

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ <i>2/95</i>	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>	County: <i>Caldwell</i>
---	---	-------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments  The Adult Care Licensure Section conducted an annual survey on-site November 4 and 5, 2014 with a telephone exit on November 6, 2014.	D 000	<p><i>On the date that resident #6 left the facility grounds - staff put in place a plan of safety that included the following:</i></p> <ol style="list-style-type: none"> <li><i>1. Resident #6 would be the last resident up in the am - (Attachment #1)</i></li> <li><i>2. Staff would keep resident #6 in their line of sight during daytime hours (Attachment #2)</i></li> <li><i>3. Medical provider would be asked to reassess and complete necessary forms on 11-5-14 (Attachment #3)</i></li> <li><i>4. Family members will help with providing one-on-one care until other arrangements can be made for a secure unit. (Attachment #4)</i></li> </ol> <p><i>Attachments 1-4 support plan of safety. I also spoke with Adult Home Specialist on 12-5-14</i></p>	
D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision for 2 of 2 sampled residents (#1 and #6) with wandering behaviors who exited the facility unsupervised.</p> <p>The findings are:</p> <p>A. Review of Resident Register revealed Resident #6 was admitted to the facility on 11/25/09.</p> <p>Review of diagnoses on current FL2, dated 5/21/14, revealed: -Alzheimer's dementia. -Anxiety. -Insomnia. -Insulin dependent diabetes mellitus. -Hypertension.</p> <p>Review of resident information on current FL2,</p>	D 270		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Jackie Wilson* TITLE: *Administrator* (X6) DATE: *12-8-14*

STATE FORM 6899 GYQ911 If continuation sheet 1 of 13

*Plan of Correction accepted with 12-15-14 Addendum.  
Brenda Boyer 12-15-14*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 1</p> <p>dated 5/21/14 revealed: -No information under "Inappropriate behavior." -Ambulatory. -Bathing, feeding, and dressing as "extensive assistance."</p> <p>Review of medications on the current FL2, dated 5/21/14 revealed: -Namenda 21mg 1 in the am. (Used for Alzheimer's dementia.) -Ativan 0.5 mg, 1 three times per day. (Used for agitation.) -Remeron 30 mg, 1 and 1/2 tablets at bedtime. (Used for insomnia.) -Risperdal 0.5 mg at bedtime. (Antipsychotic medication.)</p> <p>Review of Progress Notes, dated 11/3/14, and signed by the first shift supervisor revealed: "At 6:19am [Staff A] (a medication aide on 3rd shift) called me [first shift supervisor] at home stating that they got [Resident #6] up and dressed, went to get [another resident name] up. Came back down the hall, noticed that [Resident #6] wasn't in her room. All staff, including kitchen workers searched the building, could not find her anywhere. I advised her to call the police and I was on my way there. When I got here, I was informed that she was found on [Street name] at the [name of business]. Called her [family member] at [phone number] let her know what was going on, glad that she was safe. [Family member] came up here around 7:30am, took [Resident #6] out for breakfast."</p> <p>Telephone interview with a personal care aide, Staff C, on 11/5/14 at 12:25pm revealed: -She arrived to work early on 11/3/14 to work first shift. -Staff A told her that Resident #6 was missing.</p>	D 270	<p>At approximately 9:40 am and she verified that when she was present for an unannounced visit on 11-3-14 she observed resident #6 with staff members present. Resident #6 was discharged on 11-6-14 and moved to a secure facility that the family chose and could afford due to her private pay status. In the future if a resident leaves the campus they will be re-assessed by the management of the facility and</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

D 270	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>-Staff C drove down the street and saw Resident #6 on [street name].</li> <li>-A police car was there and the policemen were asking Resident #6 to get in their car.</li> <li>-Resident #6 refused to get in the police car.</li> <li>-Resident #6 got in the car with Staff C.</li> <li>-Resident #6 was wearing a long sleeve sweat shirt, pants, and had on shoes.</li> <li>-Resident #6 did not have on a coat nor anything on her head.</li> <li>-Resident #6 did not say anything about why she left the building.</li> </ul> <p>Review of the Police Report, dated 11/3/14, revealed:</p> <ul style="list-style-type: none"> <li>-They received the call about Resident #6 missing at 6:22am.</li> <li>-Event was "cleared" on 6:34am.</li> </ul> <p>On 11/5/14 at 7:55pm, telephone interview with a police officer who was dispatched revealed:</p> <ul style="list-style-type: none"> <li>-Resident #6 was spotted on the corner of "two city [street names]."</li> <li>-Resident #6 was found at 6:30am by a police officer.</li> <li>-The time after the call came in and the time Resident #6 was found was not long because available officers were in the area when the call came in from the facility.</li> <li>-Resident #6 appeared "disoriented and timid."</li> <li>-Resident #6 refused to get in the police car, but agreed to get in the car with a facility staff.</li> </ul> <p>Review of the "Underground weather" history for the area on 11/3/14 revealed:</p> <ul style="list-style-type: none"> <li>-23.7 degrees F. at 6:15am.</li> <li>-Wind speed, "calm."</li> <li>-"Clear."</li> <li>-Sun rise 6:50am.</li> <li>-Civil twilight, 6:24am.</li> </ul>	D 270	<p>medical provider contacted at that time - Our care plan which serves as assessment tool has been updated to provide for elopement Risk (Attachment #7) I have also added to daily staff assignment sheets to report any behavior changes noted by them - (Attachment #8) I review each assignment sheet when they are turned in daily - I will also work with contract RN to conduct annual training with regards to care staff and reporting methods of changes in resident</p>	
-------	--	-------	---	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 3</p> <p>Observation of the street on 11/5/14 at 8:30am where Resident #6 was found revealed:</p> <ul style="list-style-type: none"> <li>-The distance from the facility to the area where she was found was 3/10 of a mile.</li> <li>-The street was a busy two lane street with a turning lane and businesses on both sides of the street.</li> <li>-The street was a main thorough fare to downtown.</li> <li>-The area between the street and where she was found was mostly residential houses.</li> <li>-The street where she was found was down an incline from the facility.</li> </ul> <p>Observation of the facility on 11/5/14 at 9:00am revealed:</p> <ul style="list-style-type: none"> <li>-The facility had residential houses on two sides, a city street in front and trees in the back which separated it from other houses.</li> <li>-The facility was shaped like a "T."</li> <li>-Resident #6's room was located on the "T" beside the dining room (on the first floor).</li> <li>-Resident #6's room was diagonally across from a living room which had an exit door.</li> <li>-The exit door in the living room was 18 feet from Resident #6's room.</li> <li>-The two exit doors on each side of the "T" were 30 feet from Resident #6's room.</li> <li>-The facility had five exit doors on first floor and two exit doors on second floor.</li> </ul> <p>On 11/4/14 at 4:15pm, interview with Staff A, the supervisor on 3rd shift the morning of 11/3/14, revealed:</p> <ul style="list-style-type: none"> <li>-The door alarms were turned on at 11:00pm.</li> <li>-The door alarms were turned off at 5:15 in the morning when the cook came to work.</li> <li>-The door alarms were turned off and left off after 5:15am because many residents liked to go</li> </ul>	D 270	<p>behaviors -</p> <p>This will be completed (training) by end of Jan 2015 -</p> <p>All other parts of this will be completed by Jan 31, 2015 -</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 4</p> <p>outside and smoke early in the morning.</p> <p>-Staff A and a personal care aide assist 11 residents with getting up in the morning from 5:15am to 7:00am. (Third shift ends at 7:00am.)</p> <p>-Resident #6 was usually the "3rd or 4th" resident they "got up."</p> <p>-Staff D, a personal care aide, assisted Resident #6 with dressing on the morning of 11/3/14 at approximately 6:00am, but not certain about the time.</p> <p>-Staff A said she combed Resident #6's hair after Staff D dressed Resident #6, but was not certain of the time.</p> <p>-Staff A and Staff D left Resident #6 in her room to assist another resident with dressing (time not known).</p> <p>-After the other resident was dressed, Staff D checked on Resident #6 and found out she was not in her room, but was not certain of the time.</p> <p>-The facility staff looked inside and outside the building for Resident #6.</p> <p>-Staff A called the first shift supervisor who instructed Staff A to call the police.</p> <p>-Staff A said facility staff had no reliable interviews with any residents who observed Resident #6 leave the building.</p> <p>-Staff A said no staff observed Resident #6 leave the building.</p> <p>Staff D was not available to interview and telephone call to Staff D was unsuccessful.</p> <p>Review of record revealed the only documentation of Resident #6 leaving the building unsupervised was a "Progress Note," dated 6/20/12, and signed by the Administrator, which revealed: "Approximately at 11:00am [Resident #6] was observed walking down sidewalk in front of Administrative Building, was returned by staff.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 5</p> <p>Family called, left message. Dr. [Name] contacted will see [Resident #6] tomorrow. No med changes at this time, Started 30 minute visual checks....Factors that may have contributed to this new behavior. Facility admitted another resident who was constantly disruptive to the facility ....Resident has not tried to leave except this one occurrence."</p> <p>Review of current care plan, dated 5/19/14 revealed</p> <ul style="list-style-type: none"> <li>-Under "Risk Management Provisions," safety measures, the assessor wrote, "Watch for leaving building."</li> <li>-Under "Orientation/Memory," no information</li> <li>-Under "Social History and Mental Health (Please check all that apply)," the assessor did not check wandering .</li> <li>-Under "Explanation for any marked above," referring to Social History and Mental Health, the assessor wrote, "Has history of Alzheimer's does wander within the confines of the building - easily directed."</li> </ul> <p>Telephone interview with the Administrator on 11/5/14 at 3:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #6 walked the facility halls carrying things, ie bed coverings.</li> <li>-Resident #6 liked to "plunder."</li> <li>-The Administrator had completed the 5/19/14 care plan and stated the reason for the "Watch for leaving building." statement was that staff should "do that with anybody to protect them if they don't normally go outside."</li> <li>-She thought the incident on 6/20/12 happened when Resident #6 went outside with staff.</li> <li>-She was not aware Resident #6 had any recent behavior changes.</li> </ul> <p>Interview with Resident #6's family member on</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 6</p> <p>11/4/14 at 5:40pm revealed:</p> <ul style="list-style-type: none"> <li>-She thought Resident #6 left on 11/3/14 because Resident #6's friend, another resident, had just moved out of the facility (about 1 week ago) and Resident #6 was looking for her.</li> <li>-When the family member arrived at the facility on the morning of 11/3/14, Resident #6 said she was cold.</li> <li>-Family member said Resident #6 had never left the building before this incident.</li> <li>-A psychiatrist evaluated Resident #6 in 2009 before Resident #6 was admitted to the facility. The psychiatrist said it was "ok to place her here" and did not think she would wander.</li> </ul> <p>Review of the facility census on 11/4/14 revealed 51 residents.</p> <p>Interview with the first shift supervisor on 11/4/14 at 10:00am revealed:</p> <ul style="list-style-type: none"> <li>-Three personal care aides and two medication aides were always on duty for first and second shift.</li> <li>-Two personal care aides and one medication aide were always on duty for third shift.</li> <li>-Resident #6 had never left the building before this incident.</li> <li>-Resident #6 had been on 30 minute checks for a long time and all staff try to keep "a close eye" on her.</li> <li>-Three staff were on duty on 11/3/14 when Resident #6 left the building.</li> </ul> <p>Interview with Resident #6's primary care provider on 11/5/14 at 1:00pm revealed:</p> <ul style="list-style-type: none"> <li>-She did not have concerns before this incident that Resident #6 would leave the building.</li> <li>-Facility staff had not informed her of any recent behavior changes in Resident #6.</li> </ul>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 7</p> <p>Two confidential interviews with staff revealed: -Resident #6's behavior had changed recently in that staff had more difficulty getting her to cooperate with toileting and/or dressing. -Resident #6 seemed to be more disoriented recently.</p> <p>Confidential interview with three staff revealed: -Resident #6 would not know to look for traffic before crossing the street. -"She needs to be in a locked unit." -Resident #6 often goes to the facility doors to look outside. -Resident #6 does sit on the porch but "don't know if staff are always with her." -Staff did check on Resident #6 every 30 minutes. -Staff cannot assure Resident #6 will not go outside because when the two personal care aides are in a resident room and the medication aides are giving medications, the halls are left unsupervised.</p> <p>Interview with the Assistant Administrator on 11/5/14 at 4:15pm revealed: -Resident #6 leaving the facility on 11/3/14 was not typical behavior. -Resident #6 was not allowed to sit outside by herself, but with staff. -There were no video cameras in the facility. -The facility did not have an assessment tool to determine if residents were at risk for wandering. -She thought the care plan was the assessment tool.</p> <p>Based on record review and observation of Resident #5 on 9/22/14, the resident was determined not to be interviewable.</p> <p>B. Review of Resident Register revealed Resident #1 was admitted to the facility on</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 8</p> <p>6/18/10.</p> <p>Review of diagnoses on current FL2, dated 6/18/14, revealed:</p> <ul style="list-style-type: none"> <li>-Depressive Disorder.</li> <li>-Mild MR.</li> <li>-Psychosis.</li> <li>-Schizophrenia.</li> <li>-Left Hydrocele</li> <li>-Insomnia.</li> </ul> <p>Review of resident information on current FL2, dated 6/19/14 revealed:</p> <ul style="list-style-type: none"> <li>-No information under "Inappropriate behavior."</li> <li>-Ambulatory.</li> <li>-"Incontinent of bowel and bladder."</li> <li>-Speech and communication of needs "Limited".</li> <li>-Personal care needs Extensive Assistance for "bathing, feeding and dressing"</li> </ul> <p>Review of medications on the current FL2, dated 6/19/14 revealed:</p> <ul style="list-style-type: none"> <li>-Haldol 5mg one tablet twice per day (Used for psychosis.)</li> <li>-Risperdal 4mg 1/2 tablet per am and 1 tablet at bedtime. (Used for psychosis.)</li> </ul> <p>Review of Resident #1's Personal Care Services Care Plan dated 3/11/14 revealed:</p> <ul style="list-style-type: none"> <li>-Wandering within building.</li> <li>-Resident walks around inside of facility.</li> <li>-Staff to observe to prevent him from getting outdoors alone.</li> <li>-Extensive Assistance for eating, bathing, toileting, and dressing.</li> </ul> <p>Review of the facility census on 11/4/14 revealed 51 residents.</p> <p>Interview with the first shift supervisor on 11/4/14</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 9</p> <p>at 10:00am revealed:</p> <ul style="list-style-type: none"> <li>-Three personal care aides and two medication aides were always on duty for first and second shift.</li> <li>-Two personal care aides and one medication aide were always on duty for third shift.</li> <li>-The second floor always had a staff member working the floor.</li> <li>-Resident #1 had only left the building once about 2 years ago.</li> <li>-Resident #1 had been on 30 minute checks for a long time.</li> <li>-Resident #1 wandered inside the building, but never tried to leave.</li> </ul> <p>Telephone interview with the Administrator on 11/5/14 at 3:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 walked in the facility halls.</li> <li>-She had never known Resident #1 to leave the building.</li> <li>-She did not feel like Resident #1 would leave the building on his own.</li> </ul> <p>A confidential interview with staff revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 used to live on the first floor, but was moved to the second floor because it was too hard to keep an eye on Resident #1 and #2 since they both wandered.</li> <li>-Resident #1 occasionally would look out the second floor exit doors, but would not open them.</li> <li>-They were concerned that Resident #1 "could get out".</li> <li>-They had not discussed their concerns with the Administrator.</li> </ul> <p>A second confidential interview revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had started down the fire escape about 6 months ago before the staff working on the second floor could get to him, Resident #1 was stopped by another staff member before they</li> </ul>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 10</p> <p>could get off the fire exit.</p> <ul style="list-style-type: none"> <li>-Resident #1 had gotten out and was walking around the building about 2 years ago.</li> <li>-They had no concern about the resident leaving, but did state that he was unpredictable.</li> </ul> <p>Interview with the nurse practitioner on 11/5/14 at 1:00pm revealed she did not have concerns about Resident #1 leaving the building.</p> <p>Observation on 11/4/14 of Resident #1's room revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 room was on 2nd floor and approximately 15 feet from a fire exit door leading to a fire escape.</li> <li>-Resident #1 standing at the door looking out the door window.</li> <li>-Two fire exits on the second floor, both with fire escapes.</li> </ul> <p>Interview with the Assistant Administrator on 11/5/14 at 4:30pm revealed:</p> <ul style="list-style-type: none"> <li>-She was not aware of Resident #1 ever leaving the building.</li> <li>-Resident #1 did walk around in the building, but was monitored by staff every 30 minutes.</li> <li>-There were no video cameras in the facility.</li> <li>-The facility did not have an assessment tool to determine if residents were at risk for wandering.</li> <li>-She thought the care plan was the assessment tool.</li> </ul> <p>Based on record review and observation of Resident #1 on 11/4/14, the resident was determined not to be interviewable.</p> <p>Attempts to Interview Resident #1's psychiatrist was unsuccessful at time of exit.</p> <p>Message was left with Resident #1's Guardian,</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 11</p> <p>and call was not returned by time of exit.</p> <hr/> <p>The Plan of Protection provided by the facility revealed:</p> <ul style="list-style-type: none"> <li>-Staff have been instructed to get Resident #6 up after all other residents on that hall because she would not leave her room unless she was dressed.</li> <li>-Staff were asked to keep a closer eye on Resident #6 until the physician sees her on 11/5/14.</li> <li>-Thirty minute checks will continue for Resident #6.</li> <li>-Resident #6 had never gone outside before this incident. Resident #6 was placed on 30 minute checks because she has gone into other resident rooms.</li> <li>-All residents will be immediately assessed for risk of elopement behaviors.</li> <li>-The facility will develop an assessment tool to determine appropriate placement.</li> </ul> <p>THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 6, 2014.</p>	D 270		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:</p> <p>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by:</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL014002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA OAKS ENHANCED CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>229 WILSON STREET NW LENOIR, NC 28645</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	<p>Continued From page 12</p> <p>Based on observations, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision.</p> <p>The findings are:</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision for 2 of 2 sampled residents (#1 and #6) with wandering behaviors who exited the facility unsupervised. [Refer to Tag 270 10A NCAC 13F .0901(b) (Type A2 Violation).]</p>	D912		

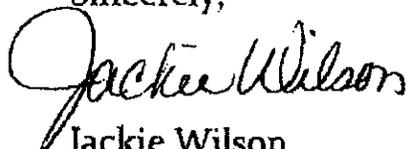
DEC 10 2014

G & M Associates  
D/B/A Carolina Oaks Enhanced Care Center  
P O Box 487  
Lenoir NC 28645  
Phone: 828-754-6106  
Fax: 828-758-0539

Brenda Boggs,

In reference to state survey report and your phone call this  
am the following citations were completed on or before  
12/6/15 in regards to Prefix tag D 270 Plan of protection was  
put into place evidenced by attachments # 1, 2, 3, 4, 5, 6 and  
7. The staff assignment sheets and training will be  
completed by 1/31/15

Sincerely,

  
Jackie Wilson,  
Administrator

Per telephone call to the Administrator  
on 12-15-14, the Administrator said  
the Plan of Carection was effective  
12-6-14. Brenda Boggs 12-15-14.

Attachment #5

NC Division of Health Service Regulation — Adult Care Licensure Section  
Plan of Protection

DEC 10 2014

To be completed by DHSR/DSS Staff

Facility Name: Caroline Oaks Enhance Care License #: NAL-014-002

Rule Violation Cited: 0901 (b) Personal Care Supervision  
(Complete separate form for each Rule Violation)

**PLAN OF PROTECTION**

(To be completed by facility staff. Attach additional pages if needed)

What immediate action will the facility take to abate the violations?

Staff decided that resident #6 would be left until the last resident to get up from bed in the morning as she will not leave her room until fully dressed. Also all staff were asked to keep a closer eye (along with 30 minute checks) until medical assessment on Wednesday.

Describe your plans to ensure residents are protected from further risk or additional harm?

Resident #6 is on 30 minute checks and even closer monitoring during daytime hours. Resident stays in room more in afternoon/evening. All staff are on alert.

Regarding A1 or A2 Violations - if you believe this to be a Past Corrected Violation, please answer the questions below.

Describe the preventative measures in place prior to the violation.

30 min. checks. - Resident has never gone outside before this incident. 30 minute checks were put in place only because resident had originally gone in other residents rooms.

Describe how and when the violation was corrected.

Note: All residents will be assessed for risk of elopement behaviors.

This facility will work on developing an assessment tool to determine appropriate placement.

Describe the corrective measures the facility implemented to achieve and maintain compliance.

Describe the facility's system to ensure compliance is maintained and how the system will continue to be implemented.

**For Unabated Violations (Type A1, Type A2 and Unabated Type B) only:**

Please provide a date by which the facility will be in compliance with the rule area cited (required). Date: \_\_\_\_\_

Facility staff completing this form:

Jym Mikeal, administrator  
Name/Title Date

DHSR/AC 4659 NCDHHS (2011/08) 11-4-14

[Signature] 11/4/14  
DHSR/DSS staff Date

Keep copy for facility file

## Shook, Linda

---

**From:** Shook, Linda  
**Sent:** Thursday, December 18, 2014 10:12 AM  
**To:** jborrero@caldwellcountync.org  
**Cc:** Boggs, Brenda (brenda.boggs@dhhs.nc.gov); Darlene Penland (darlene.penland@dhhs.nc.gov)  
**Subject:** CAROLINA OAKS ENHANCED CARE CENTER - CALDWELL COUNTY  
**Attachments:** Carolina Oaks 2014-12-08 POCA-GYQ911.pdf

Please find attached copy of the approved "Amended" Plan of Correction (POC) for the above referenced facility.

Thank you.

Linda Y. Shook, Processing Assistant  
Adult Care Licensure Section  
NC Department of Health and Human Services  
Division of Health Service Regulation  
12 Barbetta Drive, Asheville, NC 28806  
Phone: (828) 670-3391 x 149  
Fax: (828) 670-5040  
[Linda.Shook@dhhs.nc.gov](mailto:Linda.Shook@dhhs.nc.gov)  
[www.ncdhhs.gov/dhsr](http://www.ncdhhs.gov/dhsr)

---

Email correspondence to and from this address is subject to the North Carolina Public Records Law and may be disclosed to third parties by an authorized State official. Unauthorized disclosure of juvenile, health, legally privileged, or otherwise confidential information, including confidential information relating to an ongoing State procurement effort, is prohibited by law. If you have received this e-mail in error, please notify the sender immediately and delete all records of this e-mail.

---