 5 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		FCL008029	B. WING		R 12/29/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
VIRGINIA'	S PLACE		ERNOR'S ROA	D	
VII. (3)		WINDSOF	R, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 069	Continued From page	e 5	C 069		
	care physician (PCP) revealed: -He was not aware R into the road and wor facilityHe was not aware R paranoia and agitatioHe was concerned the exited to the front por roadStaff needed to reloct to ensure his safetyResident #3 could have	with Resident #3's primary on 12/29/22 at 3:33pm esident #3 had wandered ald not return with staff to the esident #3 had increased in. The hat Resident #3's bedroom inch that led to a two lane eate Resident #3's bedroom eave been injured or died if he en door alarms were not			
	properly equipped wit to a resident that had paranoia, agitation ar elopements which plaincreased risk of injur was detrimental to the of the resident and control of the	y and/or death. This failure e health, safety, and welfare onstitutes a Type B Violation. yas submitted by the facility S. 131D-34 on 12/29/22.			
C 246	10A NCAC 13G .090	2(b) Health Care	C 246		
		2 Health Care assure referral and follow-up nd acute health care needs			

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STATE FORM 6899 G30Z11 If continuation sheet 6 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:		, ,	E SURVEY PLETED		
						R	
		FCL008029	B. WING		12	2/29/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE			
VIRGINIA	'S PLACE		VERNOR'S ROAD				
		WINDSC	DR, NC 27983				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
C 246	Continued From page	e 6	C 246				
	of residents.						
	This Rule is not met TYPE A2 VIOLATION						
	reviews, the facility fa care provider (PCP), of increased paranoia elopements, one in w	ns, interviews, and record illed to ensure the primary or psychiatrist were notified a, agitation, and three hich the resident was found way for 1 of 3 sampled					
	The findings are:						
	Review of Resident #3's current FL-2 dated 12/01/22 revealed diagnoses included schizophrenia, intermittent explosive disorder, anxiety, depression and moderate intellectual disability.						
		3's Resident Register dated resident was admitted on forgetful.					
	12/01/22 revealed: -The resident had wa care and was verbally -The resident was for						
	05/04/22 revealed: -The resident had wa care and was verbally -The resident was for reminders and was so	getful and needed ometimes disoriented.					
	Review of an elopem	ent policy dated 04/01/20					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		FCL008029	B. WING		R 12/29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	0.01.4.05	1517 GOV	ERNOR'S ROA	D	
VIRGINIA'S PLACE WINDSOR			R, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 246	Continued From page	e 7	C 246		
	revealed: -There was an Identifithose at risk of wanderThe staff completed admission for resident wanderingThe assessment incit the resident's ability to decision making ability decision making ability does the resident exhagitationStaff were educated behavior, identify the preventing potential exthem immediately to the Review of facility file was no Identification for Resident #3. Review of Resident # (PCP) visit note dated	ication and Assessment of ering. an assessment at ats that were at risk of sudded questions related to a ambulate independently, by, history of wandering, and hibit restlessness and/or ato monitor for changes in warning signs to aid in elopements by reporting the Administrator. on 12/29/22 revealed there and Assessment completed 3's primary care provider to 05/02/22 revealed to report			
	any paranoid thoughts, hallucinations or anxiety to his office or after hours go to the hospital emergency department. a. Review of Resident #3's discharge summary from an inpatient psychiatric hospital dated 06/17/22 revealed: -The resident was admitted to an inpatient psychiatric hospital under involuntary status and then changed to voluntary status from 05/29/22 to 06/17/22 with a discharge diagnoses of schizophrenia and moderate intellectual disability. -The resident was admitted due to paranoia, agitation, wandering away from the facility and refusing to return to the facility. -The hospital obtained additional information from the facility's Administrator.				
	-	ported that Resident #3			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		FCL008029	B. WING		12/29/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE	
VIDONIA	O DI AGE	1517 GOV	ERNOR'S ROA	ND.	
VIRGINIA'	5 PLACE	WINDSOR	, NC 27983		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	O BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
			+	·	
C 246	Continued From page	e 8	C 246		
	became paranoid, ref	fused to come back to the			
	facility or to get in the				
		ad to contact the local police			
		was wandering down the			
	road and refused to d	come back to the facility.			
	-The Administrator re	ported that the resident			
	requested to go to the	e hospital yesterday			
	(05/28/22).				
		(a) Bab : "			
	**	3's PCP visit note dated			
	06/23/22 revealed to	report any paranoid ons or anxiety to his office or			
	after hours go to the				
	department.	nospital enlergency			
	department.				
	b. Review of a discha	arge summary for Resident			
		osychiatric hospital dated			
	09/07/22 revealed:	,			
	-The resident was ad	mitted to a psychiatrist			
		ler involuntary status from			
		with discharge diagnoses of			
	I	oderate intellectual disability.			
		mitted due to paranoia.			
		otained an involuntary			
		ne resident acting recklessly			
	and walking in the mi 08/30/22.	dule of the road off			
		ported that she noticed a			
	change in his behavio				
	_	ported that she did not think			
	his medications were				
		ported that the resident had			
		aw him in the middle of the			
	_	get into the car with her and			
	return to the facility.				
		v enforcement to take him to			
	• •	atient behavioral health unit.			
		ported that the resident			
		periods of time outside the			
	facility due to his para	anoia; staff had tried to give			

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	n rieaith Service Negu		1		1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
			B. WING		R	
		FCL008029	B. WING		12/29	9/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		
VIRGINIA'	S PLACE		ERNOR'S ROA	ט		
		WINDSOR	, NC 27983			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
			1	DEFICIENCY)		
C 246	Continued From page	, Q	C 246			
0 2-10	Continued From page	3 3	0 240			
	him a chair so he cou	ld sit down outside, and he				
	was outside between	2:00am-3:00am at times.				
	c. Review of an incide	ent report for Resident #3				
	from a local day progr					
	revealed:	am dated 55/2 1/22				
		away from the day program				
	during a morning brea					
		ompted to return to the day				
	· -	to return and continued to				
	walk away from the fa					
	-Staff located the resi	-				
		encouraged to get inside the				
	staff's vehicle so he c	ould return to the day				
	program.					
	-The day program sta	Iff notified the Administrator				
	of his elopement, sev	ere psychosis, and				
	agitation.					
	•	iff notified the Administrator				
		e day program would notify				
	her if Resident #3 cou					
	program.	and rotalin to the day				
	program.					
	Observation of Reside	ent #3 on 12/20/22 at				
	-	vas sitting on a couch in the				
		S .				
	living room watching t	television alone.				
	Interview with a medic					
	12/29/22 at 7:45am revealed: -Resident #3 did not attend the day programThe resident had attended the day program but walked away from the program in September					
	2022 and was not allo	owed to return.				
	-Resident #3 would go	et upset at times and				
	•	operty outside to calm				
	down.	, ,				
		wanted to be alone when he				
	was agitated or upset					
	was ayılaled or upsel	•				

Division of Health Service Regulation

Second interview with a MA on 12/29/22 at

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NAME OF PROVIDER OR SUPPLIER FCL088029 **STREET ADDRESS, CITY, STATE, ZIP CODE** 1517 GOVERNOR'S ROAD WINDSOR, NC 27983 **STREET ADDRESS, CITY, STATE, ZIP CODE** 1517 GOVERNOR'S ROAD WINDSOR, NC 27983 **STREET ADDRESS, CITY, STATE, ZIP CODE** 1517 GOVERNOR'S ROAD WINDSOR, NC 27983 **STREET ADDRESS, CITY, STATE, ZIP CODE** 1517 GOVERNOR'S ROAD WINDSOR, NC 27983 **CRUSS, REFERENCED OF THE ADDRESS, CRUSS, REFERENCED OF THE ADDRESS, THE SECRED	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		, , ,	E SURVEY PLETED	
NAME OF PROVIDER OR SUPPLIER **STREET ADDRESS, CITY, STATE, ZIP CODE** **STREET ADDRESS, CITY, STATE, ZIP CODE** **STREET ADDRESS, CITY, STATE, ZIP CODE** **STATE CANDESS ROAD WINDSOR, NC 27983 **PROVIDERS PLAN OF CORRECTION COMPANY STATEMENT OF PERSONNESS PULL (PORT OF THE ADDRESS OF				A. BUILDING:			
VIRGINIA'S PLACE SUMMARY STATEMENT OF DEFICIENCISS PREFIX SUMMARY STATEMENT OF DEFICIENCISS PREFIX PREFX PR			FCL008029	B. WING		12	
WINDSOR, NC 27983 ID PROVIDER'S PLAN OF CORRECTION CASE PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PROVIDER'S P	NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STATE	E, ZIP CODE		
WINDSOR, NO 27983 WINDSOR, NO 27983 SUMMARY STATEMENT OF DEFICIENCISS (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG TAG C 246 Continued From page 10 11:06am revealed: -When Resident #3 became agitated or paranoid she was talk with him to calm him down. -She checked on him very 15 minutes. -The resident saw his psychiatrist every three months unless there was an emergency. -If she felt the resident's medications were not working or if he had behavioral problems she would contact the psychiatrist office to schedule an appointment. Interview with the Administrator on 12/29/22 at 11:24am revealed: -Resident #3 had a change in behavior, he would not come out of his room, he was quelter, did not want to take baths, had increased isolation, he was taking his medications but was very jittery. -His change in behaviors seemed to be happening for too long. -She noticed a change in his behaviors prior to his admission to an inpatient psychiatrist or PCP about his change in behavior or his elopements. -She or the MA should have notified Resident #3's psychiatrist or PCP about his change in behavior or his elopements. Telephone interview with a licensed practical nurse (LPN) at Resident #3's psychiatrist was not working today (12/29/22). -When a resident had any change in behavior or elopements the psychiatrist's expected staff to notify their office immediately so an appointment			1517 GO	VERNOR'S ROAD			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) C 246 C	VIRGINIA	'S PLACE	WINDSO	R, NC 27983			
11:06am revealed: -When Resident #3 became agitated or paranoid she was talk with him to calm him downShe checked on him every 15 minutesThe resident saw his psychiatrist every three months unless there was an emergencyIf she felt the resident's medications were not working or if he had behavioral problems she would contact the psychiatrists office to schedule an appointment. Interview with the Administrator on 12/29/22 at 11:24am revealed: -Resident #3 had a change in behavior, he would not come out of his room, he was quieter, did not want to take baths, had increased isolation, he was taking his medications but was very jitteryIt is change in behaviors seemed to be happening for too longShe noticed a change in his behaviors prior to his admission to an inpatient psychiatric hospital on 06/17/22 and 08/30/22She and the MA did not contact Resident #3's psychiatrist or PCP about his change in behavior or his elopementsShe or the MA should have notified Resident #3's psychiatrist and PCP to report his behavioral changes and elopements. Telephone interview with a licensed practical nurse (LPN) at Resident #3's psychiatrist and PCP to report his behavioral changes and elopements. -Resident #3's psychiatrist was not working today (12/29/22)When a resident had any change in behavior or elopements the psychiatrist's expected staff to notify their office immediately so an appointment	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPLETE
possible.	C 246	11:06am revealed: -When Resident #3 b she was talk with him -She checked on him -The resident saw his months unless there -If she felt the resider working or if he had b would contact the psy an appointment. Interview with the Adr 11:24am revealed: -Resident #3 had a cl not come out of his ro want to take baths, ha was taking his medica -His change in behav happening for too lon -She noticed a chang his admission to an ir on 06/17/22 and 08/3 -She and the MA did psychiatrist or PCP a or his elopementsShe or the MA shoul #3's psychiatrist and changes and elopement Telephone interview was nurse (LPN) at Resid on 12/29/22 at 11:50a -Resident #3's psychia (12/29/22)When a resident had elopements the psych notify their office imm could be made for the	ecame agitated or paranoid to calm him down. every 15 minutes. psychiatrist every three was an emergency. It's medications were not behavioral problems she with a problems of the problems of	C 246			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		FOI 000000	B. WING		I	R
		FCL008029	D. WING		12/	29/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
VIRGINIA'	S PLACE		'ERNOR'S ROAI R, NC 27983	U		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
C 246	Continued From page	e 11	C 246			
	psychiatrist immediate be made to see him evisitResident #3's inpatie hospitalizations could facility staff had notific resident could have be care physician (PCP) revealed: -He was not aware of psychiatric hospitalizar routine visitsThe facility should hapsychiatrist when the behavior of increased -The resident could hemergency appointmedecrease his paranoisHe was concerned thand had elopement behim to stay outside unincreased paranoia ale -He was concerned the stay outsi	ely so an appointment could earlier than his scheduled ent psychiatric. If have been avoided if the ed their office so the een seen by his psychiatrist. With Resident #3's primary on 12/29/22 at 3:33pm If Resident #3's inpatient ations until the resident's eave notified the residents y noticed changes in his diparanoia and agitation. Eave benefited from an ent with his psychiatrist to a and agitation. The entire that the resident wandered enaupervised when he had and agitation. That the residents' bedroom				
	door exited to the from two lane road.	nt porch and was close to a				
	-Resident #3 was at r he wandered in the tw	risk of injury or death when wo-lane road.				
	care provider and psy paranoia, agitation ar three elopements wh increased risk of injur placed the resident a and constitutes a Typ	nd wandering resulting in ich placed the resident at ry and/or death. This failure t substantial risk of harm				
		.S. 131D-34 on 12/29/22.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL008029	B. WING		1:	R 2/ 29/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
VIRGINIA	'S PLACE		VERNOR'S ROAD R, NC 27983				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
C 246	Continued From page	e 12	C 246				
	CORRECTION DATE VIOLATION SHALL N 2023.	E FOR THE TYPE A2 NOT EXCEED JANUARY 28,					
C 444	C 444 10A NCAC 13G .1213 Reporting Of Accidents And Incidents		C 444				
	10A NCAC 13G .1213 Reporting of Accidents and Incidents						
	department of social incident resulting in re accident or incident r resident requiring ref	esulting in injury to a					
	facility failed to notify social services (DSS of 3 resident (#3) san for an emergency eva	as evidenced by: and record reviews, the the county department of) of an accident/incident for 1 npled that required referral aluation and inpatient ations on 05/29/22 and					
	The findings are:						
	social services (DSS)	otify the county department of) of any accident or incident near death and any accident n injury to a resident					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_	
		FCL008029	B. WING		R 12/29/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
VIDCINIA	C DI ACE	1517 GO	VERNOR'S ROA	D		
VIRGINIA'	5 PLACE	WINDSO	R, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
C 444	Continued From page 13		C 444			
	other than first aideA written report should be about the incide for the resident, -The facility should concident (I/A) report wincident. Review of Resident # 12/01/22 revealed dia schizophrenia, interm	3's current FL-2 dated				
	Review of Resident #3's resident register dated 03/13/22 revealed: -The resident was admitted on 04/07/22The residents' memory was forgetful.					
	12/01/22 revealed: -The resident had wa care and was verbally -The resident was for					
	05/04/22 revealed: -The resident had wa care and was verbally -The resident was for reminders and was so a. Review of Residen from a behavioral hear revealed: -The resident was ad psychiatric hospital units.	getful and needed ometimes disoriented. t #3's discharge summary alth unit dated 06/17/22				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTI IOATION NOMBER.	A. BUILDING:			
		FCL008029	B. WING		R	
			1		1 12/2	9/2022
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
VIRGINIA'	S PLACE		ERNOR'S ROA , NC 27983	D		
240.15	CHMMADY CT		·	DROVIDER'S DI AN OF CORRECTION	N.	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 444	Continued From page 14		C 444			
	-The resident was ad agitation, wandering a refusing to return to the -The Administrator has because the resident road and refused to complete the resident road and refused to complete the resident was addingation to the resident was addingation to the resident was addingation to the resident was addingation and disability. -The resident was addingation and disabilityThe resident was addingation and disability.	oderate intellectual disability. mitted due to paranoia, away from the home and he home. Id to contact the local police was wandering down the ome back to the home. Irge summary for Resident beychiatric hospital dated mitted to a psychiatrist er involuntary status from with a discharge diagnosis moderate intellectual mitted due to paranoia. be out involuntary he resident acting recklessly				
	no record of an Incide completed on 05/29/2					
	1:50pm revealed: -She should have cor accident (I/A) report v an involuntary commi to an inpatient psychi 08/30/22It was an oversight to IA reports for Resider	for completing IA reports				
Interview with the local adult home specialist with						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FEAT OF CONTROL OF THE PARTY OF THE PART		A. BUILDING: _				
		FCL008029	B. WING		R 12/29/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
VIRGINIA'	'S PLACE	1517 GOVE WINDSOR,	RNOR'S ROA	D		
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD			BE COMPLETE		
C 444	DSS on 12/29/22 at r -She had not received reports for Resident #	evealed: d any incident or accident f3. hat Resident #3 required an ent to an inpatient	C 444			

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