Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Harmony at Brookberry Farm
Address: 512 Brookberry Heights CG
County: Forsyth
License Number: HAL-034-112

II. Date(s) of Visit(s): 12/12/22, 1/18/23, 1/30/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 2/23/2023

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)* • *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**
Rule/Statute Number: Personal Care and Supervision/10A NCAC 13F .0901 (b) (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	☐ POC Accepted _____ *DSS Initials*	3/16/2023
Level of Non-Compliance: Type A2 Violation		
Findings: Based on observations, interviews and record reviews, the facility failed to provide supervision based on assessed needs for 1 of 5 sampled residents (Resident #1) who was diagnosed with dementia and eloped from the facility without staff's knowledge. The findings are: 1. Review of Resident #1's FL-2 dated 3/18/2022 revealed diagnoses included dementia. Review of Resident #1's resident record revealed: - Resident #1 was forgetful needing reminders. - Resident #1 had past medical history of dementia with wandering and is unable to redirect.		

- Resident #1 had a moderate impairment with a history of difficulty remembering and using information, required directions and reminders from others and could not follow written instructions.
- Resident #1 had a history of leaving his immediate area, getting lost, or being combative about returning.
- Resident #1 was admitted into facility on 3/29/2022.

Review of Resident #1's care plan signed by physician on 3/29/2022 revealed:
- The resident received medications for dementia, anxiety and behaviors.

Interview attempted with PCP (Primary Care Physician) on 2/22/2023 at 3:40pm revealed:
- Medical records responded to medical history inquiries.
- Resident #1 had not been seen by PCP since 1/3/2022.

Interviews with the law enforcement record division on 1/17/2023 at 3:20pm and 2/10/2023 at 1:28pm revealed:
- There was no law enforcement report on record for Resident #1 or for facility dated 11/26/2022.

Interview with Resident #1's family member on 1/17/2023 at 11:50am, 2/10/2023 at 9:00am and 2/15/2023 at 2:55pm revealed:
- On 11/26/2022, a person in the local community saw Resident #1 walking unsteady on a busy road and fell.
- The resident was unsure of his address but knew his name.
- The person in the local community searched the resident's telephone number and called the resident's family and the local police.
- The local law enforcement called the facility.
- Another officer was at the facility for a non-related incident and heard on his scanner that Resident #1 was found in the community.
- The facility did not know Resident #1 had left the building.
- The person in the local community called EMS to transport Resident #1 to a local hospital for medical evaluation.
- The resident did not sustain any injuries related to incident.
- She did not receive a telephone call from the facility notifying her that Resident #1 exited the building.
- She called the facility administrator upon receiving information.
- The administrator picked up Resident #1 from the local hospital and transported him back to facility.

- She did not have hospital records for Resident #1 after he was evaluated on 11/26/2022. - Resident #1 moved to another facility 12/12/2022. Interview with registered nurse (RN) on 1/18/2023 at 11:00pm revealed: - Facility staff completes supervision checks on residents every 2 hours. - She checks doors every morning and afternoon. Interview with medication aide (MA) on 2/13/2023 at 2:43pm revealed: - She was not working in the memory care unit during incident on 11/26/2022. - She was not working with Resident #1 at the time of incident. - She was called to memory care to assist with a non-related incident. - There were 2 other staff working in memory care at the time of incident. - She was told by the local law enforcement officer that his scanner reported a resident from the facility was found walking down the street. - She did not know Resident #1 had left the facility until being notified by the local law enforcement officer. - She and the independent living concierge went looking for the resident. - Resident #1 was transported to the hospital from the community. - She did not know how Resident #1 exited the facility. - She could not confirm if staff did not turn the key to lock the door. - She checked all doors to confirm they were locked after being notified that Resident #1 exited the facility. - She did not remember if an incident report was completed. Interview attempted with Personal Care Aide (PCA) on 2/15/2023 at 3:43pm revealed: - She did not respond to Adult Home Specialist's (AHS) voicemail. Observation on 1/30/2023 at 12:00pm revealed: - The memory care unit was located on the first floor with doors that opened to the independent living hallway and the assisted living lobby to the right of the memory care unit. - Assisted living lobby did not have a concierge or front desk staff. - Independent living lobby had a concierge.		

- There were 7 residents in memory care dining room.
- There were 2 facility staff assisting residents in dining room.
- The door in memory care was locked with red indicator light.
- A temporary chime alarm was placed on the door of memory care to alert staff when the door is open.
- The exit door in assisted living lobby opens automatically upon person's arrival.

Interview with Administrator on 12/12/2022 at 3:00pm, 1/18/2023 at 11:00pm, 1/30/2023 at 12:00pm, 2/14/2023 at 2:00pm and 2/22/2023 at 3:00pm revealed:
- He was not working at facility on 11/26/2022 during incident.
- He was not aware that Resident #1 left the facility until being notified by the resident's daughter at 6:00pm.
- He completed investigation with facility staff once being notified that Resident #1 had left the facility.
- Resident #1 was away from the facility approximately 45 minutes.
- On 11/26/2022, Resident #1 ate dinner in the memory care unit at 5:00pm, left the dining room at 5:15pm to sit in the memory care TV room, then exited the memory care unit as the door was not locked. The resident exited the front door of assisted living lobby.
- The assisted living door was exit only and did not have staff to monitor the door.
- The assisted living lobby door did not have a camera.
- The independent lobby camera did not show Resident #1 leaving the facility on 11/26/2022.
- Facility staff did not witness Resident #1 exit the facility and could not identify which staff member did not lock the door with a key upon exit.
- Facility staff did not confirm that the indicator light was red identifying that the door was locked upon exit.
- He cannot confirm if the door was not locked or did not latch closed.
- The main door in memory care had magnetic locks.
- Main door to memory care did not have a sound alarm installed at time of incident.
- Facility staff monitored residents every 30 minutes.
- Facility staff were to check all memory care doors and locked indicator lights at the start of each working shift.
- Facility staff did not complete an incident report for Resident #1 on 11/26/2022.
- Medication Aide and concierge from independent living went to find Resident #1 on 11/26/2022 without instruction.
- Resident # 1 was evaluated at the local hospital and was transported back to the facility the same night of incident.
- He did not have a copy of a police report on 11/26/2022.

- He did not have a copy of Resident #1's hospital records after being discharged on 11/26/2023. - Resident #1 moved out of facility on 12/12/2022. Interview with a local person in the community on 2/16/2023 at 10:00am revealed: - On 11/26/2022, she was driving down a busy street and saw a car in the middle of the road with an individual (name and contact information unknown) talking to a man walking down the street. - She stopped to assist the individual as the man walking appeared drunk or disoriented. - The man walking lost his shoe and was confused saying he wanted to go home to another city in NC. - The man told the local person in the community his first and last name. - The man walking could not provide his address. - The local person in the community completed an internet search to contact the man's family. - She spoke with the man's daughter who confirmed him as Resident #1. - The local person in the community and the driver assisted Resident #1 off the main road after losing his balance and falling. - The lady driving the car called local law enforcement. - The local police talked with Resident #1's daughter to confirm his identity. - Emergency Medical Services (EMS) transported the resident to a local hospital for an evaluation. - Facility staff arrived shocked and frantic asking what happened and how resident got out of facility. --- The facility failed to provide supervision for 1 of 5 residents (Resident #1) with diagnosis of dementia resulting in the resident leaving the facility without knowledge of facility staff and was found in a busy traffic area. The resident was found 1 block away from the facility by a person in the local community. This failure placed resident at substantial risk of physical harm which constitutes a Type A2 Violation. --- The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 1/30/2023 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 25, 2023.		

IV. Delivered Via:	In person	Date: 2/23/2023
DSS Signature:	Jaii Butler	Return to DSS By: 3/16/2023

V. CAR Received by:	Administrator/Designee (print name): Josh James	
	Signature:	Date: 2/23/23
	Title: Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)

☐ *POC Not Accepted*	By:	Date:

Comments:

☐ *POC Accepted*	By:	Date:

Comments:

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:

Comments:

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*