Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Addison of Indian Trail
Address: 5306 Secrest Short Cut Road
County: Union
License Number: HAL-090-035_____

II. Date(s) of Visit(s): 6/20/23, 6/21/23, 6/22/23, 6/28/23, 6/30/23, 7/7/23, 7/21/23 & 7/31/23
Purpose of Visit(s): Complaint

Exit/Report Date: 8/4/23

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

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

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

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

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed** 8/25/23
Rule/Statute Number: 1. 10A NCAC 13F .0305 (h) (4) PHYSICAL ENVIRONMENT. _____	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: (h) (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. _____ Rule/Statute Number: 2. 10A NCAC 13F 0901(b) PROVIDE SUPERVISION TO RESIDENTS. _____ Rule/Statutory Reference: (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.		

Level of Non-Compliance: (1) TYPE A2 Violation (2) STANDARD DEFICIENCY		
Findings: The rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to lock four (4) exit doors accessible to all the residents residing in the SCU including 1 of 5 sampled residents who had a history of wandering who eloped from the facility after exiting through the Special Care Unit (SCU) door that was not equipped with a sounding device that could be activated when the door was opened. Findings: The rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to provide supervision to 1 of 1 sampled residents who was disoriented and a history of wandering behaviors who eloped from the facility through the Special Care Unit door without staff's knowledge. The findings are: Review of Resident #1's current FL-2 dated 7/18/22 revealed: -Diagnoses included Alzheimer's Disease of early onset, dementia behaviors with disturbance, insomnia, delusions, seizures and delirium. -Resident #1 had wandering behaviors, was intermittently disoriented and ambulatory. -The level of care for Resident #1 was for a Special Care Unit (SCU). Review of Resident #1's North Carolina Health and Service Evaluation Results dated 4/4/2023 revealed Resident #1 wandered in public spaces within the residence but did not wander into other's apartments. Review of Hospice Interdisciplinary Group Comprehensive Assessment and Plan of Care Update Report dated 6/14/23 revealed resident's diagnoses included Alzheimer's Disease with early onset, dementia in other diseases classified elsewhere, severe with agitation, adult failure to thrive, repeated falls, epilepsy, and wandering in diseases classified elsewhere.		

Review for Resident #1's Accident/Incident (A/I) report dated 6/16/2023 revealed: -On 6/15/2023 at 8:15pm a Personal Care Aide (PCA) was in the parking lot and observed a lady walking with the resident. -The PCA received the resident and escorted the resident back into the facility following an elopement. -The facility was investigating how the resident got out of the facility. Review of the 911 Call received to Law Enforcement on 6/15/2023 at 9:53pm revealed: -Report showed a request for a telephone call back from Law Enforcement in reference to a patient that had gotten out and was walking down the street. -Caller was driving past and saw a lady in the road. -Call recorded under Abuse/Abandon/Neglect Care. Telephone interview with a Law Enforcement Officer on 6/28/23 at 8:53am in reference to the 911 Call received on 6/15/23 at 9:53pm for the facility revealed: -He recalled receiving a citizen complaint regarding a person walking down the road in a hospital gown. -The resident was in the traffic way and was in the middle of the road. -He learned that a resident had gotten out of the facility during shift change. -Another Law Enforcement Officer went to the facility. -A staff person had forgotten to lock the SCU door. -The facility reported that they would complete an internal investigation. -The road the resident was found on could get very busy and was definitely a busy road with a lot of activity including construction. Telephone interview with the second Law Enforcement Officer on 6/28/2023 at 9:56am in reference to the 911 Call received on 6/15/2023 at 9:53pm for the facility revealed: -She recalled responding to a call for a lady who was walking in the road. -This person had dementia issues. -She visited the facility and spoke with the Supervisor who was with a resident. -She also spoke with the staff person who assisted with getting the resident back into the facility. -The staff person observed cars were stopping in the middle of the road and happened to see traffic backing up.		

-The Supervisor stated that a staff person was on their cell phone and did not check the door to make sure it had locked when leaving the SCU. -The Supervisor spoke to management and they would be having a meeting. -The road was a busy road and was busier early mornings and after 6pm. -The road was an even more dangerous road because it was on a hill and curve. Telephone interview with the citizen who returned the resident on 6/21/23 at 12:12pm revealed: -She observed a lady walking down the road in her pajamas and thought this was odd. -The resident was not on the sidewalk but was in the actual road. -She was driving in the opposite direction and turned around and tried to get the resident into the car, however was unable to do so. -She stopped her car and walked the resident back to the facility. -The resident was unable to provide her name. -She entered the front door of the facility where the door was unlocked. The resident opened the second door to the facility which was also unlocked. -She was approached by a staff member who told the resident that someone was supposed to be watching her. -She filed a report with Law Enforcement. -She was informed by Law Enforcement that the resident escaped during shift change as the Nurse forgot to lock the door back during shift change. Second interview and citizen observation where Resident #1 was found on 6/30/23 at 12:00pm revealed: -The resident was found approximately 200 yards from the entrance of the facility. -The resident was walking in the road between the yellow and white lines. -Cars were slamming on their brakes and going around the resident in order to avoid hitting her. -The amount of cars going by at this time was similar to the amount going by on the evening of the incident which was around 8:30pm. Observations of the road in front of the facility where resident was located on 6/30/2023 at 12:10pm revealed: -AHS noted this location to be in closest proximity to the Hall D exit door than the front door of the facility.		

-The road was a two-lane road and the speed limit is forty-five (45) miles per hour (mph). -AHS counted approximately seven (7) cars to pass within one minute at the location that the resident was found. Interview with the Administrator on 6/20/23 at 1:57pm revealed: -Resident #1 had been at the facility for a year and had dementia that was progressing. -Resident #1 was unable to formulate sentences and was very busy. -Resident #1 went into other residents rooms. -Resident #1 had a tendency to hang out at the SCU door. -Facility was still investigating the incident but believed that Resident #1 got out when a staff member left early and did not lock the SCU door. -The entry door leading to the main SCU door, staff had a code to this door but staff were not using it. This door was not alarmed on the day of the elopement. -The Health and Wellness Director was gathering statements from staff. -Throughout the day the facility tried to ensure that the front entrance door was locked. -There were cameras in the building but they were not operable. -She purchased two ring cameras some months ago but they had not been installed as of yet. Observations of the SCU on 6/20/2023 at 2:45pm revealed: -To get to the SCU main door you must pass through the facility's main entrance door. -A sign in system was in the foyer area immediately followed by french double doors which led to a waiting/sitting area. -Another set of french double doors led to a central hallway which led to either the SCU wing or the Assisted Living Unit wing -Halls A and B are located on the Assisted Living Unit side. -To the left of the central hallway was the SCU and to the right was the Assisted Living Unit. -You must pass through an entry door in order to reach the main SCU door. -This entry door had a maglock and required a code to enter and exit. The door was not fully functional as it was observed to continually beep when a code was entered and had to be pulled shut in order to fully close. -The entry door led to Halls C and D. -Hall C was straight ahead when you enter through the entry door and Hall D was directly to the left.		

-Hall C was where the SCU main door is located. -Hall C was where all SCU residents live. -Hall D is another SCU wing but is under renovation for SCU expansion. -No residents live on Hall D. -To get to Hall C you must enter through the SCU main door double doors. One door was used to enter the hall and the other door was used to exit the door. -A code was entered into the keypad located next to the SCU main door in order for the door to open. -Resident #1 was standing in front of the exit door at the SCU main door-Hall C. -Resident #1's room was the first room when entering the SCU main door-Hall C. -Two exit doors was observed inside of the SCU and was located at the end of Hall C which also led to the back of the building. -The two exit doors inside of the SCU were alarmed and locked and could only be opened when a code was put into the keypad. -Another exit door led to the patio outside. The door had a keypad alarm which required a code in order to exit. -The SCU main exit door was timed and found to take 4.6 seconds to close. -The medication aide (MA) demonstrated how the door closed and that you must wait till the door closed and the device on the top of the door clicked before door was fully secure. -Upon leaving the SCU, the MA put a code into the keypad for the exit door and MA tried to provide assistance in putting a code into the entry door to SCU to let Adult Home Specialist (AHS) out into the central hallway, however had to quickly retreat to push the SCU exit door to fully close as Resident #1 had appeared at the door and tried to exit by pushing on the door. -No alarm or sounding device was observed on the SCU main exit door when this occurred. Observations of the exit door on Hall D on 6/20/2023 at 4:15pm revealed: -You must pass through two double doors in order to reach the exit door on Hall D. -The double doors do not have alarms. -The exit door on Hall D was unable to be opened when pushed. -The Administrator put a code in to disarm the alarm on the door and the door opened. -The doors alarm had to be reset in order for it to be locked.		

Interview with a PCA on 6/20/2023 at 3:41pm revealed: -She was working the second shift on 06/15/23 on the Assisted Living Unit. -At 8:15pm, she went to move her car from one side of the parking lot to the front of the parking lot. The front door was unlocked when she did so. -She noticed that cars were in the street and they were stopped. -A female and her child returned Resident #1 to her in the parking lot. -She returned Resident #1 to the SCU and informed the MA. -Another PCA had left at 8pm and did not lock the door to the SCU. -She observed that the entry door leading to the SCU main door was closed but not locked as the staff were only instructed to start using this door on 06/16/23 the day after the elopement. -She entered a code to enter the SCU main door as this door was locked. -She and the MA observed the double doors on Hall D were wide open. -They both went down to the exit door on Hall D and observed that the door was not alarming when opened. -She observed the screen door directly in front of the exit door on Hall D was also wide open. Interview with the Health and Wellness Director (HWD) on 6/21/2023 at 2:57pm revealed: -She received a call around 8:30pm from the MA who informed her that Resident #1 had eloped. -The MA thought Resident #1 went behind the PCA who left at 8pm. -The MA could not specify which door was open. -Carpet was being installed on Hall D and where the SCU main door connect to each other. She left at 4:30pm on this date but the carpet installation was not expected to be done until around 5pm or 6pm. -A lady and her child returned the resident to a PCA, who escorted the resident back into the facility. -Law Enforcement came and asked the MA if she heard the alarms going off. -The MA did not hear any alarms going off. -Law Enforcement asked the MA if she was aware that it was reported that Resident #1 was on the road in front of the facility. -The MA was not aware that Resident #1 had been found on the road in front of the facility. -Resident #1 had not eloped before as they knew to look for her due to her wandering behaviors.		

Interview with MA on 6/21/23 at 3:51pm revealed: -The elopement of Resident #1 occurred on Thursday, 06/15/23 around 8pm. -She observed a PCA leaving the SCU with her cell phone on her ear about 8pm. -Between 8:20pm and 8:25pm a PCA came and told her that a lady and her young son brought Resident #1 to her. -The PCA informed her that the entry door leading into the SCU was closed and she had put in her code to enter the SCU main door. -Hall D to the right of the SCU had double doors that were wide open. These doors had been open all day because carpet installers were putting carpet down. -She and the PCA went to check the exit door on this Hall and the alarm was not on the door. A screen door directly outside was propped open with a flower pot. -She spoke with the Administrator that evening who mentioned that the carpet installer/contractor was supposed to reset the alarm to the exit door on Hall D. -The project manager over the carpet installation parked their work truck by the Hall D exit door which was closest to the dumpster. -The project manager and his team were fixing a patch in the front of the SCU and Hall D and staff were not allowed to pass through that way that day. -Around 5:30pm they were allowed to finally pass through this area as at this time they were allowed to bring the meals over to the SCU through the SCU door. -She and the third shift MA went to check the exit door on Hall D upon her arrival and the door was able to be opened without the alarm going off. -The next morning at 8:23am she received a video from the Maintenance Director on how to reset the alarm for the exit door on Hall D. -Law Enforcement came that night and told her that they had gotten a call that one of the residents had eloped. Telephone interview with a MA on 6/26/23 at 3:00pm revealed: -She worked third shift on 06/15/23, the night Resident #1 eloped from the facility. -She learned that Resident #1 was found in the flow of traffic on the road in front of the facility. -She was informed that a staff member did not stay and wait for the SCU door to latch and click. -Staff were aware that they were supposed to wait for the click on the SCU door as this would ensure that the door was locked.		

-She went with the second shift MA to check the exit door on Hall D. -She observed that the double doors that entered to Hall D were propped open. -Both MA's checked the Hall D exit door at this time and the door just pushed open. No alarm was heard when the door was opened. Interview with the Maintenance Director on 6/22/23 at 10:45am revealed: -Carpet was being installed on Hall D, which was next to the SCU-Hall C the day and week of the incident. -He turned the alarm off to allow the carpet installers to bring in supplies. -The Project Manager/Contractor for the carpet installation was familiar with how to reset the alarms on the exit doors and was allowed to reset the alarm upon completion of the work day. -He and the Administrator both gave the Project Manager reminders to reset the alarm the week the elopement occurred. -The day of the incident he left around 2pm or 3pm. -At 12am he noticed a missed call from the Administrator at 9:29pm as urgent but was unable to reach her back. -The next morning he was informed that Resident #1 had gotten out of the facility. -He went to the Hall D exit door that morning and found that the alarm was not on. He reset the alarm at this time. -The entry door leading to the main SCU door was currently inoperable and in the process of getting fixed. -He sent a video to staff on that morning on how to arm all secured doors. Telephone interview with the Project Manager-Third Party Vendor on 6/22/2023 at 11:35am revealed: -He worked at the facility on 06/15/23 but he left at 11am or 12pm. -On this day he was only completing a walk through and completed patch work in the beginning of Hall D and the entryway to Hall C. -The double doors on Hall D were open for the completion of the project. -When he left on this day he reset the alarm on the exit door on Hall D. Interview with the Memory Care Director (MCD) on 6/22/23 at 9:58am revealed: -She was on vacation when Resident #1 eloped from the facility.		

-She was informed that a PCA did not ensure that the SCU main door was locked upon leaving. -The PCA knew the routines and residents and would have been familiar with making sure that the door was locked and no residents were at the door when leaving. -Resident #1 often walked to the door with other residents. Telephone interview with PCA on 6/22/2023 at 2:24pm revealed: -She worked the second shift on Thursday, June 15, 2023. -She was informed by co-workers about the incident. No one from management spoke to her about the incident when she returned to work. -She was informed Resident #1 followed her when she left the SCU. -Resident #1 was not behind her and she did not see her when she was leaving. -As far as she knew the SCU main door locked behind her when she left. -She clocked out at 8pm. -The SCU door had always had problems; door had a glitch. -Sometimes the door clicked when leaving and sometimes it did not. -The SCU door closed and it clicked but it must be pushed to ensure it was locked. -The doors on the SCU need to be checked. -The entry door leading to the SCU main door was not alarmed on the day of the elopement. -They were instructed to start using the entry door leading to the SCU main door the day after the incident. - The entry door leading to the SCU door did not lock all the way through; the door beeps until it was fully closed. Telephone interview with the same PCA on 6/30/23 at 10:00am revealed: -She recalled sitting at the time clock for three minutes before she clocked out at 8pm. -She left through the facility entrance door which was not locked and no one locked it behind her. -The facility front entrance was sometimes locked and sometimes it was not locked after normal business hours. Interview with Primary Care Provider (PCP) for Resident #1 on 7/12/23 at 2:57pm revealed: -She assessed Resident #1 the day after the incident. -Resident #1 had decreased the wandering for a while but this changed after she was recently treated for a Urinary Tract Infection.		

-Resident #1 was more active at this time, walking the hallways and around the common area of the SCU. -Sometimes it was difficult to enter the SCU main door because Resident #1 was at the door. -Resident #1 followed her around when she visited and usually walked right behind her. -Resident #1 room was located right next to the SCU main door. -When leaving the SCU Resident #1 could be verbally redirected away from the door. -Resident #1 was quick and could easily jet out as she did follow others. -The SCU main door locked slower than some other SCU facility doors she had observed. -She had to wait for the door to click to make sure it was closed. Interview with Hospice Staff on 7/13/23 at 1:22pm revealed: -Hospice had not been notified that Resident #1 eloped from the facility. -Resident #1 walked around a lot and wandered into others apartments. -Resident #1 was busy and got into everything. -Resident #1 could get away from your view if she was not watched. -Resident #1 did not nap long or sit long. -Resident #1 was sometimes at the SCU door and would have to be removed when entering. -Resident #1 was sometimes standing at the SCU door when exiting and had to be removed because she would try to walk out. -The SCU door closed very slowly, however she would wait until it closed. A staff member usually let her in and out of SCU. Interview with the Administrator on 7/7/2023 at 11:37am revealed: -Resident #1 may have left out of the facility either through the Hall D exit door or the front door. -A PCA neglected to close the SCU door when she had to leave early at 8pm on 6/15/2023. -Facility findings included the doors in the facility were not locked and Resident #1 eloped. -A PCA did not lock the front door when leaving the building to move their car. -The Project Manager-Contractor for carpet installation who was a third-party vendor was allowed to reset the alarm on Hall D upon exiting the building.		

-The alarm on Hall D was not reset and alarmed until the next morning after the elopement. -Staff did not receive instructions on how to reset this door until the following morning. -She did not come on site during the elopement. -The SCU doors were checked out the day after the incident occurred by the Project Manager for the carpet installation who was a General Contractor. -The Project Manager said that he would send someone out the following week. -She was not aware of the outcome of these checks and reports that no one will provide documentation of the SCU doors being checked. -She usually contacted a Door Inspection company for all door servicing but did not contact them to check the SCU doors. -She did not provide an explanation as to why she did not contact the Door Inspection company normally used when asked by AHS. Observations of the SCU on 7/21/2023 at 3:30pm revealed: -The SCU main door was opened when a code is inputted into a keypad. -To exit the SCU main door you must input a code into the keypad. -Four (4) observations of the SCU exit door were completed on this date. -In three (3) of the observations the SCU exit door did not fully close on its own and was left ajar. -A click was not heard to indicate the door was locked. -The device did not turn red to indicate the door was locked. -The device remained clear and then turned green to indicate that the door was still opened. -The door had to be pushed in, in order for it to lock. Interview with the Administrator on 7/21/2023 at 3:45pm revealed: -There was no sounding device on the SCU main doors. -Her response to the SCU exit door not fully closing and not locking on its own, was the facility trains staff to make sure they close the SCU door when exiting. Interview with the Memory Care Director on 7/21/2023 at 3:50pm revealed: -She observed the SCU door to not lock or close on 7/21/23 with AHS. -She recalled that someone had come to look at the SCU doors after the elopement.		

-She overheard them state that the door could be loosened or adjusted so that the exit doors could close faster and with more force. -She believes the Maintenance Director may have more information who came that day. -The SCU doors did not have a sounding device. Telephone interview with the Maintenance Director on 7/24/23 at 10:56am revealed: -A third-party contractor did come the following week after the elopement to check the entry door on SCU. -The third-party contactor was primarily there to work on the entry SCU door. -The third-party contractor may have looked at the main SCU door but did not work on this door. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. The facility failed to ensure that the Special Care Unit (SCU) determined by a physician to be disoriented and a wanderer, had an exit door accessible by residents that was equipped with a sounding device that was activated when the door was opened. 1 of 1 sampled resident (Resident #1) residing in the SCU who is disoriented and had known wandering behaviors eloped from the SCU on 6/15/2023 without staff knowledge and was found in the busy road located in front of the facility by a citizen driving by. This failure of the facility resulted in substantial risk of physical harm and death to residents and constitutes a Type A2 Violation. The facility failed to provide supervision to 1 of 1 sampled resident (Resident #1) who had a history of being disoriented and wandering behaviors, who eloped from the facility without staff's knowledge resulting in Resident #1 being unsupervised outside the facility and being found on a busy road. This failure of the facility resulted in non-compliance in the provision of supervision of residents and constitutes a Standard Deficiency. The facility provided a plan of protection in accordance with G.S. 131D-34 on 6/21/2023 for this violation.		

Facility Name:

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION AND STANDARD DEFICIENCY SHALL NOT EXCEED SEPTEMBER 3, 2023.		

IV. Delivered Via:	Hand Delivery	Date: 8-4-23
DSS Signature:	Bsouerlyn Holoker	Return to DSS By: 8-25-23

V. CAR Received by:	Administrator/Designee (print name): Cleo Herra	
	Signature:	Date: 8-4-23
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name): Cleo Herra	
	Signature:	Date: 8-4-23

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

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