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D 000	Initial Comments The Adult Care Licensure Section completed an annual and follow-up survey on December 30, 2024, December 31, 2024 and on January 2, 2025.	D 000		
D 066	10A NCAC 13F .0305(h)(3) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (3) All exit door locks shall be easily operable, by a single hand motion, from the inside at all times without keys; and This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure all exit door locks were easily operable by a single hand motion from inside of the facility at all times without keys related to 1 of 2 exit doors on the back hall which would not allow residents to exit the facility in the event of an emergency. The findings are: Review of the facility's current license revealed the facility was licensed as a Special Care Unit (SCU) with a capacity of 12 residents. Review of the facility's current census on 12/30/24 revealed there were 10 residents residing in the facility. Review of the FL2s for 10 residents residing in the facility revealed: -Diagnoses included vascular dementia, dementia, multi-infarct dementia, and cognitive	D 066		

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impairment.
-Eight residents were intermittently disoriented.
-Two residents were constantly disoriented.
-Six residents were ambulatory, 3 residents were semi-ambulatory, and one resident was non-ambulatory.

Observation during the initial facility tour on 12/30/24 at 8:30am revealed:
-There was a front hall with 3 bedrooms (#1, #2, and #3) on the right side of the hall.
-There was an entry/exit door located at the right front of the facility; the door was equipped with an alarm device that made a chirping sound when the door was opened.
-There was a back hall with 3 bedrooms (#4, #5, and #6) on the left side of the hall.
-There was an entry/exit door located on the back left side at the rear of the facility; the door was equipped with an alarm device that made a chirping sound when the door was opened.
-The back left side door exited onto a screened-in porch.

Review of the facility's emergency exit map revealed:
-There were 2 identified entry/exit doors.
-One door was located at the right front of the facility with the closest route of exit for rooms #1, #2, and #3 displayed as the front exit door.
-One door was located on the back left side at the rear of the facility with the closet route of exit for room #4, #5, and #6 displayed as the rear exit door.
-The exit map did not include the exit route from the enclosed screen-in porch where the back exit door opened.

Observation of the facility on 12/30/24 at 10:22am revealed:

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-The facility exit door at the back left side of the facility had a push bar on the inside of the door.
-The exit door, at the end of the back left side hallway near residents' rooms #4, #5, and #6, opened onto a screened-in porch.
-There was a solid wooden door on the screened-in porch leading to the back yard.
-The solid wooden door had a keyed dead bolt lock on the door.
-The dead bolt lock was keyed on both sides with no override latch for opening the dead bolt lock.
-The dead bolt lock was locked preventing exit from the screened-in porch to the back yard.

Interview with the Manager/Special Care Unit Coordinator (SCUC) on 12/30/24 at 3:15pm revealed:
-The facility did not have a full-time maintenance staff.
-If repairs were needed, the Administrator contacted local repairmen to perform the needed repairs.
-The screened-in porch previously had a screen door that did not lock.
-The Administrator had a repairman install a solid door with a lock to ensure residents were protected from possible outside intruders a few months prior to today.
-She did not realize the dead bolt lock had no way to release without the key.
-Facility staff did not routinely have a key to the screened-in porch door available on the keys routinely carried by the medication aides (MAs) or personal care aides (PCAs).
-She knew there was a key, but she would have to check on her master keys for the key to unlock the dead bolt.
-She had not considered residents being able to evacuate onto the screened-in porch but not being able to get from the porch area to the

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D 066	Continued From page 3 designated back safety area through the dead bolted door. -Once she unlocked the door, she would leave it unlocked until a better solution for securing the door was found. Observation on 12/30/24 at 3:18pm revealed: -The Manager/SCUC returned to the dead bolted wooden door with a set of keys. -After several attempts, she found the key that unlocked the dead bolt. Interview with a PCA on 12/30/24 at 3:50pm revealed: -Residents did not routinely use the screened-in porch -She did not know the porch door could not be opened without a key. -She did not use the back facility door with the screened-in porch to enter or exit the facility. -There was a resident who went onto the screened-in porch but she had not seen a resident on the screen-ed in porch in a long time. -She did not have a reason to check the exit doors. Telephone interview with the Administrator on 01/02/25 at 7:40pm revealed: -The screen door was replaced with a solid door for better security. -The locking mechanism was the same now as was originally installed when the solid door was put in place. -He had not considered that exiting to the screened-in porch but needing a key for unlocking the dead bolt would impede complete evacuation to a safe area. _____ The facility failed to ensure that all doors were easily operable from the inside related to a back	D 066		

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D 066	Continued From page 4 exit door from the screened-in porch which was dead bolted and staff did not have a key readily available for the dead bolt, which would prevent the residents who resided on the back hall from evacuating in the event of a fire or emergency. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on December 30, 2024 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 16, 2025.	D 066		
D 072	10A NCAC 13F .0305(m) Physical Environment 10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the screened-in porch attached to the facility and the fenced in courtyard of the facility was maintained in a clean manner as evidenced by the presence of piled up leaves, empty soda cans, and torn screens on the screened-in porch and old broken furniture within	D 072		

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D 072	Continued From page 5 the fenced patio. The findings are: Observation of the facility's screened-in porch area at the end of the back hall on 12/30/24 at 3:13 revealed: -There were 4 screen torn sections, each one 3 feet by 2 feet missing from the lower section of the outermost area of the screened-in porch. -The right side of the screened-in porch was missing 2 upper and 1 lower 2 feet sections of screen next to the facility; the lower section next to the facility was partially torn. -The right side of the concrete floor, next to the damaged right screened-in wall, had a pile of leaves with 6 empty soda cans, a plastic cup, and assorted paper trash mixed in the leaves. -The screened-in porch overlapped the facility's roof line and guttering with a detached junction along the entire length of the screened-in porch and roof; there were leaves on the roof and in the entire length of the guttering. -The porch light bulb, attached to the facility next to the exit door, was missing a covering and had spider webs on top of the bulb. -The left back bedroom window located inside the screened-in porch had a screen covering that was partially pushed out in the lower right corner (looking from the outside) and an 8-inch spider web along the middle of the right side of the screen. -There was a 2-inch open exposure between the top of the back wooden screened-in porch door. Observation of the facility's fenced courtyard area located outside the dining room on 12/30/24 at 10:24am revealed: -The patio area was accessed through double doors from the dining area.	D 072		

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D 072	Continued From page 6 -The were 5 chairs sitting on the concrete with blown leaves piled under the chairs; one chair had a broken back and vinyl cushions, one chair was laying with its back on the concrete, three solid wooden chairs had loose legs at the point of attachment to the chair cushion. Interview with the Manager/Special Care Unit Coordinator (SCUC) on 12/30/24 at 3:15pm revealed: -The Manager/SCUC was responsible for ensuring the facility grounds were clean and orderly. -She oversaw this facility, and 3 other sister facilities located adjacent or in close proximity of the facility. -She had not toured the facility grounds in quite a while due to the workload of managing 4 facilities. -The facility did not have a maintenance staff. -The facility staff were supposed to keep the screened-in porch area and courtyard area clean and orderly. -The Manager/SCUC informed the Administrator of repairs or maintenance on an as needed basis. -She had focused on the inside maintenance like plumbing and lighting but had not done a facility walk around of the exterior in several months. -Since it was cold weather season, residents had not been using the screened-in porch or outside patio areas of the facility. -She would have the facility staff clean the porch area immediately. Telephone interview with the Administrator on 01/02/25 at 7:30pm revealed the Manager/SCUC was responsible to ensure the facility and grounds were maintained in a clean and orderly manner.	D 072		

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the residents' assessed needs for 2 of 5 sampled residents (#4 and #5) who resided in a special care unit (SCU) related to a resident eloping from the facility (#4) and a resident who was observed sitting outside the facility unsupervised (#5). The findings are: 1. Review of the facility's Special Care Unit (SCU) Policy revealed: -Facility staff would trained in dementia specific skills. -The facility would keep the staff current with strategies in addressing residents' needs in wandering. Review of the facility's SCU policy for wanderers dated 05/22/23 revealed: -The facility provided a wandering alarm on all exits and provided an outside secure terrace for the residents who wanted to go outside but	D 270		

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needed extra security.
-Once a resident was identified as a wanderer, staff shall monitor closely the activities of the resident and redirect as necessary.

Review of Resident #4's current FL2 dated 05/15/24 revealed:
-Diagnoses included vascular dementia, anxiety, depression, hypertension, insomnia, and hyperlipidemia.
-The resident was intermittently disoriented.
-He was ambulatory.
-He was incontinent to bowel and bladder.
-There was no documentation for wandering behaviors.
-The resident required assistance with bathing and dressing.
-The resident's level of care was documented as SCU.

Review of Resident #4's current assessment and care plan dated 05/15/24 revealed:
-The resident's mental health and social history was not completed.
-He was ambulatory and required no assistive devices.
-His memory was adequate.
-He required extensive assistance with toileting and bathing,
-He required limited assistance by staff with dressing, grooming and personal hygiene.

a. Review of Resident #4's Accident/Incident (A/I) report dated 04/18/24 revealed:
-On 04/17/24 at 8:00pm (time documented on A/I), Resident #4 was seen by the medication aide (MA).
-On 04/17/24 at 8:30pm (time documented on A/I), the MA was informed by another resident that Resident #4 was not in the facility. -The MA

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and staff from sister facilities searched the facility, facility campus and around the block but could not locate the resident.
-On 04/17/24 at 8:30pm, the Manager/Special Care Unit Coordinator (SCUC) and Administrator were contacted.
-On 04/17/24 at about 9:00pm (documented on the A/I), the local police was informed regarding Resident #4 wandering off from the facility.
-On 04/18/24 at 3:00am, an officer from the local police department came to the facility to inform the facility Resident #4 had been found and was at a local hospital.

Review of the local police Public Incident Report dated 04/17/24 at 8:53pm revealed:
-Resident #4 was reported missing from the facility's address at 7:14pm and found at 7:34pm.
-There were no details available in the report.

Review of Resident #4's hospital discharge summary dated 04/22/24 (no time of arrival documented) revealed:
-Resident #4 was admitted to the hospital on 04/18/24 and discharged on 04/22/24.
-Resident #4 currently lived in a group home due to severe dementia, he wandered off the facility and brought to the hospital by the police was noted for information regarding his admission.
-Resident #4 was treated for a urinary tract infection (UTI) and dehydration.
-Resident #4 was discharged on 04/22/24 with an antibiotic for the UTI.

Interview with the medication aide (MA) on 02/02/25 at 7:40am revealed:
-She was working on 04/17/24 when Resident #4 wandered from the facility.
-She saw him when she came into work at 8:00pm.

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-Resident #4 was reported to not be in the facility by another resident shortly after she arrived.
-She looked for the resident in the facility and outside.
-She called the local police and notified the Manager/SCUC who she thought called the Administrator.
-Resident #4 had not left the facility before that day as far as she knew.
-She was informed Resident #4 had wandered from the facility another day, recently, but she was not working when that incident occurred.

b. Review of Resident #4's Accident/Incident report dated 12/13/24 revealed:
-On 12/13/24, Resident #4 was missing from the facility at 12:10pm.
-On 12/13/24, Resident #4 was seen by the weekend MA not long before she called residents for lunch at 12:10pm.
-The weekend MA and staff from sister facilities searched the facility and other campus facilities but could not locate the resident.
-The Manager/SCUC and Administrator were contacted, and the local police was called regarding Resident #4 wandering off from the facility.
-On 12/13/24 at 12:30pm, an officer from the local police department came to the facility with the resident.
-According to the officer, Resident #4 was located at a nearby shopping center and the resident was doing ok.

Review of the local police Event Report dated 12/13/24 revealed:
-Resident #4 was reported missing from the facility on 12/13/24 at 12:36pm.
-He was located walking toward a health center at 12:37pm and picked up at 12:42pm.

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-He was returned to the facility 12/13/24 at 12:51pm with no issue.

Observation on 02/02/25 at 9:00am of the distance from the facility to the location of the health center revealed:
-The facility was 1.1 miles from the health center by way of the main street (6 city blocks).
-There were 4 stoplights and 4-way intersections along a major street between the facility and the health center.

Interview with the weekend MA on 01/02/25 at 8:40am revealed:
-She provided personal care and administered medications for residents.
-She was working on 12/13/24 when Resident #4 wandered from the facility.
-She saw him when she came into work at 8:00am, and at least one time just before 12:00pm (but not sure of the exact time).
-Resident #4 was not in the facility when she went to his room at 12:10pm to ask him to get ready to come to lunch.
-She did not know exactly when Resident #4 left the facility or which door he used to leave.
-She looked for the resident in the facility and outside.
-She notified the Manager/SCUC who was not in the facility but on the campus. She thought the Manager/SCUC called the Administrator.
-She was informed Resident #4 had wandered from the facility another day, recently, but she was not working when that occurred.
-There was no additional supervision in place for Resident #4 before or since the elopement on 12/13/24.
-Staff just looked for residents throughout the day and did routine 2 hours incontinence checks.
-She was not familiar with any kind of increased

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D 270	Continued From page 12 supervision for Resident #4. _____ Telephone interview with Resident #4's primary care provider (PCP) on 12/31/24 at 2:23pm revealed: -He routinely visited Resident #4 at the facility. -He came to the facility around 10:00am to 11:00am when he visited. -The facility's front door was never locked. -He just walked into the facility and looked around for facility staff. -He did not recall if there was an audible sound when he opened the front door. -Resident #4 was always in his bed when he arrived. -Resident #4 was not alert and sometimes responded to his questions and other times did not. -Facility staff had not informed the PCP that Resident #4 wandered around the facility. -Facility staff had not informed the PCP that Resident #4 wandered around the facility routinely or from the facility on 04/17/24. -He was not informed Resident #4 wandered from the facility on 12/13/24. -His expectation was that the facility was a SCU and Resident #4 should not be outside the facility without direct supervision. -He did not know if Resident #4 would be able to find his way back to the facility or make good decisions related to his safety in traffic. Interview with a personal care aide (PCA) on 12/31/24 at 3:00pm revealed: -Resident #4 spent a lot of time in his bed. -Resident #4 often did not come out of his room until lunch. -Resident #4 had to be reminded to adjust his clothing to cover his body. -Resident #4 had gotten into verbal arguments	D 270		

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with her and residents occasionally.
-Resident #4 had wandered away from the facility a couple of times, one time about 2-3 weeks ago and another time a while back.
-There were no residents with instructions for increased supervision as far as she knew.
-The staff just watched for the residents' whereabouts throughout the day.
-She had never been instructed for any increased supervision for Resident #4.

Interview with the MA on 02/02/25 at 7:40am revealed:
-Staff just looked for residents throughout the day.
-The facility exit doors were alarmed to let staff know when the exit doors were opened.
-She was informed Resident #4 had wandered from the facility another day, recently, but she was not working when that incident occurred.
-She was not familiar with any kind of increased supervision for Resident #4 after the elopement on 04/17/24.

Interview with the Manager/SCUC on 01/02/25 at 3:00pm revealed:
-The Manager/SCUC completed Accident/Incident Reports for the facility.
-The staff witnessing the incident provided information used to complete the report either the same day or as soon as the Manager/SCUC was at the facility.
-Staff called her when Resident #4 could not be found on 04/17/24 and 12/13/24.
-She informed the Administrator both times.
-The facility did not have a policy available for review related to supervision of residents..
-There was no documentation that the facility had increased their supervision for Resident #4 after he wandered off from the facility on 04/17/24 or

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D 270	Continued From page 14 12/13/24. Telephone interview with the Administrator on 01/02/25 at 7:30pm revealed: -He was informed that Resident #4 had wandered from the facility on 04/17/24 and 12/13/24. -Resident #4 did not have a responsible party available for contact. -The facility had a policy for supervising residents, but he would have to locate the policy and make it available to staff. -There was no system for documenting increased supervision of residents. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. 2. Review of Resident #5's current FL2 dated 05/22/24 revealed: -Diagnoses included dementia, intellectual disability, and osteoporosis. -She was intermittently disoriented. -She was ambulatory with a walker. -She was continent to bladder and incontinent to bladder. -She required assistance with bathing. -Level of care was documented as Special Care Unit (SCU). -The resident had a history of wandering behaviors. Review of Resident #5's current assessment and care plan dated 05/22/24 revealed: -She was independent for eating, dressing and transfers. -She required supervision with toileting, ambulation/locomotion, bathing, grooming and personal hygiene.	D 270		

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D 270	Continued From page 15 Observation of Resident #5 on 12/31/24 at 3:30pm revealed: -Resident #5 was sitting in her room in front of the south facing window with her pants legs pulled up to her knees. -The sun was shining through the window onto her legs. -Resident #5 was calmly gazing out the window. Interview with Resident #5 on 01/31/24 at 3:30pm revealed she liked to get sunshine on her skin when she could. Observation of Resident #5 on 01/02/25 at 1:30pm revealed: -Resident #5 was sitting calmly in a straight-backed wooden chair just to the right of the facility's outside front entrance. -There was no facility staff visible outside of the facility. -Resident #5 had her pant legs rolled up to just below the knees and her legs extended straight out from her body. -Resident #5's walker was located to her left front side within her reach. Interview with Resident #5 on 01/02/25 at 1:35pm revealed: -She was sitting outside in the warm sunshine. -She liked to sit outside in the sunshine. -She liked to feel the sunshine when it was a pretty day. -She asked the staff inside if she could sit outside a little today. Interview with the weekend medication aide (MA) on 01/02/25 at 1:40pm revealed: -She knew Resident #5 was sitting outside the door unsupervised. -Resident #5 loved to sit where the sun would	D 270		

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shine on her.
-Resident #5 often sat in front of the window of her room with the sun shining on her legs and seemed to enjoy it.
-Resident #5 had never tried to wander away from the facility or elope when the evening MA worked.
-Resident #5 asked her to go outside for a few minutes to sit in the sun, just out the front door.
-She was going to check on Resident #5 as soon as she came out and the surveyor was coming in.
-The weekend MA had never been informed Resident #5 could not go outside for a little bit.
-She was doing laundry and put a load in the washer at the back of the hall for a short time.
-The Manager/SCUC was back and forth between the 4 facilities and did not come to the facility to tell the MA that Resident #5 was not supposed to be outside.

Telephone interview with Resident #5's primary care provider (PCP) on 01/02/25 at 2:05pm revealed:
-Resident #5 had dementia and was placed in the SCU for increased supervision.
-She knew Resident #5 liked to sunbathe.
-Resident #5 should not be left outside, in the sun or shade unsupervised.
-She did not know Resident #5 was being allowed to sit outside alone and she had not authorized her sitting outside alone.
-Resident #5 would be at risk for sunburn or even wandering away.

Telephone interview with a representative for Resident #5's Guardian on 01/02/25 at 2:30pm revealed:
-She was familiar with Resident #5 and had access to all notes provided to the Guardian.
-Resident #5 was in the SCU due to her

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dementia.
-There was no documentation for the facility contacting the guardian regarding permission for the resident to sit outside of the facility unsupervised.
-Resident #5 should not be sitting alone unsupervised outside the facility.
-Resident #5 would not be able to make decisions related to sun exposure time limits to avoid sunburn.

Interview with Manager/SCUC on 01/02/25 at 6:30pm revealed:
-Resident #5 enjoyed the sunshine.
-Resident #5 had not attempted to leave the facility in the past.
-There was only one resident that had left the facility in the past and that was not Resident #5.
-She was between facilities routinely during the day shifts from around 8:00am to 5:00pm and could keep an eye out for residents outside their facilities.
-Residents in the SCU should be supervised when outside of the facility.

Interview with the Administrator on 01/02/25 at 7:30pm revealed the Manager/SCUC was responsible for ensuring residents were supervised according to their assessed needs.

_____

The facility failed to provide supervision for 2 of 5 sampled residents (#4 and #5), who resided in a SCU, resulting in a resident (#4), who had a diagnosis of vascular dementia and was intermittently disoriented, eloping from the facility and being taken to a local hospital emergency department by the local police and hospitalized for 4 days in April 2024, and being found by the police more than one mile away on a second elopement in December 2024. Another resident

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D 270	Continued From page 18 (#5), who had a diagnosis of dementia, was intermittently disoriented, and had wandering behaviors was observed sitting outside the facility unsupervised placing the resident at risk for elopement and/or sunburn. This failure resulted in neglect of the residents which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on December 31, 2024 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 01, 2025.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure follow-up with a physician for 2 of 5 sampled residents related to a resident who eloped from the facility on 2 occasions (#4) and a resident who had a fall with injury resulting in an emergency department (ED) visit (#5). The findings are:	D 273		

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1. Review of Resident #4's current FL2 dated 05/15/24 revealed:
-Diagnoses included vascular dementia, anxiety, depression, hypertension, insomnia, and hyperlipidemia.
-The resident was intermittently disoriented.
-The resident was as ambulatory.

Review of Resident #4's Accident/Incident (A/I) report dated 04/18/24 revealed:
-On 04/17/24 at 8:00pm, Resident #4 was seen by the medication aide (MA).
-On 04/17/24 at 8:30pm, the MA was informed by another resident that Resident #4 was not in the facility.
-The MA and staff from sister facilities searched the facility, facility campus and around the block but could not locate the resident.
-On 04/17/24 at 8:30pm, the Manager/Special Care Unit Coordinator (SCUC) and Administrator were contacted, and the local police was informed regarding Resident #4 wandering off from the facility.
-On 04/18/24 at 3:00am, an officer from the local police department came to the facility to inform the facility Resident #4 had been found and was at a local hospital.

Review of Resident #4's A/I report dated 12/13/24 revealed:
-On 12/13/24, Resident #4 was missing from the facility at 12:10pm.
-On 12/13/24, Resident #4 was seen by the weekend medication aide (MA) not long before she called residents for lunch at 12:10pm.
-The weekend MA and staff from sister facilities searched the facility and other campus facilities but could not locate the resident.
-The Manager/SCUC and Administrator were contacted, and the local police was called

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regarding Resident #4 wandering off from the facility.
-On 12/13/24 at 12:30pm, an officer from the local police department came to the facility with the resident.
-Resident #4 was located at a nearby shopping center and "the resident was doing ok."

Telephone interview with Resident #4's primary care provider (PCP) on 12/31/24 at 2:23pm revealed:
-He routinely visited Resident #4 at the facility every 3 to 4 weeks.
-Resident #4 was always in his bed when he arrived.
-Resident #4 was not alert and sometimes responded to his questions and other times did not.
-Facility staff had not informed the PCP that Resident #4 wandered around in the facility or away from facility..
-He was not informed Resident #4 wandered from the facility on 04/17/24 or 12/13/24.
-He would have expected to be notified by call or fax, in a timely manner, if Resident #4 had eloped from the facility especially if the resident had been in the hospital.

Interview with the Manager/SCUC on 02/02/25 at 3:00pm revealed:
-Staff called her when Resident #4 could not be found on 04/17/24 or 12/13/24.
-She informed the Administrator on both occasions.
-She did not notify Resident #4's PCP of the elopements.

Telephone interview with the Administrator on 01/02/25 at 7:30pm revealed:
-He was informed that Resident #4 had wandered

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from the facility on 04/17/24 and 12/13/24 by the Manager/SCUC.
-The Manager/SCUC was responsible for monitoring health care for residents including notifying the providers of any changes affecting the residents' care.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

2. Review of Resident #5's current FL2 dated 05/22/24 revealed:
-Diagnoses included dementia, intellectual disability, and osteoporosis.
-The resident was documented as intermittently disoriented.
-The resident was documented as ambulatory with a walker.
-The resident's level of care was documented as Special Care Unit (SCU).

Review of Resident #5's Resident Register revealed the admission date was blank.

Observation of Resident #5 on 01/02/25 at 1:30pm revealed:
-Resident #5 was sitting calmly in a straight-backed wood chair just to the right of the facility's outside
front entrance.
-Resident #5's left arm was in a sling that extended around her neck, covered her arm from above the elbow to the wrist, and cradled the left arm next to her body.

Interview with Resident #5 on 01/02/25 at 1:35pm revealed:
-She had a fall last week, the day after Christmas (12/26/24), in her room.

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-Staff checked on her just after the fall.
-She was transported to the hospital and had to wait several hours before she was seen.
-She had a broken bone, and her arm was placed in a sling.
-She was not in a lot of pain at the present time, as long as she kept her arm in the sling.

Interview with the weekend medication aide (MA) on 01/02/25 at 1:40pm revealed:
-Resident #5 fell in her room on 12/26/24.
-Resident #5 was sent out to the hospital because she was complaining of pain in her arm.
-The weekend MA alerted the Manager/Special Care Unit Coordinator (SCUC) and completed an Accident/Incident report.

Review of the Resident #5's Accident/Incident Report dated 12/26/24 revealed:
-The report was completed by the weekend medication aide MA.
-On 12/26/24 at 12:00pm, Resident #4 was in her room and attempted to sit down in her walker.
-The walker slid out from under her.
-The staff member helped the resident get up off the floor.
-Resident #5 said her arm hurt bad.
-Resident #5 was sent out of the facility.

Review of Resident #5's after visit summary from a emergency department (ED) dated 12/27/24 revealed:
-Resident #5 was seen for a fall.
-Diagnosis was other closed nondisplaced fracture of the proximal end of left humerus.
-Treatment ordered was to apply an immobilizer/sling.

Telephone interview with Resident #5's primary care provider (PCP) on 01/02/25 at 2:05pm

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revealed:
-She routinely saw residents at the facility, including Resident #5.
-She had not been to the facility since 12/25/24 due to the holidays affecting her schedule.
-She could be contacted 24/7 via the messaging system for her practice.
-She expected to be notified if a resident had an emergency requiring a trip to the hospital, like a fall.
-She had not been notified Resident #5 had a fall on 12/26/24 resulting in a left arm fracture.
-Had she know about the fall on 12/26/24, she would have been checking on the resident's pain level.

Interview with the Manager/SCUC on 01/02/25 at 6:30pm revealed:
-She routinely notified the Responsible Party and the Administrator.
-She placed information regarding a hospital visit, including any after visit summary or hospital discharge, in a folder for the facility's PCP to review on her next visit.
-The after visit hospital summary was still in a folder awaiting Resident #5's review by the PCP on her next visit to the facility.
-Resident #5 fell on 12/26/24, the day after Christmas, and the PCP had not been to the facility since the fall due to the New Year holiday affecting the schedule.
-She had not notified Resident #5's PCP regarding the resident having a fall resulting in a fractured arm requiring a sling because the PCP usually came to the facility weekly and reviewed information in the folder for the PCP.

Telephone interview with the Administrator on 01/02/25 at 7:30pm revealed the Manager/SCUC was responsible for monitoring health care for

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D 273	Continued From page 24 residents including notifying the providers of any changes affecting the residents' care. _____ The facility failed to follow-up with a physician for 2 of 5 sampled residents regarding a resident who eloped from the facility and received treatment at a local hospital for a urinary tract infection on 04/17/24 and being returned to this facility by the local police on 12/13/24 after a second elopement, placing the resident at risk for physical injury (#4), and a resident who had a fall resulting in a fractured arm (#5). The failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on January 2, 2025 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 16, 2025.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by:	D 296		

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D 296	Continued From page 25 Based on observations, interviews, and record reviews, the facility failed to ensure there was a matching therapeutic diet menu for 1 of 1 sampled residents (#3) who had a physician's order for a low carbohydrate diet. The findings are: Review of Resident #3's current FL2 dated 07/10/24 revealed: -Diagnoses included dementia with memory loss. -There was an order for a low carbohydrate diet. Review of the facility's Resident Diet list posted in the kitchen area revealed Resident #3 was ordered a regular, low carbohydrate diet. Review of the facility's therapeutic menus revealed there was no low carbohydrate diet menu. Review of the facility's week-at-a-glance menu for the lunch meal for week one Monday meal, for regular diets, revealed chicken pot pie (one ounce of meal), vegetable blend, dinner roll, fruit cobbler, and coffee/tea/water were to be served. Observation of the lunch meal service on 12/30/24 between 12:50pm and 1:11pm revealed: -Resident #3 was served 2 ounces of pulled barbequed chicken, cubed potatoes, mixed vegetables, a slice of bread, tea, and water. -Resident #3 consumed 100% of the meal with no difficulty. Interview with a personal care aide (PCA) on 12/30/24 at 12:55pm revealed: -She prepared the meals for residents in the facility on Monday, Tuesday and Wednesdays each week.	D 296		

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-All the residents were on a regular diet as far as she knew.
-She had not been instructed on any resident receiving a diet other than regular diet.

Interview with the Manager/Special Care Unit Coordinator (SCUC) on 01/02/25 at 4:40pm revealed:
-The facility did not have a Dietary Manager.
-She was responsible for managing residents' meals by ordering the food, making sure the week at a glance menu was available and on the correct weeks.
-The residents were on a regular diet but some had chopped meats for modified textures.
-The week at a glance spread sheet listed therapeutic diet menus along with food to be served for each menu for guidance.
-She was responsible for ensuring residents' diets matched the diet ordered by the provider and the menus listed on the week at a glance spread sheet.
-She overlooked Resident #3's order for a low carbohydrate not being a diet listed on the week at a glance menu guide or available for staff guidance for preparation.

Interview with the Administrator on 01/02/25 at 7:30pm revealed the Manager/SCUC was responsible for the day-to-day operation of the facility and 3 other sister facilities located adjacent or across from the facility, including managing the residents' meals.

Based on observations, record reviews, and interviews, it was determined Resident #3 was not interviewable.

Based on observations, interviews, and record reviews, it could not be determined if Resident #3

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D 296	Continued From page 27 was served the appropriate low carbohydrate diet because there was no therapeutic diet menu available for staff guidance.	D 296		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent of dairy products were served three times daily to 8 of 10 residents in the Special Care Unit (SCU). The findings are: Observation during the initial tour on 12/30/24 from 8:20am to 9:40am revealed the facility had a current census of 10 residents. Review of the facility's daily menu for 12/30/24 and 12/31/24 revealed: -Milk was listed to be served for the breakfast and	D 299		

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dinner meal service.
-There were milk or equivalent dairy products listed on the menu to be served at lunch on 12/30/24 or 12/31/24.

Observation of the kitchen on 12/30/24 revealed there was one opened ½ gallon of milk in the side-by-side combination refrigerator/freezer.

Based on the census of 10 residents, there should have been 1.25 gallons of milk to serve at breakfast and dinner.

Observation of the lunch meal service on 12/30/24 between 12:50pm and 1:10pm revealed:
-There were 8 residents present in the dining room.
-There were 8 place settings prepared for residents with 2 empty cups at each place setting.
-The beverages were served by the personal care aide (PCA).
-Beverages included tea and water.
-All residents were served water and tea.
-There were 8 residents who were not served or offered milk and there were no other dairy products served or offered to the 8 residents.

Observation of the lunch meal service on 12/30/24 between 12:50pm and 1:11pm revealed:
-There were 8 residents present in the dining room.
-The residents were served 2 ounces of pulled barbequed chicken, cubed potatoes, mixed vegetables, a slice of bread, tea, and water.
-There was no milk or dairy product offered or served to the residents.

Interview with a resident on 12/30/24 at 1:10pm revealed he liked to drink milk, but milk was only served some days in the morning with cereal.

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D 299	Continued From page 29 Interview with a personal care aide (PCA) on 12/30/24 at 12:55pm revealed: -She prepared the meals for residents in the facility on Monday, Tuesday and Wednesdays each week. -The week at a glance menu had milk listed for breakfast and dinner but not lunch. -She was not aware milk or dairy products should have been served with each meal to residents. -The Manager/Special Care Unit Coordinator (SCUC) ordered the food supplies including milk. -She had not been informed by the Manager/SCUC regarding the new requirements for milk or dairy equivalent be served 3 times a day. Interview with the Manager/SCUC on 01/02/25 at 4:40pm revealed: -The facility did not have a Dietary Manager. -She was responsible for managing residents' meals by ordering the food including milk. -She did not realize milk or a dairy equivalent was not listed on the menu guide for lunch. Interview with the Administrator on 01/02/25 at 7:30pm revealed: -The Manager/SCUC was responsible for the day-to-day operation of the facility and 3 other sister facilities located adjacent or across from the facility, including managing the residents' meals. -He knew milk or a dairy equivalent was supposed to be served 3 times a day. -He did not know residents did not receive milk or a dairy equivalent at each meal.	D 299		
D 363	10A NCAC 13F .1004(f) Medication Administration	D 363		

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D 363	Continued From page 30 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 363		

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reviews, the facility failed to ensure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 1 of 3 residents (#2).

The findings are:

Review of Resident #2's current FL2 dated 08/28/24 revealed diagnoses included schizoaffective disorder, dementia, hypertension, diabetes mellitus Type II, seizures, right shoulder pain, and traumatic brain injury.

Observation of a medication aide (MA) in the medication room on 12/30/24 at 8:37am revealed:
-The medication aide removed a clear plastic container labeled "AM" from the medication cart.
-The clear plastic container was not labeled with a resident's name.
-The clear plastic container was divided into 7 partitioned compartments with a snap closure on each compartment.
-Each compartment was labeled with a day of the week (Sunday through Saturday).
-The compartments for Saturday and Sunday were empty.
-The compartment labeled with a day of the week from Monday through Friday contained 8 tablets.
-The compartments were not labeled with the name of the tablets to identify each tablet.
-The MA consulted the electronic medication administration record (eMAR) computer screen for Resident #2, counted 8 medications scheduled on the computer screen, transferred the contents of the compartment label Monday into a paper souffle cup for administration and administered the medications.
-The MA documented administration on Resident

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D 363	Continued From page 32 #2's eMAR at 8:43am. Interview with the MA on 12/30/24 at 8:38am revealed the medications were prepared in advance for Resident #2 by the MA. Second interview with the MA on 12/30/24 at 8:50am revealed: -Resident #2 had been a resident at the facility since late August 2024. -When the resident was admitted to the facility, he came with his medications and 2 clear plastic containers labeled "AM" and "PM". -Resident #2 was the only resident that had medications dispensed from a pharmacy other than the facility's contracted pharmacy. -Resident #2's medications were received in bulk prescription bottles from an outside pharmacy. -She decided to use the "AM and "PM" containers although she had not used them for any resident before Resident #2. -The MA worked from Thursday at 8:00am to Monday at 8:00am. -The MA administered medications during the morning, mid-day, and evening when she worked. -All the other residents' medications were sent on separate multidose bubble packed cards labeled for the day, time of day, days of the week and residents' names. -On Saturday nights, she prepared Resident #2's clear plastic container labeled for AM and another one labeled for PM for the following week's medications to make it easier to administer the medications to all the residents. -She used a printed copy of the eMAR as the guide for preparing the medications for each day morning and evening medications. -She did not know medications prepared in advance must be labeled with the resident's name, name of all medications contained in each	D 363		

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compartment, time to be administered, and stored in a sealed container.
-She thought the MAs that worked when she was not scheduled used the same container because it did not have medication in the container in the Monday to Wednesday compartments when she came in on Thursday.

Interview with the Manager/Special Care Unit Coordinator (SCUC) on 12/30/24 at 1:00pm revealed:
-She was responsible to ensure medications were administered correctly.
-She was not familiar with the requirements for MAs to prepare medications in advance.
-Resident #2's medications were dispensed from an outside pharmacy and not prepared in multidose bubble packages like the other residents' medications.
-She had not observed the MAs administering Resident #2's medications.
-The MAs should not be using the 2 clear plastic containers labeled "AM" and "PM" for administering Resident #2's medications.

Interview with a second MA on 12/31/24 at 8:05am revealed she used Resident #2's bottles dispensed from an outside pharmacy to prepare his medications for administration.

Interview with the Administrator on 01/02/25 at 7:25pm revealed:
-Each resident should have medication administered and documented before preparing and administering another resident's medications.
-The Manager/SCUC and MAs were responsible for administering medications accurately.
-The facility's policy was no preparing of medications in advance.

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D 363	Continued From page 34 Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	D 363		
D 461	10A NCAC 13F .1304 Special Care Unit Building Requirements 10A NCAC 13F .1304 Special Care Unit Building Requirements In addition to meeting all applicable building codes and licensure regulations for adult care homes, the special care unit shall meet the following building requirements: (1) Plans for new or renovated construction or conversion of existing building areas shall be submitted to the Construction Section of the Division of Facility Services for review and approval. (2) If the special care unit is a portion of a facility, it shall be separated from the rest of the building by closed doors. (3) Unit exit doors may be locked only if the locking devices meet the requirements outlined in the N.C. State Building Code for special locking devices. (4) Where exit doors are not locked, a system of security monitoring shall be provided. (5) The unit shall be located so that other residents, staff and visitors do not have to routinely pass through the unit to reach other areas of the building. (6) At a minimum the following service and storage areas shall be provided within the special care unit: staff work area, nourishment station for the preparation and provision of snacks, lockable space for medication storage, and storage area for the residents' records. (7) Living and dining space shall be provided	D 461		

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within the unit at a total rate of 30 square feet per resident and may be used as an activity area.
(8) Direct access from the facility to a secured outside area shall be provided.
(9) A toilet and hand lavatory shall be provided within the unit for every five residents.
(10) A tub and shower for bathing of residents shall be provided within the unit.
(11) Use of potentially distracting mechanical noises such as loud ice machines, window air conditioners, intercoms and alarm systems shall be minimized or avoided.

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

Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 entrance/exit doors of the Special Care Unit (SCU), accessible to residents, were locked or equipped with a security monitoring system resulting in residents leaving the facility to walk outside or walk to a sister facility in the area, and providing access for entry into the facility through both doors 24 hours a day.

The findings are:

Review of the facility's current license revealed the facility was licensed as a Special Care Unit (SCU) with a capacity of 12 residents.

Review of the facility's current census on 12/30/24 revealed there were 10 residents residing in the facility.

Review of the facility's SCU policy dated May

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D 461	Continued From page 36 2023 revealed: -The SCU would provide appropriate care to residents in order to improve resident safety outcomes. -The SCU coordinated efforts of stake holders to ensure resident safety. -The SCU staff were trained on industry requirements and stands of best practice in order to render excellent quality of care at all times to residents, tailor made, to ensure resident safety and improve outcomes. -The SCU would provide a safe, secure, familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medications. -The SCU had a wandering alarm on all the exit doors and provided an outside secure terrace for the residents who want to go outdoors but needed extra security. -The alarmed doors assisted in the supervision of residents. Review of the FL2s for 10 residents residing in the facility revealed: -Diagnoses included vascular dementia, dementia, multi-infarct dementia, and cognitive impairment. -Eight residents were intermittently disoriented. -Two residents were constantly disoriented. -Six residents were ambulatory, 3 residents were semi-ambulatory, and one resident was non-ambulatory. -One resident wandered. Review of the facility's resident sign out log revealed there was no sign-out or visitor sign-in log available for review. Observation during the initial tour of the facility on 12/30/24 from 8:15am to 9:20am revealed:	D 461		

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D 461	Continued From page 37 -The facility had 3 doors leading to the outside of the facility. -One door was located on the right side of the front of the facility. -Another door was in the middle of the back side of the facility in the dining room area. -A third door was located in the rear of the facility at the end of a hallway with residents' rooms and led out to a screened-in patio area. -There were lighted exit signs above the front door and the door located at the back left side at the rear of the building. Observation upon entering the facility on 12/30/24 at 8:15am revealed: -The front door of the facility was unlocked. -The outside of the entrance door had a lever handle with a separate round key lock. -The inside of the entrance door had a latched push bar to exit the foyer to the outside of the facility and there was a key lock on the inside of the door. The outside door made a chiming sound when opened. -The outside door opened into an eight feet by eight feet foyer. -Between the foyer and the inside of the facility there was a door which was closed. -The inside foyer door between the foyer and the facility had a twist knob that was unlocked. The door did not have a locking device and did not alarm when opened. -The exit door was not visible from inside the facility through the inside closed foyer door. Observation of the doors at the entrance of the facility on 12/30/24 at 8:40am revealed: -The inside foyer door (between the foyer and the outside entrance door) was unlocked and was easily exited by turning the doorknob and pushing.	D 461		

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D 461	Continued From page 38 -The front outside entrance door to the facility was easily exited by pushing the push bar. -There was a chiming sound when the front door was opened. -The front outside entrance door was not visible from the medication room, from the kitchen, or from the back hallway where residents' rooms were located. Observation of the facility entrance on 12/30/24 from 8:50am to 9:58am revealed: -At 8:50am, one resident exited the front door, smoked a cigarette, and came back into the front door without staff knowledge. -At 9:58am, the resident wandered back and forth outside from a sister facility in the area carrying a soda can. The resident entered the unlocked front door and entered the facility without staff knowledge. Observation of the facility on 12/30/24 at 10:22am revealed: -The facility exit door at the back left side of the facility had a push bar on the inside of the door that was not completely latched and did not alarm when opened at 10:22am. -The rear exit door opened into a screened-in porch on the left side of the facility at the end of the hallway where residents' rooms were located. -The outside of the rear exit door had a lever handle and an opening where there was once a round key lock. -There was a no chiming sound when the door was opened that led to the screened-in porch, and there was no means to lock on the door to prevent entering from the outside. -There was a solid wooden door on the screened-in porch leading to the back yard. -There was a keyed dead bolt lock on the solid wooden door leading from the screened-in porch	D 461		

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to back yard.
-The solid wooden door did not have a sounding device to alert staff when the solid wooden door was opened.
-There were double doors in the dining area leading to a fenced yard.
-One of the double doors was stationary while the other door opened to the outside and had a working lock on it. There was a chiming sound when the door was opened.

Observation of the facility on 12/30/24 at 2:23pm revealed:
-The front entry door was easily opened with the single twist door lever.
-There was a chiming sound when the front entrance door was opened.
-The foyer door leading into the facility was not locked and did not chime when opened.
-No staff were visible upon entry into the facility.

Observation of the Manager/Special Care Unit Coordinator (SCUC) on 12/31/24 at 12:20pm revealed:
-The Manager/SCUC looked for a resident and called out for the resident.
-The Manager/ SCUC went out the front door to look for the resident.
-The resident was found on the front porch, outside the facility smoking unsupervised.

Observation of the front door on 01/02/25 at 7:45am revealed:
-There was a health care provider standing outside the facility.
-The front door was locked and the provider was looking around.
-The doorbell rang and a resident opened the door for the provider.

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D 461	Continued From page 40 Interview with the provider on 01/02/25 at 7:48am revealed: -He came to the facility to check on a hospice resident. -He visited the resident weekly or maybe 2 times a month for the last several months -This was his first visit when the front door was locked. -He did not see the doorbell located 14 to 18 inches to the right of the handle. -He had never rang a doorbell to have the front door opened before this visit but had wondered why he could walk right into a SCU and had to look for staff. Observation of the facility's security cameras on 01/02/25 at 3:40pm revealed: -There were 5 security camera coverings mounted on the ceiling in different locations of the facility. -There was a camera covering in the right corner in the back of the entrance hallway where residents' rooms were located. -There was a camera covering in the middle of the entrance hallway directly in front of the main hallway that connected the men's hallway to the women's hallway and allowed access to the dining area and family room. -There was a camera covering located in the left-hand corner at the back of the men's hallway to the left of the door leading to the screened in porch. -There was a camera covering located to the right of the entrance door to the dining room inside the dining room. -There was a camera covering located in the family room. Observation of the office where the facility's monitoring system was located on 01/02/25 at	D 461		

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D 461	Continued From page 41 4:00pm revealed: -The office was located in an upstairs room of a sister facility. -The office door was not locked and there was no staff in the office. -There was a monitor set up on a stand facing the desk in the room. -There were 24 frames on the screen to monitor video. -There were live videos in some of the frames, but the video locations were not labeled. -The video frames identified by the Manager/SCUC was of the facility back door but not of staff who was working in the facility on 01/02/25. Interview with the Manager/SCUC on 01/02/24 at 4:08pm revealed: -Only some of the frames on the monitor were for cameras in the SCU. -There was a camera in the facility that was focused on the front door. -The Manager/SCUC was in and out of the office Monday through Friday during the hours 8:00am to around 5:00pm. -There was not currently someone in the office at the sister facility who monitored the camera 24 hours a day and was able to see anyone who came in and out of the facility. -She thought the Administrator had access to the videos on his telephone. -If a resident left the facility, it should be recorded on the video. Interview with a personal care aide (PCA) on 12/30/24 at 2:45pm revealed: -The front door to the facility stayed unlocked all the time, even during the night. -She did not have a key to the front door or know where a key was located.	D 461		

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-She and another PCA worked in the facility on Monday, Tuesday, and Wednesday 8:00am to 8:00pm and the Manager/SCUC checked in with the facility styaff several times a day.
-The Manager/SCUC administered some medications in the middle of the day on Monday, Tuesday, and Wednesday.
-There was a sounding device on the front door, so staff knew when anyone entered or exited the facility.
-The alarm could not be heard if she was in the laundry room because of the noise of the washer and dryer.
-Sometimes residents opened the door from the inside before she could get to the door.

Interview with the PCA on 12/31/24 at 11:50am revealed:
-She was not able to locate a register for the residents or visitors signing in and out..
-There was one resident who left the facility, independently, to walk to a local store or the sister facility across the parking lot.
-The resident went to sister facility across the parking lot 2 to 3 times a day.
-The resident let her know before he left out of the facility most times.
-There was one resident who had left the facility recently unsupervised, and the police were called to find him.

Interview with a resident on 12/30/24 at 4:41pm revealed:
-The front door was not locked.
-He walked over to the sister facility to buy a soda a few times a day.
-He came out to the front of the facility to smoke a few times a day.
-Facility staff did not come outside with him routinely, he just opened the front door to leave

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D 461	Continued From page 43 and come back into the facility.. Telephone interview with a resident's primary care provider (PCP) on 12/31/24 at 2:23pm revealed: -He came to the facility for one resident every 3 to 4 weeks for more than 6 months. -He usually arrived at the facility around 10:00am. -The front door was never locked. -He did not recall if there was a chiming sound when he entered the facility. -He had to look for staff to inform them he was there to see his resident. -He felt staff did not provide sufficient monitoring of the entry and exit doors. Interview with a medication aide (MA) on 01/02/25 at 9:00am revealed: -The front door was never locked before she came today (01/02/25). -There was 1 resident who smoked and went out of the front door to smoke on the front porch. -Staff did not go outside with the resident when he went out to smoke. -She did not have a key to the facility and the door was unlocked all day and night when she worked. -She was concerned about someone coming in off the street at night with the front door being unlocked and did not feel safe. -She had not told anyone because the Manager/SCUC was in and out of the facility several times a day and must have known the front door was unlocked. Telephone interview with the facility's primary care provider (PCP) on 01/02/25 at 2:03pm revealed: -She provided care for most of the residents residing in the facility. -She was aware the residents in the SCU facility had diagnoses of dementia or cognitive	D 461		

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D 461	Continued From page 44 impairment. -The front door to the facility was always unlocked when she came to the facility. -She knew the front door was unlocked during the day, but she did not know the front door was not locked at night. -She was concerned residents in the SCU facility could get out and wander around with the doors not being locked. -She expected staff to lock the front door of the SCU especially at night to ensure safety and security of the residents. -There were usually 2 staff in the facility when she was there, but they probably could not watch every resident all the time. -She did not know residents left the facility without staff knowledge. -There may be 1 resident who she provided care for that may be able to leave the facility independently. -She did not think any of the other residents could safely find their way back to the facility. -She had not looked for any security monitoring system in the SCU facility. Interview with the Manager/SCUC on 01/02/25 at 6:00pm revealed: -The facility doors were supposed to be locked at night. -The front door was not always locked from the outside during the day but had no reason why. -She was in and out of the SCU several times a day during her 8:00am to 5:00pm or 6:00pm shift Monday through Fridays. -She monitored the parking lot for residents as she moved from one to the other of the 4 facilities on campus. -She was in her office, located in the sister facility where the camera monitors for the facility was housed, when she was not in the facilities.	D 461		

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D 461	Continued From page 45 -The one resident that was often seen outside the facility was very oriented and independent even though he had a dementia diagnosis. -She knew one resident had eloped from the facility 2 times before, but staff watched for his location constantly. -She locked the front door on 12/31/24 and instructed staff to ensure the front door was locked all the time. -The left rear exit/entry door still did not have a locking mechanism for locking the outside single turn handle but the door chime was operating correctly provided the door was completely closed. -The dead bolt on the door to the screened-in porch was unlocked and the key was available for staff to lock it. -The Administrator had worked on securing the doors of the SCU for the last several months. -The Administrator spoke to the staff in the SCU on many occasions related to being sure the residents' whereabouts were always known. Telephone interview with the Administrator on 01/02/25 at 7:30pm revealed: -He had recently repaired the front door key lock. -The facility's front door had a functioning lock. -There had to be a sounding device on the doors, but it was not required to be locked. -Staff had been instructed to lock the exit doors and monitor the exit door chiming sounds to make sure residents were secure. -Staff kept the residents safe by knowing where the residents were at the time. -Staff should have keys to the front door of the SCU facility. -He did not know residents opened the door for visitors and staff. _____ The facility failed to ensure a secure system of	D 461		

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D 461	Continued From page 46 monitoring the SCU when the doors were unlocked which placed the residents, who all had diagnoses of dementia or cognitive impairment, at risk for elopement and compromised the residents' safety with the doors being unlocked 24 hours a day. This failure placed residents at substantial risk for serious harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on December 30, 2024 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 01, 2025.	D 461		
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: Based on observations, interviews and record reviews, the facility failed to ensure the minimum number of staff were present to meet the needs of the residents in the Special Care Unit (SCU) for 4 of 42 shifts from 12/19/24 through 01/01/25. The findings are:	D 465		

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D 465	Continued From page 47 Observation during the initial tour on 12/30/24 from 8:20am to 9:40am revealed the facility had a current census of 10 residents. Review of the facility's resident census report dated 12/30/24 revealed there were 10 residents residing in the Special Care Unit (SCU). Observations during the initial tour of the SCU on 12/30/24 revealed: -At 8:00am, revealed there were 2 personal care aides (PCAs) and 1 medication aide (MA) on duty upon entry into the facility. -At 8:35am, there were 2 PCAs staffing the facility. Review of staffing requirement for the SCU with a census of 10 residents revealed: -First shift and second shifts required 10 aide hours. -Third shift required 8 aide hours. Review of staff timecard hours, staff schedule and the daily census report for 12/21/24 revealed: -There were 10 residents in the SCU which required 10 aide hours for first and second shifts and 8 aide hours for third shift. -There were 8 documented aide hours for the first shift leaving the facility short 2 aide hours. -There were 8 documented aide hours for the second shift leaving the facility short 2 aide hours. Review of staff timecard hours, staff schedule and the daily census report for 12/28/24 revealed: -There were 10 residents in the SCU which required 10 aide hours for first and second shifts and 8 aide hours for third shift. -There were 8 documented aide hours for the first shift leaving the facility short 2 aide hours.	D 465		

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D 465	Continued From page 48 -There were 8 documented aide hours for the second shift leaving the facility short 2 aide hours. Interview with a PCA on 12/30/24 at 9:34am revealed: -She usually worked on Monday, Tuesday, and Wednesday from 8:00am to 8:00pm. -The Manager/Special Care Unit Coordinator (SCUC) was in and out of the facility during the day to administer medications and check on the staff and residents and was available by cell phone. -A MA usually worked from 8:00pm to 8:00am Monday, Tuesday, and Wednesday. -There were usually staff on-call in case someone called out of work. Interview with MA/PCA on 01/02/24 at 10:45am revealed: -The Manager/SCUC completed the scheduling for staff. -The facility staff were supposed to contact the Manager/SCUC for call-outs. -She worked starting Thursday at 8:00am to Monday at 8:00am administering medications and providing personal care for the residents. -There were PCAs who split their 12-hour shifts between the facility and a sister facility. -There had been 2 times recently when there was no PCA, and the facility had been understaffed on those days. -She worked 8:00am to 11:00pm on 12/21/24 and 8:00am to 11:00pm on 12/28/24 without a PCA assisting her due to staff call-outs. Interview with the Mnager/SCUC on 01/02/25 at 5:05pm revealed: -She was responsible for making the weekly staff schedule. -She knew the staffing requirements for the SCU.	D 465		

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D 465	Continued From page 49 -She had done all she could do with staffing shortages for the facility. -Staff called her when they were not going to be at work. -She contacted staff at this facility and sister facilities for replacement on 12/21/24 and 12/28/24, but she could not find staff to cover the first and second shifts. -She was not at the facility on 12/21/24 and 12/28/24 but was on call 24 hours a day/7 days a week and was available to respond if the MA/PCA had required additional assistance. Telephone interview with the Administrator on 01/02/25 at 7:30pm revealed: -The Manager/SCUC was responsible for creating the weekly staffing schedule. -Staff were scheduled to work and then they did not show up. -He did not know if there were particular days when the facility was not staffed according to the regulations. -They were trying to staff the facility as best as possible with present staffing conditions.	D 465		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 466		

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failed to ensure there was a care coordinator on the Special Care Unit (SCU) for 8 hours per day 5 days per week.

The findings are:

Review of the facility's resident census report dated 12/30/24 revealed there were 10 residents residing in the Special Care Unit (SCU).

Observation of the SCU on 12/30/24 at 8:00am revealed:
-There were 2 personal care aides (PCAs) and 1 medication aide (MA) on duty upon entry into the facility.
-There was no Special Care Unit Coordinator (SCUC) in the facility.

Interview with a MA on 12/30/24 at 8:03am revealed:
-She worked Thursdays at 8:00am until Mondays at 8:00am as the MA and care giver along with a dayshift (8:00am to 8:00pm) PCA.
-She reported to the Manager/SCUC or sometimes to the Administrator.
-The Manager/SCUC was responsible to administer medications after she left at 8:00am.

Interview with a PCA on 12/30/24 at 9:00am revealed:
-She worked Monday, Tuesday, and Wednesday from 8:00am to 8:00pm.
-She prepared the meals for residents in the facility on Monday, Tuesday and Wednesdays each week and provided personal care to the residents.
-There was a second PCA that worked the same shift as hers.
-The Manager/SCUC did not stay in the building during the day but was available by cell phone if

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needed.
-She did not administer residents' medications.
-The Manager/SCUC administered medications during the day on Monday, Tuesday, and Wednesday.

Interview with a staff member on 12/30/24 at 8:10am revealed:
-She identified herself as the "Manager" of the facility and 3 sister facilities adjacent to and across from the facility.
-She was always in contact with the Administrator.
-The other facilities were family care homes.
-She worked from 8:00am to 5:00 or 6:00pm on Monday through Friday and was on call for the facilities at all other times.
-She also was the Special Care Unit Coordinator (SCUC) but was in and out of the SCU all day helping in the SCU and managing the other 3 facilities.
-There were presently 10 residents in the facility.
-The nighttime MA worked 8:00pm to 8:00am on Monday, Tuesday, and Wednesday nights.
-There were 2 PCAs in the facility working 8:00am to 8:00pm shifts on Monday, Tuesday, and Wednesday.
-The night shift MA administered 8:00am and 8:00pm medications, and the Manager/SCUC administered medications during the day or any as needed (prn) medications Monday, Tuesday, and Wednesday.
-She could provide needed items, like the census, print medication administration records (MARs), and any documents needed.
-Some information was in her office above a sister facility adjacent to this facility.
-She did not have an officer in the facility.
-She would be working between the 4 facilities as was her normal routine.

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D 466	Continued From page 52 -The Manager/SCUC left the facility saying she would be back with a printed roster of the facility's residents. Observations of the Manager/SCUC on 12/30/24, 12/31/24, and 01/02/25 at various times revealed: -The Manager/SCUC was not in the facility except for short periods of time each day with examples as follows: -On 12/30/24 at 8:20am, the Manager/SCUC left the facility to bring the resident roster, back at 8:40am. -On 12/30/24 at 9:20am, the Manager/SCUC brought eMARs for residents and left the facility. -On 12/30/24 at various times, the Manager/SCUC came into the facility to check for questions but left thereafter. -On 12/31/24, the Manager/SCUC came into the facility 4 times from 8:00am to 3:00pm to check for questions but left thereafter. On 12/31/24 from 3:00pm to 3:15pm, the Manager/SCUC came into the facility to check for questions but left thereafter. -On 01/02/25 at various times the Manager/SCUC was in and out of the facility. Interview with the Manager/SCUC on 01/02/25 at 6:00pm revealed: -She was in and out of the SCU several times a day during her 8:00am to 5:00pm or 6:00pm shift Monday through Fridays. -She monitored the parking lot for residents as she moved from one to the other of the 4 facilities on campus. -She was in her office, located in the sister facility where the camera monitors for the facility was located, when she was not in the facilities. -She was aware of the requirement for SCU to have a SCUC working 40 hours per week but she did not know that meant she had to be in the	D 466		

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D 466	Continued From page 53 facility for the 40 hours. Telephone interview with the Administrator on 01/02/25 at 7:30pm revealed: -There were 4 facilities connected by the common parking lot. -The Manager was the Special Care Unit Coordinator. -The Manager/SCUC was on the facility campus area and was in and out of the facility several times a day checking on staff and residents. -The facility had several cameras throughout the facility. -The Manager/SCUC had an office in a sister facility with a monitor for the facility cameras. -The Manager/SCUC was not in the facility 8 hours a day five days a week.	D 466		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the	D 468		

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	HAL001171	A. BUILDING: _____ B. WING _____	R 01/02/2025

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D 468	Continued From page 54	D 468		

residents.
(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews the facility failed to ensure that 3 of 3 sampled staff (Staff A, Staff B and Staff C) completed 20 hours of dementia specific training within their 6 months of working in the Special Care Unit (SCU).

The findings are:

1. Review of Staff A's, medication aide (MA), personnel record revealed:
-She was hired on 06/18/23.
-There was documentation Staff A received 15 hours of training related to care for residents with dementia from 06/18/23 through 12/31/24.
-There was no documentation of 20 hours of dementia specific training within the first 6 months of hire for working in the SCU.

Interview with Staff A on 01/02/25 at 8:05am revealed:
-She administered medications for residents at the facility.
-She assisted with personal care for residents in the facility.
-She had been working at the facility in 2021 and

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D 468	Continued From page 55 2022 before the present owner took over. -She had training for dementia residents but did not know all the dates. Refer to the interview with the Manager/Special Care Unit Coordinator (SCUC) on 01/02/25 at 6:00pm. Refer to the telephone interview with the Administrator on 01/02/25 at 7:30pm. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -She was hired on 08/02/23. -There was documentation Staff B received 9 hours of training related to care for residents with dementia from 08/02/23 through 12/31/24. -There was no documentation of 20 hours of dementia specific training within the first 6 months of working in the SCU. Interview with Staff B on 01/02/25 at 10:05am revealed: -She administered medications for residents at the facility. -She assisted with personal care for residents in the facility. -She had training for dementia residents but did not know if she had 20 hours of training for dementia residents. Refer to the interview with the Manager/Special Care Unit Coordinator (SCUC) on 01/02/25 at 6:00pm. Refer to the telephone interview with the Administrator on 01/02/25 at 7:30pm. 3. Review of Staff C's, personal care aide (PCA), personnel record revealed:	D 468		

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D 468	Continued From page 56 -She was hired on 02/03/24. -There was documentation Staff C received 6 hours of training for care of dementia residents on 02/6/24. -There was no documentation of 20 additional hours of dementia specific training within the first 6 months of hire for working in the SCU. Telephone interview with Staff C on 01/02/25 at 3:35pm revealed: -She provided personal care for residents. -She did not administer medications. -She had been trained on the care of residents with dementia when she started working. Refer to the interview with the Manager/Special Care Unit Coordinator (SCUC) on 01/02/25 at 6:00pm. Refer to the telephone interview with the Administrator on 01/02/25 at 7:30pm. _____ Interview with the Manager/SCUC on 01/02/25 at 4:30pm. -It was the responsibility of the Manager/SCUC along with the Administrator to coordinate training for Special Care Unit (SCU) staff. -She was not aware of the requirement for 20 hours of training within 6 months of employment in addition to the 6 hours required in the first week of employment in the SCU. -She thought all training received Telephone interview with the Administrator on 01/02/25 at 7:20pm revealed: -It was the responsibility of the Manager/SCUC to ensure SCU staff complete the required training. -It was her responsibility to ensure the training documentation was in the personnel records.. -He thought the 6 hours of dementia training in	D 468		

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D 468	Continued From page 57 the first week of employment could count for part of the total training. -He did not know staff needed 20 additional hours of dementia related training within the first 6 months of employment in the SCU.	D 468		