STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060156	A. BUILDING: _____ B. WING _____	R 08/03/2023

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TERRABELLA LITTLE AVENUE	7745 LITTLE AVENUE CHARLOTTE, NC 28226

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey, follow up survey and complaint investigation. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 07/28/23.	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 A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 4 sampled residents with a history of wandering behaviors (#7) in the facility's Special Care Unit (SCU) by allowing the resident access to an unlocked and disarmed outside exit door resulting in the resident eloping from the facility's SCU. The findings are: Review of Resident #7's current FL2 dated 06/20/23 revealed: -Diagnoses included dementia with mixed disturbance, dementia with anxiety, dementia with psychotic disturbance, right displaced	D 270		

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intertrochanteric femur fracture, unspecified fall, laceration, and traumatic subdural hemorrhage.
-She was semi-ambulatory with a wheelchair.
-She was intermittently disoriented.
-Her recommended level of care was SCU.

Review of Resident #7's Care Plan dated 07/07/23 revealed:
-She had a previous history of wandering behaviors.
-There was documentation of wandering in the hallways and staff redirected as able.
-She ambulated with staff or an assistive device.
-Her cognitive level was documented as significant memory loss and must be directed.

Review of Resident #7's Elopement Risk Assessment completed on 06/20/23 revealed:
-Resident #7 was documented to experience intermittent confusion or short-term memory loss.
-Resident #7 was documented with a diagnosis of dementia, such as Alzheimer's or suffer other memory loss disorders.
-Resident #7 was recently moved into the Community.
-Resident #7 took medications that might increase the resident's level of confusion such as psychotropics and benzodiazepines.
-Resident #7 was ambulatory with an assistive device (wheelchair/ walker).

Review of Service Description for Resident #7, completed 06/20/23 for wandering behavior revealed:
-Resident #7 wandered into public areas but was not intrusive.
-There was documentation of an increase in wandering behavior and exit seeking behaviors.
-Resident #7 could be redirected without agitation to promote safety and to prevent intrusions into

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the apartments of other residents, as needed.

Review of Resident #7's Accident/Incident Report dated 07/24/23 revealed:
-At approximately 12:50pm on 07/23/23, Resident #7 was observed in the back parking lot of the community.
-Resident #7 was redirected inside and no injuries were noted.
-An internal investigation was initiated.
-Resident #7's family member was notified on 07/23/23 at 2:30pm.
-Resident #7's Primary Care Physician (PCP) was notified on 07/23/23 at 3:15pm.
-There was no documentation Resident #7 was sent to Emergency Room (ER) for evaluation.
-The Accident/Incident Report was signed by the Special Care Unit Coordinator (SCC).

Review of Resident #7's Facility Internal Incident Report dated 07/24/24 revealed:
-At approximately 12:50pm on 07/23/23, Resident #7 was observed in the back parking lot of the community.
-Resident #7 was found in the back parking lot.
-Resident #7 was redirected inside, evaluated, no injuries noted.
-Resident #7 was placed on increased supervision and an internal investigation was initiated.
-There was no documentation Resident #7 was sent to ER for evaluation.
-The Internal Incident Report was completed and signed by the SCC on 07/23/23.

Review of Skin Observation Sheet dated 07/23/23 revealed:
-Resident #7 had bruising to her right elbow and slight redness to her left knee.
-No complaint of pain.

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-The Skin Observation Sheet was signed by the SCC.

Review of weather report for 07/23/23 revealed the high was 86 degrees with scattered showers.

Observation of the SCU on 07/31/23 at 9:44am and on 08/02/23 at 3:01pm revealed:
-A code had to be entered on the keypad by the door to gain entrance to the SCU.
-There were two exit doors on the right side of the SCU where Resident #7's room was located, one leading to the courtyard and the other leading to a parking lot.
-Both exit doors had a red stop box that could only be turned off manually with a key, a maglock box located on the top, right upper door that could be turned off manually with a key and a maglock switch located on the wall to the right of the exit door which was covered by a clear plastic cover and a keypad.
-The exit door to the parking lot also had an alarm that sounded when the clear plastic cover was lifted to access the maglock switch.
-The exit door Resident #7 was able to exit the facility from was located approximately 60 steps from her room.
-The entryways to the dining room and sitting area were between Resident #7's room and the exit door leading to the parking lot.
-The hallway could be seen while standing inside the dinning room and the sitting area.
-There were no cameras in the common areas or hallways of the unit.
-There were no cameras for the outside of the facility.
-The employee smoking area was near the SCU exit and dumpsters in back parking lot.

Interview with the facility Maintenance Manager

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D 270	Continued From page 4 on 08/02/23 at 1:51pm revealed: -When doors were opened, a signal went to the staff's phones. -When call bells or pendants were engaged, staff got a signal on their phones. -The manager on duty and medication aide (MA) were responsible for checking all of the exit doors daily to ensure they were working and engaged. -The exit door Resident #7 was able to exit the facility from led to the parking lot. -Someone would have to use a key to manually turn off the red box alarm. -Someone would have to turn off the maglock by using a key, entering the code into the keypad and by turning off the switch located under the clear plastic cover. -Anytime an exit door in the facility was opened, it was captured on the facility door alarm report even if the maglocks or red alarm boxes were turned off. -He was responsible for checking all exit doors daily, while in the facility, to ensure all exit doors and alarms were working properly. -He thought the last time he checked the door through which Resident #7 eloped was on 07/21/23. Review of the facility Door Alarm report and Logbook on 08/02/23 revealed: -The exit door through which Resident #7 eloped was documented as open on 07/23/23 at 11:29am for a total of 20 seconds. -Prior to 07/23/23, that exit door was documented as open on 07/19/23. -The last documented exit door check prior to 07/23/23 was on 06/05/23 completed by the Maintenance Director. Review of the SCU's Weekly Rounds Building Checklist sheet on 08/02/23 revealed:	D 270		

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-The call system and door alarms were checked by the Maintenance Director.
-The checklist indicated the call system and door alarms were checked on 05/12/23, 05/30/23, 06/06/23, 06/30/23 and 07/11/23.
-There were no issues noted for the nurse call system or door alarms.

Telephone interview with Resident #7's family member on 08/02/23 at 3:29pm revealed:
-Resident #7 exhibited wandering behaviors at home prior to admission.
-Resident #7 had a private duty sitter for two and a half weeks from 10:00pm to 6:00am after admission to the facility due to being anxious and having a history of falls.
-He was called by the Administrator around 2:30pm on 07/23/23, who informed him that Resident #7 was found outside in the facility parking lot.
-He was informed Resident #7 possibly fell and had an abrasion to her right elbow and redness to her right knee.
-He was not informed of how Resident #7 was able to exit the facility or how long Resident #7 was outside.
-He was informed the facility would "keep an eye on" Resident #7 and send her to the hospital if they had any concerns.
-He came later that afternoon, uncertain of the time, to take Resident #7 out to eat but prior to leaving the facility parking lot, he brought Resident #7 back into the facility due to bleeding from her right elbow.
-The facility dressed Resident #7's right elbow.

Review of Resident #7's PCP visit report dated 07/24/23 revealed Resident #7 had a fall and sustained trauma to the right leg as well as the right elbow area.

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D 270	Continued From page 6 Interview with a first shift SCU MA on 08/02/23 at 2:47pm revealed: -She was on duty on 07/23/23 when Resident #7 exited the facility. -SCU staff were supposed to check all exit doors and exit door alarms at the beginning of every shift and document on the MA/24 hour report form. -She did not check the exit doors or exit door alarms on 07/23/23 prior to Resident #7 exiting out of the facility because she was very busy. -Resident #7 was walking the hallways when she left the facility at 11:40am to run an errand. -She returned to the facility around 12:00pm and another MA assisted Resident #7 to lie down on her bed around 11:45am. -She went to check on Resident #7 at lunch time, but she was asleep. -The Marketing Manager entered the SCU, she could not recall what time, and notified her that Resident #7 had been found outside by another resident's family member. -After another staff member brought Resident #7 back to the SCU, she and the SCC completed a body assessment on Resident #7. -Resident #7 had a skin tear to her right elbow and her right knee was red. -She and another MA completed the body/skin assessment while the SCC filled out Resident #7's Skin Observation report. Interview with a first shift SCU personal care aide (PCA) on 08/03/23 at 8:58am revealed: -She worked on the SCU on 07/23/23. -Staff were required to check on residents at least every two hours for toileting and supervision. -For residents that had wandering behaviors or were at risk of falling like Resident #7, she would try to check on more often during her shifts.	D 270		

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D 270	Continued From page 7 -On 07/23/23, Resident #7 stated she "was tired and wanted to lay down". -She assisted Resident #7 to lie down for a nap around 11:40am- 11:50am just before lunch. -She returned to Resident #7's room about 10 minutes later to see if she was sleeping or if she wanted to eat lunch and Resident #7 was asleep. -She returned to the dining room to assist with lunch. -She was not aware Resident #7 had left the SCU until the Marketing Manager notified the SCU staff that Resident #7 was found in the parking lot. -When Resident #7 returned to the SCU, she and another staff member changed Resident #7's damp clothes and checked for injuries. -She did not hear the exit door alarm on 07/23/23. Interview with another first shift SCU MA on 08/03/23 at 10:32am revealed: -Resident #7 would walk throughout the SCU with her rolling walker. -Resident #7 would go up to exit doors and put her hands on the door. -Resident #7 needed constant redirection by staff away from the exit doors. -All staff members were responsible for checking all exit doors and exit door alarms. -The MAs were to document exit doors and exit door alarm checks on the MA/24 hour report form. -If the door was not locked or the exit door alarms where not working, a staff member would be placed at the exit door(s) if staff could not reengage the exit doors/alarms until the door(s) were functioning properly. -Everyone including staff, family members, providers, vendors, and residents were supposed to enter and exit the facility though the front door.	D 270		

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D 270	Continued From page 8 Interview with an Assisted Living (AL) MA on 08/03/23 at 10:19am revealed: -She worked in the AL as a MA on 07/23/23. -She was notified by another resident's family member around 2:30pm on 07/23/23 that Resident #7 was outside near the facility's dumpster's. -She brought Resident #7 back into the facility. -Resident #7's hair and clothing were wet. -She escorted Resident #7 to the SCU and reported to the MA that Resident #7 was found outside by another resident's family member, near the dumpsters. Interview with the facility Marketing Manager on 08/02/23 at 4:52pm revealed: -She was the manager on duty on 07/23/23. -She was responsible for checking all exit doors and exit door alarms and admitted she had walked through the SCU unit earlier that day (07/23/23), but did not notice if the maglock light was on indicating the lock was operational. -She was in the front lobby of the facility around 2:00pm-3:00pm when a family member reported to her that Resident #7 was outside. -She immediately got a MA to go outside to get Resident #7. -She said resident #7 was soaking wet due to the rainstorm that day. -She then went to the SCU and notified the MA. -She and the MA started checking all exit doors. -She had not checked the SCU exit doors prior to resident exiting the facility. -She and the MA on the SCU started checking all exit doors and stated the door leading to the parking lot was cracked open and when she pushed the door, it opened and did not alarm. -Everyone was supposed to enter and exit the facility through the front door only, not the door leading to the parking lot.	D 270		

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-She had staff count residents in the SCU to ensure everyone was present in the unit.

Interview with the SCC on 08/02/23 at 2:37pm and at 4:15pm revealed:
-She arrived at the facility on 07/23/23 after she was notified by the Administrator that Resident #7 had been found outside by another resident's family member near the dumpsters sometime after lunch, but she could not remember the exact time because she had lost her work phone.
-She did not remember which exit door Resident #7 used to exit the facility.
-She did not know how long Resident #7 was outside of the facility.
-She did not know why the exit doors and exit door alarms were turned off.
-No one was supposed to enter or exit though any other door other than the facility front door.
-The MAs were supposed to complete exit door and exit door alarm checks at the beginning of each shift.
-She completed elopement drills for all three shifts on 07/23/23, after Resident #7 eloped from the facility per facility elopement policy.

Interview with the Health and Wellness Director (HWD) on 08/03/23 at 11:23am revealed:
-The SCU did not have a specific supervision policy, the residents were supervised based on their needs.
-She preferred staff to visually locate residents every two to three hours, which could easily be achieved through the medication pass, meals and daily activities.
-Staff were not required to document when they checked on a resident.
-Residents with wandering behaviors were encouraged to spend time in the common area so

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staff could easily locate them, but they did not require increased rounding.
-If a resident was observed pushing on exit doors then she would implement hourly rounding or thirty minute rounding, if possible, for that resident.
-She was not aware Resident #7 had been observed pushing on doors and would have expected a MA to document that behavior on the 24 hour report and notify her.

Interview with the Administrator on 08/03/23 at 11:26am revealed:
-She was called by the Marketing Manager on 07/23/23 around 1:05pm informing her that Resident #7 had been found outside by another resident's family member.
-She spoke with the Marketing Manager and the MA that brought Resident #7 back into the facility on the phone prior to coming to the facility.
-At approximately 12:55pm on 07/23/23, Resident #7 was observed in the back parking area near the dumpsters by another resident's family member.
-The family member called the facility and notified the MA that answered the phone that Resident #7 was near the dumpsters.
-She called the SCC to notify her.
-She notified the facility's Regional Director of Operations at 1:35pm.
-She came to the facility around 2:00pm.
-The only way to turn off the red alarm box was to manually turn it off with a key.
-The maglock also had a key to turn it off along with a power override switch.
-When she arrived at the facility, she checked all the exit doors and exit door alarms.
-The gate on the small porch outside of the door leading to the parking lot was not flush.
-She called Resident #7's family member around

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D 270	Continued From page 11 2:00pm. -She offered to send Resident #7 to the ER, but the family member declined. -All residents were to be checked on every two hours including Resident #7. -Staff were supposed to check all exit doors and exit door alarms at the beginning of every shift. -After Resident #7 was found outside, elopement drills were completed on 07/23/23 on three shifts. -The facility did not have a Supervision Policy. -The Supervisor on Duty was responsible for completing exit door and exit door alarm checks. -She knew the MA had not completed the MA/24-hour report on 07/23/23 where exit doors and exit alarm checks should have been documented. -She expected staff to complete their job duties which included exit doors and exit alarm checks and to perform resident checks every two-hours. -Resident #7 was placed on 30-minute checks after her elopement. -If exit doors or exit alarms were not functioning properly, she expected staff to notify her. Attempted telephone interview with a fourth SCU MA on 08/03/23 at 9:58am was unsuccessful. _____ The facility failed to ensure Resident #7 who resided in the SCU (Resident #7) had a diagnosis of dementia with wandering behaviors and a history of falls was supervised when staff were serving lunch allowing the resident access to an exit that required leaving through an unlocked exit door when the alarm system was manually disabled into an outside parking lot and found approximately one and a half hours later physically wet with an abrasion to her right elbow and redness to her right knee. This failure resulted in a substantial risk for serious physical harm to the resident and constitutes a Type A2	D 270		

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D 270	Continued From page 12 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on and 08/02/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2023.	D 270		