Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Wellington House Assisted Living
Address: 850 Majestic Court Gastonia, NC 28054
County: Gaston
License Number: HAL-036-031

II. Date(s) of Visit(s): 09/04/23, 09/05/23, 10/06/23, 10/26/23, & 11/01/23
Purpose of Visit(s): Complaint Investigation

Exit/Report Date: 11/01/23

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). When an Administrative Penalty will be recommended, the facility will have an opportunity to schedule a conference or submit additional information within **10 days** from the mailing or delivery of the 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 13F .0901 (b) Staff shall~~ provide supervision of residents in accordance with each residents' assessed needs, care plan and current symptoms	☑ ~~POC Accepted~~ *DSS Initials*	~~11/30/23~~
Rule/Statutory Reference: Personal Care and Supervision		
Level of Non-Compliance: Type A2 Violation		
This Rule is not met as evidenced by: Based on interviews, record reviews, and observations, the facility failed to ensure supervision for 1 of 1 sampled resident (Resident #1), who had history of wandering behaviors and a diagnosis of dementia, who eloped from the facility and was found 4.2 miles away. Record review of Resident #1's Fl-2 dated 08/06/23 revealed: -Diagnoses included Moderate late onset Alzheimer's dementia without behavioral distractions. -She was intermittently disoriented. -She was ambulatory. -Her level of Care was Special Care Unit (SCU). Review of Resident #1's Care Plan dated 08/31/23 revealed: -She was admitted on 08/31/23. -She had a history of wandering behaviors. -She was sometimes disoriented. -She had significant memory loss and must be directed.	"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law." Facility Executive Director will host an all care staff meeting to review the facilities elopement policies and conduct inservices/training on wandering and elopement. Facility Special Care Coordinator will review and update all residents for the need of increased supervision beyond 2 hour checks. If need is present during review SCC will add increase supervision to the resident's care plan and to the MAR to be implemented and monitored for completion. Facility Special Care Coordinator will review and update as necessary all resident face sheets and electronic health record to reflect wandering elopement risk Facility Special Care Coordinator upon new admission will implement increased supervision as necessary for 72 hours if resident exemplifies any behaviors associated wandering and risk of elopement and or has any past history of exit seeking behaviors upon assessment of new admission.	11/30/2023 11/30/2023 11/30/2023 11/30/2023

Review of Resident #1's Accident/Incident Report dated 09/03/23 revealed: -At approximately 12:15pm on 09/03/23, Resident #1 could not be located in the facility. -Facility staff started elopement drill. -Resident #1's family member was notified on 09/03/23 at 12:15pm. -Resident #1's Primary Care Physician (PCP) was notified on 09/03/23 at 1:30pm. -Resident #1 was transported to the Emergency Room (ER) on 09/03/23 at 1:30pm. -The Accident/Incident Report was created by a medication aide (MA) on 09/03/23 at 1:54pm. -The Accident/Incident Report was closed by the Memory Care Manager (MCM) on 09/04/23 at 1:34pm. Review of the police report dated 09/03/23 for Resident #1 revealed: -Incident of a missing resident occurred on 09/03/23 at 10:30am -Missing resident reported to police 09/03/23 at 12:17pm. -Resident was found, case closed/cleared on 09/03/23 at 1:00pm.	Facility Executive Director will purchase a back up system for exit doors in the event the mag locks fail. They will be placed on all exit doors and monitored on a weekly basis along with the mag locks by the maintenance director for function and need for replacement. Facility Executive Director will complete an elopement drill for all staff and moving forward will ensure an elopement drill is completed monthly to cover all staff.	11/30/2023 11/30/2023
Review of police documented narrative report dated 09/03/23 for Resident #1 revealed: -Police responded to a missing person special call at 12:20pm after facility staff called in a missing person report. -The missing resident was 86 years of age with Alzheimer's dementia. -The missing resident was admitted to the facility four days ago. -Facility staff reported the facility back door had been propped open and resident wandered out of the facility. -The missing resident was last seen on 09/03/23 at 10:45am. -Police and medical personnel responded to the facility. -A picture of the missing resident was distributed. -Police started a search of the area. -Police observed a Picture of the missing resident. -The resident was recognized by police to have been seen walking around 10:45am. -Police drove back to the area where the resident had been observing walking at 10:45am. -Police spoke to a couple walking and said they had seen the missing resident about an hour earlier. -The missing resident was located a few minutes later. -The missing resident stated she thought she was in another town. -The missing resident was transported by police to the facility		

where she was evaluated by paramedics.
-The missing resident was transported to hospital for tachycardia elevated heart rate) and hypotension (low blood pressure).

Review of Resident #1's hospital discharge summary dated 09/03/23 revealed:
-Resident #1 had a low blood pressure.
-Resident #1 had a history of hypotension and dehydration.
-Resident #1's exam included: lab work, chest x-ray due to fever, intensive care monitoring and pulse oximetry (oxygen level) monitoring.

Review of hospital medical record dated 09/03/23 revealed:
-Resident #1 was presented to the emergency department (ER) secondary to history of hypotension.
-Resident #1 went missing from an assisted living facility around 10:30am today.
-Resident #1 was found approximately 4 miles from facility in the heat on 09/03/23.
-Resident #1's blood pressure was apparently in the low 100's systolic.
-Resident #1 had some leg swelling.
-Resident #1 had extensive history of dementia.
-Resident #1 was confused on a daily basis.
-History was obviously limited secondary to baseline confusion secondary to dementia.
-Resident #1 had mild dehydration.
-Resident #1 received IV hydration and was observed.
-Resident #1 was discharged from ER back to the facility on 9/03/23.

Review of Resident #1's facility care notes dated 09/01/23 revealed:
-Resident #1 was angry and cursed facility staff because she could not exit the facility.
-Resident #1 was agitated, pacing from door to door trying to get out.

Review of Resident #1's Mental Health Provider's (MHP) notes dated 09/05/23 revealed:
-She was being seen for unspecified dementia, moderate, with other behavioral disturb.
-She was a high risk of falls, a risk of elopement, and her current psychotropic medication regimen ineffective.
-Her associated signs and symptoms of elopement were wandering and exit seeking.
Interview with Resident #1 on 09/04/23 at 11:20am revealed:
-The door was open, and she walked out.

-She wanted to go for a walk. -She waved and talked to the neighbors. -She did not get in the car with anyone. -She walked back to the facility. -She did not go to the hospital. -She was unable to state the time that she left the facility. Interview with a MA on 09/04/23 at 11:10am revealed: - A Personal Care Aide (PCA) went to Resident #1's room to get her for lunch. -Resident #1 was not in her room. -The PCA informed her Resident #1 was missing. - All resident rooms and the facility grounds were checked. -The resident was not located. -The police was called, and arrive at the facility. -The police distributed a picture of Resident #1 to other police officers. -The police located Resident #1 across town at an apartment complex. -Emergency Medical Services (EMS) was waiting at the facility to evaluate Resident #1 upon her return. -EMS transported Resident #1 to emergency room due to low blood pressure. -Resident #1's blood pressure was 80/50.		
Interview with a PCA on 09/04/23 at 11:45am revealed: -On 09/03/23 Resident #1 was sitting on her bed at 11:00am. -When she went to get Resident #1 for lunch she was not located in the facility. -She informed the MA Resident #1 was missing. -Staff searched inside and outside of the facility. -Resident #1 was not located. -Police was called and notified Resident #1 was missing from the facility. Interview with a second PCA on 09/05/23 at 12:55pm revealed: -On 09/03/23 Resident #1 came to area in the front of the facility and asked to get out of the facility. -Resident #1 was told she could not leave. -The only person who could let her out was the person who put her in the facility. -She was taking lunch trays to resident rooms around 12:00pm and Resident #1 was not in her room. -She called the Memory Care Manager (MCM) and said Resident #1 was missing. -Residents are supervised at least every two hours. -Residents were observed by staff while the residents are walking in the hallways and sitting in the common areas.		

-Resident #1did not receive extra supervision due to exit seeking. Interview with a third PCA on 09/04/23 at 2:00pm revealed: -On 09/03/23 she handed out snacks to residents at 10:15am. -Resident #1 was sitting on her bed and received a snack. -Resident #1 would ask daily about getting out of the facility. -Resident #1 would wait by the front door to try and leave the facility. -She did not know how Resident #1 could have wandered away from the facility. -Around 11:00am another PCA stated she observed Resident #1 packing her clothes. -She went on break at 12:00pm. -When she returned from her break, she was told Resident #1 was missing. Interview with Memory Care Manager on 09/05/23 at 12:25pm revealed: -She was informed by the MA Resident #1 was missing from the facility. -Staff had searched inside and outside of the facility. -The MA stated Resident #1 was observed in the facility for morning snack at 10:15am. -The MA stated the gate off the patio area was left open. -The gate being left opened allowed Resident #1 to walk off the facility property. -She arrived at the facility at approximately 1:15pm to assist with the search for Resident #1. -Resident #1 was located by the police at an apartment complex approximately 4 miles from the facility. -EMS transported Resident #1 to the hospital for evaluation. Interview with Memory Care Manager on 10/26/23 at 10:45am revealed: -Newly admitted SCU residents were to be supervised every hour for three days. -There was no documentation of the hourly supervision for Resident #1. -After three days the residents were to be supervised every two hours which is standard for all residents. -Resident that was exit seeking did not receive any extra supervision. -The residents with exit seeking behaviors were to be redirected from the exit doors. -Resident #1 was continuing daily to exit seek. -On 09/03/23 a MA informed her a door was left propped open and then stated the gate on the patio area was left opened too.		

-The gate that was left opened when 3rd shift staff left work on the morning of 09/03/23. -This gate was used daily for staff arriving and leaving work. -The facility door leading to the patio area was sometimes hard to close. -The door leading to the patio had to be pushed hard to make sure the door was closed. Interview with the Administrator on 09/05/23 at 12:15pm revealed: -On 09/03/23 she received a text from the MCM that Resident #1 was missing. -She called the MA on duty regarding the missing resident. -The MA said Resident #1 was missing. -The MA called the police. -She arrived at the facility at 12:45pm to assist with the search. Interview with the Administrator on 10/06/23 at 10:50am revealed: -There was no back up alarm system to the doors. -If the doors maglocks failed to operate there was no way to know the doors were not locked. -The door maglocks were not monitored or checked daily for proper operation. Interview with the Administrator on 10/26/23 at 10:50am revealed: -The gate off the patio could have been left opened by staff. -The facility doors were checked when there were monthly fire drills. -There was no documentation of the door checks. -When the maglocks on the doors were inoperable a red light on the keypad flashes. -When the red light was flashing, the fire watch protocol goes into place. -There were no indicators, such as an alarm indicating the maglocks were inoperable. -Staff had to be vigilant of the red light flashing. -Staff were posted at each door on each shift until the door was operating properly. -New residents were monitored every two hours for three days to ensure there were no medical concerns noticed. -Staff rounded on all residents every 2 hours. -Received increase supervision and were to be redirected away from exit doors. Summary Statement: The facility failed to ensure Resident #1 who resided in the		

Facility Name:

SCU with a diagnosis of dementia and exit seeking behaviors was supervised allowing the resident to elope from the facility and later found by police 4.2 miles away resulting in the resident being sent to the hospital to be treated for low blood pressure and dehydration. This failure resulted in substantial risk for physical harm to the resident and constitutes a Type A2 Violation The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/05/23. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED November 30, 2023.		

IV. Delivered Via:	Hand delivered	Date:	11/1/23
DSS Signature:	Mary Hailey	Return to DSS By:	11/22/23

V. CAR Received by:	Administrator/Designee (print name): Sheronda Newsome	
	Signature: Sheronda Newsome	Date: 11/1/23
	Title: Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name):	Sheronda Newsome	
	Signature: Sheronda Newsome	Date:	11/20/2023

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		
☐ *POC Accepted*	By: Mary Hailey	Date: 12/21/23
Comments: AHS received POC during the follow-up visit. The POC was not received prior to 12/21/23.		

VIII. Agency's Follow-Up	By: Mary Hailey		Date: 12/21/23
	Facility in Compliance: ☑ Yes ☐ No	Date Sent to ACLS:	
Comments:			

Facility Name:

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