STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	C 05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a complaint investigation on 05/15/24-05/17/24 and 05/20/24-05/21/24 with an exit conference via telephone on 05/21/24. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 05/13/24.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure the door alarms on the Special Care Unit (SCU) exit doors were maintained in safe working condition. The findings are: Observation of Special Care Unit (SCU) exit doors on 05/13/24 between 9:45am and 3:20pm revealed: -A door lock manual override switch adjacent to the 300 hallway exit door had a clear plastic cover locked closed with a plastic zip tie in place. -A numeric keypad adjacent to the 300 hallway exit door armed and disarmed the door to allow entrance into the SCU. -A battery operated door alarm was attached to the top of the 300 hallway exit door frame.	D 105		

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-The 300 hallway exit door alarm sounded intermittently with a quiet chirp sound and required battery replacement when tested by the Maintenance Director.
-The door lock override switch adjacent to the 400 hallway exit door had a plastic cover with a battery that operated the auditory alarm.
-A numeric keypad adjacent to the 400 hallway exit door armed and disarmed the door.
-A battery operated door alarm was attached to the top of the 400 hallway exit door frame with an inoperable battery-operated auditory alarm.
-A door lock manual override switch adjacent to the SCU main exit door had a plastic cover with a battery-operated auditory alarm, and the alarm was inoperable.

Interview with the facility's Maintenance Director on 05/15/24 at 10:46am and on 05/17/24 at 11:12am revealed:
-On 05/12/24 around 2:25pm, he was notified by a MA that two SCU residents had eloped from the facility.
-One resident was found almost a mile from the facility by a citizen and another resident was found on a sidewalk parallel to the facility next to a busy four-lane road.
-He was responsible for checking all exit doors daily, while in the facility, to ensure all exit doors and exit door alarms were working properly since 03/04/24.
-He checked all exit doors on the SCU around 6:50am every day when he worked.
-The 300 hallway exit door had an electronic mag-lock which utilized an electronic numerical keypad or a manual switch located to the right of the exit door, to arm or disarm the door.
-He was aware the 300 hallway exit door and 400 hallway exit door utilized a door lock override switch, but he did not know how they operated.

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D 105	Continued From page 2 -Between 03/04/24 and 05/13/24, he did not have a key to arm or disarm the door lock override switch alarms. -He did not know if any staff had a key to arm or disarm the red stop box alarms. -When he checked the 300 hall exit door on 05/12/24, there was a red security tie/seal on the clear plastic cover over the door lock manual override switch. - On 05/12/24 between 6:45am and 7:00am prior to the elopements, he pushed on all the SCU exit doors, including the 300 hall exit door, to make sure they were locked, but he did not check the alarms to ensure they were working and engaged. -When doors were opened, the alarms should sound to alert staff an exit door had been opened. -Prior to 05/12/24, all exit doors had door lock override switch alarm that could only be turned off manually with a key, a mag-lock located on the top, a mag-lock switch located on the wall to the right of the door which was covered by a clear plastic cover and a keypad located to the left of the door lock override switch. -All exit doors except for the 300 hall exit door had box covers that would alarm when the cover was pulled up allowing access to the door lock override switch. -The 300 hall exit door had a red security tie/seal on the door lock override switch cover. -Someone could disengage the exit doors by entering the code into the keypad or by turning off the door lock override switch located under the clear plastic cover. -Someone would have to use a key to manually turn off the door lock override switch alarm. -On 05/12/24 at 2:27pm, he called the Administrator to notify him of two residents eloping. -On 05/12/24, he was notified between 3:00pm	D 105		

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and 3:30pm that the SCU 300 hallway exit door red security tie/seal had been broken and the door lock override switch had been turned off allowing the residents to exit unnoticed by staff.
-He returned to the facility between 3:00pm to 3:30pm and observed the red security tie/seal had been broken and the door lock override switch had been turned off.
-He turned on the door lock override switch and replaced the red security tie/seal on the switch cover.
-He did not check the override alarm because he did not have the key to turn it off if it were to alarm.
-He was instructed to replace the cover over door lock override switch with a cover that would alarm if opened the day after the elopements on 05/13/24.
-On 05/13/24 at 3:20pm he tested the SCU main exit door manual override switch alarm and determined the battery was inoperable.
-He did not remember if or when he last checked the SCU main exit door battery-operated alarm switch cover prior to the elopements.
-He did not know the door alarm was battery operated and that the batteries were dead until it was brought to his attention by the Adult Home Specialist after the elopements on 05/13/24.

Review of the facility's Doors, Locks and Alarms Logbook on 05/16/24 revealed:
-The Logbook had check boxes labeled, "N/A, Pass or Fail."
-The 300 hall exit door through which Resident #3 and #4 eloped was documented as passed on 05/12/24.
-On 05/11/24 there was no documentation that the 300 hall exit door in which the residents eloped was checked.

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D 105	Continued From page 4 Interview with Regional Director of Operations on 05/13/24 at 1:40pm and on 05/20/24 at 2:21pm revealed: -He expected the Maintenance Director to be knowledgeable of the SCU exit door alarms, to inspect and repair all battery-operated SCU exit door alarms at least monthly and ensure SCU exit door alarms were working immediately after the elopement on 05/12/24. -He expected the Maintenance Director to replace the SCU 300 hallway exit door override switch covers with a battery-operated cover prior to 05/13/24. -He was concerned because facility management staff did not know how SCU exit alarms functioned, the facility Maintenance Director had not ensured SCU exit doors and switch batteries were operable prior to 05/12/24. -The facility Maintenance Director had not ensured SCU exit door and switch batteries were operable after two residents eloped from the SCU on 05/12/24. -The facility Maintenance Director had not replaced the SCU 300 hallway override lock switch cover with a spare battery-operated alarm cover prior to the local Adult Home Specialist (AHS) observations on 05/13/24. Interview with the Administrator on 05/20/24 at 5:34pm and on 05/21/24 at 3:22pm revealed: -She was contacted by a MA on 05/12/24 at 2:27pm, two residents had eloped from the facility. -She expected staff to check exit doors prior to the elopements but did not know if staff checked the exit door alarms. -She was notified that the exit door alarms were not working. -The Maintenance Director was supposed to check the exit doors and exit door alarms, but	D 105		

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D 105	Continued From page 5 she was not sure if he did all of the time. -She never had checked exit doors or exit door alarms herself. -To her knowledge, there was no system in place to routinely check exit doors and/or exit door alarms. -She had no idea what had been in place regarding checking of exit doors and exit door alarms to ensure they were in proper operating order to ensure the safety of residents, prior to her starting at the facility three months ago. -She did not know the batteries in the door alarms were dead, or that the door lock override switches were battery operated. -There was an elopement drill conducted by the Maintenance Director prior to 05/12/24 however she had no idea what that drill entailed because she wasn't there. -The Maintenance Director had gone over with her what had been completed during the drill, but she could not state what that was. -She did not know how often fire drills or elopement drills were supposed to be completed. -When asked if the facility had a policy related to the maintenance and service of the exit doors for the SCU she stated she was pretty sure there was a policy, but she had never seen a policy and could not answer yes or no. [Refer to tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)] The facility failed to ensure all SCU door alarms were in working order which led to two SCU residents with diagnoses of dementia and known wandering behaviors to elope from the SCU without staffs' knowledge resulting in one resident being found .58 of a mile away from the facility, and a resident walking on a sidewalk beside a	D 105		

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D 105	Continued From page 6 four-lane road. This failure placed the residents at substantial risk for serious physical harm and constitutes an A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/15/24 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 20, 2024.	D 105		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to obtain Health Care Personnel Registry (HCPR) checks for 3 of 7 sampled staff (Staff C & F) prior to working in the facility. The Findings are: 1. Review of Staff C's personnel file revealed: -A hire date of 03/13/24. -A HCPR inquiry report was completed on 04/04/24 after hire. Interview with the Administrator at on 05/20/24 at 5:35pm revealed: - Staff C had been working at the facility as an	D 137		

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agency staff prior to her start date on 3/31/24 and there should be a HCPR report in her agency file.
-A request for Staff C's HCPR was requested on 5/20/24 but not received.

Review of Staff C's HCPR on 05/20/24 revealed there were no findings.

Refer to the interview with the Compliance Nurse on 05/20/24 at 3:41pm.

Refer to the interview with the RDO on 5/20/24 at 4:21pm.

Refer to the interview with the Administrator on 05/20/24 at 5:35pm.

2. Review of Staff F's personnel file revealed:
-A hire date of 02/23/24.
-A HCPR inquiry report was completed on 05/14/24 during the survey.

Interview with the facility Compliance Nurse on 05/20/24 at 3:41pm revealed she was not aware that Staff F's HCPR inquiry report was not completed prior to Staff F's hire date and acknowledged there was no BOM working at the facility at the present time.

Interview with the Administrator on 05/20/24 at 5:35pm revealed Staff F's HCPR was completed last week on 5/14/24 during the survey.

Review of Staff F's HCPR on 05/20/24 revealed there were no findings.

Refer to the interview with the Compliance Nurse on 05/20/24 at 3:41pm.

Refer to the interview with the RDO on 5/20/24 at

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D 137	Continued From page 8 4:21pm. Refer to the interview with the Administrator at on 05/20/24 at 5:35pm. _____ Interview with the facility Compliance Nurse on 05/20/24 at 3:41pm revealed: -She was not responsible for running the HCPR inquiry report. -She assisted the newly hired Business office Manager (BOM) who started on 04/15/24 with HCPR inquiry report to show her how to run the report. -She communicated to the Administrator who was hired in February 2024, the HCPR report needed to be completed before a person was hired. Interview with the RDO on 5/20/24 at 4:21pm revealed: -The BOM was responsible for ensuring the HCPR inquiry report is completed and if the BOM is not available the Administrator would be responsible. -The HCPR was completed prior to the offer letter which is sent to the employee with a hire date. -At times, an offer letter could be sent out and would say pending background information. Interview with the Administrator on 05/20/24 at 5:35pm revealed: -She started employment with the facility on 02/19/24. -Prior to her start date she thought the Compliance Nurse and the corporate human resource department was responsible for completing the HCPR inquiry report for new employees. -A sister facility had assisted with completing the HCPR inquiring report and assisted with hiring practices.	D 137		

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D 137	Continued From page 9 -It was her expectation that the HCPR inquiry reports were completed before hire. Attempted telephone interview with the BOM on 05/20/2024 was unsuccessful.	D 137		
D 188	10A NCAC 13F .0604(e)(1) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to	D 188		

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meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

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

Based on record reviews, and interviews the facility failed to ensure the required aide duty hours were met for 4 of 24 shifts sampled from 05/03/24 through 05/06/24 and 05/10/24 through 05/13/24.

The findings are:

Review of the facility's current license by the Division of Health Service Regulation effective 01/01/2024 revealed the facility was licensed for a capacity of 90 beds for an Adult Care Home.

Review of the facility's census revealed:
-There were 21 Assisted Living (AL) residents from 05/03/24 to 05/04/24 and from 05/10/24 to 05/13/24 which required 16 aide duty hours on first shift and second shift and 8 aide duty hours on third shift.
-There were 20 AL residents from 05/05/24 to 05/06/24 which required 8 aide duty hours on first

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shift, second shift and third shift.

Review of the staff time records from 05/03/24 through 05/06/24 and 05/10/24 through 05/13/24 revealed:
-On 05/04/24, the AL census was 21 requiring 16 staff hours on first shift and a total of 11.75 staff hours were provided leaving a shortage of 4.25 hours.
-On 05/04/24, the AL census was 21 requiring 16 staff hours on second shift and a total of 12.25 staff hours were provided leaving a shortage of 3.75 hours.
-On 05/10/24, the AL census was 21 requiring 16 staff hours on first shift and a total of 14.75 staff hours were provided leaving a shortage of 1.25 hours.
-On 05/12/24, the AL census was 21 requiring 16 staff hours on second shift and a total of 8.75 staff hours were provided leaving a shortage of 7.25 hours.

Interview with a Medication Aide (MA) on 05/20/24 at 9:28am revealed:
-She was usually the lead MA on third shift; however, she worked other shifts, including coming in early and staying late.
-When she worked third shift, she was usually the only MA for both the AL and the Special Care Unit (SCU).
-There were times the facility was short staffed but could not recall dates or shifts.
-Within the past two months, she had worked when the facility was understaffed, with as little as three total staff in the facility.
-There were times she needed to start the first shift medication pass due to a MA not arriving on time for their shift.
-On 05/16/24 she administered some medications for the first shift MA because the MA

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was running late, and some residents received morning insulin before their breakfast.

Interview with a personal care aide (PCA) on 05/20/24 at 9:56am revealed:
-There were several times the facility was short staffed, and she had had to pick up extra shifts and stay over.
-She routinely worked on the AL.
-When she worked on the AL there were 2 PCA's during the week but on the weekends, there was only 1 PCA.

Interview with the Regional Director of Operations (RDO) on 05/13/24 at 1:40pm revealed:
-He expected the Administrator to staff each unit of the facility with scheduled staff according to census.
-Prior to 05/13/14, he had instructed the Administrator to ensure adequate staff were scheduled on each shift, with instructions to not share staff between the SCU and the AL.
-On 05/10/24, during a facility management call, the Administrator notified him she had sufficient care staff scheduled to work on 05/12/24 during first shift.
-He was unaware the Administrator scheduled the first shift MA on 05/12/24 to work between each unit.
-He was concerned the Administrator had not ensured the facility was adequately staff, especially with constant corporate oversight and inquires.

Interview with the Administrator on 05/20/24 at 5:34pm revealed:
-Staff were to call out to her if unable to work their shift.
-No staff had called out on 05/12/24.
-She was responsible for ensuing there was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 188	Continued From page 13 adequate staff in the building each shift. [Refer to tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] [Refer to tag 0364, 10A NCAC 13F .1004(g) Medication Administration.] _____ The facility failed to have required aide duty hours in the facility to provide supervision and care for 21 residents on 1st shift for 2 of 8 days and 2nd shift for 2 of 8 days from 05/04/24 through 05/12/24 which could result in the residents not receiving appropriate supervision, assistance with their care needs and hinder the residents' ability to evacuate the facility in case of an emergency. This failure was detrimental to the health and safety of all the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/21/24 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 5, 2024.	D 188		
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.	D 270		

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D 270	Continued From page 14 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 2 of 4 sampled residents with a history of wandering behaviors (#3 and #4) eloping from the facility's SCU without the staffs' knowledge. (#4). The findings are: Review of the facility's Elopement/Missing Resident policy with an effective date of 10/01/20 revealed: -All residents would be assessed for elopement risk by a licensed healthcare professional prior to or on move in (as required by regulation) upon significant change in condition and at regularly scheduled assessment intervals to identify risk factors that could lead to elopement. -The resident's care plan would identify if the resident were determined to be at risk for elopement and interventions to minimize risk will be included in the care plan. -All associates would be notified that the resident is at risk and the appropriate interventions to minimize risk of eloping. -The frequency and responsibility for monitoring the resident's location would be identified in the service/support plan. -All associates were required to promptly respond to door alarms and to thoroughly check the grounds surrounding the community after an alarm sounds. -When a door alarm sounded or an exit door was found unsecured, an immediate headcount was to be conducted in each area to ensure the presence of all residents, especially those considered at risk for elopement.	D 270		

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D 270	Continued From page 15 -Door alarms will not be disabled without being continuously monitored by an assigned associate. -If an associate believed a resident may be missing, and/or the resident cannot be located, the Supervisor/Manager on Duty would be notified, and a search initiated. 1. Review of Resident #3's current FL2 dated 07/03/24 revealed: -Diagnoses included dementia and hypertension. -She was ambulatory. -She was constantly disoriented. -She had a history of wandering behavior. -Her level of care was SCU. Review of Resident #3's Care Plan dated 04/26/24 revealed: -Under the orientation section, behavior, and safety, she did not need reminders or guidance to find her way to and from locations such as her room to the dining room, etc. and she wandered into inappropriate places due to an inability to find her room. -Under the services and other tasks, task checked to monitor behaviors, and intervention checked for her to respond to reorientation and redirection when wandering. -Under the communication section there was documentation that she was unable to make needs known. Review of Resident #3's SCU pre-screening dated 11/07/23 revealed: -Documentation Resident #3 had a diagnosis of dementia. -Documentation Resident #3 habitually wandered or would wander out of the building and would not be able to find her way back. Review of Resident #3's Elopement Risk	D 270		

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Assessment completed on 03/24/24 revealed:
-She had a history of elopement or exist seeking behaviors.
-She had wandering or exit seeking behaviors.
-She had a history of sundowning.
-She had a diagnosis of dementia.
-She was disorientated.
-She was highly mobile and liked to walk.

Review of Resident #3's accident and incident report dated 05/12/24 at 2:00pm revealed:
-Resident #3 eloped from an exit door in the SCU, 300 hall.
-The exit door alarm had been switched off.
-Resident #3 was located in a nearby neighborhood by an unknown person who had driven her to the hospital.
-Resident #3 was held in the hospital for observation and released back to the facility the same day.
-Resident #3's family was notified.
-Local Law Enforcement was also notified but did not complete an incident report due to resident being located.
-The exit door alarm was secured by the Maintenance Director and all exit alarms were tested on 05/12/24 following the incident.
-The report was signed by the Administrator.

Interview with a citizen on 05/14/24 at 10:51am and on 05/15/24 at 3:34pm revealed:
-She was at her home on 05/12/24 when she found Resident #3 rummaging in her open car garage and then proceeded to walk along the residential street.
-Between 1:15pm and 1:45pm, she attempted to identify the resident and where she may live but was unsuccessful.
-Resident #3 was unable to answer general questions regarding who she was and where she

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was from.
-Resident #3 had mail in hand that she had retrieved from a mailbox of a nearby street.
-She called 911 however due to 911 being unable to give her an estimated time of arrival and Resident #3 trying to walk off, she decided to take the resident to the local Emergency Department (ED).
-She took Resident #3 to the ED between 1:30pm to 1:45pm.
-Resident #3's shoes were labeled with her first name.
-She left the ED, and on her way home decided to stop by the facility to ask if there was a missing resident.
-Upon arrival at the facility around 2:20pm, she walked through the front door and located staff sitting at the Assisted Living (AL) unit staff station.
-She asked the medication aide (MA) if the facility was missing a resident.
-After providing the MA with a description and the first name of the resident, the MA stated she knew who the resident was and went over to the SCU.
-The MA pulled up a picture of a resident, but the citizen was unable to confirm as Resident #3 due to the picture being very small.
-She offered to take staff to the ED to identify Resident #3.
-When she, the MA, and a personal care aide (PCA) were walking out the front door, there was another resident that was recognized by the two staff members, walking on the sidewalk directly beside a four-lane road, in front of the facility.
-The PCA ran up the hill in front of the facility to the other resident and redirected her back into the facility.
-She drove the MA to the ED where the MA was told Resident #3 was being held for observation.
-She drove the MA back to the facility and then

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left.
-She was never asked for her name or contact information.

Telephone interview with a hospital nurse on 05/14/24 at 10:51am revealed:
-On 05/12/24 she was the lead nurse in the ED.
-On 05/12/24 at 1:45pm, a citizen brought an elderly female to the ED for evaluation.
-The concerned citizen and ED staff were unable to identify the patient who was later determined to be Resident #3.
-On 05/12/24, Resident #3 was independent with ambulation and disoriented to person or place.
-On 05/12/24, after the concerned citizen brought a facility MA to the ED, staff were able to identify the resident as Resident #3.
-On 05/12/24, ED staff notified Resident #3's family member of the residents' location and well-being.
-On 05/12/24, ED staff showered Resident #3 and changed her clothing due to a large volume of fecal matter found on her back, groin, and abdominal area.

Review of the facility Doors, Locks and Alarms Logbook on 05/16/24 revealed:
-The Logbook had check boxes labeled, "N/A, Pass or Fail."
-The exit door through which Resident #3 eloped was documented as, "passed" on 05/12/24.
-There was no documentation on 05/11/24, for the 300 hallway exit door through which Resident #3 eloped.

Observation of Resident #3 on 05/13/24 between 9:50am and 10:00am revealed:
-She was independent with ambulation.
-She walked to the end of the SCU 300 hallway exit door and with prompting by the Adult Home

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Specialist (AHS) a PCA redirected Resident #3 away from the exit door.
-She walked the SCU hallways.

Review of weather report for 05/12/24 around 1:30pm revealed the high was 76 degrees and the humidity level was 32%.

Observation of the area between the facility and where Resident #3 was found on 05/15/24 at 1:38pm revealed:
-The facility was located on a 4-lane highway with a median.
-The street had two lanes on each side of the median traveling in opposite directions.
-There was a sidewalk directly beside the four-lane highway.
-The parking lot entrance of the facility was connected to the 4-lane highway.
-The facility was surrounded by a wooded area to the left, facing the facility.
-There was a steep ravine located to the left of the facility, in between the facility driveway and the road Resident #3 walked down.

Observation from the facility to where Resident #3 was found on 05/15/24 revealed:
-It was .58 mile from outside of the exit door on the 300 hall to the citizen's residence where Resident #3 was found.
-The route included walking to the address located on the mail in Resident #3's hand.
-There was a large, wooded area to the back of the facility property and to the right side of the facility property that Resident #3 would have had difficulty navigating through.
-On the route there was a busy four-lane road with a posted speed limit of 55 mph located in front of the facility.
-The neighborhood Resident #3 was found in had

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a posted speed limit of 35 mph.

Telephone interview with Resident #3's family member on 05/15/24 at 10:30am revealed:
-She was notified by the ED on 05/12/24 at 2:08pm that Resident #3 was found walking in a neighborhood by a citizen who brought the resident to the ED.
-She called other family members who went to the ED.
-She was not notified by the Administrator of the resident eloping until two hours later, after 4:00pm.
-Resident #3 could only voice a very limited number of words due to her dementia.
-Resident #3 walked hallways constantly, went in and out of other residents' rooms and pushed on doors, especially the exit door located beside of her room.
-The only intervention the facility had put in place was replacing the red security tie/seal on the exit door she eloped.
-She said the resident was very visible due to the resident constantly walking and she expected the facility to lay eyes on the resident at least every 30 minutes to an hour.

Interview with Resident #3's Primary Care Provider (PCP) on 05/17/24 at 3:41pm revealed:
-Resident #3 had severe cognitive decline and was unable to voice needs or concerns.
-Leaving the facility without staff knowledge put Resident #3 at risk including risk of death, risk of being kidnapped, risk of being hit by traffic and risk of other injuries.
-She expected the facility to have implemented at least 30 minutes checks on Resident #3.

Based on observations, interviews, and record reviews, it was determined that Resident #3 was

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D 270	Continued From page 21 not interviewable Refer to the interview with the facility's Maintenance Director on 05/13/24 between 9:45am- 3:20pm, on 05/15/24 at 10:46am and on 05/17/24 at 11:12am. Refer to the interview with a first shift SCU PCA on 5/15/24 at 11:18am. Refer to the interview with a another first shift SCU PCA on 05/15/24 at 11:34am. Refer to the interview with a second shift SCU PCA on 05/15/24 at 3:18pm. Refer to the interview with a first shift Assisted Living (AL) PCA on 05/13/24 at 10:10am and on 05/16/24 at 12:06pm. Refer to the interview with a first shift SCU MA on 05/16/24 at 11:14am. Refer to interview with the facility Compliance Registered Nurse (RN) on 05/16/24 at 3:39pm. Refer to interview with Regional Director of Operations (RDO) on 05/20/24 at 2:21pm. Refer to interview with the Administrator on 05/20/24 at 5:34pm and on 05/21/24 at 3:22pm. 2. Review of Resident #4's current FL-2 dated 03/27/24 revealed: -Diagnoses included Alzheimer's dementia -Resident #4 was independent with ambulation. -Resident #4 was constantly disoriented. -The recommended level of care was Special Care Unit (SCU).	D 270		

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Review of Resident #4's SCU pre-screening dated 07/27/22 revealed she habitually wandered or would wander out of the building and would not be able to find her way back.

Review of Resident #4's Care Plan dated 04/12/24 revealed:
-Resident #4 was oriented to person.
-Resident #4 required assistance with bathing, grooming, dressing, and toileting.
-Resident #4 was independent with ambulation and required frequent checks for mobility, transfers, and escorts.
-Resident #4 wandered and required reminders and guidance within the unit.
-Resident #4 required monitoring for behaviors and 'wandered aimlessly or in undirected fashion without definable or obtainable purpose, i.e. looking for visitors who are not coming, or relatives who may be deceased.'
-The care plan was electronically signed by the facility regional Health and Wellness Director (HWD) on 04/12/24.
-Resident #4's primary care provider signature was dated 05/17/24.

Telephone interview with a citizen on 05/14/24 at 10:51am and on 05/15/24 at 3:34pm revealed:
-When she, the MA, and a PCA were walking out the front door, Resident #4 who was identified by the two staff members, was walking on the sidewalk directly beside a four-lane road, in front of the facility.
-The PCA ran up the hill in front of the facility to Resident #4 and redirected her back into the facility.

Review of Resident #4's accident and incident report dated 05/12/24 at 2:00pm revealed:
-Resident #4 and another SCU resident eloped

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from the SCU 300 hallway exit door due to the alarm being switched off.
-Resident #4 was located in front of the facility by staff.
-Resident #4 did not sustain any injuries.

Review of Resident #4's May 2024 Progress Notes revealed:
-On 05/12/24 at 4:17pm the Administrator documented Resident #4 eloped through an unlocked exit door in the SCU.
-Resident #4 was discovered missing by an associate which led to all staff searching.
-Resident#4 was located in front parking lot of building.
-There was no additional documentation related to behaviors.

Review of the facility Doors, Locks and Alarms Logbook on 05/16/24 revealed:
-The logbook had check boxes, "not applicable (NA), Pass or Fail."
-The exit door through which Resident #4 eloped was documented as passed.
-There was no documentation on 05/11/24, for the exit door through which Resident #4 eloped.
-On 05/12/24, the exit door through which Resident #4 eloped was documented as passed.

Observation of the location of the facility on 05/15/24 at 1:38pm revealed:
-The facility was located on a 4-lane highway with a median.
-The street had two lanes on each side of the median traveling in opposite directions.
-There was a sidewalk directly beside the highway where Resident #4 was witnessed walking by staff.
-The parking lot entrance of the facility was connected to the 4-lane highway.

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D 270	Continued From page 24 Observation of Resident #4 on 05/13/24 at 9:55am revealed: -She was independent with ambulation. -She was sitting in the SCU living room. Additional observation of Resident #4 on 05/13/24 at 10:40am revealed: -Resident #4 was pushing on the SCU main exit door. -SCU staff redirected Resident #4 away from the SCU door. Telephone interview with Resident #4's Power of Attorney (POA) on 05/17/24 at 9:22am revealed: -Resident #4 was admitted to the SCU in 2022. -Resident #4 was independent with ambulation. -Resident #4 was disoriented to person and place. -Resident #4 had a history of wandering behaviors; exit seeking; and aggression. -On 05/12/24, someone from the facility left a voicemail to notify him of Resident #4's elopement. -Between 05/12/24 and 05/17/24, he had not communicated with the facility. Telephone interview with Resident #4's PCP on 05/16/24 at 3:11pm revealed: -Resident #4 required supervision in the SCU. -On one occasion, she had observed Resident #4 exit seek at the SCU main entrance door. -Resident #4 could attempt to elope if given an opportunity. -On 05/12/24, the facility compliance RN notified her of Resident #4's elopement from the SCU. -On 05/12/24, she did not provide the facility with any recommendations for Resident #4. -She expected the facility to ensure Resident #4 always remained in the SCU.	D 270		

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D 270	Continued From page 25 -If Resident #4 eloped from the SCU, she was at risk for injury or a fall. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable. _____ Interview with the facility's Maintenance Director on 05/15/24 at 10:46am and on 05/17/24 at 11:12am revealed: -He was responsible for checking all exit doors daily, while in the facility, to ensure all exit doors and exit door alarms were working properly since 03/04/24. -He worked as the Manager on Duty on 05/12/24, from 6:30am until 10:45am. -He checked all exit doors on the SCU around 6:50am on 05/12/24. -He pushed on all the SCU exit doors, including the 300 hall exit door, to make sure they were locked, but did not check the alarms to ensure they were working and engaged. -When doors were opened, the door alarms were supposed to alert staff an exit door had been opened. -Someone could disengage the exit doors by entering the code into the keypad and by turning off the switch located under the clear plastic cover. -He could not recall if or when he checked the SCU main exit door lock override alarm switch cover. -He did not know the door alarms were battery operated and that the batteries were dead. Interview with a first shift SCU PCA on 5/15/24 at 11:18am revealed: -She worked in the SCU on 05/12/24. -Residents #3 and #4 would walk constantly throughout the SCU independently and would go	D 270		

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in and out of other residents' rooms.
-Residents #3 and #4 would go up to the exit doors and push on the doors.
-She had never been instructed to check exit doors or exit door alarms.
-She did not recall ever seeing anyone checking the exit doors and exit door alarms.
-She did not know if anyone was responsible for checking exit doors and exit door alarms.

Interview with a another first shift SCU PCA on 05/13/24 at 10:42am and on 05/15/24 at 11:34am revealed:
-She worked in the SCU on 05/12/24.
-Resident #3 was constantly disoriented.
-Resident #3 was independent with ambulation.
-Resident #3 frequently wandered in residents' rooms, rummaging for unsecured items.
-Resident #3 was known to constantly wander the SCU hallways and frequently push on exit doors.
-On 05/12/24, she observed Resident #3 between 12:15pm-12:30pm eating lunch in the dining room.
-On 05/12/24, she observed Resident #4 at 12:00pm during lunch.
-On 05/12/24 at 2:30pm the MA and an AL PCA notified SCU PCA's of a possible resident elopement.
-On 05/12/24, the MA notified SCU PCAs that the missing resident was most likely Resident #3.
-On 05/12/24, she and an additional SCU PCA initiated room checks to search for Resident #3, while a third SCU PCA was on break.
-She was informed later that Resident #4 also eloped on 05/12/24.
-SCU PCA's were responsible to observe each assigned SCU resident every two-hours.
-She was not aware of any interventions for wandering or exit seeking residents.
-She was not responsible for documenting

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resident observations.
-PCAs were not responsible for checking SCU exit doors.
-The Maintenance Director was responsible for checking SCU exit doors and replacing door alarm batteries as needed.
-There were three PCAs working first shift on 05/12/24.
-SCU PCAs were assigned specific residents on each shift to provide personal care and supervision.
-The SCU had four separate resident assignments.
-On 05/12/24, Resident #3 and Resident #4 were not assigned to a PCA.
-On 05/12/24, the three SCU PCA's shared responsibility to provide personal care as needed to Resident #3 and Resident #4 and she did not check on them every two hours.
-On 05/12/24, during first shift, one MA worked on both the AL and SCU passing medications, and she did not ask who was supervising and providing personal care for Residents #3 and #4.
-On 05/12/24, during first shift, the MA administered SCU residents' medications and returned to the AL.
-On 05/12/24, a second shift PCA found the unalarmed and opened exit door on the 300 hall.

Interview with a first shift AL PCA on 05/13/24 at 10:10am and on 05/16/24 at 12:06pm revealed:
-On 05/12/24, she worked on first shift.
-On 05/12/24, shortly after 2:00pm, a citizen entered the facility and notified her and the first shift MA about an unknown resident the citizen had taken to the ED on 05/12/24, who might be a resident of the facility.
-On 05/12/24, the citizen described the resident and facility staff determined it was Resident #3.
-On 05/12/24 at 2:30pm, the first shift MA and

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citizen were exiting the facility on the way to the ED and observed Resident #4 walking on a highway sidewalk in front of the facility.
-She immediately retrieved Resident #4 from the sidewalk and supervised her on the Assisted Living unit until the MA returned from the ED.
-Resident #4 was dressed in a shirt, pants, and shoes and was observed to be sweating and tired.
-On 05/12/24, during first shift, she observed three PCAs working on the SCU.
-On 05/12/24, a first shift MA worked between the AL and SCU administering residents' medications.

Interview with a first shift SCU MA on 05/16/24 at 11:14am revealed:
-She worked as the first shift MA in the SCU and the AL unit on 05/12/24.
-She saw Residents #3 and #4 in the dining room around 12:30pm when she was giving medications to residents on the SCU.
-She was first notified of a missing resident by a citizen that came into the facility after taking a resident to the ED.
-The citizen described the resident to her, and she knew the missing resident was Resident #3.
-She walked over to the SCU and notified staff of the missing resident and notified the Administrator.
-The citizen offered to drive her to the ED to identify the missing resident.
-On the way out of the facility with the citizen and an AL PCA, she saw Resident #4 walking on the sidewalk located directly beside a four-lane road.
-The PCA ran to Resident #4 and directed her back into the facility.
-Upon arrival at the ED, she was told Resident #3 was being held for observation.
-The citizen drove her back to the facility and then

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the citizen left.
-Residents #3 and #4 both walked throughout the SCU and pushed on exit doors.
-Prior to 05/12/24, there were no type of interventions or increased supervision in place for Residents #3 and #4.
-Staff were supposed to check on residents every two hours.
-Staff did not document any resident checks.
-She did not recall ever having any elopement training at the facility.
-She had never been instructed to check exit doors or exit door alarms.
-She did not recall ever seeing anyone checking the exit doors and exit door alarms.
-She thought the Maintenance Director was responsible for checking the exit doors and exit alarms.

Interview with the facility Compliance RN on 05/16/24 at 3:39pm revealed:
-She was notified on 05/12/24 in the afternoon by the RDO who forwarded her an email that was sent by the Administrator.
-She would have expected the Administrator to notify her of any elopements.
-She was told that Resident #4 was directed back inside of the facility and Resident #3 was being observed in the hospital.
-She expected staff to complete exit doors and exit alarm checks and to perform resident checks every two hours prior to the elopement.
-She does not recall hearing any exit door alarms sounding while in her office located in the SCU.
-She expected staff to document resident checks, and she did not know that staff were not documenting any resident checks.

Interview with RDO on 05/13/04 at 1:40pm and on 05/20/24 at 2:21pm revealed:

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D 270	Continued From page 30 -He expected the Maintenance Director to be knowledgeable of the SCU exit door alarms, inspect and repair all battery-operated SCU exit door alarms at least monthly, ensure SCU exit door alarms were working immediately after the elopement on 05/12/24, and replace the SCU 300 hallway exit door switch cover with a battery-operated cover prior to 05/13/24. -He was concerned facility management staff were unaware how SCU exit alarms functioned. -He was concerned the facility Maintenance Director had not replaced the SCU 300 hallway exit switch cover with a spare battery-operated alarm cover prior to the local Adult Home Specialist (AHS) observations on 05/13/24. -All residents were to be checked on every two hours. -He expected facility clinical management or the Administrator to implement increased supervision checks of wandering and exit seeking residents. -He expected wandering and exit seeking residents to be checked by care staff between every 15-minutes to one-hour. -He did not know increased supervision checks for Residents #3 and #4 were not implemented prior to the resident's elopement on 05/12/24. -He was concerned facility management had not implemented increased supervision of wandering or exit seeking residents prior to and after the SCU elopements which occurred on 05/12/24. -The Maintenance Director who explained the red security tie/seal had been broken which secured the mag-lock switch. -He came to the facility on 05/13/24 where he instructed the Maintenance Director to change out the mag-lock box cover to a cover that alarmed when it was pulled up to access the mag-log switch. -He was not aware the red stop box's batteries were dead until he arrived at the facility on	D 270		

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D 270	Continued From page 31 05/13/24 and the Adult Home Specialist had discovered none of the red stop boxes were operational. Interview with the Administrator on 05/13/24 at 9:05am and on 05/20/24 at 5:34pm and on 05/21/24 at 3:22pm revealed: -On 05/12/24 at 2:30pm she was notified by the first shift MA that Resident #3 and Resident #4 had eloped from the facility. -She was told Resident #4 was directed back inside of the facility and Resident #3 was being observed in the hospital. -She came to the facility after 3:00pm and was told Resident #3's family member was at the ED with her. -She was notified that the exit door alarms were not working. -She expected staff to check exit doors but did not know if staff checked the exit door alarms. -The Maintenance Director was supposed to check the exit doors and exit door alarms, but she was not sure if he had been checking them prior to the elopement. -She never had checked exit doors or exit door alarms herself. -To her knowledge, there was no system in place to routinely check exit doors and/or exit door alarms. -She had no idea what had been in place regarding checking of exit doors and exit door alarms to ensure they were in proper operating order to ensure the safety of residents, prior to her starting at the facility three months ago. -She did not know the batteries in the red stop boxes were dead, or that the red stop boxes were battery operated. -She had never seen a policy related to the SCU exit doors. -Resident #3 was known to constantly push on	D 270		

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D 270	Continued From page 32 SCU exit doors while aimlessly walking in the SCU. -Resident #4 was known to wander on the SCU. [Refer to tag 0105, 10A NCAC 13F .0311(a) Other Requirements (Type A2 Violation)] [Refer to tag 0465, 10A NCAC 13F .1308 Special Care Unit Staff (Type A2 Violation)] The facility failed to ensure residents who resided in the SCU, who had a diagnosis of dementia and known wandering behaviors (Resident #3 and #4) were supervised allowing the residents to elope from the facility, without staff's knowledge, through an exit door with a disabled alarm system. One resident (#3) walked approximately 0.58 of a mile from the facility, then found by a citizen without staffs' knowledge, and the other resident (#4) was found walking on a sidewalk beside of a busy four-lane road. This failure resulted in the facility neglecting to ensure the residents of the SCU were supervised and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/15/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 20, 2024.	D 270		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before	D 364		

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or one hour after the prescribed or scheduled time unless precluded by emergency situations.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed time for 5 of 5 sampled residents resulting in some medications with multiple administration times being administered too close to the next scheduled administration time (Residents #1, #2, #3, #4, and #5).

Observation on 05/16/24 at 8:06am revealed the Special Care Unit (SCU) first shift medication aide (MA) was not available to administer resident medications.

Observation of the medication pass on 05/16/24 at 9:15am revealed:
-The SCU MA was administered medications to residents on the SCU.
-There were 5 residents whose medications were administered late, indicated by their names changing color on the electronic medication administration record (eMar).

Interview with the SCU MA on 05/16/24 at 9:15am revealed:
-She would call and inform the Primary Care Provider (PCP) of any resident receiving late medications and follow their guidance.
-She had not administered medications late previously but she was trained what to do if she did administer medications late.

1. Review of Resident #1's current FL2 dated 04/10/24 revealed:
-Diagnoses included dementia and mild cognitive impairment.

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-There was an order for furosemide (a medication to treat fluid retention) 20mg one tablet twice daily.
-There was an order for escitalopram (a medication to treat depression) 5mg, one tablet daily.
-There was an order for lubricant eye drops, one drop in each eye twice daily.

Review of Resident #1's Mental Health Provider's orders dated 04/25/24 revealed:
-There was an order to discontinue escitalopram 5mg daily.
-There was an order for escitalopram 10mg, one tablet daily.

Review of Resident #1's April 2024 electronic eMAR revealed:
-There was an entry for furosemide 20mg, two times daily at 8:00am and 4:00pm with documentation of administration at 8:00am on 04/20/24, 04/22/24, and, 04/29/24 and at 4:00pm on 04/05/24, 04/08/24, 04/10/24, 04/12/24-04/14/24, 04/19/24, and 04/27/24 -04/28/24.
-There was an entry for escitalopram 5mg, one tablet daily with documentation of administration at 8:00am on 04/20/24 and 04/22/24.
-There was an entry for escitalopram 10mg, one tablet daily with documentation of administration at 8:00am on 04/29/24.
-There was an entry for lubricant eye drops, one drop in each eye, two times daily at 8:00am and 4:00pm with documentation of administration at 8:00am on 04/20/24, 04/22/24, and, 04/29/24 and at 4:00pm on 04/05/24, 04/08/24, 04/10/24, 04/12/24-04/14/24, 04/19/24, and 04/27/24 -04/28/24.

Review of Resident #1's April 2024 Medication

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Administration Audit Report revealed:
-Furosemide was administered outside of the one hour before/after time frame 12 occurrences out of 60 opportunities with the latest administration being for the dose scheduled at 4:00pm on 04/13/24 and administered at 8:07pm.
-Escitalopram was administered outside of the one hour before/after time frame 3 occurrences out of 30 opportunities with the latest administration being on 04/22/24 at 10:47am.
-Lubricant eye drops were administered outside of the one hour before/after time frame 12 occurrences out of 60 opportunities with the latest administration being for the dose scheduled at 4:00pm on 04/13/24 and administered at 8:07pm.

Refer to the interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm.

Refer to the interview with the Regional Director of Operations (RDO) on 05/20/24 at 4:20pm.

Refer to the interview with the Administrator on 05/20/24 at 5:34pm.

2. Review of Resident #2's current FL2 dated 04/3/23 revealed:
-Diagnoses included asthma, diabetes mellitus and chronic kidney disease.

Review of Resident #2's signed Primary Care Provider's (PCP) orders dated 05/15/24 revealed:
-There was an order for atorvastatin calcium (a medication to treat high cholesterol) 80mg 1 tablet at bedtime.
-There was an order for dutasteride (a medication to treat chronic kidney disease) 0.5 mg 1 capsule at bedtime.
-There was an order for doxycycline monohydrate (a medication to treat and prevent bacterial

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infections) 100 mg 2 x daily.
-There was an order for acetaminophen 500mg 2 tablets at bedtime for mild pain.
-There was an order for metformin HCl (a medication to treat diabetes mellitus) 1000mg 1 tablet two times daily.
-There was an order for levothyroxine sodium (a medication to treat low thyroid hormone) 125 mcg 1 tablet by mouth once daily.

Review of Resident #2's April 2024 electronic medication administration Record (eMAR) revealed:
-There was an entry for atorvastatin calcium 80mg 1 tablet at 8:00pm with documentation of administration at 8:00pm on 04/21/24, 04/27/24
-There was an entry for dutasteride 0.5 mg 1 capsule at bedtime with documentation of administration at 8:00pm on 04/21/24, 04/27/24.
-There was an entry for doxycycline monohydrate100 mg two times daily at 6:00am and 8:00pm with documentation of administration at 6:00am on 04/23/24, 04/25/24 and 04/27/24, and at 8:00pm with documentation of administration at 8:00pm given 04/21/24, 04/27/24
-There was an entry for acetaminophen 500mg 2 tablets at bedtime with documentation of administration at 8:00pm given 04/21/24, 04/27/24.
-There was an entry for metformin HCl 1000mg 1 tablet two times daily at 8:00am and 8:00pm with documentation of administration at 8:00am given on 04/21/24, and 04/27/24.
-There was an entry for levothyroxine sodium 125 mcg 1 tablet by mouth once daily with documentation of administration at 6:00am given on 04/08/24,04/23/24,04/25/24, and 04/27/24.

Review of Resident #2's April 2024 Medication

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D 364	Continued From page 37 Administration Audit Report revealed: - Atorvastatin calcium was administered outside of the one hour before/after time frame 2 occurrences out of 30 opportunities with the latest administration on 04/21/24 at 09:46pm. -Dutasteride was administered outside of the one hour before/after time frame 2 occurrences out of 30 opportunities with the latest administration on 04/21/24 at 09:46pm. -Doxycycline monohydrate was administered outside of the one hour before/after time frame 5 occurrences out of 60 opportunities with the latest administration on 04/21/24 at 09:46pm and on 04/23/24 at 07:27am. -Acetaminophen was administered outside of the one hour before/after time frame 2 occurrences out of 30 opportunities with the latest administration on 04/21/24 at 09:45pm. -Metformin HCl was administered outside of the one hour before/after time frame 2 occurrences out of 60 opportunities with the latest administration on 04/21/24 at 09:46pm. -Levothyroxine sodium was administered outside of the one hour before/after time frame 3 occurrences out of 30 with the latest administration given on 04/24/24 at 07:27am. Review of Resident #2's May 2024 eMAR from 05/01/24 - 05/15/24 revealed: -There was an entry for atorvastatin calcium 80mg 1 tablet at 8:00pm with documentation of administration at 8:00pm on 05/08/24. -There was an entry for dutasteride 0.5 mg 1 capsule at bedtime with documentation of administration at 8:00pm on 05/08/24. -There was an entry for doxycycline monohydrate100 mg 2 x daily 6:00am and 8:00pm with documentation of administration at 6:00 am on 05/02/24 and 05/07/24, and documentation of administration at 8:00pm given	D 364		

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on 05/08/24.
-There was an entry for acetaminophen 2 tablets at bedtime with documentation of administration at 8:00pm on 05/08/24.

-There was an entry for metformin HCl 1000mg 1 tablet two times daily at 8:00am and 8:00pm with documentation of administration at 8:00pm given on 05/08/24.
-There was an entry for levothyroxine sodium 125 mcg 1 tablet by mouth once daily with documentation of administration at 6:00am on 05/24/24 and 05/07/2.

Review of Resident #2's May 2024 Medication Administration Audit Report from 05/01/24 - 05/15/24 revealed:
- Atorvastatin calcium was administered outside of the one hour before/after time frame 1 occurrences out of 14 opportunities with the latest administration at 09:22pm on 05/08/24.
-Dutasteride was administered outside of the one hour before/after time frame 1 occurrence out of 14 with the time administered at 09:22pm on 05/08/24.
-Doxycycline monohydrate was administered outside of the one hour before/after time frame 3 occurrences out of 29 opportunities with the latest administration on 05/07/24 at 7:35am and on 05/08/24 at 9:22am.
-Acetaminophen was administered outside of the one hour before/after time frame 1 occurrence out of 14 with the time administered at 09:22pm on 05/08/24.
-Metformin HCl was administered outside of the one hour before/after time frame 1 occurrence out of 29 with the time administered at 09:22pm on 05/08/24.
-Levothyroxine sodium was administered outside of the one hour before/after time frame 2

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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
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occurrences out of 15 with the latest administration on 05/07/24 at 07:35am.

A telephone interview with the pharmacist on 05/21/24 revealed that metformin should be given with food to alleviate any gastrointestinal issues.

Refer to the interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm.

Refer to the interview with the Regional Director of Operations (RDO) on 05/20/24 at 4:20pm.

Refer to the interview with the Administrator on 05/20/24 at 5:34pm.

3. Review of Resident #3's current FL2 dated 07/03/24 revealed:
-Diagnoses included dementia and hypertension.
-There was an order for benazepril (used to treat hypertension) 10mg by mouth daily.
-There was an order for vitamin B12 (used to lower an amino acid, that when elevated, can increase risk of dementia) 1000mcg by mouth daily.
-There was an order for aricept (used to treat dementia) 10mg by mouth at bedtime.

Review of Resident #3's PCP orders dated 10/12/22 revealed there was an order for tylenol (to treat mild to moderate pain) 325mg, take two tablets (650mg) by mouth twice daily.

Review of Resident #3's April 2024 eMAR revealed:
-There was an entry for benazepril 10mg by mouth daily at 8:00am with documentation of administration at 8:00am on 04/15/24, 04/20/24, 04/28/24 and 04/29/24.
-There was an entry for vitamin B12 1000mcg by

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mouth daily at 8:00am with documentation of administration at 8:00am on 04/15/24, 04/20/24, 04/28/24 and 04/29/24.
-There was an entry for aricept 10mg by mouth at bedtime at 8:00pm with documentation of administration at 8:00pm on 05/08/24.
-There was an entry for tylenol 325mg, take two tablets (650mg) by mouth twice daily with documentation of administration at 8:00am on 04/15/24, 04/20/24, 04/28/24 and 04/29/24 and at 8:00pm on 04/28/24.

Review of Resident #3's April 2024 Medication Administration Audit Report revealed:
-Benazepril was administered outside of the one hour before/after time frame 4 occurrences out of 30 opportunities with the latest administration being for the dose scheduled at 8:00am on 04/20/24 and administered at 10:44am.
-Vitamin B12 was administered outside of the one hour before/after time frame 4 occurrences out of 30 opportunities with the latest administration being for the dose scheduled at 8:00am on 04/20/24 and administered at 10:45am.
-Tylenol was administered outside of the one hour before/after time frame 5 occurrences out of 60 opportunities with the latest administration being for the dose scheduled at 8:00am on 04/29/24 and administered at 9:45am and with the latest administration being for the dose scheduled at 8:00pm on 04/28/24 and administered at 9:59pm.

Review of Resident #3's May 2024 eMAR from 05/01/24-05/15/24 revealed:
-There was an entry for benazepril 10mg by mouth daily at 8:00am with documentation of administration at 8:00am on 05/06/24, 05/10/24 and 05/13/24.
-There was an entry for vitamin B12 1000mcg by mouth daily at 8:00am with documentation of

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administration at 8:00am on 05/06/24, 05/10/24 and 05/13/24.
-There was an entry for aricept 10mg by mouth at bedtime at 8:00pm with documentation of administration at 8:00pm on 05/08/24.
-There was an entry for Tylenol 325mg, take two tablets (650mg) by mouth twice daily with documentation of administration at 8:00am on 05/06/24, 05/10/24 and 05/13/24 and at 8:00pm on 05/08/24.

Review of Resident #3's May 2024 Medication Administration Audit Report revealed:
-Benazepril was administered outside of the one hour before/after time frame 3 occurrences out of 15 opportunities with the latest administration being for the dose scheduled at 8:00am on 05/06/24 and administered at 10:07am.
-Vitamin B12 was administered outside of the one hour before/after time frame 3 occurrences out of 15 opportunities with the latest administration being for the dose scheduled at 8:00am on 05/06/24 and administered at 10:07am.
-Aricept was administered outside of the one hour before/after time frame 1 occurrence out of 14 opportunities with the latest administration being for the dose scheduled at 8:00pm on 05/08/24 and administered at 9:27pm.
-Tylenol was administered outside of the one hour before/after time frame 4 occurrences out of 29 opportunities with the latest administration being for the dose scheduled at 8:00am on 05/06/24 and administered at 10:07am and with the latest administration being for the dose scheduled at 8:00pm on 05/08/24 and administered at 9:27pm.

Refer to the interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm.

Refer to the interview with the RDO on 05/20/24

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D 364	Continued From page 42 at 4:20pm. Refer to the interview with the Administrator on 05/20/24 at 5:34pm. 4. Review of Resident #5's current FL2 dated 05/15/24 revealed: -Diagnoses included dementia, hypertension, and anemia. -There was an order for Boost (used as a nutritional supplement) one can by mouth twice daily at breakfast and bedtime. -There was an order for cholecalciferol (used to treat vitamin d insufficiency) 50,000units by mouth daily on Saturdays. -There was an order for protonix (used to treat acid reflux) 20mg by mouth daily. -There was an order for metoprolol tartrate (used to treat hypertension) 25mg by mouth two times daily. Review of Resident #5's April 2024 eMAR revealed: -There was an entry for Boost one can by mouth twice daily at 8:00am and 4:00pm with documentation of administration at 4:00pm on 04/08/24, 04/10/24, 04/13/24, 04/21/24, 04/22/24 and 04/27/24. -There was an entry for metoprolol tartrate 25mg by mouth two times daily at 8:00am and 6:00pm with documentation of administration at 6:00pm on 04/13/24, 04/21/24 and 04/28/24. Review of Resident #4's April 2024 Medication Administration Audit Report revealed: -Boost was administered outside of the one hour before/after time frame 6 occurrences out of 30 opportunities with the latest administration being for the dose scheduled at 4:00pm on 04/21/24 and administered at 8:47pm.	D 364		

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-Metoprolol tartrate was administered outside of the one hour before/after time frame 3 occurrences out of 60 opportunities with the latest administration being for the dose scheduled at 6:00pm on 04/21/24 and administered at 8:47pm.

Review of Resident #5's May 2024 eMAR from 05/01/24 - 05/15/24 revealed:
-There was an entry for Boost one can by mouth twice daily at 8:00am and 4:00pm with documentation of administration at 8:00am on 05/04/24 and with documentation at 4:00pm on 05/02/24.
-There was an entry for cholecalciferol 50,000units by mouth daily on Saturdays with documentation of administration at 7:30am on 05/04/24.
-There was an entry for metoprolol tartrate 25mg by mouth two times daily at 8:00am and 6:00pm with documentation of administration at 8:00am on 05/04/24 and with documentation of administration at 6:00pm on 05/02/24 and 05/03/24.

Review of Resident #5's May 2024 Medication Administration Audit Report from 05/01/24 - 05/15/24 revealed:
-Cholecalciferol was administered outside of the one hour before/after time frame 1 occurrence out of 2 opportunities with the latest administration being for the dose scheduled at 7:30am on 05/04/24 and administered at 9:35am.
-Boost was administered outside of the one hour before/after time frame 2 occurrences out of 29 opportunities with the latest administration being for the dose scheduled at 8:00am on 05/04/24 and administered at 9:35am and for the latest administration being for the dose scheduled at 4:00pm on 05/02/24 and administered at 8:07pm.
-Metoprolol tartrate was administered outside of

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the one hour before/after time frame 3 occurrences out of 29 opportunities with the latest administration being for the dose scheduled at 8:00am on 05/04/24 wand administered at 9:34am and with the latest administration being for the dose scheduled at 6:00pm on 05/02/24 and administered at 8:07pm.

Refer to the interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm.

Refer to the interview with the RDO on 05/20/24 at 4:20pm.

Refer to the interview with the Administrator on 05/20/24 at 5:34pm.

5. Review of Resident #4's current FL2 dated 03/27/24 revealed:
-Diagnosis included Alzheimer's disease.
-Resident #4's recommended level of care was Special Care Unit (SCU).
-There was an order for citalopram 20mg (a medication used to treat depression), 1 tablet daily.
-There was an order for hydroxyzine 10mg (a medication used to treat anxiety), 1 tablet three times daily.
-There was an order for Rexulti .5mg (a medication used to treat agitation), 1 tablet daily.
-There was an order for trazodone 50mg (a medication used to treat insomnia), 1 tablet at bedtime.
-There was an order for donepezil 10mg (a medication used to treat dementia), 1 tablet at bedtime.
-There was an order for lipitor 20mg (a medication used to treat high cholesterol)., 1 tablet at bedtime.

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D 364	Continued From page 45 Review of Resident #4's April 2024 electronic eMAR revealed: -There was an entry for citalopram 20mg one tablet daily with documentation of administration at 8:00am on 04/08/24, 04/15/24, 04/20/24, 04/28/24 and 04/29/24. -There was an entry for hydroxyzine 10mg one tablet three times daily at 8:00am, 1:00pm and 6:00pm with documentation of administration at 8:00am on 04/08/24, 04/15/24, 04/20/24, 04/28/24 and 04/29/24 and at 1:00pm on 04/01/24, 04/11/24 and 04/12/24 and 6:00pm on 04/02/24, 04/05/24, 04/15/24, -04/16/24 and 04/17/24. -There was an entry for Rexulti 5mg one tablet daily with documentation of administration at 8:00am on 04/08/24, 04/15/24, 04/20/24, 04/28/24 and 04/29/24. -There was an entry for trazodone 50mg one tablet daily with documentation of administration at 6:00pm on 04/02/24, 04/05/24, 04/15/24, 04/16/24 and 04/17/24. -There was an entry for donepezil 10mg one tablet daily with documentation of administration at 6:00pm on 04/02/24, 04/05/24, 04/15/24, 04/16/24 and 04/17/24. -There was an entry for Lipitor 20mg one tablet daily with documentation of administration at 6:00pm on 04/02/24, 04/05/24, 04/15/24, 04/16/24 and 04/17/24. Review of Resident #4's April 2024 Medication Administration Audit Report revealed: -Citalopram was administered outside of the one hour before/after time frame 5 occurrences out of 30 opportunities with the latest administration being on 04/20/24 at 10:46am. -Hydroxyzine was administered outside of the one hour before/after time frame 13 occurrences out of 90 opportunities with the latest administration	D 364		

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being for the dose scheduled for 6:00pm on 04/15/24 at 9:16pm.
-Rexulti was administered outside of the one hour before/after time frame 5 occurrences out of 30 opportunities with the latest administration being on 04/20/24 at 10:46am.
-Trazodone was administered outside of the one hour before/after time frame 5 occurrences out of 30 opportunities with the latest administration being on 04/15/24 at 9:16pm.
-Donepezil was administered outside of the one hour before/after time frame 5 occurrences out of 30 opportunities with the latest administration being on 04/15/24 at 9:15pm.
-Lipitor was administered outside of the one hour before/after time frame 5 occurrences out of 30 opportunities with the latest administration being on 04/15/24 at 9:16pm.

Review of Resident #4's April 2024 progress notes revealed no documentation related to Resident #4's medication administered outside of the one hour before/after time frame.

Review of Resident #4's May 2024 electronic eMAR from 05/01/24 - 05/15/24 revealed:
-There was an entry for citalopram 20mg one tablet daily with documentation of administration at 8:00am on 05/10/24 and 05/13/24.
-There was an entry for hydroxyzine 10mg one tablet three times daily at 8:00am, 1:00pm and 6:00pm with documentation of administration at 8:00am on 05/10/24 and 05/13/24, at 1:00pm on 05/04/24 and at 6:00pm on 05/03/24.
-There was an entry for Rexulti 5mg one tablet daily with documentation of administration at 8:00am on 05/10/24 and 05/13/24.
-There was an entry for trazodone 50mg one tablet daily with documentation of administration at 6:00pm on 05/03/24.

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-There was an entry for Lipitor 20mg one tablet daily with documentation of administration at 6:00pm on 05/03/24.

Review of Resident #4's May 2024 Medication Administration Audit Report from 05/01/24 - 05/15/24 revealed:
-Citalopram was administered outside of the one hour before/after time frame 2 occurrences out of 15 opportunities with the latest administration being on 05/13/24 at 9:48am.
-Hydroxyzine was administered outside of the one hour before/after time frame 4 occurrences out of 43 opportunities with the latest administration being for the dose scheduled for 6:00pm on 05/03/24 at 7:49pm.
-Rexulti was administered outside of the one hour before/after time frame 2 occurrences out of 15 opportunities with the latest administration being on 05/13/24 at 9:48am.
-Trazodone was administered outside of the one hour before/after time frame 1 occurrences out of 14 opportunities with the latest administration being on 05/03/24 at 7:50pm.
-Lipitor was administered outside of the one hour before/after time frame 1 occurrences out of 14 opportunities with the latest administration being on 05/03/24 at 7:50pm.

Review of Resident #4's May 2024 progress notes revealed no documentation related to Resident #4's medication administered outside of the one hour before/after time frame.

Refer to the interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm.

Refer to the interview with the Regional Director of Operations (RDO) on 05/20/24 at 4:20pm.

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D 364	Continued From page 48 Refer to the interview with the Administrator on 05/20/24 at 5:34pm. _____ Interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm revealed: -The Special Care Coordinator (SCC) and the Resident Care Coordinator (RCC) were responsible for running a late medication administration report daily, but the facility currently did not have an SCC or RCC. -She was responsible to run the late medication administration report. -If a medication was administered late, the process was to notify the PCP and follow their direction. -The expectation was for the MAs to administer resident medications within one hour before or one hour after the prescribed time. Interview with the RDO on 05/20/24 at 4:20pm revealed the expectation was for the MAs to always administer resident medications within one hour before to one hour after the prescribed time. Interview with the Administrator on 05/20/24 at 5:34pm revealed: -Ideally, resident medications were to be administered one hour before to one hour after the prescribed time, but emergent situations happened. -If MAs administered a medication late, they were to notify the PCP and the Compliance Nurse and document it in the resident's record. -The Compliance Nurse was responsible for running the late medication administration report, but she was unsure how often the report was run.	D 364		

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D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation of a pre-admission screening for 2 of 4 residents (#1 and #3) was completed prior to admission to the Special Care Unit (SCU). The findings are: 1. Review of Resident #1's current FL2 dated 04/10/24 revealed: -Diagnoses included dementia and mild cognitive impairment. -She was ambulatory.	D 463		

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D 463	Continued From page 50 -She was constantly disoriented. -She had a history of wandering. -Her level of care was SCU. Review of Resident #1's record revealed she was admitted to the Assisted Living (AL) unit of the facility on 12/02/22. Review of Resident #1 staff progress notes revealed: -On 04/04/24, staff spoke with Resident #1's family member about moving Resident #1 to the SCU due to safety concerns related to memory loss. -On 04/15/24, Resident #1 was moved to the SCU. Review of Resident #1's pre-admission screening to the SCU revealed it was completed on 04/23/24, after she was moved into the SCU on 04/15/24. Interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm revealed: -The Special Care Coordinator (SCC) was responsible to complete the pre-admission screenings prior to admission to the SCU. -She was not working in the facility the week Resident #1 was moved to the SCU, so she completed the pre-screening assessment when she returned to the facility the following week. Refer to the interview with the Administrator on 05/20/24 at 5:34pm. 2. Review of Resident #3's current FL2 dated 07/03/23 revealed: -Diagnoses included dementia and hypertension. -She was ambulatory. -She was constantly disoriented. -She had a history of wandering.	D 463		

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D 463	Continued From page 51 -Her level of care was SCU. Review of Resident #3's Resident Register dated 06/29/23 revealed she was admitted to the SCU on 06/30/23. Review of Resident #3's SCU pre-admission screening dated 11/07/23 revealed: -Documentation of Resident #3 had a diagnosis of dementia. -Documentation Resident #3 habitually wandered or would wander out of the building and would not be able to find her way back. Interview with the facility's Compliance Nurse on 05/20/24 at 3:38pm revealed: -The previous Special Care Coordinator (SCC) was responsible to complete the pre-admission screenings prior to admission to the SCU. -She was not working at the facility when Resident #3 was admitted to the SCU, but did complete the pre-screening assessment when she audited records after starting at the facility in October of 2023. -She was aware that SCU pre-screenings needed to be completed prior to admission to the SCU. Refer to the interview with the Administrator on 05/20/24 at 5:34pm. _____ Interview with the Administrator on 05/20/24 at 5:34pm revealed: -She "assumed" the facility Compliance Nurse and the residents Primary Care Provider (PCP) were responsible for completing the SCU residents pre-screening. -She was aware the SCU pre-screening were to be completed prior to SCU residents being admitted. -She did not know Resident #1 and Resident #3's	D 463		

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D 463	Continued From page 52 pre-screening were completed after they were admitted to the SCU.	D 463		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules .0801 and .0802 of this Subchapter, the facility shall: (1) Within 30 days of admission to the special care unit and quarterly thereafter, develop a written resident profile containing assessment data that describes the resident's behavioral patterns, selfhelp abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 4 sampled Special Care Unit (SCU) residents (#1, #3 and #4) had a care plan that was signed by a Primary Care Provider (PCP). The findings are: 1. Review of Resident #1's current FL2 dated	D 464		

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04/10/24 revealed:
-Diagnoses included dementia and mild cognitive impairment.
-She was ambulatory.
-She was constantly disoriented.
-She had a history of wandering.
-Her level of care was SCU.

Review of Resident #1's unsigned SCU Care Plan dated 4/24/24 revealed:
-The resident required a SCU.
-Resident #1 was oriented to person but not place and time.
-She did not need reminders to find her room and did not wander into inappropriate places.
-She required staff assistance with toileting, bathing, dressing and grooming.
-She was independent with transfers and ambulation.

Refer to the interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm.

Refer to the interview with the facility's Regional Director of Operations on 05/20/24 at 4:20pm.

Refer to the interview with the Administrator on 05/20/24 at 5:34pm.
2. Review of Resident #3's current FL2 dated 07/03/24 revealed:
-Diagnoses included dementia and hypertension.
-She was ambulatory
-She was constantly disoriented.
-She had a history of wandering.
-Her level of care was SCU.

Review of Resident #3's unsigned SCU Care Plan dated 4/26/24 revealed:
-She did not need reminders or guidance to find her way to and from locations such as her room

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to the dining room, etc. and she wandered into inappropriate places due to an inability to find her room.
-She responded to reorientation and redirection when wandering.
-She was unable to make needs known.

Refer to the interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm.

Refer to the interview with the facility's Regional Director of Operations on 05/20/24 at 4:20pm.

Refer to the interview with the Administrator on 05/20/24 at 5:34pm.

3. Review of Resident #4's current FL2 dated 03/27/24 revealed:
-Diagnosis included Alzheimer's dementia
-Resident #4 was independent with ambulation.
-Resident #4 was constantly disoriented.
-The recommended level of care was Special Care Unit (SCU).

Review of Resident #4's record revealed Resident #4 did not have a Resident Register.

Review of Resident #4's SCU admission criteria dated 07/27/22 revealed Resident #4 habitually wandered or would wander out of the building and would not be able to find her way back.

Review of Resident #4's SCU Care plan dated 04/12/24 revealed:
-Resident #4 was oriented to person.
-Resident #4 required assistance with bathing, rooming, dressing, and toileting.
-Resident #4 was independent with ambulation and required frequent checks for mobility, transfers, and escorts.

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-Resident #4 wandered and required reminders and guidance within the unit.
-Resident #4 required monitoring for behaviors and 'wanders aimlessly or in undirected fashion without definable or obtainable purpose, i.e. looking for visitors who are not coming, or relatives who may be deceased.'
-A facility regional nurse electronically signed on 04/12/24.
-Resident #4's primary care provider signature was dated 05/17/24.

Refer to the interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm.

Refer to the interview with the facility's Regional Director of Operations on 05/20/24 at 4:20pm.

Refer to the interview with the Administrator on 05/20/24 at 5:34pm.

_____

Interview with the facility's Compliance Nurse on 05/20/24 at 3:40pm revealed:
-She was responsible for ensuring all SCU resident care plans were reviewed and signed by the resident's PCP.
-A facility regional nurse were responsible for completing SCU resident care plans.
-Once the regional nurse notified her the SCU care plans were completed, she was responsible for obtaining the resident's PCP signatures.
-She was aware the PCP had 15 days to sign a residents care plan.
-She did not know Resident #1, Resident #3 and Resident #4 did not have PCP signed care plans.

Interview with the facility's Regional Director of Operations on 05/20/24 at 4:20pm revealed:
-The Compliance Nurse was responsible for ensuring all SCU resident care plans were

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D 464	Continued From page 56 reviewed and signed by the resident's PCP. -A facility regional nurse were responsible for completing SCU resident care plans, printing the care plans off and giving the care plans to the facility compliance nurse. -The facility's Compliance Nurse was responsible for making sure all SCU care plans were reviewed and signed by the residents PCP. -He did not know Resident #1, Resident #3 and Resident #4 did not have care plans signed by the PCP. Interview with the Administrator on 05/20/24 at 5:34pm revealed the facility's Compliance Nurse and the regional nurses were responsible for ensuring resident care plans were completed and signed by the PCP.	D 464		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, and record reviews, the facility failed to ensure required staffing hours were met on all three shifts in the special care unit (SCU) including a shift when two residents	D 465		

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D 465	Continued From page 57 eloped from the facility. The findings are: Review of the facility's current license effective 01/01/2024 revealed the facility had a licensed Special Care Unit (SCU) with a capacity of 48 residents. Review of the facility's census record from 05/03/24 through 05/06/24 and 05/10/24 through 05/13/24 revealed that there was a census of 28 residents which required 28 staff hours on first and second shifts and 22.4 staff hours on third shift. Review of the staff time records from 05/03/24 through 05/06/24 and 05/10/24 through 05/13/24 revealed: -On 05/04/24, the census was 28 requiring 28 staff hours on second shift and a total of 14 staff hours were provided leaving a shortage of 14 hours. -On 05/11/24, the census was 28 requiring 22.4 staff hours on third shift (11:00pm on 05/10/24 through 7:00am on 05/11/24) and a total of 16.5 staff hours were provided leaving a shortage of 5.9 hours. -On 05/11/24, the census was 28 requiring 28 staff hours on first shift and a total of 25.5 staff hours were provided leaving a shortage of 2.5 hours. -On 05/12/24, the census was 28 requiring 22.4 staff hours on third shift (11:00pm on 05/11/24 through 7:00am on 05/12/24) and 8.25 staff hours were provided leaving a shortage of 14.15 hours. -On 05/12/24, the census was 28 requiring 28 staff hours on first shift and a total of 23.75 staff hours were provided leaving a shortage of 4.25 hours.	D 465		

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-On 05/13/24, the census was 28 requiring 22.4 staff hours on third shift (11:00pm on 05/12/24 through 7:00am on 05/13/24) and 16.5 staff hours were provided leaving a shortage of 5.9 hours.

Interview with a first shift Assisted Living (AL) Personal Care Aide (PCA) on 05/13/24 at 10:10am revealed:
-On 05/12/24, she worked first shift.
-On 05/12/24, she was scheduled to work on the AL.
-On 05/12/24, during first shift, she observed three PCAs working the SCU.
-On 05/12/24, a first shift Medication Aide (MA) worked between the assisted living unit and SCU to administer resident's medications.

Interview with a first shift SCU PCA on 05/13/24 at 10:42am revealed:
-On 05/12/24, she worked as a first shift SCU PCA.
-On 05/12/24, during first shift, the SCU was staffed with three PCAs.
-On 05/12/24, during first shift, one MA worked between the AL and SCU.
-On 05/12/24, during first shift, the MA administered SCU residents' medications and returned to the AL unit.

Interview with a MA on 05/13/24 at 12:22pm revealed:
-On 05/12/24, she worked first shift on both the AL and SCU as a MA.
-On 05/12/24, one PCA was scheduled to work on AL.
-On 05/12/24, three PCAs were scheduled to work the SCU.

Interview with the Administrator and Regional Director of Operations (RDO) on 05/13/24 at

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D 465	Continued From page 59 12:42pm revealed: -The Administrator was responsible to create care staff schedules. -On 05/12/24, the first shift MA was scheduled to work between the AL and SCU. Interview with the RDO on 05/13/24 at 1:40pm revealed: -He expected the Administrator to staff each unit of the facility with scheduled staff according to census. -Prior to 05/13/14, he had instructed the Administrator to ensure adequate staff were scheduled on each shift, with instructions to not share staff between units. -On 05/10/24, during a facility management call, the Administrator notified him she had sufficient care staff scheduled to work on 05/12/24 during first shift. -He did not know the Administrator scheduled the first shift MA on 05/12/24 to work between each unit. -He was concerned the Administrator had not ensured the facility was adequately staff, especially with constant corporate oversight and inquires. Interview with a first shift SCU PCA on 05/15/24 at 11:18am revealed: -There was not always enough staff to help take care of the residents. -On 05/12/24 there were three PCA's total working on the SCU and only one MA in the building passing medication on both SCU and AL. -There had only been one MA passing medications on several occasion. Interview with a first shift SCU PCA on 05/15/24 at 11:34am revealed: -On 05/12/24, there were three PCA's total	D 465		

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working on the SCU and only one MA in the building passing medication on both SCU and AL.
-Three PCA's normally work on the SCU unit.
-There had been many times there was only one MA passing medications for the entire building.

Interview with a MA on 05/16/24 at 11:14am revealed:
-Normally, there was only one first shift MA and one second shift MA scheduled to work weekends.
-On 05/12/24 there were three PCA's total working on the SCU and she was the MA for both SCU and AL.

Interview with a Medication Aide (MA) on 05/20/24 at 9:28am revealed:
-She was usually the lead MA on third shift; however, she worked other shifts, including coming in early and staying late.
-When she worked third shift, she was usually the only MA for both the Assisted Living (AL) and the Special Care Unit (SCU).
-There were times the facility was short staffed but could not recall dates or shifts.
-Within the past two months, she had worked when the facility was understaffed, with as little as three total staff in the facility.
-There were times she needed to start the first shift medication pass due to a MA not arriving on time for their shift.
-On 05/16/24 she administered some medications for the first shift MA because the MA was running late, and some residents received morning insulin before their breakfast.

Interview with a PCA on 05/20/24 at 10:24am revealed:
-The facility was short staffed "all the time", but she was unable to identify any specific dates.

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-She worked first shift on the SCU.
-There were 4 assignments for the PCAs but only 3 PCAs were scheduled, so there were 7-8 residents on an assignment that were to be split among 3 PCAs.
-The 7-8 residents that were shared between the 3 PCAs seemed to get their care last.
-PCA's were required to assist residents with toileting needs, showering, assist with feeding, and dressing.
-She could get her work done, but it was not always timely.

Interview with another PCA on 05/20/24 at 10:45am revealed:
-She routinely worked on the SCU.
-On the SCU there should be 4 PCAs during first shift, but Wednesdays were the only day that there were 4 PCAs working.
-At times she had worked when there were 2 PCAs and a MA but she could not recall the dates.

Interview with a MA on 05/20/24 at 10:11am revealed:
-She worked the first shift and was always assigned to the SCU.
-There were times the facility was short staffed, and she felt the SCU should have 4 PCA's and 1 MA.
-At times, she worked when there was only 1 or 2 PCAs and 1 MA, but that did not happen very often and could not identify any particular dates.

Interview with a MA on 05/20/24 at 11:10am revealed there were times the facility was short staffed but she could not recall how often or any particular dates.

Interview with the Administrator on 05/20/24 at

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D 465	Continued From page 62 5:34pm revealed: -Staff were to call out to her if unable to work their shift. -No staff had called out on 05/12/24. -She was responsible for ensuring there was adequate staff in the building each shift. [Refer to tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)] _____ The facility failed to ensure the Special Care Unit (SCU) was staffed to meet the required staffing hours and the needs of the residents for 6 of 24 shifts sampled, resulting in two residents eloping from the facility, one resident located in a nearby neighborhood and an unknown person driving her to the hospital and the second resident located in front of the facility by a staff member. The facility's failure resulted in a 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 05/21/24. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 20, 2024.	D 465		