Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Colonial Long Term Care
Address: 340 Snowhill Drive Mount Airy NC 27030
County: Surry
License Number: HAL-086-002

II. Date(s) of Visit(s): 06/13/2023, 06/14/2023, 06/19/2023 and 06/21/2023
Purpose of Visit(s): Facility Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: 6/27/2023

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**
Rule/Statute Number: 10A NCAC 13F .0305(h)(4) PHYSICAL ENVIRONMENT	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: 10A NCAC13F .0305(h)(4) (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.		
Level of Non-Compliance: TYPE A1 VIOLATION		
Findings: The rule is not met as evidenced by:		

Based on observations, interviews, and record reviews, the facility failed to ensure 4 of 4 exit doors were secured and alarmed with a sounding device that activated when the doors were opened, which were accessible by residents, including a resident who was intermittently confused and ambulatory and semi-ambulatory (Resident #1) who eloped from the facility without staff's knowledge and was found face down on the highway with facial injuries.

The findings are:

Review of nine residents' records identified by their physician as being constantly disoriented or intermittently disoriented and ambulatory or semi-ambulatory status that placed the residents at risk for elopement revealed:
-There was one of nine residents identified as constantly disoriented.
-There were eight of nine residents identified as intermittently disoriented.

Review of Resident #1's current FL2 dated 04/27/2023 revealed:
-Diagnoses included fracture of right femur, paranoid schizophrenia, dysphagia, hypertension, diabetes, osteoarthritis, hypothyroidism, and sleep apnea.
-Resident #1 was intermittently disoriented,
-Resident #1 was semi-ambulatory.

Review of Resident #1's Care Plan dated 04/25/2023 revealed:
-Resident #1 required limited assistance with eating, toileting, bathing, dressing, and grooming.
-Resident #1 used a walker to ambulate.
-Resident #1 received medications for mental health/behavior.

Review of Resident #1's incident report dated 06/13/2023 revealed:
-Emergency Medical Services (EMS) notified the facility on 06/13/2023 at 5:50 am that they were working with a potential facility resident who was hit by a vehicle.
-Staff were not aware Resident #1 had left the facility and only became aware when EMS contacted the facility.
-Resident #1 was last seen in the facility between 4:30am and 4:45am.

Review of EMS incident report for Resident #1 dated 06/13/2023 revealed:
-EMS received a report from unknown caller about Resident #1 on 06/13/2023 at 5:40AM.

-EMS arrived on the scene and found the fire department team treating an elderly lady lying face down in the road in front of a vehicle. -The patient had a severe laceration above her left eye. -At first, the patient was speaking incomprehensively. -A cervical collar was applied as a precaution. -There were no obvious body injuries except to the facial area. -The patient eventually was able to tell EMS her name and the facility name. -EMS called the facility and informed them they were treating Resident #1 for her injuries. -The patient was transported to a hospital with a trauma unit. Review of Resident #1's hospital discharge summary dated 06/19/2023 revealed: -Resident #1's admission date was 06/13/2023 due to being struck by a vehicle. -Resident #1 had an orbital roof fracture of her left eye. -Resident #1 had an orbital lens dislocation. -Resident #1 had a left eyebrow laceration. -Resident #1 was to follow up with the trauma clinic within 2 weeks of discharge for a head bleed. -Resident #1 was to follow up with outpatient ophthalmology for evaluation of orbital fracture within a few weeks. Observation of the facility on 06/13/2023 from 11:00am to 5:00pm revealed: -There was no sounding device on the door leading from the outside of the facility to the large lobby. -There was no sounding device on the hall entrance door. -There was no sounding device on either wing door entrances. -Residents entered and exited all four exit doors and no alarm sounded when opened. Observation of the facility on 06/14/2023 at 2:01pm revealed a resident went out the main entrance and no alarm sounded when the door was opened. Observation of the facility on 06/14/2023 at 2:25pm revealed a resident went out the hall door entrance and no alarm sounded when the door was opened. Observation of the facility on 06/14/2023 at 3:10pm revealed a resident exited the right-wing door and no alarm sounded when the door was opened.		

Observation of the facility on 06/14/2023 at 3:25pm revealed a second resident exited the right-wing door and no alarm sounded when the door was opened. Observation of the facility on 06/14/2023 at 4:02pm revealed a resident exited the left-wing door and no alarm sounded when the door was opened. Interview with the Administrator on 06/13/2023 at 11:10am revealed: -She was notified this morning around 6:00am by facility staff that (EMS) called the facility and reported that Resident #1 had been hit by a car on the road in front of the facility. -Staff did not know Resident #1 was not in the facility until EMS called. -Staff completed 2-hour checks on all residents on all shifts. -There was not a written check off policy but there was a 2-hour supervision check off sheet which staff completed. -The last time staff observed Resident #1 was between 4:30am and 4:45am which was the 5:00am check off. -It had been over 8 years since Resident #1 had any exit seeking behaviors. -The door alarms were not set this morning. -The doors were not locked this morning. -The facility was not a locked facility. -The main entrance door was never locked. -They had a lot of residents who smoked. -The residents who were smokers went out all the doors. -They had always allowed residents who smoked to smoke all during the night. -The facility doors had not been locked in a while. -The facility door alarms had not been set in a while. -The facility did not have a written policy about door alarms and locked doors. Interview with the Resident Care Coordinator (RCC) on 06/14/2023 at 2:30pm revealed: -Resident #1's normal behavior was to walk up and down the halls and go back and forth to the front porch. -Resident #1 had not had exit seeking behaviors for many years. -Resident #1 received an Invega injection (used to treat schizophrenia) every three months. -Resident #1 had been having increased agitation which she reported to the mental health clinician. -The mental health clinician had put Resident #1 on Zyprexa (used to treat agitation and Schizophrenia) but it did not work.		

-The mental health clinician changed Resident #1's Invega injection to once a month. -Resident #1 received her first monthly injection on 06/05/2023. -Resident #1's behaviors had improved since the last injection. -There was not a written policy about the door alarms or locking the facility doors. -There was a verbal policy about staff doing 2-hour checks on residents. -The door alarms used to be set and the wing doors used to be locked. -The door alarms had not been set in a couple of years. -The doors had not been locked in a couple of years. -The keys to the doors were lost and they stopped locking the doors. Interview with the third shift Medication Aide (MA) on 06/16/2023 at 9:00am revealed: -The last time she saw Resident #1 on 06/13/2023 was around 4:30am or 4:45am. -Resident #1 was sitting up on the side of her bed. -Resident #1 had nights she did not sleep well. -Resident #1 had been agitated ever since her surgery for a broken arm on 04/16/2023. -She had checked to see if there were any as needed medications for Resident #1, but they had been discontinued. -She was doing laundry when EMS called reporting the accident with Resident #1 at 5:50am. -Resident #1 had told EMS her name and where she lived. -Staff did not know Resident #1 was not in the facility until EMS called. -The door alarms had not been set since she had been working, within the last 6 or 7 months. -The doors had not been locked since she had been working. -Resident #1 had not had any exit seeking behaviors since she had been working. Interview with the mental health provider on 06/16/2023 at 2:45pm revealed: -She had been discussing Resident #1's agitation, hypersexual behavior, agitation, and refusal of care with the RCC. -She prescribed Zyprexa for Resident #1, but it did not work for her, so she discontinued it. -She then prescribed a monthly Invega injection which was working for Resident #1. -The as needed medication had to be discontinued when Resident #1 was switched to the monthly Invega injection.		

(She could not receive the monthly injection and the PRN both). -Resident #1 had never shown any kind of exit seeking behavior. Interview with a third shift PCA on 06/21/2023 at 9:51am revealed: -She had last observed Resident #1 on 06/13/2023 around 4:30am walking down the hall to her room. -Resident #1 had been sleeping on a couch in the living room and staff had redirected her to her bedroom. -Resident #1 was always more argumentative and walked around the facility more right before she received her Invega injection. -Resident #1 had never wandered away from the facility before. -She had been working at the facility for 4 months. -The door alarms had not been set during that time. -The doors had not been locked during that time. -Staff did not know Resident #1 was not in the facility until EMS called the facility at 5:50am. Interview with another third shift PCA on 06/21/2023 at 2:05pm revealed: -She had last observed Resident #1 on 06/13/2023 around 4:00am. -Resident #1 was asleep on the living room couch and she woke her up to go to bed. -Resident #1 had been up and down all night. -Later, she provided incontinence care for 2 residents and had gotten them up for breakfast. -Then, the phone rang at 5:50am, and it was EMS calling. -She did not know Resident was not in the facility when EMS called. -She had worked at the facility for 8 months and the door alarms had not been set during that time. -None of the doors had been locked during that time. Interview with Resident #1's guardian on 06/14/2023 at 9:00am revealed: -She had been Resident #1's guardian for a few weeks. -She had not been told of any concerns about Resident #1 having exit seeking behaviors. -The facility informed the guardian about the accident on 06/13/2023. Interview with Resident #1 on 06/20/2023 at 11:30am revealed: -She left the facility walking.		

-She had on a night gown.
-She fell and hit her face and eye.
-Her face and eye hurt.

Interview with a second resident on 06/21/2023 at 3:05pm revealed:
-She had been at the facility for a few months.
-There had not been any door alarms set since she had been at the facility.

Interview with a third resident on 06/21/2023 3:08pm revealed:
-Resident #1 would get up out of her bed a lot at night.
-There had not been any door alarms set since she had been at the facility.

Interview with a fourth resident on 06/21/2023 at 3:15 revealed:
-Resident #1 was walking back and forth to the front lobby door often the night before the accident.
-Resident #1 seemed agitated that night.

Interview with a fifth resident on 06/21/2023 at 3:22pm revealed Resident #1 was lying on the couch in the living room when he went to bed at 11:00pm.

Second interview with the Administrator on 06/16/2023 at 1:00pm revealed they had never been told that the door alarms had to be set at all times when they had residents who were intermittently disoriented or wandered.

The facility failed to ensure all exit doors were alarmed when there was at least one identified resident who wandered or was disoriented resulting in Resident #1 eloping form the facility without staff's knowledge and who was found face down on the highway and sustained an orbital roof fracture of her left eye, an orbital lens dislocation and a left eyebrow laceration. This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/16/2023 for this violation.

THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JULY 27, 2023.

IV. Delivered Via:	In Person	Date: 7/03/2023
DSS Signature:	Charlene Sawyer AHS	Return to DSS By: 7/25/23

V. CAR Received by:	Administrator/Designee (print name):	
	Signature: Cindy Faye	Date: 7-3-23
	Title: manager	

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: Charlene Sawyer	Date: 8/24/23
Comments: Administrator faxed POC on 7/13/23 but AHS did not receive. AHS inquired about POC and administrator resaped POC on 8/18/23.		

VIII. Agency's Follow-Up	By: Charlene Sawyer		Date: 9/14/2023
	Facility in Compliance: ☑ Yes ☐ No		Date Sent to ACLS: 9/15/2023
Comments: Facility in compliance A-1 Violation Abated			

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

POC

Colonial Care (CAR) Corrective Action Report 7-13-23

The facility immediately assed all residents to determine the potential for wandering. The assessment will be called the (Wandering Risk Assessment). The assessment will be done upon any new admission of any new resident. Assessments will also be completed bi-annually on all facility residents and when there is any change of status of a resident. All wandering risk assessments will be reviewed by either the facility Medical Director or Physician's Assistant. Each resident's wandering risk assessment will be filed in their individual chart.

The facility initiated a new safety plan. The plan will consist of bed rounds being completed on all even hours, with the rounding checklist to be completed each round. Two hour checks will be done on all odd hours to ensure all residents are accounted for; along with completing the checklist each round. The safety plan will also consist of what steps to take if a resident is not accounted for. All doors that residents have access will have alarms turned on 24/7.

The resident care coordinator (RCC) and/or her designee will ensure all residents receive the wander risk assessment upon admission, bi-annually, or with any change of status by conducting facility audits. Facility audits on wandering risk assessments will be completed monthly for 3 months and thereafter quarterly to ensure all residents are receiving wandering risk assessments timely and promptly. Any assessments found missing or incomplete will be reviewed and completed immediately. In-services will be held with all the appropriate staff members on the wandering risk assessments. Staff education shall be completed by 7-20-23.

The resident care coordinator (RCC) and/or her designee will ensure all exit doors are secured and alarmed with a sounding device that is activated when the door opens, which are accessible by residents, including a resident who is intermittently confused and ambulatory and semi-ambulatory. Door alarm checks will be completed weekly to ensure proper function, and sufficient volume that can be heard by staff members when the door is opened and alarm activated. Door alarm checks will be documented in a binder and kept by the RCC. Door alarms not working properly shall be immediately repaired and put back in proper working order.

The facility will make above mentioned Corrective Action Report (CAR) part of its quarterly Quality Assurance meetings. All documentation of the facilities QA meetings will be kept by the facility Administrator. All facility staff will receive continuous education on any new items brought to QA, up to and including resident wandering risk assessments and facility door alarm policy and procedure.