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D 000	Initial Comments The Adult Care Licensure Section and the Currituck County Department of Social Services conducted an annual, follow-up survey and complaint investigation on 07/18/23 through 07/20/23. The Currituck County Department of Social Services initiated the complaint investigation on 06/26/23.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 2 of 6 exit doors which were accessible to 4 residents who resided on the assisted living (AL) side of the facility and were intermittently disoriented, ambulatory (#1, #2, #6, #7), one resident who wandered (#6) and one resident who eloped (#1) had audible alarms activated when the exit doors were opened to alert staff.	D 067		

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D 067	Continued From page 1 The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for 90 beds of which 42 were on the assisted living (AL) side of the facility. Review of the facility's AL census on 07/18/23 revealed there were 39 residents residing on the AL side of the facility. Review of the facility's magnetic lock policy dated 08/08/16 revealed: -The magnetic locks were used for all outside entrances and exits. -All exit door locks should be easily operable by a single hand motion without keys. -Exit doors should be locked only if the devices met requirements outlined in State Building Code for special locking devices. -All magnetic locks should remain locked to maintain the safety of both the facility and the residents. -An individual entering or leaving a locked facility or unit should be responsible for securing the door and will be held responsible for any loss or damage from failure to ensure the door is secured. -Employees should not disarm or tamper with the magnetic locks for any reason. -The Administrator is the only person on site allowed to disengage or override the magnetic lock system. -In the event of an emergency, which requires the system to be disengaged or disarmed the Administrator should notify the Regional Director of Operations, Capital Asset Manager, and Building Maintenance Service. Observation of the facility's front door entrance on	D 067		

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07/13/23 at 11:52am revealed the front entrance was on the AL side of the facility and there was not an audible alarm sound at the door when opened.

Observation of the front door of the facility on 07/19/23 at 9:14am revealed there was not an audible alarm sound when the door was opened.

Observation of the front door of the facility on 07/19/23 at 1:22pm revealed there was not an audible alarm sound when the front door was open after staff entered a code to unlock the door.

Observation of the front entrance door to the facility on 07/19/23 at 9:14am revealed there was no audible alarm sound when the door was opened, the alarm switch was turned to the off position.

Observation of the front door on 07/19/23 at 4:19pm revealed the Resident Care Coordinator (RCC) entered a combination on the keypad to the left of the front door, when the front door was opened there was no audible alarm sound.

Observation of the 200 Hall exit door on 07/19/23 at 9:17am revealed:
-The 200 Hall exit door was located on the AL side of the facility.
-The mag lock was not secured, and the override switch could be turned off.
-Staff used a keypad to unlock the door, there was no audible alarm sound when the door was opened.

1. Review of Resident #1's current FL-2 dated 02/01/23 revealed:
-Diagnoses included dementia, frequent falls,

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anxiety, and depression.
-The resident was intermittently disoriented and was ambulatory with a cane.
-The resident's current level of care was AL.

Review of Resident #1's previous FL-2 dated 04/28/22 revealed:
-Diagnoses included dementia, frequent falls, anxiety, and depression.
-The resident was intermittently disoriented and was ambulatory with a cane.
-The resident's level of care was the Memory Care Unit (MCU) and the recommended level of care was AL.

Review of Resident #1's Resident Register dated 04/19/22 revealed the resident was admitted to the MCU on 04/19/22.

Review of Resident #1's current care plan dated 02/13/23 revealed:
-The resident resided on the AL side of the facility.
-The resident was sometimes disoriented and ambulated with a cane.
-The resident was forgetful and needed reminders.
-The resident required supervision with toileting, ambulating, grooming, and transferring.
-The resident required limited assistance with dressing.
-The resident required extensive assistance with bathing.

Telephone interview with a personal care aide (PCA) on 07/13/23 at 2:20pm revealed Resident #1 wandered, had behavioral issues, and tried to leave the building on 07/07/23.

Interview with a second PCA on 07/13/23 at

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D 067	Continued From page 4 2:57pm revealed Resident #1 wandered on the AL side of the facility. Interview with a medication aide (MA) on 07/19/23 at 10:21am revealed: -Resident #1 form the facility out of the front door on 07/07/23. -A PCA that worked on the MCU came to tell her that the front entrance door to the facility was unlocked. -She asked the PCA where Resident #1 was because when the PCA told her the front entrance door to the facility was unlocked, she immediately became worried about Resident #1 due to her behaviors earlier in the day. -Staff usually had to enter a code at the front door for the front door to open, but when she checked the front door, it opened by only pushing the front door, it was not locked as it should have been. -There was no sounding device when she opened the front door after she was notified by a PCA that the front door was not locked. Review of Resident #1's Incident and Accident Report dated 07/07/23 at 6:30pm revealed: -The resident eloped from the facility, overrode the magnetic lock system, and walked out. -The elopement was unwitnessed. -The resident was observed walking on the right side of the road to the right side of the facility driveway. -The resident stated that she wanted to go home and did not belong at the facility. -The resident was transported by local emergency management services (EMS) to a local emergency department (ED) for evaluation on 07/07/23 at 7:19pm. 2. Review of Resident #2's current FL-2 dated 03/15/23 revealed:	D 067		

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-Diagnoses included Alzheimer's and hypertension.
-The resident was intermittently disoriented and ambulated with a cane.
-The resident's level of care was AL.

Review of Resident #2's current care plan dated 02/15/23 revealed:
-The resident was sometimes disoriented, and ambulatory with a cane.
-The resident required supervision with toileting, bathing, dressing, and grooming.

3. Review of Resident #6's current FL-2 dated 02/01/23 revealed:
-Diagnoses included schizophrenia and insomnia.
-The resident was intermittently disoriented and ambulatory.
-The resident wandered.
-The resident's level of care was AL.

Review of Resident #6's current care plan dated 01/25/23 revealed:
-The resident was oriented and ambulatory.
-The resident required supervision with bathing and dressing.

4. Review of Resident #7's current FL-2 dated 02/01/23 revealed:
-Diagnoses included generalized weakness, chronic respiratory failure, and chronic heart disease.
-The resident was intermittently disoriented and was semi ambulatory with a cane and wheelchair.
-The resident's level of care was AL.

Review of Resident #7's current care plan dated 05/31/23 revealed:
-The resident was sometimes disoriented, was forgetful and needed reminders.

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D 067	Continued From page 6 -The resident required extensive assistance with bathing and dressing. -The resident required limited assistance with toileting and grooming. Telephone interview with a PCA on 07/13/23 at 2:20pm revealed Resident #7 had wandering behaviors. Interview with a second PCA on 07/13/23 at 2:57pm revealed Resident #7 wandered on the AL side of the facility. Interview with a medication aide (MA) on 07/13/23 at 12:47pm revealed Resident #7 had wandering behaviors and was disoriented. Interview with the Maintenance Director on 07/13/23 at 12:27pm revealed: -The facility exit door sounding devices only made an audible alarm sound when an override was completed using the override switch on the magnetic lock by each exit door. -There was also a code to override the magnetic lock switch at the nurse's station. Second interview with the Maintenance Director on 07/20/23 at 11:31am revealed: -The MCU Coordinator contacted him by phone on 07/07/23 to inform him that the front door of the facility would not lock and there was no audible alarm sound when the door opened. -He reviewed his cellular telephone and received a call on 07/07/23 at 6:40pm from the MCU Coordinator. -He completed a maintenance check list Monday thru Friday. -He checked all mag locks for operation to ensure they were secure.	D 067		

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Interview with the Business Office Manager (BOM) on 07/19/23 at 9:14am revealed:
-The alarm to the front door of the facility was turned off during normal business hours, Monday thru Friday from 8:00am to 5:00pm because more staff were in the building.
-The alarm to the front door was turned back on at 5:00pm.

Interview with the Administrator on 07/19/23 at 9:40am revealed:
-The front door alarm was turned off when the management team was at the facility but the front door is kept locked at all times.
-The mag lock made a loud sound.
-The Maintenance Director checked all the overrides.
-The Maintenance Director checked all exit door overrides Monday thru Friday during the morning hours.

Interview with the facility's primary care provider (PCP) on 07/19/23 at 1:52pm revealed the facility should have audible alarms working on the exit doors on the AL to notify staff that a resident may have possibly exited the building.

_____

The facility failed to ensure 2 of 6 exit doors had a sounding device when activated to alert staff for 4 residents, known to be intermittently disoriented and ambulatory with an assistive device. Resident #1 diagnosed with dementia and assessed as intermittently disoriented, eloped from the front entrance door of the facility and walked ½ a mile down the road. This failure was detrimental to the residents' health, safety and welfare and constitutes a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/19/23 for

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D 067	Continued From page 8 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 3, 2023.	D 067		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#1) based on the resident's assessed needs resulting in the resident eloping from the facility. The findings are: Review of the facility's Missing Resident Policy dated September 2021 revealed: -The facility should provide for the safety and security of each resident. -Each entry and exit door should be equipped with a magnetic lock system and keypad. -Codes should be managed by the staff and management and are changed periodically as needed to provide for the security of the residents.	D 270		

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D 270	Continued From page 9 Review of the facility's Identification and Supervision of Confused and Wandering Resident Policy dated September 2021 revealed: -The facility should identify residents who walk or wheel around unrestricted and are a threat to leave the facility unattended due to their confusion. -After admission the facility should complete a wanderer and/or elopement risk assessment. -Perform a reassessment and change the care plan accordingly when a significant change occurs which may indicate the potential for a resident to wander. -Check door alarms regularly to assure they work properly. -Notify all staff when alarms fail and assure extra precautions for residents at risk of wandering. -The facility should repair or reactivate alarm systems as soon as practicable. -The facility should check the operations of the magnetic lock door security system, window systems and gate systems to ensure proper working order twice a week. Review of the facility's Behavior Management Evaluation, Intervention and Documentation Policy dated September 2021 revealed: -When a behavior or behavior related accident or incident occurs a behavior related accident/incident report will be completed by the Resident Care Coordinator (RCC) or designee at which time the Behavior Intervention Care Plan will be added to the electronic records. -Vital signs and observations for any changes should be completed each shift by a medication aide (MA) after a behavior occurs and document in shift progress notes. -Within 24-48 hours of each behavior a manager will complete a Behavior Intervention Care Plan.	D 270		

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-Upon observation of at-risk-behavior, staff should notify the Supervisor; the Supervisor should notify the RCC or the Memory Care Unit (MCU) Coordinator, who is responsible for notifying the Administrator.
-Any resident at risk should be placed on increased supervision.
-A care plan meeting should be held to discuss the resident's behavior, proposed interventions, and ongoing plan to ensure care and safety for the resident.
-The resident's care plan should be updated to include at risk behavior and interventions.

Review of Resident #1's current FL-2 dated 02/01/23 revealed:
-Diagnoses included dementia, frequent falls, anxiety, and depression.
-The resident was intermittently disoriented and was ambulatory with a cane.

Review of Resident #1's previous FL-2 dated 04/28/22 revealed:
-Diagnoses included dementia, frequent falls, anxiety, and depression.
-The resident had a level of care on the Memory Care Unit (MCU) and the recommended level of care was Assisted Living (AL).
-The resident was intermittently disoriented and was ambulatory with a cane.

Review of Resident #1's Resident Register dated 04/19/22 revealed the resident was admitted to the Memory Care Unit (MCU) on 04/19/22.

Review of Resident #1's current care plan dated 02/13/23 revealed:
-The resident resided on the AL side of the facility.
-The resident was sometimes disoriented and

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ambulated with a cane.
-The resident was forgetful and needed reminders.
-The resident required supervision with toileting, ambulating, grooming, and transferring.
-The resident required limited assistance with dressing.
-The resident required extensive assistance with bathing.

Review of Resident #1's previous care plan dated 06/20/22 revealed:
The resident was sometimes disoriented and ambulated with a cane.
-The resident was forgetful and needed reminders.
-The resident required supervision with toileting, ambulation, and transferring.
-The resident required limited assistance with dressing.
-The resident required extensive assistance with bathing, and grooming.

Intermittent observations of Resident #1 from 07/18/23 to 07/20/23 revealed the resident ambulated with a cane slowly.

Review of Resident #1's Incident and Accident Report dated 07/07/23 at 6:30pm revealed:
-A MA that worked on the AL side of the facility on 07/07/23 completed the I/A report.
-The resident eloped from the facility and overrode the magnetic lock system and walked out.
-The elopement was unwitnessed.
-The resident stated that she wanted to go home and did not belong at the facility.
-The resident had behaviors and was restless.
-The resident behaviors were reported to the resident's primary care provider (PCP) prior to the

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elopement.
-The resident was observed walking on the right side of the road to the right side of the facility driveway.
-The resident was returned to the facility by a staff member and when asked her name, the resident was able to state her name to the MA
-The resident was transported by local emergency management services (EMS) to a local emergency department (ED) for evaluation on 07/07/23 at 7:19pm.
-The resident was placed on a monitor status for 72 hours from 07/07/23 to 07/10/23; medication aides (MAs) had to document the resident status in chart progress notes daily.

Review of an after visit summary for Resident #1 dated 07/07/23 revealed the resident was seen for general medical exam and was discharged back to the facility.

Review of Resident #1's facility progress notes revealed:
-On 07/05/23 at 7:45am revealed a MA notified the resident's PCP that the resident refused medications; she attempted to put her medications in pudding but the resident spit out the pudding.
-On 07/05/23 at 10:23pm revealed a MA notified the PCP that the Resident #1 refused her medications at 8:00pm.
-On 07/06/23 at 1:24pm revealed a MA notified the resident's mental health Nurse Practitioner (NP) that the resident had refused medications for several days.

Observation of the five lane highway at the end of a road from the facility on 07/19/23 at 5:02pm revealed:
-The road in front of the facility to the right was a

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two lane road.
-The two lane road in front of the facility had a construction site to the right of the road with heavy equipment and uneven ground.
-There was a railroad track without a signal crossing that crossed the two lane road to the right of the facility.
-There was a stop sign at the end of the two lane road to the right of the facility.
-The end of the two lane road to the right of the facility intersected with a five lane highway.
-There was a posted speed limit sign approximately 50 yards to the right of the five lane highway for traffic moving north.
-The speed limit changed from 50 miles per hour (MPH) to 45 mph for traffic moving south on the five lane highway.
-There was a turning lane that separated the four lanes on the highway.
-The walking distance from the facility to a business across the five lanes of the highway estimated an 8 minute walk.
-At 5:02 pm on 07/19/23 for 39 seconds there were 30 vehicles that were observed traveling the five lane highway.
-27 of the 30 vehicles were traveling south and were approximately 50 yards from a 45mph sign.
-2 of the 30 vehicles traveled north and were approximately 50 yard from a 50mph sign.
-1 of the 30 vehicles was observed in the center turning lane entering the two lane road where the facility was located.

Review of weatherunderground.com revealed the temperature on 07/07/23 between 6:30pm and 7:00pm was 83 degrees Fahrenheit (F).

Review of Resident #1's mental health Nurse Practitioner (NP) progress note dated 07/06/23 revealed:

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-Resident #1 was seen for refusing medications.
-Staff reported the resident refused her medications over the past several days.
-Staff should encourage the resident to get out of bed and participate in activities.
-Staff should monitor the resident for any change in condition or ongoing behavioral escalation and notify her of any changes.

Review of Resident #1's PCP visit note on 07/05/23 revealed:
-Resident #1 was seen for a follow up visit.
-The resident was forgetful and had a diagnosis of dementia.
-Staff should monitor the resident for any changes in condition, escalation of behaviors and notify the PCP of any changes.

Review of a Behavior Notification report for Resident #1 dated 07/07/23 at 6:30pm revealed:
-The MCU Coordinator completed the behavior notification report on 07/07/23 at 6:30pm.
-The resident had behaviors and eloped from the facility around 6:30pm on 07/07/23.
-The resident had destructive behaviors, constantly paced, was restless, and had increased anger and frustration.
-The resident overrode the Mag Lock and eloped from the facility, staff found the resident and returned the resident to the facility.
-The resident was placed on increased supervision for behaviors every 30 minutes from 07/07/23 to 07/10/23.

Interview with a personal care aide (PCA) on 07/18/23 at 3:24pm revealed:
-She worked on the MCU from 3:00pm to 11:00pm on 07/07/23.
-She usually worked on the AL side of the facility.
-The resident had been talking about wanting to

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D 270	Continued From page 15 go home during the past month and became fixated on wanting to go home. -The resident had increased agitation, anxiety, and restlessness several days prior to 07/07/23. -She had notified the MA on duty when the resident had increased behaviors such as agitation and anxiety. -After residents had finished supper, she left the MCU and entered the AL section of the facility to take a break. -When she walked toward the front of the building, the MA from the AL section of the facility informed her that Resident #1 could not be located. -The MA told her that the PCA for the AL side of the facility found the front door unsecured and drove to the left of the facility to look for the resident. -She informed the MA that she would go to the right exit of the facility to try to locate the resident. -When she exited the front entrance door to look for the resident, the door was shut but she only pushed the bar on the door and the door opened with no audible alarm sound. -The door was not supposed to open without entering a code to override the mag lock system. -She drove on a two lane road to the right of the facility, came to a stop sign and looked down the highway to see if she saw the resident. -She observed the resident wearing a bright orange or bright pink shirt and knew that was Resident #1. -She observed the resident on the other side of the highway (5 lanes) in a business parking lot. -When she drove into the parking lot of a business on the other side of the highway, the resident got into her car without hesitation. -When she returned to the facility the MA was at the front of the building outside waiting for the resident.	D 270		

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D 270	Continued From page 16 -The resident was placed on increased supervision with 30 minute checks. Interview with a second PCA on 07/13/23 at 2:57pm revealed: -Resident #1 wandered at times. -Resident #1 cursed at staff and wanted to go home on 07/07/23. -She was the first to discover that the front entrance door opened without needing a code. -She did not hear an audible alarm sound on the day Residents #1 eloped. -She notified the MA on the AL section of the facility that the front door was not locked and did not alarm when she pushed the door open. -She and the MA were not able to locate Resident #1 in her room. -She searched for Resident #1 in her vehicle in the neighborhood to the left of the facility. Interview with a MA on 07/13/23 at 12:47pm revealed: -Resident #1 wanted to leave the facility all day on 07/07/23. -She noticed Resident #1 was not in her room and staff began to search for the resident. -She did not hear an audible door alarm on the day Residents #1 eloped. -She lifted the cover of the override switch by the front door entrance after the elopement occurred and the audible alarm was quiet and turned off before the cover was placed back down. -The front door was unlocked and did not require a code to open the front door. -She was not aware where Resident #1 was located outside. -She was not aware of how long Resident #1 was outside. -She checked on Resident #1 about every 15 minutes on 07/07/23 due to her behaviors.	D 270		

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-Staff needed to check on Resident #1 more often than every hour due to her behaviors, and she felt that the resident needed to be checked on every 15 minutes.

A second interview with a MA on 07/19/23 at 10:21am revealed:
-Resident #1 had a history of becoming agitated and anxious.
-Resident #1 would yell, fuss and could be difficult to redirect at times.
-The resident's memory was "here and there."
-She worked on the AL section of the facility on 07/07/23, her shift began at 7:00am.
-When she arrived at work on 07/07/23 at 7:00am the resident was quiet and resting in her bed.
-The MA getting off work reported that the resident was on 30 minute checks because she had refused her medications.
-Resident #1 had only refused her medications one to two times that she was aware of, it was unusual for the resident to refuse her medications.
-When a resident refused their medications, she was responsible for contacting the Resident Care Coordinator (RCC) and the primary care provider (PCP).
-She kept the resident in her sight all day and evening because she had refused her medications the shift prior to her elopement.
-The resident was agitated on 07/07/23, paced the hall and kept saying she wanted to go home.
-She was on her medication cart on 07/07/23 on the 300 hall near the dining room and last observed Resident #1 at 6:00pm sitting in a chair in the hallway across from the dining room.
-She left the medication cart in the hallway and thought she administered a resident their medications after she saw Resident #1 sitting in the hallway across from the dining room.

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D 270	Continued From page 18 -A PCA that worked on the AL section of the facility came to tell her that the front entrance door to the facility was unlocked. -She asked the PCA where Resident #1 was because when the PCA told her the front entrance door to the facility was unlocked, she immediately became worried about Resident #1 due to her behaviors earlier in the day. -Staff usually had to enter a code at the front door for the front door to open, but when she checked the front door, it opened by only pushing the front door, it was not locked. -There was no audible alarm when she opened the front door. -She looked to see if Resident #1 was in her room and when she did not see the resident in her room, she notified the PCA from AL section of the facility to go outside and look for the resident. -She had called the RCC prior to her elopement on 07/07/23 to report the resident had behavioral issues during her shift and had refused medications on 07/06/23. -A PCA that was working on the MCU section of the facility returned to the facility with the resident in her vehicle. -She sent the resident to the local emergency room (ER) for an evaluation since she had eloped form the facility. -She thought that she last saw the resident at 6:15pm when she was sitting in a chair in the hallway across from the dining room. -She thought that the last time she saw the resident on 07/07/23 was after the resident had finished supper and was observed sitting in a chair in the hallway across from the dining room. -She thought it all happened after the resident completed supper and 6:30pm. Interview with a second MA on 07/19/23 at 4:30pm revealed:	D 270		

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-Resident #1 ambulated with a cane in the facility.
-She worked on the AL side of the facility on 07/05/23 and 07/06/23 each evening from 11:00pm to 7:00am.
-She and MAs were responsible to report any changes a resident had in their behavior or their physical condition to the RCC.
-She provided a shift report with the next MA beginning their shift and reported any concerns about residents or changes in their behavior or physical condition.
-Resident #1 had a history of behavioral problems and became tearful, agitated, and refused medications at times.
-Resident #1 had packed up all her belongings several times and told staff she was moving.
-She could not remember if she reported the resident's behaviors to the PCP or the mental health provider.
-Resident #1 was easily redirected when she was upset or agitated.

Interview with the Maintenance Director on 07/20/23 at 11:31am revealed:
-The MCU Coordinator contacted him by phone on 07/07/23 to inform him that the front door of the facility would not lock and there was no audible alarm sound when the door opened.
-He reviewed his cellular telephone and received a call on 07/07/23 at 6:40pm from the MCU Coordinator.

Interview with the MCU Coordinator on 07/20/23 at 2:00pm revealed:
-Resident #1 became agitated, irritable, and wanted to go home during the first few days of the month.
-She was at the front of the facility when the resident was returned to the facility by a PCA.
-She observed the resident cursing and yelling at

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staff; she was worried about losing her home.
-The facility staff knew the resident very well and considered her family; staff were used to the resident's increased behaviors the first of each month.
-She was not aware that the resident had crossed five lanes on the highway at the end of the two lane road at the facility.
-Resident #1 was at risk of being hit by a vehicle, passing out from the heat, broken a bone, or died.

Interview with RCC on 07/13/23 at 1:39pm revealed:
-Resident #1 was initially admitted to the MCU due to wandering behaviors.
-The resident had dementia and would exhibit irritability and agitation around the first of the month because she wanted to go home.
-Resident #1 had a telehealth appointment earlier in the day on 07/07/23 due to medication refusal.
-She was not at the facility when the elopement occurred.
-She contacted the psychiatric provider after Resident #1 was returned to the facility.
-She advised staff to complete an incident report due to Resident #1 being outside the parking lot.
-She was not aware that Resident #1 was found by a staff member across a five lane highway.

Second interview with the RCC on 07/19/23 at 10:58am revealed:
-Staff on the AL side of the building knew that Resident #1 became agitated and want to go home.
-Resident #1 had a behavioral pattern of crying, refusing medications, and wanting to go home each month between the 3rd and 7th of each month.
-The resident received her monthly allowance

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from the business office manager by the 3rd of each month and her behaviors usually lasted until the 7th of each month.
-Staff knew to always watch the resident especially around the first of the month, because her agitation and restlessness became worse around the first of the month.
-PCAs worked hard to help redirect the resident, they took time to paint her fingernails and engage her in activities to help calm her down when she was upset.
-The MA that worked on 07/07/23 reported to her that the resident had eloped from the facility.
-She was not aware that the resident had eloped across five lanes of a highway on 07/07/23, she thought the resident had been found on the facility grounds outside.
-She sent an email to Resident #1's mental health provider on 07/07/23 at 7:03pm to report that the resident had been manic on 07/06/23 and 07/07/23.
-PCAs and MAs made regular rounds to check on residents on the AL side of the facility every hour.
-PCAs checked on residents on the AL side of the facility for continence care every two hours.
-She did not see an issue with the resident being unsupervised on the AL side of the facility because her PCP had previously listed the resident as alert and oriented to person, place, and time.
-When the resident was first admitted to the facility, she was admitted to the MCU.
-The resident's level of care was changed from MCU to AL and the resident was moved to the AL side of the building.
-Resident #1 had her rights and it was not fair for staff "to be on her every five minutes."
-The resident was added to the facility's wandering list after she eloped from the facility on 07/07/23.

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-When a resident was placed on the facility's wandering list PCAs and MAs were expected to pay attention to the resident, there was no scheduled time that staff should provide increased supervision.
-The RCC reported that the five lanes of traffic on the highway the resident crossed on 07/07/23 upset her because she knew that she and staff supervised all of their residents.
-Staff had become too comfortable with the resident.
-Staff had become complacent with Resident #1 and did not supervise her appropriately when her behaviors escalated from 07/05/23 to 07/07/23.
-When the resident refused her medications, the MA should have asked for another MA or the RCC to attempt to administer the resident's medications.
-Staff did not follow the supervision she implemented for Resident #1.
-She expected staff to check on the resident every 30 minutes.
-The MA working on 07/07/23 should have ensured a PCA was stationed at the hall where the 100 hall and 200 hall intersect to monitor the resident.

Interview with Resident #1 on 07/13/23 at 1:00pm revealed:
-She was on the front porch of the facility when she received a telephone call from her granddaughter.
-She wanted to walk to visit her granddaughter at her place of employment to get money.
-After she spoke with her granddaughter, she went to her room to change her shoes.
-She walked down a road to the right of the facility.
-The facility did not allow her to be outside unsupervised after the elopement.

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D 270	Continued From page 23 Interview with the Administrator on 07/13/23 at 12:44pm revealed she was not sure if Resident #1 left the facility by using the override switch or by following behind another individual. Second interview with the Administrator on 07/13/23 at 3:33pm revealed: -Only maintenance staff, the management team, medication aides, some vendors, and emergency responders had codes to the facility exit doors. -The codes would be changed if it was discovered that unauthorized individuals obtained the code. Third interview with the Administrator on 07/20/23 at 6:57pm revealed: -Staff should have been at the 100 hall and 200 hall to monitor the resident and ensure the resident's safety. -Staff should have ensured that the resident was supervised because it was the busiest time of the day, and she had an escalation of behaviors. -She expected the front door to the facility to be locked and operate correctly. -The resident was listed on the facility behavior list since 02/01/23 and staff should have monitored the resident to ensure her safety. -The resident could have been injured when she eloped from the facility. Interview with the facility's contracted Nurse Practitioner (NP) mental health provider on 07/20/23 at 1:31pm revealed: -Resident #1 had been stable and enjoyed sitting on the front porch prior to her elopement. -The resident usually had increased anxiety and agitation the first few days of each month. -The resident did not have a history of refusing her medications.	D 270		

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D 270	Continued From page 24 -Resident #1 had never eloped from the facility to her knowledge. -The resident walked with a cane and walked with a shuffle. -She was contacted by a MA to report that the resident had refused to take her medications on 07/06/23. -She instructed staff to continue to monitor the resident and to notify her of any escalation of behaviors. -She was informed by the RCC that the resident had eloped on 07/07/23. -The resident was at risk of a heat stroke, dehydration and falling on the uneven pavement on the road. -The resident was in danger when she was out eloped from the facility and was unsupervised. Interview with Resident #1's PCP on 07/19/23 at 1:52pm revealed: -Resident #1 was alert and oriented to person, place and time but had poor insight. -Resident #1 had a history of behavioral issues and often became agitated and had temper tantrums. -Resident #1 was cognitively able to make her own decisions. -Facility staff notified her that the resident eloped on 07/07/23. -When the resident had behavioral issues, the facility notified the resident's mental health provider of the behaviors. The failure of the facility to provide supervision to Resident #1, who was diagnosed with dementia and known wandering behaviors, resulted in the resident leaving the facility without the knowledge of staff after exiting the front door of the facility. The resident walked 0.8 miles on a two lane road and then crossed a busy five lane highway. The	D 270		

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D 270	Continued From page 25 resident was found by staff and brought back to the facility. This failure resulted in substantial risk of serious physical harm and death and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/19/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 19, 2023.	D 270		
D 346	10A NCAC 13F .1002(c) Medication Orders 10A NCAC 13F .1002 Medication Orders (c) The medication orders shall be complete and include the following: (1) medication name; (2) strength of medication; (3) dosage of medication to be administered; (4) oute of administration; (5) specific directions of use, including frequency of administration; and (6) if ordered on an as needed basis, a stated indication for use. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure a medication that was prescribed to be administered as needed included an indication for use and administration for 1 of 5 sampled residents (#3)	D 346		

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for a medication used to treat high blood pressure.

The findings are:

Review of Resident #3's current FL-2 dated 06/21/23 revealed:
-Diagnosis included dementia.
-He was constantly disoriented.
-There was an order for Hydralazine 25mg to be administered every 8 hours as needed. (Hydralazine is a vasodilator used to decrease blood pressure.)
-There was no indication for use.

Review of Resident #3's electronic medication administration record for June 2023 revealed:
-There was an entry for Hydralazine 25 mg to be administered every 8 hours as needed.
-There was no indication for use.
-There was no documentation Hydralazine 25mg had been administered.
-Blood pressure was taken 8 times from 06/15/23 to 06/18/23.
-Blood pressure ranged from 122/66 mmHg to 133/62 mmHg.

Review of Resident #3's electronic medication administration record for July 2023 revealed:
-There was an entry for Hydralazine 25 mg to be administered every 8 hours as needed.
-There was no indication for use.
-There was no documentation Hydralazine 25mg had been administered.

Observation of Resident #3's medications on hand for administration on 07/19/23 at 10:59am revealed:
-There was a bubble pack labeled Hydralazine 25mg to be administered every 8 hours as

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needed with no indication for use.
-The quantity of 30 Hydralazine 25mg tablets was dispensed on 06/15/23.
-There were 30 doses of Hydralazine 25mg remaining.

Interview with the medication aide (MA) on 07/19/23 at 10:59am revealed:
-Resident #3 was usually non-verbal.
-She did not know what Hydralazine was used to treat but it should have been on the eMAR.
-She did not know when the medication was needed.
-She had not noticed the Hydralazine 25 mg did not include an indication for use.

Interview with a second MA on 07/19/23 at 3:58pm revealed:
-All medications prescribed as needed should be detailed and include the reason it should be used.
-She did not know what Hydralazine was used to treat and would not know when to administer the medication.
-She had not noticed the Hydralazine 25mg did not include an indication for use.

Interview with Resident #3's pharmacist on 07/20/23 t 10:38am revealed:
-30 doses of Hydralazine 25mg were dispensed on 06/15/23.
-All medications prescribed as needed should have an indication for use so staff would know when to administer the medication.
-Hydralazine was prescribed to lower blood pressure and prevent stroke or heart attack from high blood pressure.

Interview with the Resident Care Coordinator (RCC) on 07/20/23 at 5:56pm revealed:
-Medication orders were faxed to the pharmacy

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and pharmacy entered the medications on the eMAR.
-Medication orders had to be approved by her or the Memory Care Coordinator (MCC) for the medication to be visible on the eMAR and available for administration.
-She was not aware of Resident #3's Hydralazine 25mg every 8 hours order and did not there was no indication for use.
-Staff should have contacted Resident #3's primary care provider (PCP) for an indication when the order was approved.
-It was important to know when and why a medication should be administered for as needed medications and MA staff would not know without the written indication.

Interview with the MCC on 07/20/23 at 6:50pm revealed:
-She and the RCC were responsible for approving orders once the order was entered by the pharmacy.
-She was aware an indication for use was required for medications prescribed as needed.
-Staff needed an indication for use to know when to administer the medication in order to treat the condition in which it was prescribed.

Interview with the Administrator on 07/20/23 at 7:10pm revealed:
-The RCC and the MCC were responsible for approving orders on the eMAR and should have noticed there was no indication for use at that time.
-MA staff would need to know when to administer the medication but may not know without the indication for use.

Based on observation, interviews and record reviews, it was determined Resident #3 was not

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D 346	Continued From page 29 interviewable. Attempted telephone interview with Resident #3's primary care provider on 07/20/23 at 2:30pm was unsuccessful.	D 346		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents including a medication used to treat high blood sugar levels (#5). The findings are: Review of Resident #5's current FL-2 dated 02/01/23 revealed diagnoses included self care deficit and type II diabetes with hyperglycemia. Review of Resident #5's physician's order dated 05/31/23 revealed fingerstick blood sugar (FSBS) checks were to be completed daily. Review of Resident #5's nursing note entered by	D 358		

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a medication aide (MA)dated 06/26/23 at 10:07am revealed his blood sugar reading was 497 at 9:20am that morning and the primary care provider (PCP) was notified.

Review of Resident #5's primary care provider (PCP) note dated 06/26/23 at 11:19am revealed Resident #5 had fragile diabetes and volatile blood glucose with hyperglycemia after being removed from all insulin at a recent hospital visit and Januvia was to be started as soon as it arrived.

Review of Resident #5's physician's order dated 06/26/23 revealed Januvia 100mg was to be administered daily and the quantity to be dispensed was one. (Januvia is a medication used to treat high blood sugar levels in people with diabetes.)

Review of Resident #5's progress note entered by a MA dated 06/26/23 at 5:29pm revealed Resident #5's blood sugar was 550 at 1:30pm that day, the provider was notified and Novolog 5 units was administered.

Review of Resident #5's nursing note entered by a MA dated 06/28/23 at 9:00am revealed Resident #5's blood sugar registered as "high" with no value and the PCP was notified.

Review of a PCP note dated 06/28/23 at 7:41am revealed:
- Resident #5 had multiple issues of hyperglycemia since being taken off insulin.
-He was started on Januvia but continued to over eat.
-Staff reported Resident #5 ate lots of snacks and visited the snack machine 2-3 times each day.

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Review of Resident #5's electronic medication administration record (eMAR) for June 2023 revealed:
-There was an entry for Januvia 100mg to be administered each day with a note in the special instructions that said "needs script".
-There was documentation Januvia 100mg was administered each day at 8:00am on 06/28/23 through 06/30/23.
-FSBS were obtained daily at 8:00am.
-FSBS range was 161-376 from 06/01/23 through 06/10/23.
-FSBS range was 215-588 from 06/11/23 through 06/20/23.
-FSBS range was 198-507 from 06/21/23 through 06/30/23.
-There was no entry for Novolog 5 units on the eMAR.
-There was no documentation Novolog 5 units was administered on 06/26/23.
-There was documentation Resident #5's FSBS was 497 on 06/26/23 at 8:00am.
-Resident #5's FSBS was documented as "high" with no value given on 06/28/23 at 8:00am.

Review of Resident #5's electronic medication administration record (eMAR) for July 2023 revealed:
-There was an entry for Januvia 100mg to be administered each day with a note in the special instructions that said "needs script".
-There was documentation Januvia 100mg was administered each day at 8:00am on 07/01/23 through 07/06 and on 07/11/23 through 07/18/23.
-There was documentation Januvia 100mg was not administered on 07/07/23 because the resident was unavailable and 07/08/23 through 07/10/23 because the resident was hospitalized.
-FSBS were obtained daily at 8:00am.
-FSBS range was 280-469 from 07/01/23 through

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07/06/23 and 198-461 from 07/11/23 through 07/18/23 with 1 reading that registered as "high" with no value given on 07/13/23.
-There was documentation Resident #5's FSBS was not obtained on 07/07/23 through 07/10/23 because Resident #5 was not available and in the hospital.

Review of Resident #5's progress note entered by a MA dated 07/01/23 at 7:46am revealed Resident #5's blood sugar was 469.

Review of Resident #5's Accident/Injury Report dated 07/06/23 revealed:
-Resident #5 was found in his bedroom with a change in mental status, increased weakness and a blood sugar of 565 at 2:40pm.
-He was transported to the nearest hospital for evaluation via emergency management services (EMS) and was admitted with diagnoses of hyperglycemia and acute kidney injury.

Review of Resident #5's progress note entered by a MA dated 07/06/23 at 3:11pm revealed Resident #5 was transported to the hospital via EMS at 2:50pm due to a change in condition.

Review of Resident #5's progress note entered by the Resident Care Coordinator (RCC) on 07/08/23 at 2:38pm revealed the RCC spoke with the nurse at the hospital who reported Resident #5's admitting diagnoses were hyperglycemia with acute kidney injury.

Review of Resident #5's progress note entered by the RCC on 07/10/23 at 8:58pm revealed Resident #5 returned to the facility from the hospital.

Review of Resident #5's hospital discharge

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summary dated 07/10/23 revealed:
-Resident #5 was brought into the emergency department (ED) with complaint of passing out on 07/06/23.
-Resident #5 was found to be hyperglycemic with evidence of acute kidney injury.

Review of Resident #5's PCP note dated 07/13/23 revealed his FSBS was 506.

Observation of Resident #5's medications on hand on 07/20/23 at 3:43pm revealed Januvia 100mg was not available for administration.

Interview with a medication aide (MA) on 07/20/23 at 3:43pm revealed:
-Resident #5 had diabetes and was prescribed medications for the condition.
-She was unable to locate Januvia on the medication cart.
-She thought she gave Resident #5 the last dose of Januvia 100mg that morning on 07/20/23.
-She asked the Memory Care Coordinator (MCC) about the medication last week because the electronic medical record said "needs script."

Interview with Resident #5 on 07/20/23 at 3:50pm revealed:
-He thought he received all the medication he was prescribed but his blood sugars always ran high.
-He passed out about 2 weeks prior and was hospitalized for 2-3 days because if high blood sugar levels.

Telephone interview with Resident #5's pharmacist with the facility's contracted pharmacy on 07/20/23 at 5:32pm revealed:
-The pharmacy received a prescription for Januvia 100mg to be given each day on 06/26/23

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for a quantity of 1 dose.
-The medication was not dispensed because Januvia was not a 1 dose medication.
-There was no documentation in the pharmacy system to indicate the facility had reached out to inquire about not receiving Januvia for Resident #5.
-Januvia was for long term control of blood sugar levels and usually given in conjunction with other anti-diabetic medications.
-Not receiving medications to control blood sugar could cause glucose levels to be uncontrolled leading to injury of the eyes and kidneys, poor healing and changes in level of consciousness including coma and death.

Interview with the Memory Care Coordinator (MCC) on 07/20/23 at 5:06pm revealed:
-Resident #5's blood glucose levels were often high and he was recently hospitalized but she was not sure if it was related to increased blood sugar levels.
-She was aware Januvia 100mg was ordered but she was not sure when it was ordered.
-A MA informed her the previous week that Januvia was not available for Resident #5.
-She contacted the pharmacy but she did not document the pharmacy contact.
-She was not aware a new prescription was needed for Resident #5's Januvia.
-She was not aware Januvia 100mg was not received from pharmacy until after calling the pharmacy on 07/15/23.
-She did not inform the Resident Care Coordinator (RCC) Januvia was not available and she had contacted the pharmacy.
-She should have told the RCC but she did not because she got busy.
-There was no process in place to ensure medications were received from the pharmacy.

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D 358	Continued From page 35 Interview with the RCC on 07/20/23 at 5:56pm revealed: -MAs were responsible for weekly cart audits that included pulling current orders for residents and comparing medications on hand for the residents noting number of doses available. -She was not aware Januvia was not available for Resident #5. -The MCC did not notify her the medication was not available on 07/15/23 and that a refill had been requested as she would have expected. -It was important to administer Januvia as ordered by the provider to control blood glucose levels. -Resident #5's PCP could not know if a medication was effective if it was not administered. -There was no process in place to ensure medications were received from the pharmacy. Interview with the Administrator on 07/20/23 at 7:10pm revealed: -She was not aware Januvia 100mg was not received from the pharmacy. -The MCC should have communicated that she called the pharmacy regarding a refill for Resident #5's Januvia on 07/15/23 to ensure follow-up on receiving the medications. -Medications were expected to be administered as ordered to treat disease processes and guide care. Attempted telephone interview with Resident #5's PCP on 07/20/23 at 2:30pm was unsuccessful. _____ The facility failed to administer medications as ordered to 1 of 5 sampled residents (#5) medications for diabetes which resulted in Resident #5 having an elevated blood glucose	D 358		

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D 358	Continued From page 36 level of 565 which lead to hospitalization and acute kidney injury. The failure of the facility to administer medications as ordered resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/20/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 19, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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This Rule is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure the electronic medication administration records were accurate for 1 of 5 sampled residents (#5) including a medication used to treat high blood sugar levels.

The findings are:

Review of Resident #5's current FL-2 dated 02/01/23 revealed diagnoses included self care deficit and type II diabetes with hyperglycemia.

Review of Resident #5's physician's order dated 06/26/23 revealed Januvia 100mg was to be administered each day. (Januvia is a medication used to treat high blood sugar levels in people with diabetes.)

Interview with Resident #5 on 07/20/23 at 3:50pm revealed he thought he received all the medication he was prescribed but his blood sugars always ran high.

Review of Resident #5's electronic medication administration record (eMAR) for June 2023 revealed:
-There was an entry for Januvia 100mg to be administered each day with a note in the special instructions that said "needs script"..
-There was documentation Januvia 100mg was administered each day at 8:00am on 06/28/23 through 06/30/23.

Review of Resident #5's electronic medication administration record (eMAR) for July 2023 revealed:
-There was an entry for Januvia 100mg to be administered each day with a note in the special

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instructions that said "needs script".
-There was documentation Januvia 100mg was administered each day at 8:00am on 07/01/23 through 07/06/23 and on 07/11/23 through 07/18/23.
-There was documentation Januvia 100mg was not administered on 07/07/23 because the resident was unavailable and 07/08/23 through 07/10/23 because the resident was hospitalized.

Observation of Resident #5's medications on hand on 07/20/23 at 3:43pm revealed Januvia 100mg was not available for administration.

Interview with a medication aide (MA) on 07/20/23 at 3:43pm revealed:
-Resident #5 had diabetes and was prescribed medications for the condition.
-She was unable to locate Januvia on the medication cart.
-She thought she gave Resident #5 the last dose of Januvia 100mg that morning on 07/20/23.
-She asked the Memory Care Coordinator (MCC) about the medication last week because the electronic medical record said "needs script."

Telephone interview with Resident #5's pharmacist on 07/20/23 at 5:32pm revealed:
-The pharmacy received a prescription for Januvia 100mg to be given each day on 06/26/23 for a quantity of 1 dose.
-The medication was not dispensed because Januvia was not a 1 dose medication.
-There was no documentation in the pharmacy system to indicate the facility had reached out to inquire about not receiving Januvia for Resident #5.
-Medications should be documented accurately on the eMAR to ensure providers are aware of what medications are being administered in order

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to treat a resident or adjust medications appropriately.

Interview with the Memory Care Coordinator (MCC) on 07/20/23 at 5:06pm revealed:
-Resident #5's blood glucose levels were often high and he was recently hospitalized but she was not sure if it was related to increased blood sugar levels.
-She was aware Januvia 100mg was ordered but she was not sure when it was ordered.
-A MA informed her on 07/15/23 that Januvia was not available for Resident #5 and she contacted the pharmacy but she did not document the pharmacy contact.
-She was not aware a new prescription was needed for Resident #5's Januvia to be dispensed.
-She was not aware Januvia 100mg was not received from pharmacy upon ordering and after calling the pharmacy on 07/15/23.
-There was no process in place to ensure medications were received from the pharmacy.

Interview with the Resident Care Coordinator (RCC) on 07/20/23 at 5:56pm revealed:
-She was not aware Januvia was not available for Resident #5.
-MAs were expected to document medications, administered and not administered, accurately on the eMAR.
-Resident #5's primary care provider (PCP) could not know if a medication was effective if it was not administered.

Interview with the Administrator on 07/20/23 at 7:10pm revealed:
-She was not aware of a process in place to ensure medications were received from the pharmacy.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 367	Continued From page 40 -MAs were expected to complete weekly cart audits and request refills for medications before the medication on hand ran out or was not found on the cart. -It was important for the eMAR to be an accurate reflection of what was administered in order to treat the resident condition and guide care for providers.	D 367		