STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008029	A. BUILDING: ______ B. WING ______	R 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA'S PLACE	**1517 GOVERNOR'S ROAD WINDSOR, NC 27983**

(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
C 000	Initial Comments The Adult Care Licensure Section and the Bertie County Department of Social Services conducted an annual, follow-up survey and complaint investigation on 12/29/22.	C 000		
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) 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 for resident use 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 bedroom of the person on call, the office area 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 B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 3 of 3 exit doors were equipped with a sounding device that was audible throughout the facility when the door was opened and accessible to 1 of 3 sampled residents (#3) who had a history of wandering in the road when he had increased paranoia, agitation and elopement from the facility. The findings are: Review of a facility policy for door alarms dated 04/01/20 revealed:	C 069		

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C 069	Continued From page 1 -All staff will respond to door alarms immediately. -Any employee who hears a door alarm will proceed to the area and note the time of the alarm. -The staff member will observe for cause of alarm, look for resident or other person who may have caused the door alarm to be activated. -The surrounding area must be thoroughly checked. -Before deactivating alarm, the responding employee will identify the cause for alarm and rectify cause and/or thoroughly check surrounding area of alarm for a resident who may be lost or eloping from the facility. -If an employee deactivates an alarm and did not find cause, the employees must report the situation immediately to the Administrator. -The employee will conduct a head count and staff will implement the missing person search protocol if needed. 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. Review of Resident #3's Resident Register dated 03/13/22 revealed the resident was admitted on 04/07/22 and was forgetful. Review of Resident #3's current care plan dated 12/01/22 revealed: -The resident had wandering behaviors, resisted care and was verbally abusive. -The resident was forgetful and needed reminders and was sometimes disoriented. Review of Resident #3's previous care plan dated 05/04/22 revealed:	C 069		

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C 069	Continued From page 2	C 069		

-The resident had wandering behaviors, resisted care and was verbally abusive.
-The resident was forgetful and needed reminders and was sometimes disoriented.

Observation of the two-lane highway in front of the home on 12/29/22 at 9:20am revealed the speed limit was 55 miles per hour (MPH).

Observation of the exit doors on 12/29/22 at 8:10am revealed:
-There was no exit alarm on the front door which led into a bedroom for Resident #3 and his roommate.
-There was an exit alarm on the kitchen door which led to a deck in the backyard, but it was turned off position and did not alarm when opened.
-There was an exit alarm on the side door which led to the driveway, but it was turned off and did not alarm when opened.

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 on 05/29/22 and refusing to return to the facility.
-The hospital obtained additional information from the facility Administrator.
-The Administrator reported that Resident #3 became paranoid, refused to come back to the home or to get in the van.
-The Administrator had to contact the local police because the resident was wandering down the

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C 069	Continued From page 3	C 069		

road and refused to come back to the facility.
-The Administrator reported that the resident requested to go to the hospital yesterday (05/28/22).

b. Review of a discharge summary for Resident #3 from an inpatient psychiatric hospital dated 09/07/22 revealed:
-The resident was admitted to a psychiatrist inpatient hospital under involuntary status from 08/30/22 to 09/07/22 with a discharge diagnoses of schizophrenia and moderate intellectual disability.
-The resident was admitted due to paranoia.
-The Administrator obtained an involuntary commitment due to the resident acting recklessly and walking in the middle of the road on 08/30/22.
-The Administrator reported that she noticed a change in his behavior two weeks ago.
-The Administrator reported that she did not think his medications were working.
-The Administrator reported that the resident had been paranoid, she saw him in the middle of the road and refused to get into the car with her and return to the facility.
-She notified local law enforcement to take him to the local hospital inpatient behavioral health unit.
-The Administrator reported that the resident would stand for long periods of time outside the facility due to his paranoia; staff had tried to give him a chair so he could sit down outside, and he was outside between 2:00am-3:00am at times.

Interview with a medication aide (MA) on 12/29/22 at 8:20am revealed:
-She did not know why the alarm on the exit door in the kitchen was turned off.
-She did not know why it did not alarm when she turned it on; it probably needed new batteries or

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needed to be replaced.
-She and the Administrator checked all door alarms yesterday.
-She thought the Administrator removed the exit door alarm sounding device from the front door yesterday when they realized it was not attached correctly and did not work.
-The alarm on the front door was not attached correctly; it was hanging down from the door.
-She did not know how long the alarm on the front door had been hanging down and not attached correctly.
-She usually turned door alarms on at 9:00pm each evening and turned them off at 6:00am.

Interview with the Administrator on 12/29/22 at 11:24am revealed:
-She removed the door alarm device from the front door on 12/28/22 at approximately 8:00pm because the medication aide (MA) informed her last night that it was hanging off the front door.
-Staff did not document door alarm checks but were expected to test them daily.
-She expected staff to monitor the door alarms to ensure they worked correctly.
-Door alarms were turned on each evening at 7:30pm and turned off each morning at 6:30am.
-The medication aide (MA) did not sleep at night.
-All exit doors should have been alarmed from 7:30pm to 6:30am to ensure resident safety.

Telephone interview with a licensed practical nurse (LPN) at Resident #3's psychiatrist's office on 12/29/22 at 11:50am revealed:
-Resident #3's bedroom should not be located where he could exit to the front porch that led to a two-lane highway.
-She was concerned about his safety when he had increased paranoia, agitation and wandered away from the facility.

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C 069	Continued From page 5 Telephone interview with Resident #3's primary care physician (PCP) on 12/29/22 at 3:33pm revealed: -He was not aware Resident #3 had wandered into the road and would not return with staff to the facility. -He was not aware Resident #3 had increased paranoia and agitation. -He was concerned that Resident #3's bedroom exited to the front porch that led to a two lane road. -Staff needed to relocate Resident #3's bedroom to ensure his safety. -Resident #3 could have been injured or died if he exited the facility when door alarms were not working. ______________________________ The facility failed to ensure exit doors were properly equipped with a sounding device related to a resident that had episodes of increased paranoia, agitation and wandering resulting in two elopements which placed the resident at increased risk of injury and/or death. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. ______________________________ A plan of protection was submitted by the facility in accordance with G.S. 131D-34 on 12/29/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 12, 2022.	C 069		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs	C 246		

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of residents.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure the primary care provider (PCP), or psychiatrist were notified of increased paranoia, agitation, and three elopements, one in which the resident was found wandering in the highway for 1 of 3 sampled residents (#3).

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.

Review of Resident #3's Resident Register dated 03/13/22 revealed the resident was admitted on 04/07/22 and he was forgetful.

Review of Resident #3's current care plan dated 12/01/22 revealed:
-The resident had wandering behaviors, resisted care and was verbally abusive.
-The resident was forgetful and needed reminders and was sometimes disoriented.

Review of Resident #3's previous care plan dated 05/04/22 revealed:
-The resident had wandering behaviors, resisted care and was verbally abusive.
-The resident was forgetful and needed reminders and was sometimes disoriented.

Review of an elopement policy dated 04/01/20

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revealed:
-There was an Identification and Assessment of those at risk of wandering.
-The staff completed an assessment at admission for residents that were at risk of wandering.
-The assessment included questions related to the resident's ability to ambulate independently, decision making ability, history of wandering, and does the resident exhibit restlessness and/or agitation.
-Staff were educated to monitor for changes in behavior, identify the warning signs to aid in preventing potential elopements by reporting them immediately to the Administrator.

Review of facility file on 12/29/22 revealed there was no Identification and Assessment completed for Resident #3.

Review of Resident #3's primary care provider (PCP) visit note dated 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.
-The Administrator reported that Resident #3

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C 246	Continued From page 8 became paranoid, refused to come back to the facility or to get in the van. -The Administrator had to contact the local police because the resident was wandering down the road and refused to come back to the facility. -The Administrator reported that the resident requested to go to the hospital yesterday (05/28/22). Review of Resident #3's PCP visit note dated 06/23/22 revealed to report any paranoid thoughts, hallucinations or anxiety to his office or after hours go to the hospital emergency department. b. Review of a discharge summary for Resident #3 from an inpatient psychiatric hospital dated 09/07/22 revealed: -The resident was admitted to a psychiatrist inpatient hospital under involuntary status from 08/30/22 to 09/07/22 with discharge diagnoses of schizophrenia and moderate intellectual disability. -The resident was admitted due to paranoia. -The Administrator obtained an involuntary commitment due to the resident acting recklessly and walking in the middle of the road on 08/30/22. -The Administrator reported that she noticed a change in his behavior two weeks ago. -The Administrator reported that she did not think his medications were working. -The Administrator reported that the resident had been paranoid; she saw him in the middle of the road and refused to get into the car with her and return to the facility. -She notified local law enforcement to take him to the local hospital inpatient behavioral health unit. -The Administrator reported that the resident would stand for long periods of time outside the facility due to his paranoia; staff had tried to give	C 246		

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him a chair so he could sit down outside, and he was outside between 2:00am-3:00am at times.

c. Review of an incident report for Resident #3 from a local day program dated 09/21/22 revealed:
-Resident #3 walked away from the day program during a morning break.
-The resident was prompted to return to the day program, he refused to return and continued to walk away from the facility.
-Staff located the resident walking in the community and was encouraged to get inside the staff's vehicle so he could return to the day program.
-The day program staff notified the Administrator of his elopement, severe psychosis, and agitation.
-The day program staff notified the Administrator that the Director of the day program would notify her if Resident #3 could return to the day program.

Observation of Resident #3 on 12/29/22 at 9:50am revealed he was sitting on a couch in the living room watching television alone.

Interview with a medication aide (MA) on 12/29/22 at 7:45am revealed:
-Resident #3 did not attend the day program.
-The resident had attended the day program but walked away from the program in September 2022 and was not allowed to return.
-Resident #3 would get upset at times and wander around the property outside to calm down.
-The resident usually wanted to be alone when he was agitated or upset.

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

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11:06am revealed:
-When Resident #3 became agitated or paranoid she was talk with him to calm him down.
-She checked on him every 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 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 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 psychiatric hospital on 06/17/22 and 08/30/22.
-She and the MA did not contact Resident #3's psychiatrist or PCP about his change in behavior or his elopements.
-She 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's office on 12/29/22 at 11:50am revealed:
-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 could be made for the resident as soon as possible.
-The facility should have notified the resident's

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psychiatrist immediately so an appointment could be made to see him earlier than his scheduled visit.
-Resident #3's inpatient psychiatric hospitalizations could have been avoided if the facility staff had notified their office so the resident could have been seen by his psychiatrist.

Telephone interview with Resident #3's primary care physician (PCP) on 12/29/22 at 3:33pm revealed:
-He was not aware of Resident #3's inpatient psychiatric hospitalizations until the resident's routine visits.
-The facility should have notified the residents psychiatrist when they noticed changes in his behavior of increased paranoia and agitation.
-The resident could have benefited from an emergency appointment with his psychiatrist to decrease his paranoia and agitation.
-He was concerned that the resident wandered and had elopement behaviors and staff allowed him to stay outside unsupervised when he had increased paranoia and agitation.
-He was concerned that the residents' bedroom door exited to the front porch and was close to a two lane road.
-Resident #3 was at risk of injury or death when he wandered in the two-lane road.

____
The facility failed to notify Resident #3's primary care provider and psychiatrist of increased paranoia, agitation and wandering resulting in three elopements which placed the resident at increased risk of injury and/or death. This failure placed the resident at substantial risk of harm and constitutes a Type A2 Violation.

____
A plan of protection was submitted by the facility in accordance with G.S. 131D-34 on 12/29/22.

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C 246	Continued From page 12 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 28, 2023.	C 246		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) of an accident/incident for 1 of 3 resident (#3) sampled that required referral for an emergency evaluation and inpatient psychiatric hospitalizations on 05/29/22 and 08/30/22. The findings are: Review of a facility policy dated 05/13/13 revealed: -The home should notify the county department of social services (DSS) of any accident or incident resulting in resident near death and any accident or incident resulting in injury to a resident requiring referral for emergency medical	C 444		

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C 444	Continued From page 13 evaluation, hospitalization, or medical treatment other than first aide. -A written report should be provided to the local DSS about the incident including follow up care for the resident, -The facility should complete an incident and accident (I/A) report within 24 hours of the incident. 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. Review of Resident #3's resident register dated 03/13/22 revealed: -The resident was admitted on 04/07/22. -The residents' memory was forgetful. Review of Resident #3's current care plan dated 12/01/22 revealed: -The resident had wandering behaviors, resisted care and was verbally abusive. -The resident was forgetful and needed reminders and was sometimes disoriented. Review of Resident #3's previous care plan dated 05/04/22 revealed: -The resident had wandering behaviors, resisted care and was verbally abusive. -The resident was forgetful and needed reminders and was sometimes disoriented. a. Review of Resident #3's discharge summary from a behavioral health unit dated 06/17/22 revealed: -The resident was admitted to an inpatient psychiatric hospital under involuntary status and then switched to voluntary status from 05/29/22 to	C 444		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008029	A. BUILDING: ______ B. WING ______	R 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA'S PLACE	**1517 GOVERNOR'S ROAD WINDSOR, NC 27983**

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C 444	Continued From page 14	C 444		

06/17/22 with a discharge diagnosis of schizophrenia and moderate intellectual disability.
-The resident was admitted due to paranoia, agitation, wandering away from the home and refusing to return to the home.
-The Administrator had to contact the local police because the resident was wandering down the road and refused to come back to the home.

b. Review of a discharge summary for Resident #3 from an inpatient psychiatric hospital dated 09/07/22 revealed:
-The resident was admitted to a psychiatrist inpatient hospital under involuntary status from 08/30/22 to 09/07/22 with a discharge diagnosis of schizophrenia and moderate intellectual disability.
-The resident was admitted due to paranoia.
-The Administrator took out involuntary commitment due to the resident acting recklessly and walking in the middle of the road on 08/30/22.

Review of the facility file revealed that there was no record of an Incident and Accident report completed on 05/29/22 or 08/30/22.

Interview with the Administrator on 12/29/22 at 1:50pm revealed:
-She should have completed an incident and accident (I/A) report when Resident #3 required an involuntary commitment resulting in admission to an inpatient psychiatrist unit on 05/29/22 and 08/30/22.
-It was an oversight that she did not complete the IA reports for Resident #3.
-She was responsible for completing IA reports and sending them to the local DSS.

Interview with the local adult home specialist with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008029	A. BUILDING: ______ B. WING ______	R **12/29/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA'S PLACE	**1517 GOVERNOR'S ROAD** **WINDSOR, NC 27983**

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C 444	Continued From page 15 DSS on 12/29/22 at revealed: -She had not received any incident or accident reports for Resident #3. -She was not aware that Resident #3 required an involuntary commitment to an inpatient psychiatric unit on 05/29/22 and 08/30/22.	C 444		