Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Addison of Fuquay-Varina
Address: 6516 Johnson Pond Rd, Fuquay-Varina, NC 27526
II. Dates of Contacts/Visits: 5/29/24, 5/30/24, 5/31/24, 6/03/24, 6/04/24, 6/07/24, 6/10/24, 6/27/24

County: Wake
License Number: HAL-092-219
Purpose of Visit(s): Complaint Investigation

Exit/Report Date: 7/03/24

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: Personal Care & Supervision, 10A NCAC 13F .0901 (b)	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: Personal Care & Supervision, 10A NCAC 13F .0901 (b), Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan, and current symptoms.		
Level of Non-Compliance: Type A1 Violation		
Findings: Based on observations, record reviews, and interviews the facility failed to ensure 1 of 5 residents sampled (Resident #4) who exhibited extreme confusion, memory loss, and judgement impairment eloped 3 times into city street within 3 days. The findings are: Review of Resident #4's FL-2 dated 10/25/23 revealed: -A diagnosis of dementia, cardiac pacemaker, osteoarthritis, bilateral hearing loss, and a history of hip replacement surgery. -Resident #4 was constantly disoriented. -Wandering behaviors were not documented as reviewed. -Resident #4 was ambulatory with a walker.		

-Resident #4 required total care with his Activities of Daily Living (ADLs), toileting, dressing, bathing, and feeding.
-Resident #4's recommended level of care was Special Care Unit (SCU).

Review of Resident #4's FL-2 dated 12/07/23 revealed:
-Resident #4 had a dementia diagnosis with constant disorientation.
-Wandering behaviors were not documented as reviewed.
-Resident #4 was semi-ambulatory with walker.
-Resident #4's recommended level of care was Assisted Living (AL).

Review of Resident #4's Resident Register dated 10/27/23 revealed:
-Resident #4 was admitted to the facility SCU on 10/27/23.
-Resident #4 had significant memory loss.
-Resident #4 required a walker to ambulate.

Review of Resident #4's unsigned facility initial Care Plan dated by the Primary Care Provider (PCP) 10/30/23 revealed:
-Resident #4 was disoriented and forgetful.
-Resident #4 ambulated independently.

Review of Resident #4's Primary Care Physician (PCP) evaluation note dated 10/30/23 revealed:
-Resident #4 resided in the SCU.
-Resident #4 had advanced dementia.
-Resident #4 had severe memory and judgement impairment.

Review of Resident #4's Progress Note by the Special Care Unit Coordinator (SCUC) dated 10/30/23 at 11:29pm revealed:
-Resident #4 was admitted to the SCU 10/30/23.
-Resident #4 told the Power-of-Attorney (POA) during SCU admission 10/30/23 to take him home; he stated he was ready to go.
-SCU staff walked him around the enclosed SCU.
-Upon return to the SCU, Resident #4 stated, he had to go home.
-After dinner, Resident #4 began to pace back and forth, trying to find a way out.

Review of Resident #4's PCP evaluation note dated 11/02/23 revealed:
-Diagnoses included unsteadiness on his feet and repeated falls.

-Resident #4's left leg was shorter than his right, due to a pre-admission fall resulting in hip surgery. -An order included staff were to monitor Resident #4 for falls Review of Resident #4's Licensed Health Professional Support (LHPS) evaluation by a Registered Nurse dated 11/03/23 revealed Resident #4 required SCU level of care for safety (unspecified). Review of Resident #4's PCP evaluation note dated 11/28/23 revealed: -Resident #4 resided in the SCU. -Resident #4's dementia had progressed. -Resident #4 was very confused with memory problems. -Resident #4's thought content was disorganized and delusional. Review of Resident #4's facility SCU pre-assessment dated 11/30/23 revealed: -Resident #4 had a cognitive impairment. -Resident #4 was at risk for elopement. -Resident #4 had no wandering or elopement history. Review of Resident #4's Care Plan by the SCUC dated 12/11/23 revealed: -Resident #4 was disoriented and was forgetful. -Resident #4 was moved to AL since Resident #4 did not have exit-seeking behaviors (date not documented). -Resident #4 required supervision with ambulation, toileting, bathing, and transferring. Review of Resident #4's Saint Louis University Mental Status Examination (SLUMS) administered by the SCUC with an undated test revealed: -Resident #4's SLUMS Exam was incomplete and unscored. -Resident #4 answered approximately 4 questions; 2 of 4 questions were answered by Resident #4 inaccurately. The SLUMS Examination is used for early detection of cognitive impairment and mild dementia. SLUMS Examination does not represent a clinical diagnosis and requires a full assessment and evaluation by a qualified healthcare or psychiatric professional.		

Interview with the SCUC on 5/30/24 at 10:30am revealed:
-The uneven length of Resident #4's legs and shoe lift was an ambulation challenge.
-He needed assistance finding his room due to his disorientation.
-She did not read Resident #4's medical documentation or his Progress Notes, so she was unaware Resident #4 had advanced dementia with severe confusion.
-She wrote Resident #4's Care Plans and administered his SLUMS test in October-December 2023 and January-March of 2024.
-It was policy to complete SLUMS Tests on every resident with disorientation upon admission and upon change of condition.
-She did not recall why Resident #4 could not accurately complete some of the questions on the SLUMS test or why the test was incomplete.
-She did not know why Resident #4's SLUMS test was not scored; all SLUMS tests should be scored.
-A resident's cognitive inability to answer the questions on a SLUMS test would indicate a zero.
-Scores of 0-16 indicated a need for memory care.
-Resident #4's incomplete SLUMS test should have initiated a "911 Huddle", an emergency corporate clinical review.
-She was not aware of the facility's review of Resident #4's SLUMS results and needs since she was on leave then.

Interview with the SCUC on 5/31/24 at 11:30am revealed:
-Staff Stand-Up Meetings reviewed resident needs and changes upon admission and as needed information with Medication Aides (MA).
-The Health & Wellness Director (HWD) reviewed residents' health needs, but there was no HWD in late 2023-March 2024.
-Sometime in early December 2023, she and the Administrator reviewed Resident #4's needs and placement.
-Since Resident #4 was not known to have exit-seeking behaviors in the SCU, she and the Administrator consulted the PCP for AL placement on 12/07/23.
-The POA wanted Resident #4 to remain in the SCU since the POA was afraid Resident #4 would elope from AL.
-The Director of Marketing (DM) and The Administrator reviewed resident needs and made final resident placements.
-She was on leave when The Administrator and DM made the decision to move Resident #4 from the SCU to AL on 12/07/23 and to move him back to the SCU on 12/20/23.

Review of Resident #4's PCP evaluation note dated 12/07/23 revealed: -Confused Resident #4 was confused but was to be moved to AL 12/07/23 due to not meeting the facility's requirement for the SCU. -Resident #4 ambulated with a rollator and was not an elopement risk. -Staff were to monitor Resident #4 for falls, due to progressed dementia and age. Review of Resident #4's Progress Note by the Resident Care Coordinator (RCC) dated 12/11/23 at 9:00pm revealed: -Resident #4 was moved from the SCU to the AL on an undocumented date and time. -The RCC issued an emergency call pendant to Resident #4. -Staff were to assist and supervise Resident #4 (frequency not documented). Interview with the RCC on 5/31/24 at 2:42pm revealed: -She did not know Resident #4's cognitive needs or disorientation since he was an SCU resident. -She was not involved in Resident #4's move from SCU to AL. -The POA told the SCUC not to move Resident #4 from the SCU upon his SCU admission, and on 12/07/23 since he had eloped from the POA's home one night. -The Administrator, SCUC, and the HWD reviewed residents' needs with the PCP; then the Administrator, the SCUC, and the HWD made resident placement decisions. -In December 2023, there was no HWD; so the Administrator and the SCUC reviewed and changed Resident #4's placement from the SCU to AL. -She was not involved with PCP orders; the SCUC acted on resident PCP orders, including Resident #4's. -The SCUC, only, coordinated changes with Resident #4's (residents') care plans. -She was unaware of any changes to Resident #4's care plan. -When Resident #4 was not in his room, he constantly walked and wandered the AL. Review of Resident #4's Change of Condition Progress Note by the SCUC dated 12/14/23 at 7:08am revealed: -Late Entry 12/14/23 – 12/20/23, Resident #4 was redirected back to his room front exit doors on A-Hall and B-Hall. -Resident #4's PCP and POA were notified of his exit-seeking behaviors (dates were not documented).		

-Resident #4 was placed in the SCU for safety during the day and until bedtime and transferred to his AL room to sleep nights 12/14/23 – 12/18/23.
-Resident #4 was permanently moved back to the SCU on 12/20/23, when an SCU bed became available.

Review of Resident #4's Progress Note by a medication aide (MA) dated 12/18/23 at 6:54am revealed:
-Resident #4 was found sitting on a curb outside the facility on 12/18/23 at an undocumented time.
-Resident #4 fell and sustained a skin tear on his left arm/elbow, and staff cleaned the wound.
-The RCC notified the POA Resident #4 eloped at an undocumented time on 12/18/23.

Interview with a MA 5/31/24 at 6:40am revealed:
-Sometime in November 2023, Resident #4 began to sleep in his clothes, so staff assisted him change his clothes for bed.
-She would sometimes catch Resident #4 sitting on the edge of his bed, dressed in the middle of the night.
-She and the personal care aide (PCA) caught him one night on AL in December 2023 when it was dark, trying to elope out of the facility's front door.
-She reported Resident #4's attempted early December 2023 elopement to the RCC.
-Resident #4 was on 2-hour checks on AL.
-During rounds on AL on another December 2023 night, she found Resident #4 dressing into clothes.
-She and the PCA made continuous rounds (checks) on all AL residents throughout the night.
-She and the PCA decided to check on Resident #4 every ½ hour.
-When she and the PCA did rounds on 12/18/23 at 3:00am, they could not find Resident #4 in his room.
-The PCA went out the front door; she went out B-Hall to search for him.
-When she got outside it was still dark out, and she heard someone yelling, "Help! Help! Someone help me"'.
-Resident #4 had fallen and was found sitting on a curb in the Northside, employee parking lot and grass area.
-Resident #4 fought their attempts to guide him back into the facility; he adamantly stated he was going home.
-Resident #4 had no visible injuries at 3:00am on 12/18/23.
-On 12/19/23, first shift reported, the morning of 12/18/23, Resident #4 eloped to the front parking lot.
-Resident #4 remained on 2-hour checks on AL after his 12/18/23 and 12/19/23 elopements.
-On 12/20/23, Resident #4 eloped from the facility during 1st shift at an unknown time to the daycare across the street.

Interview with a PCA on 6/03/24 at 4:20pm revealed: -Resident #4 was very confused and forgot where his room was. -When Resident #4 was on AL, he was on 2-hour checks. -Resident #4 was in his room for the night on 12/18/23. -During resident checks on 12/18/23 at 5:00am, they could not find Resident #4 in his AL room. -They dropped everything to search for him. -They checked the alarm at the nurse's station monitor because they did not hear the monitor or exit doors alert. -The nurse's station monitor faintly alerted the A-Hall exit was opened. -They found him lying outside in the middle of the grass by the employee's parking lot curb where he had fallen. -He appeared very confused and smiled at them. -Resident #4 had no visible injuries at 5:00am on 12/18/23. -They immediately took him to the SCU for safety, since they were busy performing morning resident personal care and were afraid he would elope again. -He remained on AL after eloping 12/18/23 with no additional changes to his plan of care of 2-hour checks, until his move back to the SCU on 12/21/23. -Resident #4 remained in the SCU after 12/21/23. -She was not aware if Resident #4 had other elopements. Interview with a PCA on 5/30/24 at 3:00pm revealed: -Resident #4 was very confused, hearing impaired, and often could not comprehend others' interactions with him. -All AL residents were on 2-hour checks, including Resident #4, but she decided to check him every 30 minutes. -Another staff leaving the facility for their break witnessed, and immediately informed staff, Resident #4 eloped out of the A-Hall exit door on 12/19/23 at an unrecalled time during 1st shift. -She ran out the A-Hall exit door, while a 2nd PCA ran out the front door, to get Resident #4. -Resident #4 had fallen and was sitting on a curb in the handicap parking lot in the front of the facility. -She and the other PCA assisted Resident #4 back inside the facility. -She had not witnessed Resident #4 sit outside on the porch, exit-seek, or attempt to elope prior to 12/19/23. -She was not directed to provide additional care or supervision of Resident #4 prior to, or after, 12/19/23. -Resident #4 remained on AL with 2-hour checks after 12/19/23 until he was moved back to the SCU 1 week later. Telephone interview with a PCA on 6/03/24 at 10:50am revealed:		

-She was unaware Resident #4 eloped 12/18/23, 12/19/23, or 12/20/23. -Resident #4's supervision frequency of every 2-hours did not change after he eloped 12/18/23. -She worked on 12/20/23 but did not know he eloped from the facility 12/20/23. Interview with a 2nd PCA on 6/03/24 at 11:20pm revealed: -He usually worked on the SCU. -Resident #4 would try to open SCU exit doors upon admission, but he and other staff redirected him away from the doors. -Resident #4 would walk around the SCU at night. -Staff reported Resident #4 eloped twice on AL on 1st shift (dates and times were unknown). -He was unaware of Resident #4's elopement on 12/20/23. -He originally was assigned to Resident #4's AL hall on 12/20/23, but he switched with a staff to work in the SCU, instead. Telephone interview with a 3rd PCA on 6/03/24 at 10:50am revealed: -Resident #4 would sometimes exit-seek on AL and the SCU. -Resident #4 wandered the SCU in November and December 2023 looking for a way out, stating he was going home. -She reported Resident #4's exit-seeking behaviors to the MA on duty. -She was not instructed to provide additional care to Resident #4 other than the standard AL resident 2-hour checks. -She worked 12/20/23 but was unaware he eloped from the facility 12/20/23. Interview with a PCA on 5/30/24 at 3:00pm revealed: -Resident #4 knew his name but thought he lived in another city. -Resident #4 struggled to comprehend use of his walker and wheelchair. -Resident #4 expressed thinking he was walking in another city when he walked around the SCU. -Resident #4 would look for his car out of the end hall exit door; then walk to another exit door. -Resident #4 would often jump up from breakfast, stating he was leaving for another city. -Resident #4 was moved back to the SCU 3 days after his AL elopement sometime in December 2023. -Resident #4 appeared more confused in comprehension and speech the 2nd time he was moved to the SCU.		

Interview with the RCC on 5/31/24 at 3:00pm revealed: -The MA notified her, Resident #4 could not be found in his room 12/18/23 during 5:00am rounds, and staff found him in the side parking lot without injuries. -She instructed the MA on 12/18/23 to permanently place Resident #4 in the SCU for his safety. -The afternoon of 12/18/23, she found Resident #4 walking around the AL. The SCUC and the Administrator moved Resident #4 back to AL without consulting with her. -Resident #4 remained in AL permanently until the SCUC and the Administrator moved him back to the SCU the afternoon of 12/20/23. -She did not work on 12/19/23, she was not updated, and there was no documentation, so she did not know Resident #4 eloped on 12/19/23. Telephone interview with Resident #4's POA on 5/29/24 at 9:43am revealed: -Resident #4 ambulated with unsteadiness with a rollator. -Resident #4 had advanced dementia with severe confusion and was not oriented to time or place since 2018. -Resident #4's neurologist recommended SCU placement for his facility admission. -The facility discussed AL care for Resident #4 upon admission, but she insisted on SCU placement due to his elopement history. -She informed the facility of Resident #4's severe confusion, exit-seeking behavior, and night elopement from her home prior to his facility admission 10/30/23. -In early December 2023, the facility informed her they needed Resident #4's SCU room, so they moved Resident #4 to AL on 12/07/23. -On 12/18/23, an anonymous neighbor posted on social media at 6:00am Resident #4 was heard repeatedly yelling for help in the facility's front parking lot on the morning of 12/18/23. -Staff notified her in late morning of 12/18/23, Resident #4 eloped at an unknown time in the early hours of 12/18/23. -Resident #4 was found across the facility parking lots on 12/18/23. -The RCC notified her on 12/18/23 Resident #4 went out a front facility door on 12/18/23, sat outside on a curb; then staff redirected him inside the facility (time not known). -She went to the facility on 12/18/23 to see Resident #4 and to speak with Resident #4's PCP. -The PCP reported, Resident #4 had a skin tear, he was deteriorating due to age, and staff directed him back inside the facility 12/18/23. -She observed Resident #4 to have a huge bruise which covered ½ his forearm with large, bleeding gash near his		

elbow, and a dark-purple bruised, swollen lip after he was returned from the parking lot on 12/18/23. -Resident #4 was placed in the SCU 12/18/23 at 12:00pm for the rest of the day and placed in the AL to sleep that night. -The SCUC informed her on 12/18/23, there were no available SCU beds for Resident #4 after Resident #4's elopement on 12/18/23, since another AL resident was moved into Resident #4's original SCU room. -The RCC notified her on 12/19/23, Resident #4 eloped from AL during 1st shift on 12/19/23 into the facility's front parking lot/grass median, fell, was found sitting on a facility parking lot curb, until staff redirected him back inside the facility (times unknown). -Resident #4 did not appear to have new injuries 12/19/23, but he was dressed in long sleeves and pants. -Resident #4 was placed in the SCU 12/19/23 at 12:00pm for the rest of the day; then he was returned to AL to sleep that night. -Resident #4 told her the evening of 12/19/23, "We can leave [the facility] when it's quiet"'. He then stood up, told her to be quiet; then told the POA to follow him out of the facility. She directed him to stay. -She warned the RCC and the DM on 12/19/23 Resident #4 stated he could leave when the facility was quiet. -The RCC called to inform her on 12/20/23 at 11:30am and 2:09pm, Resident #4 eloped off facility grounds close to a child daycare center across the city street sometime on 12/20/23. -The Business Office Manager (BOM), DM, and a PCA informed her Resident #4 did not elope off property 12/20/23. -Resident #4 was picked up from a city street curb at the daycare by staff sometime on 12/20/23. -The facility then moved Resident #4 back to the SCU on 12/20/23, after his 12/20/23 elopement across the street. -The facility informed her with each elopement, Resident #4 did not leave facility grounds, he was redirected by staff back inside the facility, and he had no injuries. -Resident #4's PCP reported Resident #4 eloped off facility property to the daycare center across the city street 12/20/23. -The PCP stated, Resident #4 was found by staff, sitting on a street curb, waiting for the POA. -The staff knew Resident #4 eloped on 12/18/23, 12/19/23, and 12/20/23. Telephone interview with a family member on 5/29/24 at 9:55am revealed: -Resident #4 was very confused and needed assistance to find his AL and SCU rooms since he forgot where they were. -Staff reported, Resident #4 eloped late night/early morning from the facility to the facility parking lot on 12/18/23.		

-He observed dark, purple bruising and swelling 12/18/23 to Resident #4's lip and a large, bruised skin tear on the resident's forearm/elbow. -The staff promised 12/18/23 to provide closer supervision of Resident #4 on AL after the resident's 12/18/23 elopement. -During his weekly visits, he did not observe staff check on Resident #4 in his room November-December 2023. -Staff began "day-programming" Resident #4 in the SCU, which meant having him on the SCU during the day and returning him to his AL room to sleep nights 12/18/23-12/20/23. -Resident #4 was moved full-time to the SCU by his visit to Resident #4 on 12/21/23. Measurement of the distance from the facility to the daycare Resident #4 walked to was .1 mile. Observation of the approximate route Resident #4 walked on 12/20/23 across the city street from the facility revealed: -The facility was situated on a 2-lane, 35 mph commercial/ residential street. -The city sidewalk ran to a church and school to the South and a subdivision to the North. -A daycare was located across the street. -Cars entered the South end and exited the North end of the daycare's U-shaped driveway onto the city street. -School carpool lines backed up onto the city street and the street shoulder to the facility at 8:30am and 2:20pm. Review of pictures of Resident #4 revealed: -Dark purple bruising, swelling, and abrasion to half his right forearm. -Resident #4 had a scrape with dried blood approximately 2" x 2" on his left forearm/elbow. Review of Resident #4's FL-2 dated 12/20/23 revealed: -Resident #4 had constant disorientation. -Resident #4 had diagnoses of dementia and unsteady gait. -Resident #4 was semi-ambulatory with a walker. -Resident #4 had wandering behaviors. -Resident #4's physician-recommended level of care was SCU. Review of Resident #4's PCP evaluation note dated 12/21/23 revealed: -Resident #4 was evaluated on 12/21/23 after he eloped off facility grounds on 12/20/23 and fell.		

-Resident #4 was found sitting on a curb 12/20/23 and reported he was waiting for his POA at an unknown time. -She did not know what time or who returned Resident #4 to the facility on 12/20/23. -Resident #4 had no new injuries on 12/21/23. -The PCP ordered SCU level of care 12/20/23. -Resident #4 was moved back to the SCU on 12/21/23. Telephone interview with Resident #1's PCP on 4/10/24 at 11:45pm revealed: -Resident #4 had a history of severe dementia, confusion, stroke, left hip surgery repair and ambulation instability, and repeated falls. -She was unaware Resident #4 had a history of a pre-admission elopement or exit-seeking behavior. -The facility did not report Resident #4 had exit-seeking behaviors in SCU or AL. -She expected staff to provide supervision for AL residents, including Resident #4. -She ordered Resident #4 a wheelchair in November 2023, due to his leg and ambulation challenges, repeated falls, and his inability to comprehend use of his rollator walker. -She did not recall how Resident #4's transfer from SCU to AL was initiated. -She considered AL placement of Resident #4 since he required a wheelchair in the SCU, could not self-propel his wheelchair, and she was not aware of any exit-seeking behaviors he had in the SCU. -She was not aware Resident #4 had a history at home of an elopement, wandering and exit-seeking behaviors. -Resident #4's brain still thought he could walk but he could not. -Physical Therapy (PT) worked with Resident #4. -The facility notified her Resident #4 eloped into the facility parking lot and fell on 12/18/23. -Resident #4 had no visible injuries when she evaluated him after his elopement the morning of 12/18/23. -She was unaware of Resident #4's 12/19/23 elopement. -She recommended Resident #4 be placed in the SCU during the day and sleeping in AL at night if an SCU bed was not available on 12/18/23. -She agreed with the facility's supervision plan to have staff in the hall to monitor Resident #4. -The facility informed her, Resident #4 was found off facility grounds, sitting on a curb, waiting for his POA at a child daycare across the street on 12/20/23. -She ordered SCU placement on 12/20/23. -Resident #4 was transferred back to the SCU on 12/20/23. -Her evaluation found Resident #4 to have no injuries on 12/21/23.		

Review of Resident #4's updated Care Plan dated 12/20/23 revealed:
-Resident #4 was disoriented and forgetful.
-Resident #4 began exit-seeking behaviors (date not documented).
-Resident #4 exited the facility 3 times on facility property (dates not documented).
-Resident #4 reported he was going home when he eloped 3 times.

Interview with the RCC on 5/31/24 at 3:05pm revealed:
-She did not work 12/20/23, but staff (name/s not recalled or documented) notified her they found Resident #4 across the street on 12/20/23 at a daycare.
-She did not know how Resident #4 was found at the daycare or who returned him to the facility on 12/20/23.
-She notified the POA and PCP of Resident #4's 12/18/23 and 12/20/23 elopements.
-She instructed the MA to place Resident #4 in the SCU for his safety once the PCP signed the FL-2 for SCU on 12/20/23.
-The POA and PCP initiated Resident #4's move back to the SCU on 12/20/23.
-She coordinated the PCP's evaluation of Resident #4 for memory care on 12/20/23 after his elopement.

Interview with the Director of Marketing on 6/03/24 at 3:30pm revealed:
-She was not part of the facility's clinical team, so she was unaware of Resident #4's care needs or placement planning.
-She was unsure if Resident #4 eloped on 12/18/23, 12/19/23 or 12/20/23.

Interview with the SCUC on 6/04/24 at 11:50am revealed:
-She was unaware Resident #4 eloped from the facility on 12/18/23, 12/19/23, and on 12/20/23 to the daycare across the street since she was on leave then.
-Managers and staff did not report Resident #4's elopements to her, and she did not read his 12/18/23 Progress Notes.
-Resident #4's 2-hour checks on AL did not change after he eloped from the facility 12/18/23, 12/19/23, and 12/20/23.
-On 6/04/24, she read the management team documentation Resident #4's needs and changes were reviewed, including the need to redirect him (from what, she did not know).
-She was unaware of the reason the Resident #4's placement was changed from AL back to SCU on 12/20/23.
-When Resident #4 was moved to AL, he sought to get back to the SCU.

Attempted telephone interviews with the Administrator on 5/31/24 at 10:00am and 4:00pm and on 6/03/24 at 11:25am were unsuccessful since the Administrator was unavailable and subsequently no longer worked at the facility effective 6/05/24. Telephone interview with the Administrator's supervisor, the Director of Operations (DO), on 6/10/24 at 4:00pm revealed: -He was the DO December 2022-April 2024. -He was the Administrator's supervisor. -The Administrator was trained in risk management behaviors, including wandering and exit-seeking behaviors, elopement, and disorientation. -The Administrator was required to report any resident safety concerns, including elopement, to him. -He was not aware there were 15 residents on AL with disorientation. -For residents with disorientation behaviors or health risks upon admission or change of condition, he expected The Administrator/facility to call him or the corporate clinical team for a "911 Huddle" for emergency intervention or placement review. -He did not receive a "911 Huddle" call to review Resident #4's placement change from SCU to AL on 12/07/23, or AL to SCU on 12/20/23. -It was not corporate (facility) protocol to move a resident from the SCU to AL. -It was not corporate protocol to place a resident in both SCU and AL units at the same time (1/2 days). -AL residents were moved to SCU with clinical team review and PCP evaluation, an FL-2 that specified SCU placement, and facility documentation. -He was not notified by the Administrator/facility Resident #4 eloped on 12/18/23, 12/19/23, or 12/20/23. -If he was notified of Resident #4's 12/18/23 elopement, he would have convened a "911 Huddle" clinical call with the facility managers to discuss and place safety interventions such as increased supervision, increased staff or sitter, or evaluate Resident #4 for SCU placement. -He was not aware Resident #4 had eloped off facility property across the street to a daycare. Telephone interview with the Area Nurse II (AN II) on 6/07/24 at 1:35pm revealed: -The Administrator reported to the former DO. -She and the DO reported to the Division Director of Health & Wellness (DDHW). -The DDHW reported to the Vice President of Operations (VPO).		

-The Administrator did not follow her recommendations in December 2023 to ensure all AL residents with disorientation &/or a dementia diagnosis were assessed by the PCP and a SLUMS test administered. -It was not corporate protocol to transfer a resident from the SCU to AL. -She informed the Administrator in September 2023 internal resident transfers were allowed from AL to SCU only. -Since May 2024, internal resident transfers were reviewed with the corporate clinical team. -She was not notified by the Administrator or facility team Resident #4 was transferred from the SCU to AL 12/07/23. -If she knew Resident #4 (a resident) was transferred from the SCU to AL, she would have stopped the transfer. -She expected the Administrator to report all resident safety issues, like elopement, to her immediately. -The facility did not immediately report Resident #4's 12/18/23 elopement to her until the past 1-2 months. -Resident #4 eloped onto facility grounds on 12/18/23 so they did not consider it an elopement. -She arranged a PCP evaluation and consultation for Resident #4, when she was notified of his 12/18/23 elopement. -The PCP assessed Resident #4 as needing SCU care on 12/20/23, so Resident #4 was placed in the SCU on 12/20/23. -If Resident #4 had eloped off facility grounds on 12/18/23, or if she knew Resident #4 eloped on 12/19/23 and 12/20/23, she would have convened a "911 clinic Huddle" to discuss and place safety precautions for him. -Safety precautions could include PCP evaluation, placement evaluation, or discuss alternate interventions with the PCP. -The facility did not report Resident #4's 12/19/23 or 12/20/23 elopements. -She was not aware Resident #4 eloped from facility grounds across the street to the daycare (on 12/20/23). -Corporate reviews of resident placements and internal placement changes were not done previous to May 2024. -Intensive corrections to the facility's supervision violations began with the violation cited in May 2024. Telephone interview with the new Director of Operations (DO) on 6/07/24 at 1:45pm revealed: -She began as DO in May 2024. -The former DO left his position 5/03/24. -She was training at the time of the former DO's instructions to the Administrator. -The Administrator did not want to implement corporate directives to ensure resident safety. -The Administrator eventually made the necessary corrections after she and the corporate team persisted with the Administrator.		

-The Administrator did not notify and consult with corporate clinical managers on resident elopements, needs, and placement changes. Telephone interview with the Division Director of Health & Wellness (DDHW) on 6/07/24 at 1:10pm revealed: -The Administrator's instructions were to review residents' FL-2s closely, discuss any resident who did not meet AL criteria for placement with the corporate team, and relaying all review information to the AN II/corporate team. -If any residents were unsafe, The Administrator was expected to immediately call her, the AN II, and the DO (initiate a "911 Huddle"). -Based on the resident's needs, the corporate team determined additional interventions, including 1:1 staff, PCP care, etc. -The Administrator should have requested a "911 Huddle" for Resident #4's 12/18/23 elopement and for safety precautions. -If the corporate team knew about the 12/18/23 elopement timely, they would have instructed additional safety measures be implemented for Resident #4. -She did not know why the facility did not call for a "911 Huddle" for Resident #4's placement change from SCU to AL. -It was not corporate protocol for residents to be moved from the SCU to AL. -Based on the resident's needs, the corporate team determined any additional interventions, including 1:1 staff, PCP care, etc. -Resident SLUMS and health evaluations were to be completed by the facility clinical team (HWD, RCC, & SCUC). Attempted reviews of Resident #4's 12/18/23, 12/19/23, and 12/20/23 Incident/Accident (I/A) Reports were unsuccessful upon request 5/29/24 at 9:00am, 5/30/24 at 1:00pm, and 6/27/24 at 11:30am since his I/A Reports were unavailable.		
The facility failed to provide supervision for 1 of 5 residents (Resident #4), who had a diagnosis of dementia with severe confusion and disorientation. Prior to admission, Resident #4 was admitted after an elopement from his home during the night, and he was assessed by his neurologist as needing SCU placement. The facility's PCP admission evaluation revealed the resident had severe memory and judgement impairment due to advanced dementia. The PCP had no knowledge of his history of elopement prior to admission, his exit-seeking behavior after admission, and per the facility's request, changed the level of care to assisted living due to a change in ambulatory status. Following his transfer to the assisted living unit, Resident #4 eloped 3 times in 3 days		

without staff's knowledge and Resident #4 experienced falls causing bruising, a gash near his elbow, and a swollen lip. This failure resulted in serious neglect and constitutes a Type A1 Violation.		
The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 5/31/24.		
CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED: 8/03/24.		

IV. Delivered Via:	Electronic Delivery	Date: 7/03/24
DSS Signature:	Roberta Schmidt-Beebe	***Return Signed to DSS By:*** ~~7/30/~~24 7/03/24 RSBeebe

V. CAR Received by:	The Administrator/Designee (print name): SHARON RODGERS	
	Signature: Sharon Rodgers	Date: 7/3/24
	Title: RCC	

VI. Plan of Correction Submitted by:	The Administrator (print name):	
POC DUE BY: 7/25/24	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		