STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 05/26/22 - 05/27/22.	{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 A2 VIOLATION Non-compliance continues with increased severity resulting in serious neglect. THIS IS A TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure supervision for 1 of 5 sampled residents (#1) who exited the assisted living facility and was found in a ravine behind the facility approximately 24 hours later. The findings are: Review of the facility's policy for Monitoring Residents dated 06/08/21 revealed: -Residents in assisted living were to be checked on at least once each shift unless the resident requested to not be disturbed. -Day and evening shift were to check on every resident at least once a shift. -The night shift was the only shift in which a resident may have requested to not be disturbed.	{D 270}		

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{D 270}	Continued From page 1 -A "Night Shift Resident Check Waiver" form was to be signed by the resident and resident's responsible party and placed in the residents' record. Review of Resident #1's record revealed: -There was no "Night Shift Resident Check Waiver" form signed by the resident and resident's responsible party. Review of Resident #1's Resident Register dated 02/08/22 revealed: -The resident's admission date was "02/13-14/22". -The resident had adequate memory. Review of Resident #1's current FL-2 dated 05/06/22 revealed: -Diagnoses included history of a cerebral vascular accident with frontotemporal dementia and elevated blood sugar. -The recommended level of care was an assisted living. -The resident was ambulatory, and continent of bowel and bladder. Review of Resident #1's current care plan dated 05/03/22 revealed: -The assessment was dated 04/29/22. -There was a note stating "Resident has recent instance of leaving [the] assisted living and becoming lost on his way back to the community. He is being closely monitored with frequent checks." -The resident was oriented but forgetful and needed reminders. -The resident needed supervision with his activities of daily living (ADLs) including eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring.	{D 270}		

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{D 270}	Continued From page 2 Review of Resident #1's previous FL-2 dated 02/03/22 revealed: -Diagnoses included history of cerebral vascular accident with frontotemporal dementia and elevated blood sugar. -The recommended level of care was an assisted living. -The resident was ambulatory, and continent of bowel and bladder. -The resident needed verbal cues and reminders. -The resident needed reminders for bathing, feeding and dressing. Review of Resident #1's previous care plan dated 03/21/22 revealed: -The assessment was dated 03/16/22. -The resident was oriented but forgetful and needed reminders. -The resident needed supervision with his ADLs, including eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring. Review of Resident #1's Incident Report dated 04/22/22 revealed: -The resident was discovered to not be in the building at 5:00pm. -The resident was located behind a neighboring business in a creek at 7:00pm. -The resident stated he went to get a steak sandwich and became lost on his way back. -The resident had no bruising or open skin but sunburn to his face. -Emergency medical services (EMS) were present and evaluated the resident, but he was not transported to the hospital. -There was documentation the resident was oriented before and after the incident. -The Resident Service Director (RSD) completed	{D 270}		

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{D 270}	Continued From page 3 and signed the form. Review of the provider statement of assisted living eligibility dated 05/06/22: -The resident had either a diagnosis of dementia, cognitive impairment or intermittent confusion. -The resident may safely reside in an assisted living that is not secured. -The resident may safely leave the assisted living community unescorted. Review of Resident #1's facility progress note entry created by the Resident Service Director (RSD) dated 04/23/22 revealed: -There was a late entry dated for 04/22/22 at 8:12pm the resident was not in the building around 5:00pm on 04/22/22 and the family was notified. -The resident was found behind a neighboring business down an embankment in a small creek. -The resident did not have an injury at the time, EMS evaluated him and did not transport him to the hospital. -There were no progress note entries between 02/022/22 and 04/23/22. Review of Resident #1's facility progress note entry created by the RSD dated 04/23/22 at 10:25am revealed the resident had a reddened face from sun exposure but the resident "felt fine". Review of a local police department dispatch list of events revealed a missing person call was received by the local police department on 04/22/22 at 6:38pm from the facility. Review of an EMS incident report dated 04/22/22 revealed: -At 7:05pm, EMS was alerted by a local police	{D 270}		

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{D 270}	Continued From page 4	{D 270}		

department, when EMS arrived at 7:31pm, the resident was sitting in a lawn chair at the facility.
-The resident's chief complaint listed was dehydration and the secondary complaint was sunburn.
-Psychological impairment was listed as a barrier to care.
-The resident's family was present and reported the resident had dementia, wandered off from the facility, and had been missing for 9 hours.
-The resident was found sitting on a rock near a small creek.
-The resident was conscious and alert to self only, and family report him acting normal to his baseline.
-The resident had a minor sunburn on his face and hands and dehydration.
-The resident and family were advised EMS transport to the hospital, which they refused.
-The resident was released against medical advice.

Telephone interview with an EMS paramedic on 06/02/22 at 11:16am revealed:
-He was one of the paramedics to answer the call from Resident #1's assisted living facility on 04/22/22 at approximately 7:30pm.
-The complaint was heat/cold exposure for an elderly male at a care facility.
-The resident's family member was present at the scene and reported the resident was known to have wandering behaviors.
-The report was the resident got lost and wandered into a creek bed area behind the facility, and the he was there all day because he was not able to walk out of the ravine.
-The ravine was positioned about 100-150 feet from the road.
-The creek bed area was dry and was positioned about 6 feet down from the edge of the ravine.

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{D 270}	Continued From page 5	{D 270}		

-The resident required 2-person assist to walk up the from the creek bed area.
-He did not recall what the resident was wearing at the time of rescue.
-The resident appeared to be dehydrated and had sunburn to his face and hands.

Review of weather reported for the area of the incident between 04/21/22 and 04/22/22 revealed:
-The overnight low temperature for 04/21/22 to 04/22/22 was 36 degrees Fahrenheit.
-The daytime high temperature for 04/22/22 was as high as 81 degrees Fahrenheit.

Interview with Resident #1 on 05/26/22 at 10:44am revealed:
-He went out of the facility one evening to a local restaurant by himself.
-He bought a steak sandwich but did not have enough money for a drink.
-He got lost out "in the wilderness", sat down on a rock, and waited for someone to find him.
-He stayed awake all night, then the staff found him sometime the next day and brought him back to the facility.
-He was wearing pants, a t-shirt, a jacket and shoes.

A second interview with Resident #1 on 05/26/22 at 3:50pm revealed:
-He remembered leaving the facility on his own a while back but did not remember the exact day.
-He thought he signed out when he left but did not sign back in when the staff brought him back to the facility the next day.

Review of the restaurant's black and white security footage dated 04/21/22 revealed:
-Resident #1 entered the restaurant on 04/21/22

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{D 270}	Continued From page 6	{D 270}		

at 6:29pm and spoke with staff at the front desk near the entrance doors.
-The resident appeared to be wearing dark or grey sweatpants and a hoodie.
-Resident #1 walked toward the bar area at 6:31pm and then back to the front desk at 6:32pm.
-At 6:33pm a bartender and a waiter joined the resident at the front desk.
-At 6:36pm a light-colored bag is delivered to the resident at the front desk.
-At 6:38pm Resident #1 exited the restaurant through the main entrance doors, turned to his right, and walked down walkway parallel to the building.

Review of the restaurant's black and white security footage dated 04/22/22 revealed Resident #1 did not enter or exit the restaurant.

Interview with a restaurant employee on 05/26/22 at 5:54pm revealed:
-He was working as a waiter on the evening of 04/21/22 and remembered Resident #1 coming to the restaurant.
-Resident #1 came in on 04/21/22 between 6:30pm and 7:00pm.
-He ordered a sandwich at the front desk at the main entrance, waited at the bar, and left with his sandwich before "Thursday Night Trivia" started at 7:00pm.
-The resident tried to order a mixed drink at the bar.
-The resident looked confused and disoriented.
-The resident was wearing dark grey pants and jacket or hoodie, sneakers and glasses.
-He did not notice which direction the resident came from prior to entering the restaurant.
-The resident went to his right when he exited the restaurant.

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{D 270}	Continued From page 7 Interview with a second restaurant employee on 05/26/22 at 6:00pm revealed: -He was working as the bartender on 04/21/22 when Resident #1 came to the restaurant at around 6:30pm. -The resident ordered a sandwich to go at the front desk, then he went to the bar to order a drink. -The resident did not have enough money to purchase the mixed drink he had requested. -The resident wanted to cancel the sandwich order so he could purchase the mixed drink. -He went to the front desk with the resident to cancel the order, but the sandwich had already been prepared. -Because the resident seemed confused, he would not have served him a drink from the bar even if the resident had enough money with him. -The resident took his sandwich and left out of the restaurant down the right-side walkway. Telephone interview with Resident #1's family member on 05/26/22 at 4:20pm revealed: -She usually came to visit the resident 3 or more times a week. -They usually left the facility for either lunch or dinner at a local restaurant. -She and the resident had often walked from the facility to the same restaurant the resident reported he walked to on the evening of 04/21/22. -She was out of state during the week of 04/21/22 and the resident had $20.00 in his possession in case he did go out. -The facility called her at approximately 5:00pm on 04/22/22 to ask if she, another family member, or a family friend had picked up the resident that day. -Another family member was present when the resident was found at approximately 7:00pm on	{D 270}		

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{D 270}	Continued From page 8	{D 270}		

04/22/22.
-The resident told her he went to a local restaurant because he wanted a steak sandwich on 04/21/22.
-The resident told her he got lost on his way back to the facility, so he walked down a ravine and sat on a rock near a creek all night until they found him the following day on 04/22/22.
-The resident told her he did not get to eat his sandwich because he dropped it when he walked down to the rock.
-The facility RSD told her a medication aide (MA) thought the resident was in his restroom when she went to give him his 8:00am medications on 04/22/22, and she did not go back to check on him or to give him his medications.
-The facility RSD told her the personal care aides (PCAs) on the morning shift of 04/22/22 thought the other PCA had checked in on Resident #1, but neither had done so.
-The facility RSD told her the PCAs on the evening shift of 04/22/22 thought the other PCA had checked in on Resident #1, but neither had done so.
-Resident #1 was noticed to be missing from the facility at approximately 5:00pm on 04/22/22.
-She spoke with Resident #1 on the telephone on 04/22/22 between 7:15pm and 7:30pm.

Observation of the restaurant parking and highway area on 05/26/22 between 6:30pm and 7:15pm revealed:
-The shopping center was L-shaped and the main entrance to the restaurant was located at the middle corner of the L.
-A walkway (approximately 54 ft long) leads from the restaurant main entrance, through landscaping bushes, to the sidewalk parallel to a four-lane highway with a center turning lane.
-The posted speed limit was 45 miles per hour.

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{D 270}	Continued From page 9 -Approximately 40 vehicles passed the sidewalk area nearest the restaurant within 1 minute. -There were 2 business located to the left of the business and 5 business located to the right of the business running parallel to the highway. Observation of the four-lane highway area and business complex surrounding the facility on 05/27/22 between 9:00am and 10:30am revealed: -At the end of the shopping center walkway to the right of exiting the restaurant there was an entrance and exit drive to the busy four-lane highway. -There was a connecting sidewalk access towards the right and left of the exit drive and parallel to the four-lane highway. -The sidewalk to the right of the exit drive led up hill in a direction behind the facility towards another side entrance road for a separate business complex. -There was a medical office with the same siding color, same trim color, and a similar stone façade as the resident's facility building. -There were two separate brick buildings positioned behind the medical office. -There was a ravine between the medical office and the brick buildings that continued behind the facility. -The drop distance on the medical office side of the ravine was approximately 25-30ft. -The drop distance on the brick buildings' side of the ravine was approximately 6-10ft. -At the bottom of the ravine was flattened rock positioned in a run-off creek bed with approximately 3-4 inches of water. -There was dense vegetation throughout the ravine at the time of this observation. -The brick buildings faced the same road Resident #1's assisted living facility was located.	{D 270}		

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{D 270}	Continued From page 10 Interview with the Director of the Culinary Experience on 05/27/22 at 3:56pm revealed the MA/supervisor completed the dietary tracker at each meal for each resident eating in the dining room, their room or being out of the facility. Interview with a MA on 05/27/22 at 4:40pm revealed: -The MA on duty filled out the dietary tracker at each meal by putting a check mark for each resident in the dining room. -If a resident was not in the dining room the MA or a PCA went to check on the resident. Review of the facility's resident diet checker form dated 04/22/22 revealed Resident #1 was documented as out of the facility (OOF) for breakfast, lunch and dinner meals. Telephone interview with a former 1st shift MA on 05/27/22 at 10:32am revealed: -She was the MA assigned to Resident #1 on 04/22/22 during the 7:00am to 3:00pm shift. -She did not recall seeing the resident during her shift on 04/22/22. -She documented Resident #1's morning medications were administered to him on the morning of 04/22/22, but that was an error. -She went to Resident #1's room to administer his medications on the morning of 04/22/22 but did not see him in his room. -The resident's bathroom light was on and she assumed he was using the restroom, but she did not check to see if he was there. -The RCD called her at 4:30pm and around 5:00pm on 04/22/22 asking where Resident #1 was. -The facility procedure for a missing resident was to contact the Administrator and RSD first, then contact resident family members next, and then	{D 270}		

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call 911 for law enforcement when instructed to do so by the SIC, RSD, or Administrator.

Review of Resident #1's April 2022 electronic medication administration record (eMAR) revealed there was documentation the resident was out of the facility on 04/22/22.

Attempted telephone interview with the 2nd shift MA on 05/27/22 at 3:52pm was unsuccessful.

Telephone interview with an agency PCA on 05/27/22 at 4:00pm revealed:
-She was the PCA on Resident #1's hallway on 1st and 2nd shift on 04/21/22.
-She was the PCA on Resident #1's hallway on 1st shift on 04/22/22.
-It was the facility's process for PCAs to check in on all residents at the beginning of their shift.
-She recalled seeing Resident #1 on 04/21/22 during 1st and 2nd shift.
-She did not recall if she checked in on Resident #1 on 04/22/22 during 1st shift or if the other PCA on duty checked on the resident.
-Routine resident checks at the beginning of each shift were not documented anywhere in the facility.
-The MAs/supervisors were responsible to complete the resident diet check off in the dining area during mealtimes.

Attempted telephone interview with a second agency PCA on 05/27/22 at 3:57pm was unsuccessful.

Interview with a second PCA on 05/27/22 at 4:14pm revealed:
-Resident #1 was in his room on 04/21/22 at approximately 5:30pm - 6:00pm when she went to remind him it was time for dinner.

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{D 270}	Continued From page 12 -The resident told her he did not want anything they were serving for dinner. -The resident came down later during dinnertime, peeked into the dining area, and then left. -The resident did not mention anything to her about leaving the facility to go to a restaurant. Telephone interview with another staff PCA on 05/27/22 at 6:06pm revealed: -He was the MA/supervisor for assisted living and memory care on 04/21/22 for 3rd shift 11:00pm to 7:00am. -Resident #1 did not have any medications scheduled during 3rd shift on 04/21/22. -He did not recall seeing Resident #1 during 3rd shift on 04/21/22. -The facility process for a missing resident for MA/supervisor was to first check the resident's room, then check other resident rooms, facility building and grounds; then call the department heads like the Administrator, RSD, and RCD. -The MA/supervisor was expected to call 911 for law enforcement when instructed by Administrator, RSD, or RCD. Telephone interview with a concierge on 05/27/22 at 5:27pm revealed: -She worked as the concierge on Thursdays and Fridays from 9:00am until 6:00pm. -She did not remember seeing Resident #1 leave the facility on Thursday 04/21/22. -She was not always at the concierge desk to see everyone who came and went. -Resident #1 was an ambulatory resident and left the facility regularly with family members. -Residents were supposed to sign out in the sign out book at the front entrance when leaving the building. -She was not responsible for checking the sign out book when residents left the facility.	{D 270}		

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(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 13 Review of the facility's resident sign out log revealed Resident #1 did not sign out of the facility on 04/21/22 or 04/22/22. Interview with the Community Relations Director on 05/27/22 at 1:34pm revealed: -She returned to the facility on 04/22/22 with the RSD when notified of Resident #1's whereabouts unknown. -She located the resident in a ravine behind two neighboring business at approximately 7:00pm on 04/22/22. -The resident was setting on a flat rock near a creek bed. -He was wearing pants and a t-shirt. -His pants were wet in the groin area as if he had been incontinent of his bladder. -The resident's hands and face were sunburned but he did not complain of any pain. -She, the Administrator, law enforcement officers and the resident's family members were present at the time of EMS assessment of the resident, but she could not remember the exact time. Interview with the Resident Care Director (RCD) on 05/27/22 at 11:34am revealed: -She saw Resident #1 sitting on the couch near the second-floor nurses' station on the morning of 04/21/22 but she did not see him the rest of that day. -Another resident and their family member asked the staff of the resident's whereabouts on 04/22/22 at around 4:00pm. -She called the first shift MA to find out when she last saw Resident #1 on 04/22/22 at around 5:00pm. -The MA reported she did not see Resident #1 that morning or give him his medications because the resident appeared to be in his restroom at the	{D 270}		

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{D 270}	Continued From page 14	{D 270}		

time of the morning medication pass on 04/22/22.
-The MA reported she was told by a 1st shift PCA the resident was going out of the facility the morning of 04/22/22.
-The resident was not at breakfast on 04/22/22 but sometimes he did not come down for breakfast.
-The PCAs on duty for 1st and 2nd shift on 04/22/22 did not do the walk through to check on each resident.
-She called the RSD and Administrator to inform them Resident #1 was not in the building and had not been seen on 04/22/22 but did not remember the time of the call.
-She called Resident #1's family members to see if they may have picked him up from the facility on 04/22/22 but did not remember the time of the calls.
-The 2nd shift MA went to the local restaurant that Resident #1 went to frequently, but he was not there at that time on 04/22/22.
-Law enforcement officers were called after the resident was not located at the local restaurants.
-The Community Relations Director went farther up the road past the facility and located the resident down in a ravine in between two neighboring business.
-The resident was wearing black or dark colored sweatpants, a grey or lighter colored shirt, and a grey jacket.
-The resident was wet and appeared to have been incontinent of his urine.
-The resident was normally continent of bladder.
-The facility did not call 911 for law enforcement or EMS at first because the staff were searching the building and surroundings.
-The resident was considered missing at around 5:00pm and law enforcement was present when the resident was found but she did not the exact times.

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{D 270}	Continued From page 15 -She thought the facility called 911 within an hour of discovering the resident was missing from the facility. -Resident #1 told her he left the facility to go to the restaurant on the evening of 04/21/22 after the MA gave him his evening medication; sometime around 7:00pm. -Assisted living resident whereabouts were checked during each medication pass, during each meal, and during each change of shift. -MAs/supervisors were expected to complete a diet tracker form in the dining room at each mealtime by checking off the residents that are present for their meal. -The MAs/supervisors were expected to follow-up with any residents that did not go to the dining hall for mealtimes. -The facility process for when a resident was thought to be missing from the facility was to first search the building and the facility grounds first. -Then the MA/supervisor was expected to notify the Administrator, the RSD and the RCD about the possibility of a missing resident. -The MA/supervisor was then expected to contact the resident's family member or power of attorney (POA) to verify if the resident was or was not with them. -Law enforcement was expected to be contacted after the resident's family or POA confirmed they did not have the resident. -The assisted living facility front door usually remained unlocked while it was still day light or while residents were still walking or sitting outside. -Residents were educated to sign out when leaving the facility grounds. -The front door area was observed by the concierge staff until 6:00pm each evening. A second interview with the RCD on 05/27/22 at	{D 270}		

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{D 270}	Continued From page 16 5:52pm revealed: -Residents should use the sign out book when leaving and returning to the facility. -If a resident did not use the sign out book, the second layer of monitoring a resident's whereabouts was the shift change checks, meal checks and medication administration. -MAs and PCAs should have picked up on Resident #1 not being in the facility on one of those checks but they did not. -She reported everything she learned about what did not happen on 04/21/22 and 04/22/22 regarding the absence of Resident #1 from the facility except 3rd shift not completing shift change checks on every resident. -She did not know at the time of the investigation that the 3rd shift MA did not complete the checks. -She did not remember when she found out the 3rd shift checks were not done, but she did let the RSD know when she found out. Interview with the Administrator on 05/27/22 at 12:45pm revealed: -He saw Resident #1 drinking his cup of coffee on the morning of 04/21/22 before the breakfast mealtime. -He saw Resident #1 in the dining hall at dinnertime on 04/21/22. -He did not see Resident #1 again until he was found on the evening of 04/22/22. -Resident #1 had flexibility to leave the facility when he wanted. -Staff noticed Resident #1 missing from the facility between 4:30pm - 5:00pm on 04/22/22. -The resident was not signed out of the facility by himself or his family member on 04/21/22 or 04/22/22. -Resident #1's family was called first when it was determined he was not in the facility on 04/22/22. -He went to 3 local restaurants within walking	{D 270}		

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{D 270}	Continued From page 17	{D 270}		

distance to the facility looking for Resident #1 on 04/22/22 but did not locate him.
-Two other staff members went to an ice cream stand north of the facility on 04/22/22 but did not locate the resident.
-Law enforcement was initially contacted when he and the other staff returned to the facility after searching local restaurants for the resident on 04/22/22.
-The facility process for resident's missing from the facility and whereabouts unknown was to first notify the RSD, RCD, and Administrator, then notify the missing resident's POA or family.
-The facility was expected to call 911 for law enforcement within an hour of recognizing a resident was missing.
-MAs were expected to check on each resident at the change of each shift, during medication passes, and at mealtimes.
-Residents or their family members were expected to sign out when living the facility grounds and sign back in when they returned.
-He viewed 23 hours of the facility's front door security camera starting from around dinner time on 04/21/22.
-Resident #1 was seen exiting the facility at approximately 5:00pm - 6:00pm on 04/21/22.
-Resident #1 was wearing dark colored pants, a light-colored shirt, and a dark colored hoodie on the security video from 04/21/22.
-He did not view Resident #1 again during the subsequent 23 hours of video from approximately 6:00pm on 04/21/22 to afternoon of 04/22/22.
-There was no documentation that noted Resident #1's whereabouts for 3rd shift on 04/21/22, 1st shift on 04/22/22, or for 2nd shift on 04/22/22.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 05/26/22 at

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{D 270}	Continued From page 18 4:48pm was unsuccessful. _____ The facility failed to provide supervision for Resident #1, who had a diagnosis of dementia and was forgetful. The facility's failure resulted in the resident exiting the facility and being found approximately 24 hours later in a ravine behind the facility, sitting on a flat rock in a creek bed, with sunburn to his face, head and hands, was dehydrated and was wearing urine soaked pants. The failure to supervise Resident #1 resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/27/22 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 06/26/22.	{D 270}		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 328		

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Based on interviews and record reviews, the facility failed to notify the appropriate local law enforcement agency and the local County Department of Social Service (DSS) immediately after discovering a resident (Resident #1) was missing from the facility.

The findings are:

Review of Resident #1's current FL-2 dated 05/06/22 revealed:
-Diagnoses included history of a cerebral vascular accident with frontotemporal dementia (a progressive, degenerative brain disease) and elevated blood sugar.
-The recommended level of care was an assisted living.
-The resident was ambulatory, and continent of bowel and bladder.

Review of Resident #1's previous FL-2 dated 02/03/22 revealed:
-Diagnoses included history of cerebral vascular accident with frontotemporal dementia and elevated blood sugar.
-The recommended level of care was an assisted living.
-The resident was ambulatory, and continent of bowel and bladder.
-The resident needed verbal cues and reminders.
-The resident needed reminders for bathing, feeding and dressing.

Review of Resident #1's current care plan dated 05/03/22 revealed:
-The resident was oriented but forgetful and needed reminders.
-The resident needed supervision with his activities of daily living (ADLs) including eating, toileting, ambulation, bathing, dressing,

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D 328	Continued From page 20 grooming/personal hygiene, and transferring. Review of Resident #1's previous care plan dated 03/21/22 revealed: -The resident was oriented but forgetful and needed reminders. -The resident needed supervision with his ADLs including eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring. Interview with the Resident Care Director (RCD) on 05/27/22 at 11:34am revealed: -She saw Resident #1 sitting on the couch near the second-floor nurses' station on the morning of 04/21/22 but she did not see him the rest of that day. -Another resident and their family member asked the staff of the resident's whereabouts on 04/22/22 at around 4:00pm. -She called the first shift medication aide (MA) to find out when she last saw Resident #1 on 04/22/22 at around 5:00pm. -The MA reported she did not see Resident #1 that morning or give him his medications because the resident appeared to be in his restroom at the time of the morning medication pass on 04/22/22. -The MA reported she was told by a 1st shift personal care aide (PCA) the resident was going out of the facility the morning of 04/22/22. -The resident was not at breakfast on 04/22/22 but sometimes he did not come down for breakfast. -The PCAs on duty for 1st and 2nd shift on 04/22/22 did not do the walk through to check on each resident. -She called the Resident Service Director (RSD) and Administrator to inform them Resident #1 was not in the building and had not been seen on 04/22/22 but did not remember the time of the	D 328		

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call.
-She called Resident #1's family members to see if they may have picked him up from the facility on 04/22/22 but did not remember the time of the calls.
-The 2nd shift MA went to the local restaurant that Resident #1 went to frequently, but he was not there at that time on 04/22/22.
-Law enforcement officers were called after the resident was not located at the local restaurants on 04/22/22.
-The Community Relations Director went farther up the road past the facility and located the resident down in a ravine between two neighboring business.
-The resident was wet and appeared to have been incontinent of his urine.
-The facility did not call 911 for law enforcement or emergency medical services (EMS) at first because the staff were searching the building and surroundings.
-The resident was considered missing at around 5:00pm and law enforcement was present when the resident was found but she did not the exact times.
-She thought the facility called 911 with an hour of discovering the resident was missing from the facility.
-Resident #1 told her he left the facility to go to the restaurant on the evening of 04/21/22 after the MA gave him his evening medication; sometime around 7:00pm.
-Assisted living resident whereabouts were supposed to be checked during each medication pass, during each meal, and during each change of shift.
-The MA/supervisor was expected to notify the Administrator, the RSD and the RCD about the possibility of a missing resident.
-The MA/supervisor was then expected to contact

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the resident's family member or power of attorney (POA) to verify if the resident was or was not with them.
-Law enforcement was expected to be contacted after the resident's family or POA confirmed they did not have the resident.

Review of a local police department dispatch list of events revealed a missing person call was received by the local police department on 04/22/22 at 6:38pm from the facility.

Review of an EMS incident report dated 04/22/22 revealed:
-At 7:05pm, EMS was alerted by a local police department, when EMS arrived at 7:31pm, the resident was sitting in a lawn chair at the facility.
-The resident's chief complaint listed was dehydration and the secondary complaint was sunburn.
-Psychological impairment was listed as a barrier to care.
-The resident's family was present and reported the resident had dementia, wandered off from the facility, and had been missing for 9 hours.
-The resident was found sitting on a rock near a small creek.
-The resident was conscious and alert to self only, and family report him acting normal to his baseline.
-The resident had a minor sunburn on his face and hands and dehydration.
-The resident and family were advised EMS transport to the hospital, which they refused.
-The resident was released against medical advice.

Review of Resident #1's incident report dated 04/22/22 revealed:
-The resident was discovered to not be in the

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building at 5:00pm.
-The resident was located behind a neighboring business in a creek at 7:00pm.
-There was documentation the resident stated he went to get a steak sandwich and became lost on his way back.
-The resident had no bruising or open skin but sunburn to his face.
-EMS were present and evaluate the resident, but he was not transported to the hospital.
-There was documentation the resident was oriented before and after the incident.
-The RSD completed and signed the form.

Review of Resident #1's facility progress note dated 04/23/22 revealed:
-There was a late entry dated for 04/22/22 by the RSD at 8:12pm the resident was not in the building around 5:00pm on 04/22/22 and the family was notified.
-The resident was found behind a neighboring business down an embankment in a small creek.
-The resident did not have an injury at the time, EMS evaluated him and did not transport him to the hospital.

Interview with Resident #1 on 05/26/22 at 10:44am revealed:
-He went out of the facility one evening to a local restaurant by himself.
-He bought a steak sandwich but did not have enough money for a drink.
-He got lost out "in the wilderness", sat down on a rock, and waited for someone to find him.
-He stayed awake all night, then the staff found him sometime the next day and brought him back to the facility.
-He was wearing pants, a t-shirt, a jacket and shoes.

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D 328	Continued From page 24 Interview with a restaurant employee on 05/26/22 at 5:54pm revealed: -He was working as a waiter on the evening of 04/21/22 and remembered Resident #1 coming to the restaurant. -Resident #1 came in on 04/21/22 between 6:30pm and 7:00pm. Interview with a second restaurant employee on 05/26/22 at 6:00pm revealed he was working as the bartender on 04/21/22 when Resident #1 came to the restaurant at around 6:30pm. Telephone interview with Resident #1's family member on 05/26/22 at 4:20pm revealed: -The facility called her at approximately 5:00pm on 04/22/22 to ask if she, another family member, or a family friend had picked up the resident that day. -Another family member was present when the resident was found at approximately 7:00pm on 04/22/22. -Resident #1 was noticed to be missing from the facility at approximately 5:00pm on 04/22/22. -She spoke with Resident #1 on the telephone on 04/22/22 between 7:15pm and 7:30pm. Observation of the restaurant parking area on 05/26/22 between 6:30pm and 7:15pm revealed: -A walkway (approximately 54 ft long) leads from the restaurant main entrance, through landscaping bushes, to the sidewalk parallel to a four-lane highway with a center turning lane. -The post speed limit was 45 miles per hour. -Approximately 40 vehicles passed the sidewalk area nearest the restaurant within 1 minute. -At the end of the shopping center walkway to the right of exiting the restaurant there is an entrance and exit drive to the busy 4-lane highway.	D 328		

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D 328	Continued From page 25 Observation of the area Resident #1 was located on 05/27/22 revealed: -The drop distance on the medical office side of the ravine was approximately 25-30ft. -The drop distance on the brick buildings' side of the ravine was approximately 6-10ft. -At the bottom of the ravine was flattened rock positioned in a run-off creek bed with approximately 3-4 inches of water. -There was dense vegetation throughout the ravine at the time of this observation. Telephone interview with a former 1st shift MA on 05/27/22 at 10:32am revealed: -She was the MA assigned to Resident #1 on 04/22/22 during the 7:00am to 3:00pm shift. -The RCD called her at 4:30pm and around 5:00pm on 04/22/22 asking where Resident #1 was. -The facility procedure for a missing resident was to contact the Administrator and RSD first, then contact resident family members next, and then call 911 for law enforcement when instructed to do so by the supervisor, RSD, or Administrator. Interview with the Administrator on 05/27/22 at 12:45pm revealed: -Staff noticed Resident #1 missing from the facility between 4:30pm - 5:00pm on 04/22/22. -The resident was not signed out of the facility by himself or his family member on 04/21/22 or 04/22/22. -Resident #1's family was called first when it was determined he was not in the facility on 04/22/22. -He went to 3 local restaurants within walking distance to the facility looking for Resident #1 on 04/22/22 but did not locate him. -Two other staff members went to an ice cream stand north of the facility on 04/22/22 but did not locate the resident.	D 328		

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	HAL092213	A. BUILDING: _____ B. WING _____	R 05/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(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 328	Continued From page 26 -Law enforcement was initially contacted when he and the other staff returned to the facility after searching local restaurants for the resident on 04/22/22. -The facility process for resident's missing from the facility and whereabouts unknown was to first notify the RSD, RCD, and Administrator, then notify the missing resident's POA or family. -The facility was expected to call 911 for law enforcement within an hour of recognizing a resident was missing. -He viewed 23 hours of the facility's front door security camera starting from around dinner time on 04/21/22. -Resident #1 was seen exiting the facility on 04/21/22 at approximately 5:00pm - 6:00pm. Interview with the county adult home specialists on 05/27/22 at 10:30am revealed: -She was first notified of Resident #1 missing from the facility when she received the faxed incident report. -She did not receive any phone calls from the facility on 04/22/22 to report Resident #1 was missing. Telephone interview with another staff PCA on 05/27/22 at 6:06pm revealed: -He was the MA/supervisor for assisted living and memory care on 04/21/22 for 3rd shift 11:00pm to 7:00am. -The facility process for a missing resident for MAs/supervisors was to first check the resident's room, then check other resident rooms, facility building and grounds; then call the department heads like the Administrator, RSD, and RCD. -The MA/supervisor was expected to call 911 for law enforcement when instructed by Administrator, RSD, or RCD.	D 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 05/27/2022

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D 328	Continued From page 27 The facility failed to immediately notify law enforcement or the county department of social services when a resident, who was diagnosed with frontotemporal dementia, was discovered to be missing from the facility at 4:00pm on 04/22/22. The facility did not contact local law enforcement until 6:38pm, which resulted in a 2 ½ hour delay of search for a missing resident, in a high traffic area and a 4-lane highway. The resident was found in a ravine with a drop distance of 6-10 feet, with 3-4 inches of water, sitting on a rock. This failure resulted in a substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/27/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 06/26/22.	D 328		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Personal Care and Supervision, and	{D914}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D914}	Continued From page 28 Other Resident Care and Services. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure supervision for 1 of 5 sampled residents (#1) who exited the assisted living facility and was found in a ravine behind the facility approximately 24 hours later. [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision. (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to notify the appropriate local law enforcement agency and the local County Department of Social Service (DSS) immediately after discovering a resident (Resident #1) was missing from the facility. [Refer to Tag D0328 10A NCAC 13F .0906(f)(4) Other Resident Care and Services. (Type A2 Violation)].	{D914}		