Adult Care Home Corrective Action Report (CAR)

I. Facility Name: LiveWell Cary
Address: 208 Midenhall Way, Cary, NC 27513
County: Wake
License Number: FCL-092-305

II. Date(s) of Visit(s): 12/14/2023; 1/17/2024
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 2/09/2024 – 2/16/2024

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 Corrective Action Plan. 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, Unabated Type B, Citation)* • *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: **10A NCAC 13G .0901 (b) Personal Care and Supervision** 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: **Type A2 Violation** This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure supervision of 1 of 3 sampled residents (#1) who was identified as having wandering, and exit seeking behaviors who eloped on 1/21/2024. The findings are: Review of Resident #1's current FL-2 dated 2/24/2024 revealed: -Resident #1 was intermittently disoriented. -Resident #1 was a wanderer. -Resident #1 was ambulatory. -Diagnoses included anxiety, depression, atrial-fibrillation, hypertension, Congestive Heart Failure, dementia. Review of Resident Register revealed Resident #1 was admitted to the facility on 2/17/2022.	☐ POC Accepted _____ *DSS Initials* Cameras have been placed in all of the common areas of home. Staff are no longer allowed to wear wireless ear buds while on working on shift. Door alarms are placed on each outgoing door to ensure that staff are notified when someone enters/leaves residence. Staff also have been instructed to lock main doors after visiting hours to secure safety of facility. Residents will be evaluated every month and as needed to determine resident's wandering status. If a resident is deemed a wander, House Manager and staff will be notified of the list of individuals who are wander risks will be placed in central location of the facility (binder in medroom). Each binder will have face sheet, including picture of resident, face sheet, emergency contact, etc. and will be updated by House Manager accordingly.	02/16/2024 02/16/2024 03/17/2024

ABATED 7/15/2024
CAW

Review of Resident #1's Care Plan dated 2/24/2023 revealed: -Mental health and social history of wandering. -Ambulation/locomotion was ambulatory with aide or device(s) with limited assistance. -Memory was significant loss – must be directed. Review of facility's Resident Wandering and Elopement Policy revealed: -Residents will be assessed by their physician and facility's Registered Nurse (RN) consultant to identify residents at risk for wandering. -Facility's RN consultant will conduct a wandering assessment to include the following factors: Is the resident independently mobile? Is the resident cognitively intact? Does the resident have competent decision-making capability? Does the resident wander? Does the resident have exit-seeking behavior? Is there a history of unsafe wandering or exiting a home or facility without the needed supervision? Does the resident accept their current residency in the facility? Does the resident verbalize a desire to leave? Has the resident asked questions about the facility's rules about leaving the facility? Is there a special event/anniversary coming due that the resident normally would attend? Is the resident exhibiting restlessness and/or agitation? -Facility's RN consultant will develop a care plan based on the results of the assessment and all care plans will be shared with the staff. -Wanderers will be included in the "At Risk" binder. Review of facility's Supervision of Wanderers Policy revealed: -The supervision of wanderers will include ongoing risk assessment, ongoing revisions of individualized plan of care to reduce risk, sight supervision and periodic checks, one-on-one monitoring, medication review, sitters, ongoing activity to engage residents, behavior logs, communication with staff, family, and visitors regarding risk, GPS tracking systems." -Staff will be trained upon hire and periodically on: 1. Staff roles and responsibilities during a search 2. Behavior management for wanderers 3. Quarterly missing person search drills	Livewell Cary Facility Elopement Policy to be updated with most current process to address elopement risks. wanderers safety, location of assessments in facility, phone tree for emergencies, educational in-services in regards to elopement. Dementia re-training to be performed with all staff including how to handle elopement risks and/or wanders. Resident/staff ratio will be evaluated each month and as needed to ensure care needs of residents are fully supported. These assessment will be documented and placed in resident's chart as well as in the Elopement Binder at the facility.	3/17/24 05/31/2024 03/17/2024

Review of Resident #1's "Root Cause Analysis" dated 1/21/2024 revealed:
-On 1/21/2024 at approximately 8:00 pm, Resident #1 eloped from the facility.
-Resident #1 was observed as being confused and disoriented that entire day according to staff.
-Resident #1 had been opening and closing the front and back doors throughout the day on 1/21/2024.
-Resident #1 had stated she "wanted to go home."
-A neighbor returned Resident #1 to the facility after approximately 25 to 28 minutes.
-Staff at that time noticed that Resident #1 was not present in the facility.
-Resident #1 was assessed for injuries and family was notified of the incident who opted out of sending Resident #1 for further evaluation.
-Resident #1 remained confused.

Review of Progress Note dated 1/22/2024 revealed:
-The Administrator notified the Primary Care Provider (PCP) of the elopement on 1/21/2024.
-No medical changes were made at that time by PCP.
-Facility's Registered Nurse (RN) was continuing to monitor and would notify PCP of any issues or concerns.

Observation on 2/05/2024 of the area where Resident #1 was located on 1/21/2024 revealed:
-There was a concrete sidewalk in the front of the facility and along the street on the same side with a street light post at the corner of the driveway.
-There was a ramp as well as stairs with approximately 3 steps in front of the facility leading down to the U-shaped driveway.
-The steps were to the left of the doorway when exiting the facility.
-The facility was located in a subdivision with a sidewalk on one side of the street which was on the same side as the facility.
-The distance Resident #1 walked from the facility was observed to be approximately 64.36 meters (211.15 feet) away from where she was found by a neighbor on the sidewalk.

Observation on 1/11/2024 during an onsite visit in the afternoon revealed:
-Resident #1 had exit seeking behaviors as exhibited by her attempting to go out the front door approximately 3 times during Adult Home Specialist (AHS) visit and was

redirected away from door by staff.
-Staff was observed responding to the door chime each time and redirected as well as engaged the residents in an activity.
-AHS observed 3 other residents were wanderers with exit seeking behaviors as exhibited by opening and closing of front and back doors.

According to www.weather.com, temperature on 1/21/2024 was high 40°, sunny, low 19°, and sunset was 5:31pm.

Based on interviews, record reviews and observations it was determined Resident #1 was not interviewable.

Telephone interview with a Medication Aide (MA) revealed:
-She was preparing medicines to be administered to Resident #1 and started at 8:03pm.
-She was not clear on whether she heard the chime on the front door.
-Resident #1 had been going back and forth to the front and back doors all day opening and closing the doors.
-Resident #1's behavior was not reported to Primary Care Provider (PCP) nor the Administrator as wandering was baseline for this resident and this was not seen as a change in behavior.
-Resident #1 was easily redirected.
-Staff knew to redirect and engage Resident #1 in an activity or just sit with her.
-She was training another staff on procedures of administering medicines at the time of the elopement.
-She recalled that Resident #1 was in the facility in close proximity to her at the beginning of prepping medicines.
-A passerby that lived in the neighborhood rang the doorbell to report a resident standing outside on the sidewalk in proximity of the facility.
-She located Resident #1 standing outside to the left of the facility on the sidewalk with her walker, night clothes and shoes on.
-She wrapped a blanket around Resident #1 and redirected her back inside the facility.
-Resident #1 was disoriented and made the comment that she was not going back and that she had to leave for a doctor's appointment.
-She assessed Resident #1, notified the Administrator as well as family.

Telephone interview attempted with another MA at 12:37pm on 2/05/2024 was unsuccessful.

Telephone interview with another MA at 3:26pm on

2/07/2024 revealed:
-She was training to be a MA at the facility at the time of the elopement on 1/21/2024.
-She recalled that Resident #1 had come up to her and the other MA mumbling something.
-Resident #1 was wandering around the facility and was back and forth a couple of times mumbling something to them.
-She was focused on her training to ensure that she was clear on the procedures of administering medications.
-The medicines that were being prepared were for Resident #1 who has a lot of medicines.
-Once completed she and the other MA was looking for resident to give medications.
-When they realized that Resident #1 was not in the facility, the other MA was going to look outside.
-A neighbor ranged the doorbell and reported they believed one of facility's residents was outside and cold.
-The other MA retrieved Resident #1 from outside the facility.
-She was not made aware of where Resident #1 was located.
-Resident #1 was assessed by the other MA, the family and administrator were notified.
-She was focused on her training and could not recall when or if the door chimed nor how long Resident #1 was missing.

Telephone interview with Resident #1's PCP at 1:12pm on 2/08/2024 revealed:
-She was notified of the incident the day after on 1/22/2024.
-A urinalysis was ordered to rule out a urinary tract infection, no antibiotics were ordered as a result.
-Resident #1 was seen by PCP on 1/30/2024 and appeared to be at baseline.
-It was discussed with the Administrator for staff to supervise more closely.

Telephone interview with Administrator on 1/25/2024 revealed:
-She had interviewed staff that was on duty at the time of the elopement.
-She discovered that Resident #1 was confused and disoriented during the day that was beyond baseline.
-Staff had not contacted her about increased confusion and disorientation of Resident #1.
-Staff had not responded to the door alarm to determine if a resident or visitor had come or gone out the door.
-Staff failed to ensure that all residents were accounted for after hearing the door alarm.
-Staff was distracted by having their earphones in their ears while working.

-She provided staff with re-education on supervision, elopement, wanderers, and provided staff with written corrective action after concluding the internal investigation.
-Resident #1's PCP was notified the next day of the elopement with increased confusion and disorientation the day of incident, and there were no changes made by PCP.

The facility failed to provide supervision for Resident #1, who was intermittently disoriented and had wandering behaviors, which resulted in Resident #1 eloping from the facility without staff's knowledge. Staff was unaware that Resident #1 was missing until returned by a neighbor, who found her standing on the sidewalk near the facility in her nightgown and it was believed she was missing for approximately 25-28 minutes. According to www.weather.com, the temperature on 1/21/2024 was to get as low as 19° that evening. The failure of the facility to ensure Resident #1 was properly supervised resulted in risk for serious physical harm of the resident and constitutes a Type A2 Violation.

Facility provided a Plan of Protection in accordance with G.S. 131D-34 on 1/26/2024 for this violation.

CORRECTION DATE FOR A2 VIOLATION SHALL NOT EXCEED <u>March 17, 2024</u>.

Rule/Statute Number: **10A NCAC 13F .0601(d) Management and Other Staffing**

Rule/Statutory Reference: (d) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents.

Level of Non-Compliance: **TYPE B VIOLATION**

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to assure adequate staffing in accordance with residents' assessed needs, care plans, and current symptoms which resulted in 1 of 3 residents (#1) who was identified as a wanderer with demonstrated exit seeking behaviors eloping from the facility without staff knowledge and was found by a neighbor outside on the sidewalk in front of the facility approximately 25-30 minutes later.

☐ POC Accepted _____
DSS Initials

Cameras have been placed in all of the common areas of home. Staff are no longer allowed to wear wireless ear buds while on working on shift.

2-16-24

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ABATED 7/15/2024

CAW

The findings are: Review of Resident Register revealed Resident #1 was admitted to the facility on 2/17/2022. Review of Resident #1's current FL-2 dated 2/24/2024 revealed: -Resident #1 was intermittently disoriented. -Resident #1 was a wanderer. -Resident #1 is ambulatory. -Diagnosis was anxiety, depression, A-Fib, hypertension, CHF, dementia. Review of Resident #1's Care Plan dated 2/24/2023 revealed: -Mental health and social history of wandering. -Ambulation/locomotion was ambulatory with aide or device(s) with limited assistance. -Memory was significant loss – must be directed. Observation of the facility on 1/11/2024 revealed: -There were two staff on duty. -Resident #1 was a wanderer with exit seeking behaviors as exhibited by her attempts to go out the front door on more than one occasion during Adult Home Specialist (AHS) visit. -AHS observed 3 other residents were wanderers with exit seeking behaviors as exhibited by opening and closing of front and back doors. -The two staff were being challenged to redirect as well as supervise these residents and provide care. -There was a front and back door to the facility with 2 wandering, exit seeking residents attempting to go out both doors. -When one staff was in the bathroom toileting a resident there was only one staff to supervise and redirect the other residents. -AHS observed staff attempting to prepare lunch while having to redirect a wandering resident out of the kitchen away from the stove. Telephone interview with Medication Aide (MA) on 2/06/2024 revealed: -MA worked all shifts at the facility. -MA was familiar with Resident #1 being a wanderer with exit seeking behaviors. -MA was preparing meds for Resident #1 at the time of the elopement while training another staff person. -MA was the only staff on duty that day along with another staff in training.	Door alarms are placed on each outgoing door to ensure that staff are notified when someone enters/leaves residence. Staff also have been instructed to lock main doors after visiting hours to secure safety of facility. Residents will be evaluated every month and as needed to determine resident's wandering status. If a resident is deemed a wander, House Manager and staff will be notified of the list of individuals who are wander risks will be placed in central location of the facility (binder in medroom). Each binder will have face sheet, including picture of resident, face sheet, emergency contact, etc. and will be updated by House Manager accordingly. Livewell Cary Facility Elopement Policy to be updated with most current process to address elopement risks, wanderers safety, location of assessments in facility, phone tree for emergencies, educational in-services in regards to elopement. Dementia re-training to be performed with all staff including how to handle elopement risks and/or wanders. Resident/staff ratio will be evaluated each month and as needed to ensure care needs of residents are fully supported. These assessment will be documented and placed in resident's chart as well as in the Elopement Binderat the facility.	2-16-24 3-17-24 3-17-24 05/31/2024 3-17-2024

ABATED 7/15/2024

-MA was often the only staff during the weekends after 8pm with 5 residents.
-After 8pm there was only one staff during the weekends due to on the weekends it was a 12-hour shift schedule.
-During the week there are 3 shifts (7am-3pm, 3pm-11pm, 11pm-7am) with only one staff person on the 11pm-7am shift.
-MA was comfortable with working alone with the 5 residents because the staff would put residents to bed before leaving and she would put the walking residents to bed after administering the 8pm medicines.
-MA never had an elopement happen before.

Telephone interview with another MA at 3:26pm on 2/07/2024 revealed:
-She was unable to assist with locating Resident #1 because that would mean leaving the other residents alone in the facility.
-She would not have been able to go after Resident #1 because the other residents would have been left in the facility alone if she was the only staff on duty.
-There was only one staff assigned to work the evening shifts in the facility.

Interview with the Administrator on 1/11/2024 revealed:
-The Administrator believed that she was staffing the facility in accordance with the census and guidelines.
-She was aware of the high number of residents in the facility that were wanderers with exit seeking behaviors.
-She was aware of there being one Medication Tech (MT) and one Personal Care Aide (PCA) on first and second shifts with one staff on third shift.
-AHS discussed with the Administrator about reevaluating staffing to meet the assessed needs and current symptoms of residents in the home which included Resident #1.

Telephone interview with the Administrator on 1/25/2024 and 1/26/2024 revealed:
-There were 2 staff on duty at the time of the elopement.
-One staff was new and was being trained by the other staff, which was the MT when Resident #1 eloped from the facility without staff knowledge.
-The Administrator was not aware that she was not in compliance in staffing. The new staff was not familiar with the residents which only left one staff person to provide supervision.
-The Administrator conducted an internal investigation which revealed that staff was distracted with their phones, saw Resident #1 in the front area around the door and failed

to redirect, and failed to respond to the door alarm when it chimed letting them know to check location of residents.
-The facility would increase staff on all shifts to meet the residents' assessed needs as well as current symptoms.

The facility failed to staff according to the assessed needs and current symptoms of the residents which resulted in Resident #1 eloping from the facility without staff knowledge and was found by a neighbor outside on the sidewalk in front of the facility. The failure of the facility to ensure adequate staffing resulted in a detrimental risk to the safety and welfare of residents and constitutes a Type B violation.

Facility provided a Plan of Protection in accordance with G.S. 131D-34 on 1/26/2024 for this violation.

CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED April 01, 2024.

IV. Delivered Via:	Electronic mail	Date: 2/16/2024
DSS Signature:	Carla Adams-White	Return to DSS by: 3/02/2024

V. CAR Received by:	Administrator/Designee (print name): Nicole Combs, RN/Administrator	
	Signature: Nicole Combs	Date: 3/7/24
	Title: RN/Administrator	

VI. Plan of Correction Submitted by:	Administrator (print name): Nicole Combs RN/Admin.	
	Signature: Nicole Combs RN	Date: 3/7/24

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: Carla Adams-White		Date: 7/15/2024
	Facility in Compliance: ☒ Yes ☐ No	Date Sent to ACLS:	7/16/2024
Comments:			

Type atext here

Facility Name: LiveWell Cary

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