

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL097014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2016
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NAME OF PROVIDER OR SUPPLIER WILKES COUNTY ADULT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 176 REST HOME ROAD WILKESBORO, NC 28697
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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation from May 2, 2016 through May 4, 2016 with an exit conference via telephone on May 6, 2016.	D 000		
D 067	<p>10A NCAC 13F .0305(h)(4) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are:</p> <p>(4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on these findings the previous Type A2 Violation was not abated.</p> <p>Based on observation, interview, and record review, the facility failed to assure that six of six exit doors were maintained secure with alarms resulting in four residents (Resident #1, #2, #5, and #6) exiting outside without staff knowledge, including two residents (#2 and #6) leaving the facility and found walking along a busy state highway and two residents (#1 and #5) requiring</p>	D 067		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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D 067	<p>Continued From page 1</p> <p>supervision when leaving facility leaving unsupervised.</p> <p>The findings are:</p> <p>Observations and Interviews during a facility tour with the Operations Manager on 5/3/16 from 1:42pm to 2:00pm revealed:</p> <ul style="list-style-type: none"> -There were a total of six exit doors throughout the facility. -The doors were all equipped with a magnetic locking system with keypad which required a code to release. -Beside the keypads on all six doors there was a separate switch (which looked like a light switch control.) When the switch was flipped up, the magnetic lock on the exit door was deactivated without the use of the keypad and code. The deactivation switches were there to be able to quickly unlock the door in the case of an emergency. -Some of the deactivation switches were covered with plastic cases which were equipped with a 9 volt battery. When the plastic cases were lifted, the case was supposed to illicit a loud alarm so staff would be aware the deactivation switch was being accessed. The plastic cases were not equipped with a locking mechanism and thus could be opened by anyone. -Battery operated pressure sensitive alarms had also been installed at some of the exits, so if the deactivation switches were exposed and not alarmed staff would be alerted when the doors were being opened. The pressure sensitive alarms were battery operated and had a slid switch easily accessible to anyone to turn the alarm on or off without staff knowledge. Residents could remove or break the plastic pressure sensitive alarms from the doors. 	D 067		

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D 067	<p>Continued From page 2</p> <p>Observation of the 600 hall coded exit door on 5/3/16 at 1:42pm revealed: -The alarming switch cover was missing from the keypad deactivation switch which allowed anyone to deactivate the key pad without staff knowledge. -The exit door could be opened without an alarm sounding and without staff knowledge.</p> <p>Interview with the Operations Manager on 5/3/16 at 1:42pm revealed: -He was aware the alarming switch cover was missing from the keypad deactivation switch at the 600 hall exit door. -"In the meantime, we have a [electronic store name] pressure sensitive alarm." -The Operations Manager looked up at the top edge of the door and realized the pressure sensitive alarm was not present and stated "but it's not working." -Maintenance had installed the backup pressure sensitive alarms on the 600 exit door two times since the end of February 2016, but the residents had removed both of the alarms. -"I don't know how long [the pressure sensitive alarms] have been gone here at this door." -The residents remove the backup pressure sensitive alarms from the doors without staff knowledge.</p> <p>Observation of the 500 hall coded exit door on 5/3/16 at 1:45pm revealed: -The keypad and alarming switch cover were operable, however the door was ajar and the magnetic lock was not engaged. -The exit door could be opened without an alarm sounding and without staff knowledge.</p> <p>Interview with the Operations Manager on 5/3/16 at 1:45pm revealed: -"We just need to adjust the door [closer</p>	D 067		

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D 067	<p>Continued From page 3</p> <p>hardware at the top of the door] so it will close tighter so that the magnet will catch." -If the door is gently opened, it will not slam hard enough when let go to "catch" the magnet and thus activate the magnetic lock. -The door needs to be "firmly closed" for the magnet to lock the door. -"I will get [another maintenance employee's name] to come and adjust the door."</p> <p>Observation of the 200 hall coded exit door on 5/3/16 at 1:47pm revealed: -The alarming switch cover was missing from the keypad deactivation switch which allowed anyone to deactivate the key pad without staff knowledge. -The door was equipped with a battery operated pressure sensitive alarm. -The exit door could be opened without an alarm sounding and without staff knowledge.</p> <p>Interview with the Operations Manager on 5/3/16 at 1:50pm revealed the 9 volt battery was dead in the backup alarm.</p> <p>Observation of the 300 hall Living Room coded exit door on 5/3/16 at 1:50pm revealed: -The keypad and alarming switch cover were operable, however the 9-volt battery was dead in the alarm switch cover. -The exit door could be opened without an alarm sounding and without staff knowledge.</p> <p>Observation of the 300 hall coded exit door on 5/3/16 at 1:52pm revealed: -The alarming switch cover was missing from the keypad deactivation switch which allowed anyone to deactivate the key pad without staff knowledge. -The door was equipped with a battery operated pressure sensitive alarm, however the alarm did not alarm when the door was opened.</p>	D 067		

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D 067	<p>Continued From page 4</p> <p>-The exit door could be opened without an alarm sounding and without staff knowledge.</p> <p>Interview with the Operations Manager on 5/3/16 at 1:52pm revealed:</p> <p>-The keypads and alarming switch covers were checked monthly by maintenance staff.</p> <p>-The battery operated pressure sensitive alarms were also supposed to be checked monthly by maintenance staff.</p> <p>-All staff were responsible for immediately reporting when the exit alarms were not working.</p> <p>A. Review of Resident #6's FL2 dated 2/25/16 revealed:</p> <p>-Diagnoses included schizophrenia chronic with acute exacerbation and unspecified neurocognitive disorder.</p> <p>-Resident #6 was documented ambulatory, intermittently disoriented, and a wanderer "at times."</p> <p>Review of Resident #6's Resident Register revealed an admission date of 1/15/16.</p> <p>Review of Resident #6's Petition for Adjudication of Incompetence and Application for Appointment of Guardian dated 3/16/16 revealed the resident was deemed incompetent and had a Guardian.</p> <p>Review of Resident #6's Care Plan dated 1/28/16 revealed:</p> <p>-Resident was documented "sometimes disoriented" and "forgetful-needs reminders."</p> <p>Review of Resident #6's Care Plan dated 4/20/16 revealed:</p> <p>-Resident was documented as "oriented" and with "adequate memory."</p>	D 067		

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D 067	<p>Continued From page 5</p> <p>Review of the facility's Accident and Injury Report for Resident #6 dated 3/26/16 revealed: -"Resident walked off from facility down [busy 4 lane highway bordering the facility]." -The resident was alone. -Resident #6 told staff "she needed her money and was hungry." -No injuries were documented.</p> <p>Review of Resident #6's Nurses Note dated 4/17/16 at 10am revealed: -"Resident was last seen at 9:00[am] round." -"She left before the next hourly round at 10[am]." -"Resident did not sign out on the facility sign out sheet." -"Called 911 and filed a missing person's report." -Resident #6 was found at a local fast food restaurant located approximately 7 miles away from the facility.</p> <p>Telephone interview with Staff L, Medication Aide (MA), on 5/4/16 at 1:02pm revealed: -"I'm the one that found [Resident #6] and picked her up." -Resident #6 was at a local fast food restaurant and "me and another staff member rode to get her." -An off duty staff member had identified Resident #6 and then called the facility to let them know Resident #6 was at the restaurant. -Resident #6 "hadn't been saying anything about leaving" before the incident. -"The residents go out the 200 hall door cause it doesn't alarm." -"I don't know why they don't just put lock boxes over the [keypad deactivation] switches." -"It gets so stressful when the [Personal Care Aides] do their hourly checks and people have gone outside they start freaking out thinking someone has run away."</p>	D 067		

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D 067	<p>Continued From page 6</p> <p>Review of Resident #6's Nurse's Note dated 4/23/16 at 2:00pm revealed: -Resident was last seen at 1:30[pm] to get cigarette at 2:00[pm] round." -She left facility without signing out." -The Sheriff's Department and the Guardian was notified.</p> <p>Review of Resident #6's Nurse's Note dated 4/23/16 at 11:30pm revealed: -Resident had walked away from facility earlier in the day as reported by off going staff." -Resident was still missing." -A report had already been filed with [local law enforcement] when I arrived." -Resident was found by staff at approx[imately] 11:00pm." -Resident had strong smell of alcohol on breath and clothes [and] was visibly intoxicated." -The resident's "breathing was rapid" and her "skin was saturated [with] sweat." -Resident #6 was placed on 15 minute checks for observation. -Resident #6's Guardian was contacted.</p> <p>Interview with the Activity Director on 5/4/16 at 12:50pm revealed: -"I had worked second [shift] and I was leaving to go home." -"I was parked up front and [Resident #6's name] was coming up the driveway and I brought her into the building and called [Administrator's name] to let her know she was back."</p> <p>Review of Resident #6's Nurse's Note dated 4/24/16 at 4:30am revealed: -"Resident went outside facility up [name of 4 lane highway outside the facility]." -"She went passed [local elementary school 1.3</p>	D 067		

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D 067	<p>Continued From page 7</p> <p>miles from the facility] to a house." -"The people at the house called 911 and the police showed up and apprehended resident until [two staff members names] got to her." -Resident #6 was taken back to the facility by the two staff members.</p> <p>Review of Resident #6's Nurses Note 15 Minute Check sheet documented by the Personal Care Aides (PCAs) dated 4/23/16 11:00pm to 4/24/16 6:15am revealed: -At 4:30am, Resident #6 was documented "not in facility." -At 4:45am, Resident #6 was documented "not in facility." -At 5:00am, Resident #6 was documented with Personal Care Aides "coming back to facility."</p> <p>Review of Resident #6's Nurses Note 15 Minute Check sheet documented by the MA dated 4/23/16 11:00pm to 4/24/16 7:00am revealed: -At. 4:30am, an entry documented "had to go after resident."</p> <p>Telephone interview with Staff M, MA, on 5/4/16 at 4:30pm revealed: -"That night [Resident #6] continued to get out." -"We think she was going out [the] 500 hall door and getting through the fence." -"All the other doors were locked. She didn't know the codes." -"The alarms didn't go off." -Staff had Resident #6 on 15 min. checks the night of 4/23/16 to 4/24/16. -At the 6am medication pass, "I was finishing up my med pass and another resident from the 200 hall said another resident had let [Resident #6's name] out and 'she was headed towards town." -Resident #6 was "still on [the driveway outside the facility] and had not gotten to [4 lane highway</p>	D 067		

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D 067	<p>Continued From page 8</p> <p>name] when [staff member's name] got to her."</p> <p>Review of Resident #6's Nurses Note 15 Minute Check sheet documented by the MA dated 4/23/16 11:00pm to 4/24/16 7:00am revealed: -At 6:45am, an entry documented "had to go after resident."</p> <p>Interview with Resident #6's Primary Care Physician's Assistant on 5/4/16 at 12:57pm revealed: -"I heard she got out once, was brought back and ended up getting out again." -The psychiatric provider would have been handling the resident's psychiatric problems.</p> <p>Telephone interview with Resident #6's Guardian on 5/5/16 at 9:28am revealed: -When Resident #6 was first admitted she was able to sign herself out and go out unsupervised. -Due to her leaving the facility without staff knowledge, she was then limited to only going out with staff. -As Resident #6 left the facility again without notifying staff, the resident was placed on 15 minute checks, but "she figured out how to get out between the 15 minute checks." -Resident #6 "had eloped" on 4/26/16 from the facility and had been found later that day by mobile crisis psychiatric provider 29 miles away from the facility in another city.</p> <p>Based on record review and interview, Resident #6 exited the facility without staff knowledge six times between 3/26/16 and 4/26/16.</p> <p>Resident #6 was not interviewable due to discharge from the facility on 4/26/16.</p> <p>Refer to interview with Staff A, Medication Aide,</p>	D 067		

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D 067	<p>Continued From page 9 on 5/2/16 at 4:26pm.</p> <p>Refer to interview with Staff H, Personal Care Aide, on 5/3/16 at 4:09pm.</p> <p>Refer to telephone interview with Staff M, Medication Aide on 5/4/16 at 4:30pm.</p> <p>Refer to interview with Maintenance Staff on 5/3/16 at 2:49pm.</p> <p>B. Review of Resident #2's current FL2 dated 2/25/16 revealed: -Diagnoses included: Autism Spectrum, stimulant and cannabis abuse, and Bi-Polar Disorder. -The resident was documented ambulatory. -There was no information concerning if the resident was disoriented or documented inappropriate behaviors.</p> <p>Review of Resident #2's Resident Register revealed an admission date of 9/9/15.</p> <p>Review of Resident #2's Care Plan dated 12/30/15 revealed: -Resident #2 was documented forgetful "at times." -The resident required limited assistance from staff with eating and supervision for bathing and dressing.</p> <p>Review of Resident #2's Nurses Note dated 3/5/16 revealed: -At 5pm, "I went and got resident from walking down the road on [name of busy 4 lane highway in front of the facility]. He said that everyone hated him and that he didn't want to be here anymore. I explained to him he couldn't be walking down [name of busy 4 lane highway in front of the facility]."</p>	D 067		

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D 067	<p>Continued From page 10</p> <p>Telephone interview with Resident #2's Psychiatric Provider on 5/2/16 at 1:55pm revealed: -On 4/28/16, Resident #2 reportedly had "run off from the facility 4 times that day before running into the road." -"The Administrator had said they could not control him."</p> <p>Telephone interview with local County Adult Protective Services (APS) Worker on 5/5/16 at 9:52am revealed: -On 4/28/16 at approximately 5:45pm, she and another APS Worker were standing in the front hallway at the facility and looked out the front door and "saw a fella in a black t-shirt and black shorts walking up [a busy 4 lane highway]" in front of the facility. -The Administrator identified the person walking along the road as Resident #2. -The Administrator "got a staff member to go pick him up."</p> <p>Telephone interview with Resident #2's family member on 5/3/16 at 11:05am revealed: -Resident #2 had "left the facility and went places unsupervised" and it had happened "numerous times." -"People leave there left and right. People just wander off." -The residents "unplug" the keypad at the front door to keep the door open and "that's something we were highly bothered by."</p> <p>Telephone interview with Resident #2's Guardian on 5/4/16 at 10:54am revealed Resident #2 was not supposed to be outside the facility without one on one supervision due to his prior history of substance abuse.</p>	D 067		

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D 067	<p>Continued From page 11</p> <p>Telephone interview with the Administrator on 5/6/16 at 3:31pm revealed "...[Resident #2] had gotten out without staff knowledge [on 4/28/16]. I don't know how he got out, but as soon as we saw him we acted immediately."</p> <p>Resident #2 was not interviewable due to hospitalization.</p> <p>Refer to interview with Staff A, Medication Aide, on 5/2/16 at 4:26pm.</p> <p>Refer to interview with Staff H, Personal Care Aide, on 5/3/16 at 4:09pm.</p> <p>Refer to telephone interview with Staff M, Medication Aide on 5/4/16 at 4:30pm.</p> <p>Refer to interview with Maintenance Staff on 5/3/16 at 2:49pm.</p> <p>C. Review of Resident #5's current FL2 dated 1/14/16 revealed: -Diagnoses included encephalopathy, aphasia, Type II Diabetes, hypertension, mild intellectual disorder, and cognitive communication deficits. -Resident #5 was documented ambulatory with an abnormal gait. -Resident #5 was documented intermittently disoriented, a wanderer, and injurious to property.</p> <p>Review of Resident #5's Nurse's Note dated 4/18/16 at 8am revealed: -"Resident was going down the driveway." -"Stated his sister was coming to get him." -The Medication Aide "got him to come back in the building."</p> <p>Review of Resident #5's hospital discharge</p>	D 067		

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D 067	<p>Continued From page 12</p> <p>summary dated 4/19/16 revealed the resident was diagnosed as "dementia with delusions."</p> <p>Interview with Staff C, Medication Aide (MA), on 5/2/16 at 4:16pm revealed Resident #5 was a wanderer, "but he's not done it in a long time."</p> <p>Interview with Staff I, MA, on 5/4/16 at 8:30am revealed: -Resident #5 "is confused." -"He's gotten out, but I don't think he's gotten to the road." -"The alarms are all messed up. It would help us if they worked."</p> <p>Interview with Staff J, MA, on 5/4/16 at 10:35am revealed: -Resident #5 "likes to go outside. I don't let him go out on his own." -"I will take him outside and walk around the building with him when I have time and that seems to pacify him."</p> <p>Interview with Resident #5's Primary Care Physician's Assistant on 5/4/16 at 12:57pm revealed: -Resident #5 was ambulatory and oriented to self, but not oriented to situation. -Resident #5 was "okay for him to be outside the facility, but not down near the road."</p> <p>Based on record review and observation of Resident #5 on 5/2/16 through 5/4/16, he was determined not to be interviewable.</p> <p>Refer to interview with Staff A, Medication Aide, on 5/2/16 at 4:26pm.</p> <p>Refer to interview with Staff H, Personal Care Aide, on 5/3/16 at 4:09pm.</p>	D 067		

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D 067	<p>Continued From page 13</p> <p>Refer to telephone interview with Staff M, Medication Aide on 5/4/16 at 4:30pm.</p> <p>Refer to interview with Maintenance Staff on 5/3/16 at 2:49pm.</p> <p>D. Review of Resident #1's current FL2 dated 12/9/15 revealed: -Diagnoses included: Bi-Polar 1 Disorder, Most Recent Episode-Mixed; Dependent Personality Disorder; Hyperthyroidism; history of Traumatic Brain Injury. -The resident was documented ambulatory. -There was no information concerning if the resident was disoriented or and documented inappropriate behaviors. -An admission date of 6/18/15.</p> <p>Review of Resident #1's record revealed: -The resident was deemed incompetent and had a legal guardian. -The resident had been discharged on April 4, 2016.</p> <p>Interview with Staff E, Personal Care Aide (PCA), on 5/3/16 at 11:45am revealed: -On 3/23/16 she had observed Resident #1 walk out the front door. She went with him and was able to return him to the facility. -On 3/24/16 she observed Resident #1 in front of the facility along the road (U.S. Highway 421 is a four-lane, divided highway approximately 200-300 yards from the front of the facility). -There were no facility staff with Resident #1.</p> <p>Review of a Nurses Note for Resident #1 dated 3/23/16 at 9:15am revealed Resident #1 went out the front door and walked down to [Highway] 421 and was walking down the road. The form was</p>	D 067		

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D 067	<p>Continued From page 14</p> <p>signed by Staff E, PCA.</p> <p>Review of a Nurses Note for Resident #1 dated 3/24/16 at 4:20pm revealed Staff E, PCA was driving up [Highway] 421 and observed Resident #1 along the side of the road. The form was signed by Staff E, PCA.</p> <p>Interview with the Resident Care Coordinator (RCC) on 5/3/16 at 3:30pm revealed: -Resident #1 never wandered away from the facility, "he never went anywhere". -His family members visited him monthly. -The RCC thought at the last visit the parents had told Resident #1 he would be leaving and moving to a facility closer to their home. She thought this may have caused Resident #1's wandering incidents.</p> <p>Interview with the Administrator and Operations Manager (OM) on 5/4/16 at 10:35am revealed they were not aware that Resident #1 was found along the side of U.S. Highway 421 by Staff E on 3/24/16.</p> <p>Refer to interview with Staff A, Medication Aide, on 5/2/16 at 4:26pm.</p> <p>Refer to interview with Staff H, Personal Care Aide, on 5/3/16 at 4:09pm.</p> <p>Refer to telephone interview with Staff M, Medication Aide on 5/4/16 at 4:30pm.</p> <p>Refer to interview with Maintenance Staff on 5/3/16 at 2:49pm.</p> <p>_____</p> <p>Interview with Staff A, Medication Aide, on 5/2/16 at 4:26pm revealed:</p>	D 067		

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D 067	<p>Continued From page 15</p> <p>- "We do have some wanderers."</p> <p>- "The door locks have been fixed as far as I know. You can flip the covers up [to deactivate the keypads], but it makes the alarm sound."</p> <p>Interview with Maintenance Staff on 5/3/16 at 2:49pm revealed:</p> <p>- "It's every staff's responsibility to ensure the exit doors are working properly and report it if they aren't."</p> <p>- The exit door alarms are "supposed to be checked monthly."</p> <p>- A log was not kept of the door alarm checks.</p> <p>- "Most of the time, I check them when I check my fire extinguishers around the first of the month."</p> <p>- "The residents have torn the covers off the [keypad deactivation] switches."</p> <p>- The Operations Manager had been "trying to order" more covers for the switches, but had not yet been able to find any.</p> <p>Interview with Staff H, Personal Care Aide, on 5/3/16 at 4:09pm revealed:</p> <p>- The exit doors "all work."</p> <p>- "If I hear an alarm, I'm supposed to go to the door."</p> <p>Telephone interview with Staff M, Medication Aide on 5/4/16 at 4:30pm revealed:</p> <p>- "I don't know if it was just the 200 hall door or if it was the 200 and 300 hall doors...but both were not in working order before last night."</p> <p>_____</p> <p>The facility's failure to ensure multiple door alarms, which included six of six coded exit doors accessible by residents, were maintained with alarms resulted in Resident #2, who had diagnosis of bipolar disorder and documented as forgetful at times and the inability to make safe</p>	D 067		

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D 067	<p>Continued From page 16</p> <p>decisions, leaving the facility on two occasions and found walking along a busy State highway; Resident #6, who was documented as intermittently disoriented and a wanderer at times, leaving the facility on six occasions and found walking along a busy State highway and on one occasion was found 29 miles away from the facility; and, Resident #5, who was documented as intermittently disoriented and a wanderer, leaving the building unsupervised and without staff knowledge. The ability of these residents to leave the facility unsupervised and without staff knowledge placed the residents at substantial risk of serious physical harm and serious neglect.</p> <hr/> <p>A plan of protection was obtained from facility staff on 5/3/16 as follows: -Applied pressure sensitive alarms to 6 exit doors. -Immediately meet with clinical staff to check and documenting door alarm checks every 2 hours. -Staff is to immediately notify the Maintenance Department, Operations Manager, or Administrator if any door alarm is not working.</p>	D 067		
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>	D 270		

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D 270	<p>Continued From page 17</p> <p>Based on these findings the previous Type A2 Violation was not abated.</p> <p>Based on observation, interview, and record review the facility failed to assure staff provided supervision in accordance with 4 of 6 residents (#1, #2, #5, and #6) assessed needs, care plan, and current symptoms resulting in Resident #2 suicide attempt and two elopements, Resident #6 six occasions of elopement, Resident #5 leaving the building unsupervised, and Resident #1 leaving the building unsupervised.</p> <p>The findings are:</p> <p>A. Review of Resident #2's current FL2 dated 2/25/16 revealed: -Diagnoses included: Autism Spectrum, stimulant and cannabis abuse, and Bi-Polar Disorder. -The resident was documented ambulatory. -There was no information concerning if the resident was disoriented or and documented inappropriate behaviors.</p> <p>Review of Resident #2's Resident Register revealed an admission date of 9/9/15.</p> <p>Review of Resident #2's Care Plan dated 12/30/15 revealed: -Resident #2 was documented forgetful "at times." -The resident required limited assistance from staff with eating and supervision for bathing and dressing.</p> <p>1. Review of Resident #2's Hospital Discharge Summary dated 3/3/16 revealed: -"Last night [patient] states he broke into the medicine cabinet and took 40 Benadryl. [Patient]</p>	D 270		

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D 270	<p>Continued From page 18</p> <p>states he took 40 more Benadryl this morning at 7:00am."</p> <p>Review of Resident #2's Discharge Summary dated 3/5/16 revealed: -Resident #2 reported "having suicidal thoughts and ingesting 100 25 mg Benadryl.." in an attempt to "end his life." -Resident #2 "reports that he broke into the main med room at the facility to obtain the medications."</p> <p>Review of Resident #2's 15 minute watch log revealed on 3/5/16 from 5:30pm to 3/6/16 at 6:45am the resident was documented to have received 15 minute checks by staff with exception of 7:15pm to 2:15am when the resident was in the hospital.</p> <p>Review of Resident #2's Discharge Summary dated 4/26/16 revealed: -Resident #2 "...tonight drank approximately 8 ounces of rubbing alcohol in an attempt to get high. He records past history of alcohol abuse as well as other forms of addiction. He has substantial psychiatric disease.." -The resident's documented blood pressure was 128/89 and pulse 105. -Resident #2 was admitted to the hospital for observation on 4/26/16 and then discharged on 4/27/16 at 4:13pm.</p> <p>Review of Resident #2's 15 minute watch log revealed on 4/27/16 from 7:00pm at 6:45am on 4/28/16 the resident was documented to have received 15 minute checks by staff.</p> <p>Telephone interview with Resident #2's Psychiatric Provider on 5/2/16 at 1:55pm revealed:</p>	D 270		

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D 270	<p>Continued From page 19</p> <p>- "Reports say he's suicidal." - On 4/27/16, Resident #2 ingested rubbing alcohol. - On 4/28/16, Resident #2 had a "self-reported suicide attempt. He was trying to illicit pain pills and [pain] patches from [other] residents and somebody told." - "The Administrator had said they could not control him."</p> <p>Telephone interview with Resident #2's family member on 5/3/16 at 11:05am revealed "We told the facility and told them [Resident #2] was suicidal. He has a history of following through will all suicidal threats.."</p> <p>Telephone interview with Resident #2's Guardian on 5/4/16 at 10:54am revealed: - "He has a really serious substance abuse disorder." - "My impression. He doesn't get enough supervision. It's not a full time substance abuse program." - He did not feel Resident #2 was adequately supervised however, "There's not another home that has the counter measures [facility name] has. There are no other locked facilities except those with the elderly."</p> <p>Interview with the Administrator on 5/3/16 at 5:50pm revealed: - She had been unaware Resident #2 had overdosed on Benadryl on 3/3/16. - She had been made aware by staff of Resident #2's overdose occurrence on 3/5/16. In response the medication room door was fixed and the facility changed their procedure for the storage and accounting of house stock medications.</p> <p>Interview with Staff C, MA, on 5/2/16 at 4:16pm</p>	D 270		

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D 270	<p>Continued From page 20</p> <p>revealed:</p> <p>- "We have to be very careful with [Resident #2]."</p> <p>- "He will take stuff off the med carts. So we can only have our books on the top of the cart and water [pitcher]. Everything else is locked up."</p> <p>- "I was down there when [Resident #2] threw up and he admitted he had drank [rubbing alcohol]."</p> <p>- Resident #2 had not told her how he had obtained the rubbing alcohol he ingested.</p> <p>Interview with Staff A, MA, on 5/2/16 at 4:26pm revealed:</p> <p>- "I know [Resident #2] has been real agitated."</p> <p>- She had reported Resident #2's increased agitation to his Psychiatric Provider "a couple times."</p> <p>- "The doctor had recently changed his Ativan [used to treat anxiety] recently and he was really upset about it."</p> <p>- "The day they changed his [Ativan order] he went into [another resident's name] closet and got a bottle of rubbing alcohol."</p> <p>- "We didn't know the resident had [the rubbing alcohol] or it would have been on the cart."</p> <p>- "After he drank [the rubbing alcohol] and started feeling the effects, he sat in the dining room and he threw up."</p> <p>- "As I was taking his blood pressure, [the resident whom the alcohol had belonged] walked up and he told her he had gotten the alcohol and drunk it."</p> <p>- Resident #2's blood pressure "was a little high."</p> <p>- She called emergency medical service and had Resident #2 transported to the local emergency room (ER) for evaluation.</p> <p>- "The day we had him [involuntarily committed] staff had to keep a close eye on him. We had him on 15 minute watch. Our Activity Director did one on one with him...up until after supper."</p> <p>- "It was the day when the Sheriff was supposed to</p>	D 270		

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D 270	<p>Continued From page 21</p> <p>pick [Resident #2] up and they told us they couldn't come get him cause of [local festival was in progress]."</p> <p>"I don't know what time [law enforcement] finally came."</p> <p>Interview with the Activity Director on 5/2/16 at 4:45pm revealed:</p> <p>-Resident #2 had one on one supervision "after the alcohol episode."</p> <p>-Resident #2 "has an addiction and he's very sneaky."</p> <p>Interview with the Operations Manager on 5/3/16 at 2:00pm revealed:</p> <p>-The 4/26/16 incident, "[Resident #2] told one of the staff he drank rubbing alcohol, we weren't told where he got it."</p> <p>"Residents aren't allowed to have any item that lists drug facts on the label without a doctor's order."</p> <p>Interview with the Administrator on 5/3/16 at 5:50pm revealed:</p> <p>-The night Resident #2 had drank the rubbing alcohol, the resident had just found out that one of the other residents that he was friends with could possibly be moving soon. "I saw him sad."</p> <p>"I don't really know where he got [the rubbing alcohol]..."</p> <p>"That day [Resident #2] had talked about being sad. He wrote things about being sad."</p> <p>"He went to the dining room and I went to the bathroom and when I came out [Resident's name] was hollering something was wrong with [Resident #2's name]. [Resident #2] was saying 'I'm sorry.' [Resident's name]said 'He knew I had some [rubbing alcohol].'"</p> <p>Resident #2 was not interviewable due to</p>	D 270		

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D 270	<p>Continued From page 22</p> <p>hospitalization.</p> <p>Refer to the interview with Staff H, Personal Care Aide (PCA), on 5/2/16 at 4:15pm.</p> <p>Refer to the interview with Staff N, Medication Aide (MA) on 5/3/16 at 3:15pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 5/3/16 at 3:30pm.</p> <p>Refer to the interview with the RCC on 5/4/16 at 9:55am.</p> <p>Refer to the review of the corporate policy on elopement and wandering.</p> <p>Refer to the interview with Staff F, MA, on 5/4/16 at 10:10am.</p> <p>Refer to the interview with the RCC on 5/5/16 at 11:08am.</p> <p>Refer to the telephone interview with the Operations Manager on 5/5/16 at 1:24pm.</p> <p>Refer to the telephone interview with the Administrator on 5/6/16 at 3:30pm.</p> <p>2. Review of Resident #2's Nurses Note dated 3/5/16 revealed: -At 5pm, "I went and got resident from walking down the road on [name of busy 4 lane highway in front of the facility]. He said that everyone hated him and that he didn't want to be here anymore. I explained to him he couldn't be walking down [name of busy 4 lane highway in front of the facility]."</p> <p>Telephone interview with Resident #2's</p>	D 270		

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D 270	<p>Continued From page 23</p> <p>Psychiatric Provider on 5/2/16 at 1:55pm revealed: -On 4/28/16, Resident #2 reportedly had "run off from the facility 4 times that day before running into the road." -"The Administrator had said they could not control him."</p> <p>Telephone interview with a local County Adult Protective Services (APS) Worker on 5/5/16 at 9:52am revealed: -On 4/28/16 at approximately 5:45pm, she and another APS Worker were standing in the front hallway at the facility and looked out the front door and "saw a fella in a black t-shirt and black shorts walking up [a busy 4 lane highway]" in front of the facility. -The Administrator identified the person walking along the road as Resident #2. -The Administrator "got a staff member to go pick him up."</p> <p>Telephone interview with Resident #2's family member on 5/3/16 at 11:05am revealed: -Resident #2 had "left the facility and went places unsupervised" and it had happened "numerous times." -"People leave there left and right. People just wander off."</p> <p>Telephone interview with Resident #2's Guardian on 5/4/16 at 10:54am revealed Resident #2 was not supposed to be outside the facility without one on one supervision due to his prior history of substance abuse.</p> <p>Telephone interview with the Administrator on 5/6/16 at 3:31pm revealed "...[Resident #2]had gotten out without staff knowledge [on 4/28/16]. I don't know how he got out, but as soon as we</p>	D 270		

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D 270	<p>Continued From page 24</p> <p>saw him we acted immediately."</p> <p>Resident #2 was not interviewable due to hospitalization.</p> <p>Refer to the interview with Staff H, Personal Care Aide (PCA), on 5/2/16 at 4:15pm.</p> <p>Refer to the interview with Staff N, Medication Aide (MA) on 5/3/16 at 3:15pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 5/3/16 at 3:30pm.</p> <p>Refer to the interview with the RCC on 5/4/16 at 9:55am.</p> <p>Refer to the review of the corporate policy on elopement and wandering.</p> <p>Refer to the interview with Staff F, MA, on 5/4/16 at 10:10am.</p> <p>Refer to the interview with the RCC on 5/5/16 at 11:08am.</p> <p>Refer to the telephone interview with the Operations Manager on 5/5/16 at 1:24pm.</p> <p>Refer to the telephone interview with the Administrator on 5/6/16 at 3:30pm.</p> <p>B. Review of Resident #6's FL2 dated 2/25/16 revealed: -Diagnoses included schizophrenia chronic with acute exacerbation and unspecified neurocognitive disorder. -Resident #6 was documented ambulatory, intermittently disoriented, and a wanderer "at times."</p>	D 270		

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D 270	<p>Continued From page 25</p> <p>Review of Resident #6's Resident Register revealed an admission date of 1/15/16.</p> <p>Review of Resident #6's Petition for Adjudication of Incompetence and Application for Appointment of Guardian dated 3/16/16 revealed the resident was deemed incompetent and had a Guardian.</p> <p>Review of Resident #6 Care Plan dated 1/28/16 revealed: -Resident was documented "sometimes disoriented" and "forgetful-needs reminders." -Resident #6 required supervision for bathing and grooming/personal hygiene. -Resident #6 required limited assistance with eating.</p> <p>Review of Resident #6's Care Plan dated 4/20/16 revealed: -Resident was documented as "oriented" and with "adequate memory." -Resident #6 was totally dependent for toileting with documented "daily" bladder and bowel incontinence. -Resident #6 required supervision for bathing and grooming/personal hygiene. -Resident #6 required limited assistance with eating.</p> <p>Review of the facility's Accident and Injury Report for Resident #6's dated 3/26/16 revealed: -"Resident walked off from facility down [busy 4 lane highway bordering the facility]." -The resident was alone. -Resident #6 told staff "she needed her money and was hungry." -No injuries were documented.</p> <p>Review of Resident #6's Nurses Note dated</p>	D 270		

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D 270	<p>Continued From page 26</p> <p>4/17/16 at 10am revealed: -"Resident was last seen at 9:00[am] round." -"She left before the next hourly round at 10[am]." -"Resident did not sign out on the facility sign out sheet." -"Called 911 and filed a missing person's report." -Resident #6 was found at a local fast food restaurant located approximately 7 miles away from the facility.</p> <p>Review of Resident #6's Nurses Note 15 Minute Check sheet dated 4/18/16 revealed staff had acknowledged, by documenting their initials, having seen Resident #6 every 15 minutes from 7:00am to 10:45pm.</p> <p>Review of Resident #6's Nurses Note 15 Minute Check sheet dated 4/19/16 revealed staff had acknowledged, by documenting their initials, having seen Resident #6 every 15 minutes from 7:00am to 11:15pm.</p> <p>Telephone interview with Staff L, Medication Aide (MA), on 5/4/16 at 1:02pm revealed: -"I'm the one that found [Resident #6] and picked her up." -Resident #6 was at a local fast food restaurant and "me and another staff member rode to get her." -An off duty staff member had identified Resident #6 and then called the facility to let them know Resident #6 was at the restaurant. -Resident #6 "hadn't been saying anything about leaving" before the incident.</p> <p>Review of Resident #6's Nurse's Note dated 4/23/16 at 2:00pm revealed: -"Resident was last seen at 1:30[pm] to get cigarette at 2:00[pm] round." -"She left facility without signing out."</p>	D 270		

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D 270	<p>Continued From page 27</p> <p>-The Sheriff's Department and the Guardian was notified.</p> <p>Review of Resident #6's Nurse's Note dated 4/23/16 at 11:30pm revealed:</p> <p>-"Resident had walked away from facility earlier in the day as reported by off going staff." -"Resident was still missing." -"A report had already been filed with [local law enforcement] when I arrived." -"Resident was found by staff at approx[imately] 11:00pm." -"Resident had strong smell of alcohol on breath and clothes [and] was visibly intoxicated." -"The resident's "breathing was rapid" and her "skin was saturated [with] sweat." -"Resident #6 was placed on 15 minute checks for observation." -"Resident #6's Guardian was contacted.</p> <p>Interview with the Activity Director on 5/4/16 at 12:50pm revealed:</p> <p>-"I had worked second [shift] and I was leaving to go home." -"I was parked up front and [Resident #6's name] was coming up the driveway and I brought her into the building and called [Administrator's name] to let her know she was back."</p> <p>Review of Resident #6's Nurse's Note dated 4/24/16 at 4:30am revealed:</p> <p>-"Resident went outside facility up [name of 4 lane highway outside the facility]." -"She went passed [local elementary school 1.3 miles from the facility] to a house." -"The people at the house called 911 and the police showed up and apprehended resident until [two staff members names] got to her." -"Resident #6 was taken back to the facility by the two staff members.</p>	D 270		

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D 270	<p>Continued From page 28</p> <p>Telephone interview with Staff M, MA, on 5/4/16 at 4:30pm revealed: -Staff had Resident #6 on 15 min. checks the night of 4/23/16 to 4/24/16. -"That night [Resident #6] continued to get out." -"We think she was going out [the] 500 hall door and getting through the fence." -"All the other doors were locked. She didn't know the codes." -"The alarms didn't go off." -At the 6am medication pass, "I was finishing up my med pass and another resident from the 200 hall said another resident had let [Resident #6's name] out and 'she was headed towards town." -Resident #6 was "still on [the driveway outside the facility] and had not gotten to [4 lane highway name] when [staff member's name] got to her."</p> <p>Review of Resident #6's Nurses Note 15 Minute Check sheet documented by the Personal Care Aides (PCAs) dated 4/23/16 11:00pm to 4/24/16 6:15am revealed: -Staff had acknowledged by documenting their initials having seen Resident #6 sleeping every 15 minutes from 11:00pm to 2:45am. -At 3:00am, Resident #6 was documented "seen in hallway." -At 3:15am, Resident #6 was documented "seen in hallway." -At 3:30am, Resident #6 was documented "in room." -At 3:45am to 4:15am, Resident #6 was documented "in hallway." -At 4:30am, Resident #6 was documented "not in facility." -At 4:45am, Resident #6 was documented "not in facility." -At 5:00am, Resident #6 was documented with Personal Care Aides "coming back to facility."</p>	D 270		

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D 270	<p>Continued From page 29</p> <p>-At 5:15am, Resident #6 was documented "in hallway." -At 5:30am, Resident #6 was documented "in room." -From 5:45am tp 7:00am, no comments documented.</p> <p>Review of Resident #6's Nurses Note 15 Minute Check sheet documented by the MA dated 4/23/16 11:00pm to 4/24/16 7:00am revealed: -From 11:00pm to 4:15am, no comments documented. -At. 4:30am, an entry documented "had to go after resident." -From 4:45am to 6:30am, no comments documented. -At 6:45am, an entry documented "had to go after resident." -At 7:00am, no comments documented.</p> <p>Interview with Resident #6's Primary Care Physician's Assistant on 5/4/16 at 12:57pm revealed "I heard she got out once, was brought back and ended up getting out again."</p> <p>Telephone interview with Resident #6's Guardian on 5/5/16 at 9:28am revealed: -When Resident #6 was first admitted she was able to sign herself out and go out unsupervised. -Due to her leaving the facility without staff knowledge, she was then limited to only going out with staff. -As Resident #6 left the facility again without notifying staff, the resident was placed on 15 minute checks, but "she figured out how to get out between the 15 minute checks." -Resident #6 "had eloped" on 4/26/16 from the facility and had been found later that day by mobile crisis psychiatric provider 29 miles away from the facility in another city.</p>	D 270		

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D 270	<p>Continued From page 30</p> <p>Interview with the Administrator on 5/4/16 at 11:36am revealed:</p> <ul style="list-style-type: none"> -Resident #6 had gone to the local emergency room (ER) for evaluation on 4/25/16 for suicidal thoughts. -The ER "said she was clear to come back and [psychiatric treatment provider name] had assessed her." -On 4/26/16, "She came back and was not here very long...about 45 minutes." -Resident #6 went up to the onsite psychiatric physician and said "I want to hurt myself and die. I want to commit suicide." -The physician had the Resident Care Coordinator (RCC) sit with Resident #6 while the Administrator contacted the mobile crisis psychiatric service and left a voicemail message. -The Administrator called the Guardian and left a voicemail message. -Resident #6 had to go to the bathroom, so a Personal Care Aide (PCA) came to go with her and Resident #6 did not want the PCA to go in the bathroom with her so the PCA stood outside the bathroom door. -As soon as Resident #6 came out of the bathroom, she "started running and all the staff was trying to stop her." -The alarm on the door went off as the resident went out. -Resident #6 headed up the hill to a building located less than 50 feet from the facility. -Staff went to the building and all staff found were Resident #6's shoes and jacket. -Law enforcement and the Guardian were contacted. -Psychiatric mobile crisis was contacted. -Resident #6 was found later that day by the psychiatric mobile crisis staff 29 miles away from the facility in another city and was taken to a local 	D 270		

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D 270	<p>Continued From page 31</p> <p>hospital for evaluation.</p> <p>Interview with a Maintenance Staff on 5/4/16 at 1:05pm revealed:</p> <ul style="list-style-type: none"> -On 4/26/16 when driving past the facility, he observed Resident #6 walking near a metal building (Maintenance Staff pointed to a building located approximately one-quarter of a mile, west of the facility). -He drove up to Resident #6 and got out of his car to talk with her. -He was trying to get Resident #6 to return to the facility. -Resident #6 told him she just wanted to take a walk. -He then called the facility and reported the situation (he could not recall the name of the staff person he spoke to). -He got into his vehicle and started driving towards the facility (a blacktop road went from the front of the facility to the metal building). -He did not stay with Resident #6, because he could see her in his rearview mirror. -He drove to the front of the building and staff was exiting the front door. -He turned, told staff of Resident #6's location, turned back in the rearview mirror and Resident #6 had disappeared behind the metal building. <p>Resident #6 was not interviewable due to discharge from the facility on 4/26/16.</p> <p>Refer to the interview with Staff H, Personal Care Aide (PCA), on 5/2/16 at 4:15pm.</p> <p>Refer to the interview with Staff N, Medication Aide (MA) on 5/3/16 at 3:15pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 5/3/16 at 3:30pm.</p>	D 270		

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D 270	<p>Continued From page 32</p> <p>Refer to the interview with the RCC on 5/4/16 at 9:55am.</p> <p>Refer to the review of the corporate policy on elopement and wandering.</p> <p>Refer to the interview with Staff F, MA, on 5/4/16 at 10:10am.</p> <p>Refer to the interview with the RCC on 5/5/16 at 11:08am.</p> <p>Refer to the telephone interview with the Operations Manager on 5/5/16 at 1:24pm.</p> <p>Refer to the telephone interview with the Administrator on 5/6/16 at 3:30pm.</p> <p>C. Review of Resident #5's current FL2 dated 1/14/16 revealed: -Diagnoses included encephalopathy, aphasia, Type II Diabetes, hypertension, mild intellectual disorder, and cognitive communication deficits. -Resident #5 was documented ambulatory with an abnormal gait. -Resident #5 was documented intermittently disoriented, a wanderer, and injurious to property.</p> <p>Review of Resident #5's Care Plan dated 2/9/16 revealed: -Resident #5 required extensive staff assistance for bathing. -Resident #5 required limited staff assistance for eating, toileting, and grooming/personal hygiene. -Resident #5 required staff supervision for dressing.</p> <p>Review of Resident #5's Nurse's Note dated 4/18/16 at 8am revealed:</p>	D 270		

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D 270	<p>Continued From page 33</p> <p>-"Resident was going down the driveway." -"Stated his sister was coming to get him." -The Medication Aide "got him to come back in the building."</p> <p>Review of Resident #5's hospital discharge summary dated 4/19/16 revealed the resident was diagnosed as having "dementia with delusions."</p> <p>Interview with Staff C, Medication Aide (MA), on 5/2/16 at 4:16pm revealed Resident #5 was a wanderer, "but he's not done it in a long time."</p> <p>Interview with Staff I, MA, on 5/4/16 at 8:30am revealed: -Resident #5 "is confused." -"He's gotten out, but I don't think he's gotten to the road." -"The alarms are all messed up. It would help us if they worked."</p> <p>Interview with Staff J, MA, on 5/4/16 at 10:35am revealed: -Resident #5 "likes to go outside. I don't let him go out on his own." -"I will take him outside and walk around the building with him when I have time and that seems to pacify him."</p> <p>Interview with Resident #5's Primary Care Physician's Assistant on 5/4/16 at 12:57pm revealed: -Resident #5 was ambulatory and oriented to self, but not oriented to situation. -Resident #5 was "okay for him to be outside the facility, but not down near the road."</p> <p>Based on record review and observation of Resident #5 on 5/2/16 through 5/4/16, he was</p>	D 270		

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D 270	<p>Continued From page 34</p> <p>determined not to be interviewable.</p> <p>Refer to the interview with Staff H, Personal Care Aide (PCA), on 5/2/16 at 4:15pm.</p> <p>Refer to the interview with Staff N, Medication Aide (MA) on 5/3/16 at 3:15pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 5/3/16 at 3:30pm.</p> <p>Refer to the interview with the RCC on 5/4/16 at 9:55am.</p> <p>Refer to the review of the corporate policy on elopement and wandering.</p> <p>Refer to the interview with Staff F, MA, on 5/4/16 at 10:10am.</p> <p>Refer to the interview with the Administrator on 5/4/16 at 10:35am.</p> <p>Refer to the interview with the RCC on 5/5/16 at 11:08am.</p> <p>Refer to the telephone interview with the Operations Manager on 5/5/16 at 1:24pm.</p> <p>Refer to the telephone interview with the Administrator on 5/6/16 at 3:30pm.</p> <p>D. Review of Resident #1's current FL2 dated 12/9/15 revealed: -Diagnoses included: Bi-Polar 1 Disorder, Most Recent Episode-Mixed; Dependent Personality Disorder; Hyperthyroidism; history of Traumatic Brain Injury. -The resident was documented ambulatory. -There was no information concerning if the</p>	D 270		

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D 270	<p>Continued From page 35</p> <p>resident was disoriented. -An admission date of 6/18/15.</p> <p>Review of Resident #1's Resident Register revealed no admission date documented on the form.</p> <p>Review of Resident #1's record revealed: -The resident had a legal guardian. -The resident had been discharged on April 4, 2016.</p> <p>Interview with Staff E, Personal Care Aide (PCA), on 5/3/16 at 11:45am revealed: -On 3/23/16 she observed Resident #1 walk out the front door. She went with him and was able to return him to the facility. She documented the incident. Resident #1 was put on "15 minute checks". -On 3/24/16 she was returning from a shopping trip and observed Resident #1 in front of the facility along the road (U.S. Highway 421 is a four-lane, divided highway approximately 200-300 yards from the front of the facility). There was no facility staff with Resident #1. She stopped the vehicle and asked Resident #1 to return with her to the facility. Resident #1 refused. She attempted to place a cell phone call to the facility for assistance but Resident #1 knocked the phone out of her hand. A local law enforcement officer stopped and assisted with getting Resident #1 into Staff E's vehicle. They returned to the facility, Staff E walked with Resident #1 into the facility. She had documented the incident. -15 minute checks meant PCAs were to visually observe a resident, to lay eyes on. A resident would remain on 15 minute checks for one or two days.</p> <p>Review of a Nurses Note for Resident #1 dated</p>	D 270		

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D 270	<p>Continued From page 36</p> <p>3/23/16 at 9:15am revealed: -Resident #1 went out the front door and walked down to [Highway] 421 and was walking down the road. -Staff E went after him and got him back to the building. -Resident was put on a 15 minute watch. -The form was signed by Staff E, PCA.</p> <p>Review of a Nurses Note for Resident #1 dated 3/24/16 at 4:20pm revealed the information on the Nurses Note confirmed the interview on 5/3/16 at 11:45am with Staff E, PCA. The form was signed by Staff E, PCA.</p> <p>Review of a 3/24/16 Nurses Note that had Resident #1's name revealed: -Time recorded as 4:20pm. -Form was signed by Staff E, PCA.</p> <p>Interview with the Resident Care Coordinator (RCC) on 5/3/16 at 3:30pm revealed: -Resident #1 never wandered away from the facility, "he never went anywhere". -His family members visited him monthly. -The RCC thought at the last visit the parents had told Resident #1 he would be leaving and moving to a facility closer to their home. She thought this may have caused Resident #1's wandering incidents.</p> <p>Review of the facility's 15 minute check record dated 3/23/16 and 3/24/16 for Resident #1 revealed: -The pre-printed times on the form recorded a 24-hour time frame, listed in 15 minute intervals that started at 7:00am and ended at 6:45am. -Staff initials were documented next to each 15 minute interval beginning at 1:00pm on 3/23/16 and ended at 11:45pm on 3/24/16.</p>	D 270		

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NAME OF PROVIDER OR SUPPLIER WILKES COUNTY ADULT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 176 REST HOME ROAD WILKESBORO, NC 28697
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D 270	<p>Continued From page 37</p> <p>Interview with Staff H, PCA, on 5/3/16 at 4:06pm revealed: -She had worked second shift on 3/24/16. -She had initialed the 3/24/16, 15 minute log form from 3:00pm to 11:45pm for Resident #1. -She stated Resident #1 did not exit the building and get to the road (U.S. Highway 421) during her shift on 3/24/16.</p> <p>Interview with the Administrator and the Operations Manager (OM) on 5/4/16 at 10:35am revealed: -They were not aware that Resident #1 was found along the side of U.S. Highway 421 by Staff E on 3/24/16. -They had not received an incident/accident report. A report should have been completed and they would have to further investigate the incident.</p> <p>_____</p> <p>Interview with Staff H, Personal Care Aide (PCA), on 5/2/16 at 4:15pm revealed PCA's were responsible for "hourly checks" on the residents, meaning they were to visually observe each resident every hour. They would keep a closer check on residents if needed.</p> <p>Interview with Staff N, Medication Aide (MA) on 5/3/16 at 3:15pm revealed: -Staff "lay eyes on" residents every 15 minutes for medical or behavioral reasons. -The length of time a resident remained on 15 minute checks depended upon the issue. If someone tried to run-away, it usually was 24 hours, longer if they tried to run again or hurt themselves. They would remain on 15 checks until evaluated by a mental health professional or the residents' personal care provider (PCP).</p>	D 270		

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D 270	<p>Continued From page 38</p> <p>-MA's documented 15 minute checks on the shift report form. PCA's kept a list of who was on 15 minute checks in the PCA office.</p> <p>Interview with the Resident Care Coordinator (RCC) on 5/3/16 at 3:30pm revealed for 15 minute checks, a MA or PCA would be assigned to check on the resident every 15 minutes throughout their shift. The assignment was based on if staff were working A-wing or B-wing. The PCA was responsible to pass the 15 minute check list to the next PCA coming on shift. 15 minute checks ran for 24 hours.</p> <p>Interview with the RCC on 5/4/16 at 9:55am revealed:</p> <p>-She did not know of any specific admissions policy indicating what room to assign a new resident if documented resident was disorientated or a wanderer, resident would be placed where there was an open bed.</p> <p>-She did not know of a specific protocol for assessing residents on an on-going basis related to wandering or disorientated behaviors.</p> <p>-When a resident's behavior changed, or the resident became disorientated, she would notify the resident's PCP.</p> <p>Interview with Staff F, MA, on 5/4/16 at 10:10am revealed when a resident's behavior changed she would notify the RCC and call the resident's PCP.</p> <p>Review of a corporate policy on elopement and wandering (undated) revealed:</p> <p>-Elopement was defined as to leave without notification and included residents who had not signed out and were noted to be gone greater than 6 hours without medications.</p> <p>-The definition of elopement also included non-demented residents whose guardians</p>	D 270		

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D 270	<p>Continued From page 39</p> <p>requested they not leave the property without their prior permission.</p> <p>-If a resident did not have a diagnosis of Alzheimer's or Dementia and was not listed as a wanderer by a physician or psychiatrist and they were seen leaving the property, this served as notification of leaving.</p> <p>-Wandering was defined as to roam, to go about aimlessly, or who had been listed as a wanderer by a physician or psychiatrist.</p> <p>Interview with the Administrator on 5/4/16 at 10:35am revealed:</p> <p>-It was her plan to move all males into section of the building and all females into another section. She also had intended to assess residents with a diagnosis of dementia to determine if the facility could meet the resident's personal care needs.</p> <p>-She has provided staff with dementia training.</p> <p>-A resident's room assignment would change based on their assessed needs or behaviors changed.</p> <p>Telephone interview with the RCC on 5/5/16 at 11:08am revealed:</p> <p>-When a resident threatened to hurt themselves, staff are instructed to call the local mental health provider, the guardian/power of attorney and the PCP. "Do what we can to get them help."</p> <p>-A resident would be placed on one-on-one supervision or 15 minute checks until the resident had been assessed and they received instructions/orders on how to proceed.</p> <p>-When admitting a new resident, their personal care and supervision requirements were obtained by the resident's diagnoses, medical history, psychiatric history, family or guardian interviews.</p> <p>Telephone interview with the Operations Manager (OM) on 5/5/16 at 1:24pm revealed:</p>	D 270		

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D 270	<p>Continued From page 40</p> <p>-When a resident threatened to hurt themselves, staff would follow the chain of command and notify the RCC or the Administrator, call the local mental health provider, the guardian/power of attorney and the PCP.</p> <p>-The resident would be placed on one-on-one supervision, asked to sit in the medication room so a staff could keep direct supervision.</p> <p>Telephone interview with the Administrator on 5/6/16 at 3:30pm revealed:</p> <p>-When a resident threatened to hurt themselves, immediately place the resident on one-on-one supervision, call the PCP, and if appropriate, call the local mental health provider. Follow the chain of command. Send the resident to the local hospital.</p> <p>-Before returning a resident from the hospital, would want to know if they had been assessed by the local mental health provider. If assessment says it is safe for the resident to return, even if I might feel differently, I would still have to take the resident back. Would want to make sure there was supportive documentation in the discharge paperwork.</p> <p>-The facility uses the rules and regulations as stated in 13F .0702 as policy for discharge.</p> <p>_____</p> <p>The violation of the rule placed residents at substantial risk of serious physical harm or serious neglect as evidenced by: Resident #2, who had a known history of suicide attempts, to deliberately ingest substances in an attempt to inflict self-harm and the facility failed to implement interventions to protect the resident from trying to inflict self-harm and Resident #2's ability to leave the facility unsupervised and without staff knowledge and found walking along an interstate on two occasions, when the resident</p>	D 270		

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D 270	<p>Continued From page 41</p> <p>was not to leave the facility without supervision; Resident #6, who has been adjudicated incompetent or who due to the resident's diagnoses lacks the ability to make safe decisions independently, was able to leave the facility unsupervised and without staff knowledge and on one occurrence walked 7 miles along an interstate and on a second occurrence was found 29 miles away from the facility, unsupervised when the resident was not to leave the facility without supervision resulting in substantial risk for serious physical harm, serious neglect or death.</p> <p>_____</p> <p>A Plan of Protection was submitted by the facility on 5/4/16 as follows: -The door switch plate cover has been replaced on the main door. -New switch plates will be completely installed on all doors by Thursday 5/5/16. -Immediately, staff will be assigned 15 minute watch, extra staff assigned to residents having potential to leave building. -Extra staff assigned to be with individuals, 15 minute documentation. -Wander Guard installation. -In-service all staff on Wander Guard, documentation and battery change.</p> <p>Addendum submitted by the facility on 5/6/16 as follows: -Wander guard installation. -All obvious residents that have potential to leave building have been assigned a staff member to monitor and document in building. We have identified 5 residents and 1 staff member is assigned to them each shift. -Resident Care Coordinator and Administrator, with assistance of staff will do resident assessments to determine level of care</p>	D 270		

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D 270	Continued From page 42 appropriate and /or wander guard will be sufficient. We will include medical and psych input for a care team approach.	D 270		
D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all residents were free of neglect related to the requirements for outside entrances and exits, and supervision of residents.</p> <p>The findings are:</p> <p>A. Based on observation, interview, and record review, the facility failed to assure that six of six exit doors were maintained secure with alarms resulting in four residents (Resident #1, #2, #5, and #6) exiting outside without staff knowledge, including two residents (#2 and #6) leaving the facility and found walking along a busy state highway and two residents (#1 and #5) requiring supervision when leaving facility leaving unsupervised [Refer to Tag 067, 10A NCAC 13F .0305(h)(4) Physical Environment (Unabated A2 Violation)].</p> <p>B. Based on observation, interview, and record review the facility failed to assure staff provided supervision in accordance with 4 of 6 residents (#1, #2, #5, and #6) assessed needs, care plan, and current symptoms resulting in Resident #2 suicide attempt and two elopements, Resident #6</p>	D914		

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D914	Continued From page 43 six occasions of elopement, Resident #5 leaving the building unsupervised, and Resident #1 leaving the building unsupervised [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Unabated A2 Violation)].	D914		