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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on May 31, 2023, June 1, 2, 5 and 6, 2023. The complaint was initiated on April 14, 2023, by the Richmond County Department of Social Services.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 6 sampled residents resulting in a resident eloping from the facility's locked Special Care Unit (SCU) by accessing an outside porch through a sitting room at approximately 1:04am without staff knowledge and being found outside on the facility grounds approximately 9 hours later deceased (#6). The findings are: Review of Resident #6's current FL-2 dated 02/27/23 revealed: -Diagnoses include dementia, chronic kidney disease, bradycardia, hyperlipidemia, status post pacemaker placement. -He was ambulatory.	D 270		

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-He was intermittently disoriented.
-There was documentation he had a history of wandering behaviors.
-His level of care was Special Care Unit (SCU).

Review of Resident #6's Resident Register dated 02/27/23 revealed:
-He was admitted to the facility on 02/27/23.
-He required assistance with dressing, bathing, nail care, shaving, correspondence, toileting, scheduling appointments and orientation to time and place.
-He was forgetful and needed reminders.

Review of Resident #6's current care plan dated 03/06/23 revealed:
-He had significant memory loss and had to be re-directed.
-He was independent with ambulation.

Review of Resident #6's Mental Health Provider (MHP) visit note dated 03/14/23 revealed:
-Resident #6 was seen for a new patient referral.
-Resident #6 was "pleasantly confused and forgetful".
-Resident #6's assessment of psychiatric/mental status revealed thought process: confused and delayed, forgetful, recent and remote memory loss, judgement/Insight: poor.

Review of Resident #6's Primary Care Provider (PCP) visit note dated 03/06/23 revealed:
-Resident #6 was seen as a new patient to establish with the practice.
-Resident #6 was a transfer from a nearby facility which did not have a locked unit, and apparently, he wandered out of the building at some point.
-Staff denied concerns about Resident #6.

Review of Resident #6's PCP visit note dated

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04/03/23 revealed:
-Resident #6 was seen as a follow up visit.
-Staff denied any behavioral changes or concerns regarding Resident #6.

Review of Resident #6's Incident/Accident report dated 04/14/23 at 9:51am revealed:
-Found resident on the ground on backside.
-Type of occurrence was elopement/wandering
-Location was documented as outside.
-Vital signs and blood pressure were noted as not applicable.
-Description of unusual occurrence revealed "found resident".
-The PCP and County Department of Social Services were notified.

Review of Emergency Medical Services (EMS) encounter document dated 04/14/23 revealed:
-A call was received from the facility at 9:52:54am.
-EMS was dispatched at 9:56:18AM
-EMS was at the patient (Resident #6) at 10:01am
-EMS was called out to the facility for a cardiac arrest.
-EMS found Resident #6 lying on the ground supine behind the building.
-Facility staff were doing chest compressions on Resident #6.
-Resident #6 was cyanotic (bluish or grayish color of the skin) and had dark coagulated blood (clotted blood, the process of blood tuning from a liquid to a gel, forming a blood clot) around his mouth.
-Resident #6's body was cold to touch.
-None of the facility staff knew when Resident #6 was last seen alive, but staff advised that Resident #6 did not come to breakfast this morning at 7:30am.

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-Cardiac monitor was applied and showed asystole (asystole is the cessation of electrical and mechanical activity of the heart).
-Time of death was called at 10:04am.
-Resident #6's body was left in the care of the Special Care Coordinator (SCC).
-EMS departed the scene at 10:12:06am.

Interview with a first shift Kitchen and Maintenance staff on 04/14/213 at 11:17am revealed:
-He worked in the kitchen and helped the Maintenance Supervisor.
-Around 9:40am on 04/14/23 he and the Maintenance Supervisor saw Resident #6 lying on the ground and he appeared to be unconscious.
-He did not think Resident #6 was breathing but he did not actually go up to him.
-When he saw Resident #6 lying on the ground, he went upstairs to get the Special Care Coordinator (SCC).
-Two staff members came down the stairs where Resident #6 was, but he did not know their names.
-The porch area off the Veranda Room was usually where the residents smoked.
-He did not think Resident #6 smoked.

Interview with the Maintenance Supervisor on 04/14/213 at 11:24 am revealed:
-He clocked in for his shift around 9:32am.
-He was doing his rounds,
-He and his maintenance assistant went to the laundry room to talk with the laundry staff.
-He and his maintenance assistant stepped outside of the laundry facility past a brick pillar and that was when they saw a resident laying on the ground
-He alerted two staff who were on an enclosed

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porch above that a resident was on the ground underneath the porch.
-He told the 2 staff he did not know who the resident was but told them he was on the ground.
-He called the Administrator around 9:47am.
-Then everyone started coming outside asking who was on the ground

Observation of the Veranda Room and porch on 06/02/23 at 3:35pm revealed:
-The Veranda Room door was locked.
-Staff unlocked the Veranda Room door.
-There was a door directly across from the Veranda Room entrance door which led to a porch.
-The door leading to the Veranda Room porch was unlocked and there was no sounding device when the door was opened.
-The porch was concrete.
-The perimeter of the porch had brick pillars separated by white wood pickets.
-There was lattice atop the porch rails.
-There were 5 plastic chairs on the porch against the building wall.
-There were no stairs leading off of the porch.
-From the top of the lattice to the ground was approximately 16 to 17 feet.

Interview with a day shift Personal Care Aide (PCA) on 04/20/23 at 5:04pm revealed:
-She had been employed at the facility since 2018 as a PCA.
-She checked on her residents every 30 minutes to 2 hours and sometimes, more frequently depending on the situation.
-If a resident could not be located, she would notify a supervisor and do a search and the administrator and 911 are notified if the resident can't be found.
-She worked on 04/14/23 on the day shift.

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-She was not assigned to Resident #6 but knew he usually ate breakfast around 8:00am.
-She was told by one of the kitchen staff that 5 residents, including Resident #6 had not come to the dining room.
-She went to locate the 5 residents and found all except for Resident #6.
-She notified the Medication Aide (MA) that she could not find Resident #6 and the MA continued passing medications.
-She returned to working with her residents and later heard Resident #6 was found outside on the ground downstairs.
-The communication between the current shift and the on-coming staff at shift change could be better.

Interview with the day shift MA on 04/14/23 at 11:09am revealed:
-She was the MA in charge on 04/14/23.
-Her shift started at 6:00am.
-She last saw Resident #6 in the hallway on 04/13/23 around 6:00pm when she got off from her shift.
-Resident #6 liked going into the Veranda Room, but she was unsure if he used the porch.
-The residents were to be supervised when they go to the Veranda Room porch to smoke but as far as residents just going out, she did not think they required supervision because the porch was enclosed.
-She received a call from a staff member, and they reported a resident on the ground outside.
-Resident #6 was found by the Maintenance Supervisor and his maintenance assistant.

Second interview with the day shift MA on 04/20/23 at 4:12pm revealed:
-She worked on 04/13/23, 04/14/23 and 04/15/23.
-She last saw Resident #6 on 04/13/23 before

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she got off her shift at 6:00pm.
-Her job description included making sure everybody was accounted for.
-She did treatments, administered medication, checked finger stick blood sugars, and made sure that her staff was doing what they are supposed to do.
-The staff checked residents every 2 hours, sometimes every 30 minutes, depending on the state of the resident.
-If the resident just got out of the hospital or been to the ED, they were required to have every 30-minute checks.
-When another shift came in and the current shift was about to leave, the staff was supposed to walk the hall with the staff member that was relieving them and ask who ate, who had not eaten and if someone was sent to the hospital had a medical emergency, the current staff would need to let the on-coming staff know.
-They verified on the computer when staff, the PCAs, completed the residents' ADLs.
-They did not have a logbook.
-Residents got supervised smoke breaks every 2 hours.
-There was no set time of when residents could go outside on the porch before the Veranda Room was locked as a result of accident.
-It was the residents' right to be able to go outside.
-A staff PCA was responsible for Resident #6 starting at 6:00am on 04/14/23.
-If a resident could not be located during medicine time, she would ask the PCA if they saw them and then she would do a search.
-She noticed Resident #6 was not in his room for her medicine check.
-She forgot to give Resident #6 his morning medication.

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D 270	Continued From page 7 Third interview with the day shift MA on 06/05/23 at 2:43 revealed: -She was the Supervisor and MA. -She was responsible for making sure the PCAs performed and documented their resident tasks. -The PCAs were to check at the start of each shift to make sure the residents are accounted for. -If a resident was missing, she was to be notified and a resident head count and full search would be done that included all doors were checked, all rooms, all resident rooms and all bathrooms were checked, if the resident was not found inside then the immediate outside grounds were checked. -She was the 1st shift MA on 4/14/23. -She arrived at work late that day and was behind on everything. -Resident #6 was the last resident she had to administer medication for the 7:00am to 8:00am medication pass, and she forgot to give his medication. -A PCA told her one of the kitchen staff said Resident #6 did not come to the dining room for breakfast. -She thought he was probably in the TV room. -She had planned to look for Resident #6, but someone called her name and she got distracted. -She should have initiated a search for Resident #6. Interview with the night shift PCA on 4/20/23 at 7:06pm revealed: -She worked from 6:00pm to 6:00am. -She had been employed at the facility for about 1 month. -She was a PCA, and her job description consisted of providing feeding assistance, changing, and checking the residents. -Resident #6 was kind of new to the facility and he did not communicate with a lot of people and he kind of did his own thing.	D 270		

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-She usually checked on her residents every 2 hours, it depended on their needs, such as needing to be changed.
-She often went to her residents' room and asked if they needed anything.
-She described the missing resident policy as, if a resident could not be located, the supervisor was to be notified and everyone looked for the resident, if the resident was not found, 911 was called.
-She was assigned to Resident #6 on 04/14/23.
-Both the oncoming and ending shifts were supposed to communicate at shift change but before Resident #6's death, there was not a lot of communication among the shifts.
-The residents had smoke breaks at 6:45pm, 8:45pm and 10:45pm.
-The residents were not supposed to be outside after the last smoke break.
-Resident #6 was usually in the Veranda Room watching TV.
-On 04/14/23 at 5:00am she walked into Resident #6's room to check on him and it was very dark, and she thought he was in there, but she found out later he was not after Resident #6 was discovered outside.

Interview with the night shift MA on 04/20/23 at 7:31pm revealed:
-She had been employed at the facility for nearly 3 years.
-Staff were to check the residents every 2 hours, depending on what the residents had going on.
-If a resident had been in the hospital, they are supposed to check them every 15 minutes for the next 24 hours and every 30 minutes for 24 hours if a resident fell but did not go to the hospital and they are supposed to document every 2 hours.
-The facility protocol for a missing resident was to notify the supervisor when a resident could not be

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found, everybody was supposed to look for the resident then call the Administrator, even after hours.
-The staff coming in and the staff ending their shift were to communicate, for instance, if a resident went to the hospital or with a family member or going to church, staff were to communicate verbally.
-The last time she saw Resident #6 on 04/14/23 was around 12:30am to 1:00am in the Veranda Room.
-Resident #6 was pushing the volume on the TV and it made a lot of noise.
-Resident #6 usually sat in the Veranda Room and watched TV.
-The PCA assigned to Resident #6 on 04/14/23 night shift was "kind of new".
-She never received a report from the PCA that Resident #6 was missing.
-She received a call from the Special Care Coordinator (SCC) on 04/14/23 around 9:30am stating what had happened to Resident #6.
-She told the SCC that she last saw Resident #6 between 12:30am and 1:00am in the Veranda Room.

Interview with the Assisted Living Resident Care Coordinator (RCC) on 04/14/23 at 11:18am revealed:
-Someone called the 1st shift PCA.
-She made her way to where Resident #6 was found on the ground and once she got there, she and another staff member started Cardiopulmonary Resuscitation (CPR) until EMS arrived.
-When EMS arrived, they hooked Resident #6 to a cardiac monitor and put the pads on him and he was flat-lined.
-From her medical experience she knew that Resident #6 had already passed but she

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continued to do CPR until EMS arrived.

Interview with the Special Care Coordinator (SCC) on 04/14/23 at 11:31am revealed:
-She had been employed at the facility previously from 2014 to 2016 or 2017 and had returned in 2021.
-The last time she saw Resident #6 was on 04/13/23 in the dining room, probably around lunch time.
-She was notified of what happened to Resident #6 on 04/14/23 when she walked into her office that morning.
-She heard the medication aide (MA) say "we got a resident outside".
-She went outside to where Resident #6 was and saw 2 staff performing CPR on him.
-The 2 staff performed CPR for about 10-15 minutes and EMS arrived.
-EMS hooked Resident #6 to the machine and he flat-lined (the absence of a heartbeat) and EMS confirmed Resident #6's death.
-She notified Resident #6's PCP.
-She never saw Resident #6 on the porch but had seen him in the Veranda Room.
-The last time she saw Resident #6, she did not notice any change in his behavior, and nothing was reported as unusual by the staff.
-The porch off the Veranda Room was where the residents were allowed to smoke.
-The staff were supposed to supervise and monitor the residents that went out to smoke.
-The purpose of the staff was to supervise the residents, so that nobody fell asleep and dropped a cigarette or burnt themselves.

Telephone interview with the PCP on 06/06/23 at 10:24am revealed:
-She saw Resident #6 twice at the facility.
-She had not heard from the staff that he was exit

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seeking.
-Staff had not voiced any concerns about Resident #6.
-The facility notified her of Resident #6's death on 04/14/23 and she described it as a "horrible accident".
-She expected all residents of the facility to be supervised and accounted for.

Interview with a housekeeper on 04/19/23 at 6:20am revealed:
-She usually got to work around 5:00am on her scheduled days.
-Resident #6 was very withdrawn when he was first admitted to the facility but had recently just started to make friends.
-On 04/14/23, the day Resident #6 went missing, she was cleaning the Veranda Room.
-She could not remember if she went to the Veranda Room porch or not, but she said anytime she went to the porch to get trash from out there, she would look around and see if she saw anything out of the ordinary.
-She did not see Resident #6 the day that he passed away.
-The Veranda Room was locked now since the incident occurred but was not prior to the incident.

Interview with the Administrator on 04/14/23 at 12:30pm revealed:
-She learned about what happened to Resident #6 from the Maintenance Supervisor, who called her at around 9:51am and said there was a resident laying outside on the ground near the laundry room.
-She immediately went out of her office and ran down the stairs to get where Resident #6 was found.
-She saw Resident #6 laying there and saw blood coming out of his mouth and saw that he was not

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breathing.
-She yelled to the Business Office Manager (BOM) and asked her for assistance with the resident on the ground.
-The Assisted Living RCC started CPR.
-While the RCC was performing CPR, she called 911 at 9:53am.
-She called the Adult Home Specialist with the county Department of Social Services after she called 911.
-She asked the staff when the last time Resident #6 was seen and was told they looked for him during breakfast.
-She started looking at the security cameras.
-She looked at the security cameras and saw Resident #6 in the Veranda Room at 1:00am on 04/14/23 wearing a red jacket.
-Resident #6 was seen in the dining room at 1:03am wearing a red jacket.
-Resident #6 re-entered the Veranda Room and was seen walking around, he sat down and got up again and then went out the door to the porch.
-He was wearing the same clothes when he was found outside on the ground with the red jacket beside him.
-There was no camera on the porch.
-The camera was motioned activated and only recorded when there was motion.
-She reviewed cameras of other areas of the building to see if Resident #6 had come up somewhere else but did not see Resident #6 on any other footage.

Review of the Veranda Room camera video on 06/05/23 at 3:34pm revealed:
-Resident #6 was observed walking into the Veranda Room at 12:48am on 04/14/23, he was wearing a red jacket and jeans, he sat down and got up at 1:01am and left the Veranda Room.
-Resident #6 re-entered the Veranda Room

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D 270	Continued From page 13 1:04:32am on 04/14/23 and exited through the unlocked porch patio door and the door closed behind him. -The video resumed recording at 5:38am on 04/14/23 when a housekeeper entered the Veranda Room and was seen vacuuming. Second interview with the Administrator on 04/17/23 at 11:45am revealed: -She completed the 24-hour initial investigation report on 04/17/23. -She called her staff and interviewed them on 04/14/23. -No one had notified her that Resident #6 was missing during their rounds on 04/14/23. -After the incident, there was discussion with corporate as to whether the porch area off the Veranda Room was to remain locked. -According to the facility's policy, they had to provide a free open space for residents to go outside and smoke. Third interview with the Administrator on 06/06/23 at 9:28am revealed: -Staff were expected to do a census check at each shift change. -Residents were to be checked every 2 hours and every 15 minutes for 24 hours if they had returned from the hospital or had a fall. -If a resident was missing, they were to notify the supervisor, do a sweep, going from room to room, including bathrooms, all available staff were to participate in the search, if the resident was not located inside then the search moved to outside premises and the woods line, if the resident was still not located, 911 was called as well as the Department of Social Services and the family or responsible party. -Her supervisor checked the cameras periodically overnight.	D 270		

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D 270	Continued From page 14 -Staff were expected to check on residents in the SCU every 2 hours and to report to supervisor if anyone was missing. -The supervisor was to monitor every 30 minutes by walking the SCU hallway and making sure staff were doing their duties. -Residents were not to be outside unattended. -The Veranda Room door had been locked since the 04/14/23 incident with Resident #6. _____ The facility failed to ensure Resident #6, with a history of wandering behavior, was supervised. The lack of supervision resulted in Resident #6 eloping from the facility's locked Special Care Unit by accessing an outside porch through a sitting room at approximately 1:04am and not being found until approximately 9:40am, when the resident was found deceased after having fallen from the 16-foot high porch. The facility's failure resulted in serious neglect and serious physical harm which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/14/23 and 06/06/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 6, 2023.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	D 271		

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

Based on record reviews and interviews, the facility failed to respond immediately when staff became aware Resident #6 was missing from the Special Care Unit (SCU).

The findings are:

Review of the facility's Missing Resident Policy dated 02/01/2005 revealed:
-A resident will be considered missing when he/she is not in the facility and we cannot verify their whereabouts; and in addition, there is reason to be concerned for the resident's safety.
-If the facility discovers a resident is missing, we will notify the supervisor and all other staff immediately, perform a quick but thorough search of the building and the immediate area outside of the building.
-If the resident is not found, we will immediately notify North Carolina Project Life Saver 1-800-420-7604 and follow instructions in the Project Life Savers handbook and any instructions that are given by them over the phone.
-Notify the resident's family member/responsible party.
-Notify the county Department of Social Services.
-Cooperate fully with law enforcement and or authority in charge of search and rescue.

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Review of Resident #6's current FL-2 dated 02/27/23 revealed:
-Diagnoses include dementia, chronic kidney disease, bradycardia, hyperlipidemia, status post pacemaker placement.
-His level of care was Special Care Unit (SCU).
-He was ambulatory and intermittently disoriented.
-There was documentation he had a history of wandering behaviors.

Review of Resident #6's Resident Register dated 02/27/23 revealed:
-He was admitted to the facility on 02/27/23.
-He required assistance with activities of daily living (ADLs) and was not oriented to time and place.
-He was forgetful and needed reminders.

Review of Resident #6's current care plan dated 03/06/23 revealed:
-He had wandering behaviors.
-He had significant memory loss and had to be re-directed.
-He was independent with ambulation.
.
Review of Resident #6's Mental Health Provider (MHP) visit note dated 03/14/23 revealed:
-Resident #6 was seen for a new patient referral.
-Resident #6 was "pleasantly confused and forgetful".
-Resident #6's assessment of psychiatric/mental status revealed thought process: confused and delayed, forgetful, recent and remote memory loss, judgement/Insight: poor.

Review of Resident #6's Primary Care Provider (PCP) visit note dated 03/06/23 revealed:
-Resident #6 was seen as a new patient to establish with the practice.

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-Resident #6 was a transfer from a nearby facility which did not have a locked unit,
-Apparently, he wandered out of the building at some point.
-Staff denied concerns about Resident #6.

Review of Resident #6's PCP visit note dated 04/03/23 revealed:
-Resident #6 was seen for a follow up visit.
-Staff denied any behavioral changes or concerns regarding Resident #6.

Review of the Veranda Room camera video on 06/05/23 at 3:34pm revealed:
-Resident #6 was seen walking into the Veranda Room at 12:48am on 04/14/23, he was wearing a red jacket and jeans, he sat down and got up at 1:01am and left the Veranda Room.
-Resident #6 re-entered the Veranda Room 1:04:32am on 04/14/23 and exited through the unlocked porch door and the door closed behind him.
-The video resumed recording at 5:38am on 04/14/23 when a housekeeper entered the Veranda Room and was seen vacuuming.

Review of Resident #6's Incident/Accident Report dated 04/14/23 at 9:51am revealed:
-Found Resident #6 on the ground on backside.
-Type of occurrence was elopement/wandering
-Location was documented as outside.
-Vital signs and blood pressure were noted as not applicable.
-Description of unusual occurrence revealed "found resident".
-Primary care provider (PCP) and the County Department of Social Services were notified.

Review of Emergency Medical Services (EMS) encounter document dated 04/14/23 revealed:

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-A call was received from the facility at 9:52:54am.
-EMS arrived on scene at 9:59:53am.
-EMS was at the patient (Resident #6) at 10:01am
-EMS was called out to the facility for a cardiac arrest.
-EMS found Resident #6 lying on the ground supine behind the building.
-Facility staff were doing chest compressions on Resident #6.
-Resident #6 was cyanotic (bluish or grayish color of the skin) and had dark coagulated blood (clotted blood, the process of blood tuning from a liquid to a gel, forming a blood clot) around his mouth.
-Resident #6's body was cold to touch.
-None of the facility staff knew when Resident #6 was last seen alive, but staff advised that Resident #6 did not come to breakfast this morning at 7:30am.
-Cardiac monitor was applied and showed asystole (asystole is the cessation of electrical and mechanical activity of the heart).
-Time of death was called at 10:04am.
-Resident #6's body was left in the care of the Special Care Coordinator (SCC).
-EMS departed the scene at 10:12:06am.

Interview with a first shift Kitchen and Maintenance staff on 04/14/213 at 11:17am revealed:
-At around 9:40am on 04/14/23 he and the Maintenance Supervisor saw Resident #6 lying on the ground and he appeared to be unconscious.
-He did not think Resident #6 was breathing but he did not actually go up to him.

Interview with the Maintenance Supervisor on

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04/14/213 at 11:24 am revealed:
-He and his maintenance assistant stepped outside of the laundry facility past a brick pillar and that was when they saw a resident laying on the ground.
-He called the Administrator around 9:47am.

Interview with the night shift Personal Care Aide (PCA) on 4/20/23 at 7:06pm revealed:
-She worked from 6:00pm to 6:00am.
-She had been employed at the facility for about 1 month.
-She was a PCA, and her job description consisted of feeding, changing, and checking the residents.
-Resident #6 was new to the facility and he did not communicate with a lot of people, and he did his own thing.
-She usually checked on her residents every 2 hours, it depended on their needs, such as needing to be changed.
-She described the missing resident policy as, if a resident could not be located, the Supervisor was to be notified and everyone looked for the resident, if the resident was not found, 911 was called.
-Both the oncoming and ending shifts were supposed to communicate but before Resident #6's death, there was not a lot of communication among the shifts.
-The residents had smoke breaks at 6:45pm, 8:45pm and 10:45pm.
-The residents were not supposed to be outside after the last smoke break and since the passing of Resident #6, no one goes outside after the last break.
-Resident #6 was usually in the Veranda Room watching TV.
-On 04/14/23 at 5:00am she walked into Resident #6's room to check on him and it was very dark,

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and she thought he was in there, but she found out later he was not after Resident #6 was discovered outside.

Interview with the night shift medication aide (MA) on 04/20/23 at 7:31pm revealed:
-She has been employed at the facility for nearly 3 years.
-The PCAs were to check the residents every 2 hours, depending on what the residents had going on.
-The facility protocol was to notify the supervisor when a resident could not be found.
-Everybody was supposed to look for the resident then call the Administrator, even after hours.
-The staff coming in and the staff ending their shift were to communicate verbally, for instance, if a resident went to the hospital or with a family member or went to church.
-The last time she saw Resident #6 on 04/14/23 was around 12:30am to 1:00am in the Veranda Room.
-Resident #6 was pushing the volume on the TV and it made a lot of noise.
-Resident #6 usually sat in the Veranda Room and watched TV.
-The PCA assigned to Resident #6 on 04/14/23 night shift was "kind of new".
-She never received a report from the PCA that Resident #6 was missing.
-She received a call from the SCC on 04/14/23 around 9:30am stating what had happened to Resident #6.
-She told the SCC that she last saw Resident #6 between 12:30am and 1:00am in the Veranda Room.

Interview with a day shift PCA on 04/20/23 at 5:04pm revealed:
-She had been employed at the facility since 2018

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as a PCA.
-If a resident could not be located, she would notify a supervisor and do a search and the Administrator and 911 were notified if the resident could not be found.
-She worked on 04/14/23 on the day shift.
-She was not assigned to Resident #6 but knew he usually ate breakfast around 8:00am.
-She was told by one of the kitchen staff that 5 residents, including Resident #6 had not come to the dining room.
-She went to locate the 5 residents and found all except for Resident #6.
-She notified the MA that she could not find Resident #6 and the MA stayed on the medication cart.
-She returned to working with her residents and later heard Resident #6 was found outside on the ground downstairs.
-The communication between the current shift and the on-coming staff at shift change could be better.

Interview with the day shift MA on 04/20/23 at 4:12pm revealed:
-She worked on 04/13/23, 04/14/23 and 04/15/23 on first shift.
-She last saw Resident #6 on 04/13/23 before she got off at 6:00pm.
-Her job description was to make sure everybody was accounted for.
-If a resident could not be located, the facility protocol was to check all doors, all bathrooms and other rooms which include the residents' rooms.
-If not found, then call 911 so that a missing person report could be completed.
-A staff PCA was responsible for Resident #6 starting at 6:00am on 04/14/23.
-If a resident could not be located during

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medication time, she would ask the PCA if she had seen them and then she would do a search.
-She noticed Resident #6 was not in his room for her medicine check.
-She forgot to give Resident #6 his morning medication.

Second interview with the day shift MA on 06/05/23 at 2:43 revealed:
-If a resident was missing, she was to be notified and a resident head count and full search would be done.
-That included all doors were checked, all rooms, all resident rooms and all bathrooms were checked, if the resident was not found inside then the immediate outside grounds were checked.
-She was the 1st shift MA on 4/14/23.
-She arrived to work late that day and was behind on everything.
-Resident #6 was the last resident she had to administer medication for the 7:00am to 8:00am medication pass, and she forgot to administer his medication.
-A PCA told her one of the kitchen staff said Resident #6 did not come to the dining room for breakfast.
-She thought he was probably in the TV room.
-She had planned to look for Resident #6, but someone called her name and she got distracted.
-She did not initiate and search for Resident #6 because she was behind on her medication pass and was distracted.
-She should have initiated a search for Resident #6.

Interview with the Resident Care Coordinator (RCC) on 04/14/23 at 11:18am revealed:
-Someone called the 1st shift PCA.
-The RCC made her way to where Resident #6 was found on the ground and once she got there,

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she and another staff member started Cardiopulmonary Resuscitation (CPR).
-The RCC and another staff member took turns doing CPR until EMS arrived.
-When EMS arrived, they hooked Resident #6 to the cardiac monitor and put the pads on him and he was flat-lined (the absence of a heartbeat) and EMS confirmed Resident #6's death.
-From her medical experience she knew that Resident #6 had already passed but she continued to do CPR until EMS arrived.

Interview with the SCC on 04/17/213 at 12:30pm revealed staff did not notify her that Resident #6 was missing or that he was not around at breakfast time or during the 7:00am medication pass.

Second interview with the SCC on 06/06/23 at 11:25am revealed:
-There had been no resident elopement prior to 04/14/23.
-If a resident was missing, the supervisor was to be notified and a search was started, checking all doors, all rooms and resident's room and bathrooms.
-If the resident cannot be found then, they were to check outside.
-If unable to locate the resident, 911, law enforcement and the Administrator was to be notified.
-Walking rounds were to be done at each shift change to account for the residents.
-Walking rounds should have been done on 04/14/23 to account for the residents.

Interview with a day shift MA on 04/20/23 at 6:14pm revealed:
-She normally worked on the front hall (assisted living).

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-If a resident's whereabouts were unknown, the supervisor would do a headcount and they would search for the resident and would contact the Administrator and call 911 if the resident could not be found.
-When a resident was unavailable during the medication pass, they checked locked doors, and contacted the supervisor to do a head count and asked everyone to help in the search.

Interview with the Administrator on 04/14/23 at 12:30pm revealed:
-She learned about what happened to Resident #6 from the Maintenance Supervisor, who called her at around 9:51am and said there was a resident laying outside on the ground near the laundry room.
-She immediately went out of her office and ran down the stairs to get where Resident #6 was found.
-She saw Resident #6 laying there and saw blood coming out of his mouth and saw that he was not breathing.
-She yelled to the Business Office Manager (BOM) and asked her for assistance with the resident on the ground.
-The Assisted Living RCC started CPR.
-While the RCC was performing CPR, she called 911 at 9:53am.
-She called the Adult Home Specialist with the county Department of Social Services after she called 911.
-She asked the staff when the last time Resident #6 was seen and was told they looked for him during breakfast.
-She started looking at the security cameras.
-She looked at the security cameras and saw Resident #6 in the Veranda Room at 1:00am on 04/14/23 wearing a red jacket.
-Resident #6 was seen in the dining room at

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1:03am wearing a red jacket.
-Resident #6 re-entered the Veranda Room and was seen walking around, he sat down then got up again and went out the door to the porch.
-He was wearing the same clothes when he was found outside on the ground with the red jacket beside him.
-There is no camera on the porch.
-The camera was motioned activated and only recorded when there was motion.
-She reviewed cameras of other areas of the building to see if Resident #6 had come up somewhere else but did not see Resident #6 on any other footage.
-She had the Maintenance Supervisor lock the door to the Veranda Room so the residents could no longer go out there.

Second interview with the Administrator on 04/17/23 at 11:45am revealed:
-No one had notified her that Resident #6 was missing during their rounds on 04/14/23.
-She was shocked when she was notified by the Maintenance Supervisor on 04/14/23 at 9:51am when he found Resident #6 outside on the ground.

Third interview with the Administrator on 06/06/23 at 9:28am revealed:
-Staff were expected to do a census check at each shift change.
-Residents were to be checked every 2 hours and every 15 minutes for 24 hours if they had returned from the hospital or had a fall.
-If staff found a resident was missing, they notified the supervisor, did a sweep, going from room to room, including bathrooms, all available staff were to participate in the search, if the resident was not located inside then the search moved to the outside premises and the woods

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D 271	Continued From page 26 line, if resident was still not located, 911 was called as well as the Department of Social Services and the family or responsible party. -Staff were expected to check on residents in the SCU every 2 hours and to report to the Supervisor if anyone was missing. -The supervisor was to monitor every 30 minutes by walking the SCU hallway and making sure staff were doing their duties. -She had implemented Missing Resident drills every quarter after the incident with Resident #6 occurred. -Residents were not to be outside unattended. Attempted telephone interview with the night shift PCA on 06/05/23 at 2:50pm, and 06/06/23 at 11:25am and 4:11pm were unsuccessful. _____ The facility failed to immediately respond when Resident #6 was missing. When the medication aide was alerted that the resident was not present at breakfast, the facility failed to perform a search of the building and outside of the building. Approximately 2 hours later the resident was discovered outside lying on the ground and was deceased. This failure resulted in serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/14/23 and 06/06/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 6, 2023.	D 271		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

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to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (#3) for complaints of a headache, and a positive COVID test.

The findings are:

A. Review of Resident #3's current FL2 dated 04/13/23 revealed:
-Diagnoses included dementia.
-He was semi-ambulatory, and he was intermittently disoriented.

Review of Resident #3's Resident Register dated 04/26/23 revealed he was admitted to the facility on 04/26/23.

Review of Resident #3's Nurses Notes dated 04/26/23 revealed:
-The was an entry at 2:00pm that Resident #3 was a new resident to the hall, had dementia with behavioral disturbance, walked with a cane, was hard of hearing, oriented to person, intermittently oriented to place and time and needed assistance with all activities of daily living (ADLs).
-There was an entry at 6:00pm that the resident was coming into the kitchen looking for his sister.
-The resident was re-directed to the dayroom; resident was very confused and was roaming the hall.
-There was an entry at 8:00pm that resident was still roaming the halls looking for his sister.

Review of Occurrence Report dated 04/29/23 at 12:00am revealed:

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-Resident #3 fell and hit his head on the floor, Resident #3 was bleeding and had a knot on his head.
-Under Type of Occurrence, fall/slip/found on floor was checked.
-Location was marked as hallway.
-The fall was unwitnessed.
-Resident #3 was sent to the Emergency Department (ED).
-Resident #3's family was notified.
-Resident #3's PCP was notified via fax.

Review of Resident #3's Nurse Notes dated 04/29/23 revealed:
-There was an entry at 3:00am that resident was found on the floor in the hall and was sent out, resident had bleeding from the head and family was notified.
-There was an entry at 8:45am that the resident returned from the ED.

Review of a hospital after visit summary dated 4/29/23 revealed:
-Non sutured laceration care.
-Go to the ED if you have new or worsening symptoms.
-Imaging Tests done: CT Cervical Spine without contrast, X-ray Pelvis AP 1 or 2 views.

Review of Resident #3's ED Course and Medical Decision-making notes dated 04/29/23 revealed:
-History of dementia, presents to ED with facial laceration status post fall.
-Vital signs unremarkable.
-Patient neurologically intact baseline on physical examination.
-Found to have facial laceration repaired as documented on separate procedure note.
-Superficial skin avulsions bilateral elbows did not require repair.

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-No evidence of life-threatening traumatic injury.
-Negative CT of head and cervical spine imaging.
-Appropriate for discharge.
-Should follow with primary care for re-assessment later this week.

Review of the nurses' notes for Resident #3 dated 04/30/23 revealed:
-There was an entry with no time documented that the resident complained of a headache, a rapid COVID test was administered, and it came back positive.
- Called and left a message on family member's answering machine.
-There was a second entry with no time documented that another family member was contacted, and the family member said she would be calling to check on resident.
-There was no documentation, the PCP was notified of Resident #3's positive COVID test.

Interview with the Supervisor on 06/01/23 at 8:05am revealed:
-She was the on-call supervisor for the weekend and was in the facility Sunday 04/30/23 in the morning until about 2:00pm.
-Resident #3 complained of not feeling well, not wanting to eat and complained of a headache.
-She did a Rapid COVID test because other residents in the building with COVID complained of headache as their only symptom.
-The Rapid COVID test was positive.
-She was not concerned about Resident 3's complaint of headache because he had been to the ED the day before after a fall and had been checked out and was ok.
-Resident #3 was scheduled to see the primary care provider (PCP) the following day.
-Since it was the weekend and Resident #3 was not symptomatic for COVID other than a

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headache, the PCP would be notified the following day at his visit.
-She last saw Resident #3 in the afternoon around 2:00 or 2:30pm and he was sleeping.
-She failed to document the time of her nurses' notes.

Interview with the Administrator on 06/02/23 at 9:54am revealed:
-Resident #3 would be expected to have pain and bruising after his recent fall.
-She was not concerned about Resident #3's complaint of headache after a fall and head injury because he was sent to the ED the day before to be checked and was ok.
-She would have been concerned about "real changes", she described as increased confusion or change in mental status, weakness, changes in the eye or pupils, fever, then the PCP would have been contacted and possibly sent back to the ED.
-There had been cases of COVID in the facility around 04/30/23 and one of the symptoms had been a headache.

Interview with the Special Care Coordinator (SCC) on 06/06/23 at 10:58am revealed:
-If a resident tested positive for COVID, the PCP was notified, but since Resident #3 tested positive on Sunday and the only symptom was headache, he was to see the PCP the following day.
-It was her understanding that Resident #3's only symptom of COVID was a headache.

Interview with the night shift Medication Aide (MA) on 06/01/23 at 11:08am revealed:
-If a resident complained of a headache, they sometimes notified the PCP.
-Some of the residents with COVID had

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D 273	Continued From page 31 complained of a headache as a symptom. -Resident #3 had tested positive for COVID but she was not sure exactly when. Interview with the on-call Supervisor on 06/02/23 at 8:16am revealed she did not contact the PCP the day before when Resident #3 complained of a headache and tested positive for COVID. Second interview with the Administrator on 06/06/23 at 10:58am revealed: -The PCP was always notified of positive COVID tests. -Resident #3 had not been seen by the facility's contracted PCP and was scheduled for his 1st visit the following day so the PCP was not contacted. -She did not have contact information for Resident #3's previous PCP. Telephone interview with the facility's contracted PCP on 06/06/23 at 9:59am revealed: -She was to see Resident #3 on 05/01/23 as a new patient. -She was not aware Resident #3 was positive for COVID. -She received notification on 05/01/23 that Resident #3 had expired.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION	D 338		

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Based on interviews, record reviews, and observations, the facility failed to protect a resident from neglect related to staff providing an illegal substance to Resident #8 who resided on the Special Care Unit (SCU).

The findings are:

Review of Resident #8's current FL2 dated 09/12/22 revealed:
-Diagnoses included Parkinson's Disease and substance abuse.
-The recommended level of care was Special Care Unit (SCU).

Review of Resident #8's records revealed:
-The SCU disclosure statement signed by resident's responsible party on 08/01/17.
-SCU disclosure was signed when resident was admitted to assisted living facility.
-The SCU pre-screening completed on 08/09/22.

Review of Resident #8's care plan dated 05/30/23 revealed he required limited assistance with bathing and set up and supervised with eating.

Interview with Resident #8 on 05/26/23 at 4:09pm revealed:
-There was a girl that worked in the SCU that offered him marijuana.
-He had smoked marijuana on the porch outside of the Veranda room.
-He had smoked marijuana with staff in the SCU at night.
-A staff member had bought him $10.00 worth of marijuana on two different occasions.

Interview with Resident #8 on 06/05/23 at 10:30am revealed:

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-Staff members smoked marijuana on the SCU porch at night.
-A staff member gave him marijuana but he could not remember her name.
-Another staff member found the marijuana in his drawer and took it.

Interview with the Supervisor on duty at the time of the incident on 06/05/23 at 2:35pm revealed:
-She was not aware of how Resident #8 obtained the marijuana.
-Another staff member found the marijuana and took it from Resident #8.
-She called the Administrator and informed her about the incident.

Interview with the Special Care Unit Coordinator on 06/05/23 at 2:25pm revealed:
-She was told a staff member caught Resident #8 with marijuana and took it from him.
-She thought staff gave the marijuana to the Administrator.
-She did not investigate the incident.

Interview with the Administrator on 06/05/23 at 3:10pm revealed:
-On 05/18/23, the Supervisor on duty of the SCU called and told her Resident #8 had been caught with marijuana.
-Staff G was sent home because she was suspected of giving the marijuana to Resident #8.
-When she arrived at work the following day there was marijuana on her office floor, where staff had slid it under her door.
-A staff member told her that she did not give Resident #8 the marijuana and she did not know how he got it.
-She asked the Staff G to submit to a drug test and the drug test was positive for marijuana.

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D 338	Continued From page 34 Telephone interview with Staff G on 06/06/23 at 10:45am revealed: -She called her brother who came to the facility and sold $10 worth of marijuana to Resident #8. -She did not smoke the marijuana with the resident. -All the staff members on the SCU on the 3rd shift smoked marijuana on the porch of the facility. -On the night when a resident was found outside on the facility grounds deceased, the staff assigned to monitor him had been outside smoking marijuana during 3rd shift. -She agreed to take a drug test and was never given the results. _____ The facility failed to protect Resident #8 from neglect by providing and allowing him to smoke marijuana. Resident #8, resided on the SCU and diagnoses included Parkinson's Disease and substance abuse. This was detrimental to the health, safety and welfare of Resident #8 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/26/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 6, 2023.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and	D 438		

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D 438	Continued From page 35 .0102. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed report allegations of neglect and abuse to the Health Care Personnel Registry (HCPR) for 2 of 2 staff (Staff G and Staff F). The findings are: 1. Review of Resident #8's current FL2 dated 09/12/22 revealed diagnoses included Parkinson's Disease, seizure disorder, schizophrenia, anxiety, chronic pain, essential hypertension, and substance abuse. Review of Resident #8's care plan dated 05/30/23 revealed he required limited assistance with eating and bathing. Review of Staff G's Personal Record revealed the following: -She was hired as a PCA on 01/24/20. -Facility completed a criminal background check on Staff G on 01/24/20. -There was documentation of 20 hours of Special Care Unit (SCU) training on 04/04/08, three hours of SCU training on 01/20/20, and three hours of SCU training on 01/24/20. Interview with Resident #8 on 05/26/23 at 4:09pm revealed the following: -There was a girl that worked on the SCU that offered him marijuana. -He had smoked marijuana on the porch outside of the Veranda room. -He had smoked marijuana with staff in the SCU at night.	D 438		

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Interview with Resident #8 on 06/05/23 at 10:30am revealed:
-A staff member gave him marijuana but he could not remember her name.
-A staff member found the marijuana in his drawer and took it.
-He did not know what the staff member did with the marijuana after she took it from his room.

Interview with the SCU Coordinator on 06/05/23 at 2:25pm revealed:
-She was told a staff member caught Resident #8 with marijuana and took it from him.
-She thought staff gave the marijuana to the Administrator.
-The Administrator conducted an investigation, she was not sure of the outcome.

Interview with the Supervisor on 06/05/23 at 2:35pm revealed:
-She was not aware of how Resident #8 got the marijuana.
-A staff member found the marijuana and took it from Resident #8.
-She called the Administrator and informed her about the incident.
-The Administrator did an investigation, she was not aware of the outcome.
-She did not witness staff members smoking marijuana at the facility.

Interview with the Administrator on 06/05/23 at 3:10 pm revealed:
-On 05/18/23, the Supervisor on shift of the SCU called and told her Resident #8 had been caught with marijuana.
-Staff G was sent home because she was suspected of giving the marijuana to Resident #8.
-When she got to work the following day there was marijuana on her office floor, staff had slid it

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under her door.
-Staff told her that she did not give Resident #8 the marijuana and she did not know how he got it.
-She informed Staff G not to return to work until she completed an investigation.
-She asked the Staff G to take a drug test, staff member agreed to take the test.
-Staff G's drug test was positive for marijuana.
-She sent the staff member a text message informing her not to return for her shift.
-She did not notify the Health Care Personnel Registry about the incident.

Telephone interview with the Staff G on 06/06/23 at 10:45am revealed:
-All the staff members on the SCU on the 3rd shift smoke marijuana on the porch of the facility.
-She called her brother who came to the facility and sold $10 worth of marijuana to Resident #8.
-She was put on leave by the Administrator after the incident was reported.
-She was terminated from her position at the facility after failing the drug test.

Attempted interview with Resident #8's Power of Attorney on 06/06/23 at 9:35am was unsuccessful.

2. Review of Resident #7's current FL-2 dated 08/29/22 revealed diagnoses included acute respiratory failure, COVID-19 pneumonia, acute kidney injury, chronic kidney disease, epilepsy, hypertension, pan lobar emphysema, depression, and cerebral vascular accident.

Review of Staff F's employee record revealed she was hired on 12/15/21 as a personal care aide (PCA).

Review of Resident #7's progress note dated

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D 438	Continued From page 38 05/03/23 revealed: -The resident took a pair of scissors from the hall, refused to give them to staff and threw them under his closet door. -The medication aide (MA) used a ruler to get the scissors from the under the closet door using a ruler. -Resident #7 attempted to move toward the MA in the room and the personal care aide (PCA) pulled him back in his wheelchair. -The resident was trying to hit the PCA as she pulled him in his wheelchair out of the room. -Neither the MA nor the PCA hit Resident #7. Review of an internal investigation report for Resident #7 dated 05/03/23 revealed: -Staff F came to the office and said Resident #7 had taken a pair of scissors that she could not get back from him. -Staff F asked for help from other staff in getting the scissors because Resident #7 was always saying something about her. -A MA went to assist Staff F. -A staff called out for assistance because Resident #7 was trying to fight Staff F and the MA. -The Administrator went to see what was happening, but the incident was over by the time she arrived. -Resident #7 told her Staff F and the MA tried to jump him in his room. -Staff F said she remained at the door of the resident's room and did not hit him. -The family member came to the facility and called local law enforcement. -The Administrator and the law enforcement officer reviewed the camera footage. -The investigation was closed with nothing to support the accusations.	D 438		

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Observation of facility camera footage dated 05/03/23 revealed:
-At 8:48am, Staff F walked to Resident #7 door where the resident was sitting in a wheelchair.
-A MA was in the hallway at the door next to the resident.
-Staff F moved the resident's right arm and pulled the wheelchair back out of the doorway and into the hall.
-The MA went into the resident's room.
-Resident #7 began swinging his arms upwards, sitting forward and then back.
-Staff F grabbed the resident's shoulder and shirt to prevent him from going forward.
-The resident then began propelling the wheelchair down the hall and Staff F walked toward the resident's room.

Telephone interview with Resident #7's family member on 06/05/23 at 3:14pm revealed:
-The resident came to her house and told her Staff F went into his room, choked, and hit him.
-She told the Administrator and called local law enforcement.
-The law enforcement officer told her the camera footage did not substantiate the accusations against Staff F.
-The resident could be very difficult to deal with and was very hard of hearing.
-He also had a stroke which had affected how he remembered and understood things.
-She believed what he told her because he had scratches on his arm, neck and back.

Telephone interview with Staff F on 06/06/23 at 10:52am revealed:
-Resident #7 was difficult to provide care and assistance to.
-If Resident #7 was out of cigarettes, he tended to make accusations against staff who did not

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provide him with a cigarette.
-She was trained to walk away, let the situation calm down and get a supervisor when a resident was agitated and when she was frustrated or angry.
-She and the MA were trying to get a pair of scissors Resident #7 took from the hallway.
-He had thrown the scissors under his closet door.
-She was moving his wheelchair to allow the MA access to his room to obtain the scissors.
-She did not think she handled the resident roughly.
-She did not hit or choke the resident.
-She was trying to keep him from hurting himself by throwing himself out of his wheelchair.

Interview with the Administrator on 06/05/23 at 2:08pm revealed:
-She became aware of the incident with Staff F and Resident #7 because the family member came to the facility and called local law enforcement on 05/03/23.
-The family member accused Staff F of jumping the resident in his room and choking him.
-She immediately viewed the camera footage and showed the law enforcement officer as well.
-She saw Staff F try to keep the resident from hitting staff and throwing himself out of the wheelchair.
-She completed an internal investigation by reviewing the camera footage and interviewing Staff F and the MA.
-She did not complete and send a 24 hour initial report and 5 day investigation to the HCPR because she did not think anything happened.
-She thought 24 hour initial reports and 5 day investigations were completed and sent to the HCPR when allegations were substantiated.
-She was responsible for completing 24 hour

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D 438	Continued From page 41 initial and 5 day investigation reports for the HCPR.	D 438		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. 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 and the local law enforcement authority of abuse for 1 of 3 sampled residents (Resident #8). The findings are: Review of Resident #8's current FL2 dated 09/12/22 revealed diagnoses included Parkinson's Disease, seizure disorder, schizophrenia, anxiety, chronic pain, essential hypertension, and substance abuse. Review of Resident #8's care plan dated 05/30/23 revealed he required limited assistance with eating and bathing. Interview with Resident #8 on 05/26/23 at 4:09pm revealed: -There was a girl that worked in the special care	D 453		

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unit that offered him marijuana.
-He had smoked marijuana on the porch outside of the Veranda room.
-He had smoked marijuana with staff in the special care unit at night.

Interview with Resident #8 on 06/05/23 at 10:30am revealed:
-Staff members smoked marijuana on the special care unit porch at night.
-A staff member gave him marijuana but he could not remember her name.
-A staff member found the marijuana in his drawer and took it.
-He did not know what the staff member did with the marijuana after she took it from his room.

Interview with the Special Care Coordinator on 06/05/23 at 2:25pm revealed:
-She was told a staff member caught Resident #8 with marijuana and took it from him.
-She thought staff gave the marijuana to the Administrator.
-The Administrator conducted an investigation, she was not sure of the outcome.

Interview with the Shift Supervisor at the time of the incident on 06/05/23 at 2:35pm revealed:
-She was not aware of how Resident #8 got the marijuana.
-A staff member found the marijuana and took it from Resident #8.
-She called the Administrator and informed her about the incident.
-The Administrator did an investigation, she was not aware of the outcome.
-She did not witness staff members smoking marijuana at the facility.

Interview with the Administrator on 06/05/23 at

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D 453	Continued From page 43 3:10pm revealed: -On 05/18/23, the Supervisor on shift of the SCU called and told her Resident #8 had been caught with marijuana. -Staff G was sent home because she was suspected of giving the marijuana to Resident #8. -When she got to work the following day there was marijuana on her office floor, staff had slid it under her door. -A Staff member told her that she did not give Resident #8 the marijuana and she did not know how he got it. -She informed Staff G not to return to work until she completed an investigation. -She asked the Staff G to take and drug test and the drug test was positive for marijuana. -She sent the staff member a text message texted informing her not to return for her shift. -She did not notify the county department of social services or law enforcement about the incident. Telephone interview with Staff G on 06/06/23 at 10:45am revealed: -All the staff members on the SCU on the 3rd shift smoke marijuana on the porch of the facility. -She called her brother who came to the facility and sold $10 worth of marijuana to Resident #8. -She did not smoke the marijuana with the resident. -She agreed to take a drug test and was never given the results. Attempted interview with Resident #8's Power of Attorney on 06/06/23 at 9:35am was unsuccessful.	D 453		
D 462	10A NCAC 13F .1305 Special Care Unit Policies And Procedures	D 462		

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D 462	Continued From page 44 10A NCAC 13F .1305 Special Care Unit Polices And Procedures The facility shall assure that special care unit policies and procedures are established, implemented by staff and available for review within the facility. In addition to all applicable policies and procedures for adult care homes, there shall be policies and procedures that address the following: (1) the philosophy of the special care unit which includes a statement of mission and objectives regarding the specific population to be served by the unit which shall address, but not be limited to, the following: (a) safe, secure, familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medications; (b) a structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each resident's abilities; (c) individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning; and (d) methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance; (2) the process and criteria for admission to and discharge from the unit; (3) a description of the special care services offered in the unit; (4) resident assessment and care planning, including opportunity for family involvement in care planning, and the implementation of the care	D 462		

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D 462	Continued From page 45 plan, including responding to changes in the resident's condition; (5) safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior; (6) staffing in the unit; (7) staff training based on the special care needs of the residents; (8) physical environment and design features that address the needs of the residents; (9) activity plans based on personal preferences and needs of the residents; (10) opportunity for involvement of families in resident care and the availability of family support programs; and (11) additional costs and fees for the special care provided. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to establish and implement a safety policy of monitoring unlocked exit doors on the special care unit (SCU) where one door without an alarm led to a porch approximately 16 feet above the ground and a second door locked from the outside with no means of re-entry once the door closed. The findings are: Review of the facilty's undated policy and procedure for the special care unit (SCU) provided in response for safety and monitoring of exit doors and outside enclosures on or attached to the SCU revealed: -The SCU was developed for the task of caring	D 462		

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for residents with Alzheimer's.
-The SCU provided a safe, secure and stimulating environment for residents.
-There was a secure courtyard as part of the SCU community.
-Staff received training regarding activation of the fire alarm system and the door locking system would no longer be operational.
-All exits from the facility were constantly monitored and there was an accounting for each resident during an emergency.
-The SCU doors were equipped with magnetic door locks.
-The outside area was enclosed by a six foot fence and had a magnetic door lock on the exit gate in the courtyard.
-There was no documentation of the facility's policy for unlocked exit doors.
-There was no documentation of the facility's policy for monitoring residents in outside enclosed areas.

1. Review of Resident #6's current FL-2 dated 02/27/23 revealed:
-Diagnoses include dementia, chronic kidney disease, bradycardia, hyperlipidemia, status post pacemaker placement.
-He was ambulatory and intermittently disoriented.
-There was documentation of wandering behaviors.
-His level of care was Special Care Unit (SCU).

Review of Resident #6's Resident Register dated 02/27/23 revealed:
-He was admitted to the facility on 02/27/23.
-He required assistance with dressing, bathing, nail care, shaving, correspondence, toileting, scheduling appointments and orientation to time and place.

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D 462	Continued From page 47 -He was forgetful and needed reminders. Review of Resident #6's current care plan dated 03/06/23 revealed: -He had wandering behaviors. -He had occasional incontinence (less than daily) of bowel and bladder. -He had significant memory loss and had to be re-directed. -He was independent with ambulation. Review of Resident #6's primary care provider (PCP) visit note dated 03/06/23 revealed: -Resident #6 was seen as a new patient to establish with the practice. -Resident #6 was a transfer from a nearby facility which did not have a locked unit, and apparently, he wandered out of the building at some point. Review of the Veranda Room camera video on 06/05/23 at 3:34pm revealed: -Resident #6 was seen walking into the Veranda Room at 12:48am on 04/14/23, he was wearing a red jacket and jeans, he sat down and got up at 1:01am and left the Veranda Room. -Resident #6 re-entered the Veranda Room 1:04:32am on 04/14/23 and exited through the unlocked porch door and the door closed behind him. -There was no footage of Resident #6 re-entering the facility. -The video resumed recording at 5:38am on 04/14/23 when a housekeeper entered the Veranda Room and was seen vacuuming. -The camera video was motion activated and only recorded when there was motion in the room. Interview with a night shift personal care aide (PCA) on 04/19/23 at 5:12am revealed: -She had been employed at the facility as a PCA	D 462		

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for 1 year.
-The latest the residents could go outside to the Veranda Room porch was 10:45pm, whether it was a regular break or a smoke break.
-When the residents go to smoke on the Veranda Room porch, they were to be supervised.

Interview with a day shift medication aide (MA) on 04/14/23 at 11:09am revealed:
-The residents were supposed to be supervised for smoke breaks on the Veranda Room porch.
-As far as residents just coming out on the porch, she did not think they required supervision because the porch was closed in.

Interview with a night shift PCA on 04/20/23 at 7:06pm revealed:
-She has been employed at the facility for 1 month as a PCA.
-The residents on her shift were allowed smoke breaks at 6:45pm, 8:45pm and the last smoke break was 10:45pm.
-The residents are not supposed to be outside after the last smoke break.

Second interview with a day shift MA on 04/20/23 at 4:12pm revealed:
-The residents were permitted smoke breaks every 2 hours.
-There was no set time when residents could go out to the Veranda Room porch when it was accessible.
-It was the residents' right to go outside.

Interview with a day shift PCA in the SCU on 04/20/23 at 5:50pm revealed:
-The residents were permitted smoke breaks every 2 hours.
-The 1st smoke break of the day was at 8:45am.
-The last smoke break was at 10:45pm.

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D 462	Continued From page 49 -The staff was required to sit outside with the residents when they smoked, -Even when the residents were not smoking and on the porch, she would sit outside with them. Interview with a second day shift PCA on the SCU on 4/20/23 at 4:24pm revealed: -The residents took smoke breaks on her shift starting at 8:45am. -The last smoke break was at 10:45am. -She said when certain residents go to the porch, they were to be supervised. Interview with third day shift PCA on the SCU on 04/20/23 at 4:43pm revealed when the residents took breaks on the Veranda Room porch, they had to go outside with them all the time when they smoked. Interview with the Administrator on 04/14/23 at 12:30pm revealed: -Resident #6 was wearing the same clothes when he was found outside on the ground with the red jacket beside him. -There was no camera on the porch off of the Veranda Room. -The camera was motioned activated and only recorded when there was motion. -She reviewed cameras of other areas of the building to see if Resident #6 had come up somewhere else but did not see Resident #6 on any other footage. -She had the Maintenance Supervisor lock the door to the Veranda room so the residents could no longer go out there. 2nd interview with the Administrator on 06/06/23 at 9:28am revealed: -Staff were expected to do a census check at each shift change.	D 462		

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-Residents were to be checked every 2 hours and every 15 minutes for 24 hours if they had returned from the hospital or had a fall.
-Residents were not to be outside unattended.
-The Veranda Room door had been locked since the 04/14/23 incident with Resident #6.

Observations of the Veranda Room on 06/02/23 at 3:35pm revealed:
-The entrance door to the Veranda Room was locked.
-Staff unlocked the door with a key.
-There was an unlocked exit door across the room from the entrance door.
-There was no sounding device on the exit door.
-The exit door led to a balcony (at the back of the building) with brick topped with lattice around the perimeter.
-The porch was approximately 16 feet from the ground.

Interview with a medication aide (MA) on 06/02/23 at 3:35pm revealed:
-The Veranda Room was kept locked since the incident with Resident #6 (04/14/23).
-Residents on the SCU used to be able to go out on the porch off the Veranda Room to smoke.
-The door to the balcony did not lock.
-She declined to answer if the unlocked doors on the SCU were monitored by staff.
-Staff knew when residents went out on the porch off the Veranda Room when it was kept open.
-She did not have an answer for how staff knew when residents went out on the porch off the Veranda Room.

2. Interview with the Administrator on 06/02/23 at 4:00pm revealed:
-The left hall exit door on the SCU was always unlocked for residents to have access to outside.

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-The gate outside was kept locked.
-Staff were responsible for accompanying residents outside via the left hall exit door. (The left hall exit door locked from the outside.)
-She did not know if staff routinely monitored the outside area for residents who may be locked out.
-She thought the outside area was a safe area because it was enclosed with a locked gate.
-She did not have a policy and procedure implemented for safety monitoring of unlocked SCU doors and related outside areas.

Observations of the left hall exit door on the special care unit (SCU) on 06/01/23 from 11:20am until 11:24am revealed:
-The exit door was unlocked with a sounding device that was activated upon opening the door.
-The sounding device de-activated once the exit door closed.
-The exit door led to a balcony (at the side of the building) with a concrete ramp going down to a large outside area (side and center of the building) that was enclosed with a locked gate.
-The exit door locked, once shut, from the outside with no means of re-entry or alerting staff.
-The balcony was approximately 7 feet from the ground and had a picket fence installed around the inside perimeter.
-Staff did not respond to sounding device and surveyor outside of building.
-Staff had to be contacted by phone for re-entry.

Interview with a personal care aide (PCA) on 06/01/23 at 11:24am revealed:
-The left hall exit door was kept unlocked.
-The door locked from the outside.
-Staff did not monitor the exit door because it had a sounding device on it to alert staff when someone went out the door.
-She did not hear the alarm when the door was

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HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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 462	Continued From page 52 opened at 11:20am. Observations of the left hall exit door on the special care unit (SCU) on 06/01/23 from 2:32pm until revealed: -There was no staff on the left hall of the SCU. -The left hall exit door was opened and the sounding device was activated long enough for someone to step outside onto the balcony. -The sounding device de-activated once the door was closed. -No staff responded to the sounding device or checked the outside area. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision] _____ The facility failed to establish and implement a safety policy for monitoring the special care unit's (SCU) unlocked and locked exit doors. The facility's failure resulted in a door without an alarm leading to a porch approximately 16 feet above the ground and a second door locked from the outside with no means of re-entry once the door closed not being monitored which placed residents on the SCU at risk for falls, prolonged exposure to outdoor elements and injury. The facility's failure was detrimental to the health, safety, and welfare of the residents on the SCU and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 6, 2023.	D 462		