Adult Care Home Corrective Action Report (CAR)

I. Facility Name: McCullough's Rest Home
Address: 720 Orr's Camp Road, Hendersonville, NC 28792
County: Henderson
License Number: HAL-045-005

II. Date(s) of Visit(s): 07/12/23, 08/03/23, 08/23/23, 09/05/23
Purpose of Visit(s): Complaint Investigations
Exit/Report Date: 10/06/23

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 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 .0909 RESIDENT RIGHTS	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	"Residents' Rights Training" was initiated and completed for All staff providing services to the residents by 10/31/23. The training was conducted by Cori Search 828-251-6622 (Lead Regional Ombudsman) from Land of the Sky Regional Council.	10/31/23
Level of Non-Compliance: Type A1 Violation Findings: Based on observations, interviews, and record reviews the facility failed to ensure 1 of 1 resident (Resident# 2) was free from exploitation by Staff A, Medication Technician/Supervisor (MT/S): Review of facility's undated policy on Employee-Patient Relationships revealed: • A licensee's responsibility is to provide competent, compassionate care that is in the best interest of the patient. • Personal relationships between individuals in unequal positions, such as a professional with authority over another, may be inappropriate in the workplace.	Patient 2 was moved to another facility. to accommodate DSS request. I have included statements from the patient in question and the staff member in reference the the friend ship they have.	

- Relationships based on trust, openness, and good communication are key to working with patients.
- Employees must not engage in personal relationships with patients they meet through their employment.

Review of Resident #2's Resident Register revealed:
- Resident #2 was admitted to the facility 10/5/22.
- Resident #2 did not have a power of attorney, guardian, or responsible party.

Review of Resident #2's care plan dated 10/21/22 revealed:
- Resident required extensive assistance with bathing, dressing, and grooming/personal hygiene.
- Resident was independent for eating, toileting, ambulation/locomotion and transferring.
- Handwritten notes in the other section documented Resident #2 required the assistance of one person to help in and out of tub, lay clothes out, hang clothes, help with shampoo, room cleaned, help dress and undress.

Review of Resident #2's current FL2 dated 02/06/23 revealed:
- Diagnosis of schizoaffective disorder, bipolar type with a 05/11/17 date of onset.
- Resident #2 was discharged from the hospital to domiciliary level of care.

Review of Resident #2's Psychological Evaluation dated 05/17/23 revealed:
- Resident seemed to understand most questions and was able to follow simple instructions but had difficulty with multi-step instructions.
- Resident had difficulty retaining information and maintaining attention over time.
- Resident had a history of trauma, bipolar disorder, borderline personality disorder, neurocognitive disorder due to TBI (traumatic brain injury), substance abuse disorder and mild intellectual disability.
- Resident reported experiencing significant mental health, cognitive impairments, and traumatic events in their history.
- Resident reported a traumatic brain injury in 2005 from a car accident and was in a coma for a significant amount of time.
- Resident had post trauma symptoms including nightmares, flashbacks, avoidance of thoughts and feelings, and sleep difficulties.
- Resident appeared to lack insight into having any current symptoms of depression and was a poor historian.

I have advised in the future that any patient that has checked themselves out of the facility must not be picked up by staff and driven back to the facility.

This resident needed help with self esteem and genuine care.

- Resident was born prematurely (after five months) and only weighed one pound and five ounces and was likely delayed in reaching all of their developmental milestones at a normal rate.
- Resident obtained a full-IQ scale of 50 on 05/17/23 which placed resident within the extremely low range of intellectual functioning, communication skills, and daily living skills. (An IQ scale is a total score derived from a set of standardized tests or subtests designed to assess human intelligence. The range of an average IQ score is 85-115).
- Resident's Vineland Adaptive Behavior Scales test indicated: communication skills as low, daily living skills as low, and socialization skills as low (score was greater than or equal to less than 1% of individuals in this age range).
- Resident's Wide Range Achievement test indicated resident scored extremely low in math computation, spelling, word reading, and sentence comprehension with grade level equivalency of kindergarten through 2nd grade with their abilities falling significantly below the normal limits of functioning.
- Resident met the criteria for a moderate intellectual disorder.
- Resident would benefit from continuing to reside in an assisted living facility.
- Resident would always need assistance with self-care, daily living, communication, and social functioning.
- Resident would benefit from weekly individual therapy, social skills group therapy, vocational skills training, and close psychiatric medication management.
- Resident was likely easily influenced by others and is socially naïve.
- Resident's cognitive impairments were life-long, and resident would continue to need services indefinitely.

Telephone interview with Resident #2's home health nurse on 07/07/23 at 8:17 am revealed:

- On 06/26/23 they arrived at the facility between 7:30 am and 7:45 am to complete a blood draw for Resident #2.
- The nighttime Supervisor reported that Resident #2 was not at the facility and was out with Staff A.
- Resident #2 arrived at the facility at 8:17 am in a private vehicle with Staff A.

Interview with Resident #2 on 07/12/23 at 2:00 pm revealed:

- They have never spent the night at any staff member's house.

Included statement.

- They were not having a relationship with any staff members or any facility residents.
- They do not remember missing the initial home health visit on 6/26/23 and do not know why the complaint indicated they were not in the facility that morning.

Interview with the Administrator on 08/03/23 at 12:00 pm revealed:

- Staff A typically works at the facility Monday through Friday from 8:00 am to 8:00 pm.
- Staff A would often take Resident #2 out of the facility on weekends to "pick up drinks" at the grocery store.
- Staff A would often take other residents out of the facility on weekends to go to the store or to a fast-food restaurant.
- It was not uncommon for Staff A to come to the facility on weekends.
- She did not know if Resident# 2 was at the facility every night.
- The nighttime Supervisor previously reported to her that Resident #2 was out of the facility with Staff A when they were off shift.
- Resident #2 would go to their room as soon as Staff A left for the night and lock their door.
- Resident #2 requested that they not be checked on after the evening medication pass.
- She received two complaints from people prior to today who were concerned Staff A was involved "in a relationship" with Resident #2.
- AHS social worker asked how those complaints were handled and the Administrator responded that she could not control what Staff A did on their own time.
- AHS social worker asked about the facility's policy regarding Employee-Patient Relationships and she did not respond.

Interview with Staff A on 08/03/23 at 12:50 pm revealed:

- They did not bring Resident #2 to their home.
- Resident #2 did not spend the night with them.
- They were unsure where Resident #2 was the morning of 06/26/23.
- They did not know if Resident #2 ever left the facility at night and did not return.
- Resident #2 never left the facility when they worked on Thursday nights.

Telephone interview with the nighttime Supervisor on 08/03/23 at 1:40 pm revealed:

- They currently work Monday through Friday and arrive

Staff A looks out for all the patients.

Staff A is liked by all residents and is kind to them.

between 7:30 and 8:00 pm.

- They were not aware if Resident #2 ever spent the night outside of the facility.
- Resident #2 typically went into their room after the evening medication pass, locked the door, and requested not to be bothered after 8:00 pm.
- Staff A may take Resident #2 outside of the facility for shopping at the store.

Telephone interview with the Administrator on 08/03/23 at 2:24 pm revealed:

- She interviewed Staff A and Resident# 2 separately and then together.
- The information gathered from those interviews did not match the information they had given to the AHS social worker earlier.
- Staff A told her that they and Resident #2 "are in love and just want to be together".
- Staff A wanted Resident #2 to leave the facility and come live at their house.
- She explained to Staff A that Resident # 2 could not spend nights away from the facility because the facility was their home.
- Staff A told her they wanted Resident #2 to move out of the facility immediately and live at their home.
- When she spoke with Resident #2 alone, Resident #2 verified they wanted to move out and live with Staff A.
- Staff A and Resident #2 together asked her to allow Resident #2 to move out and live with Staff A.
- Resident #2 is planning to move out of the facility over the next two to three days.
- Resident #2 provided a handwritten note on a sheet of notebook paper with their intent to discharge from the facility within 14 days.
- Resident #2 was notified that a 14-day discharge had also been issued by the facility.
- She was unsure if Resident #2 had spent any nights away from the facility with Staff A.
- Resident #2's mental health provider was at the facility today, 08/03/23 and met with Resident #2 and is fine with Resident# 2 moving out of the facility to live with Staff A.
- Administrator realized during the interview that a 30-day discharge notice was required and indicated she would correct the 14-day discharge.

Interview with Staff A on 08/23/23 at 10:35 am revealed:

- One morning when they were driving to work Resident #2

Staff A and Resident 2 became good friends and Staff A helped Resident 2 with her self esteem and Resident 2 always wanted to be around Staff A. This was not a romantic relationship. Its was one of mutual respect and concern for one another's well being.

was walking toward the facility and was picked up in their car and driven back to the facility.
- This could have been the day the home health nurse reported Resident #2 was not at the facility.
- Resident #2 did not tell them where they had been that morning.
- Staff A denied "being in love" with Resident #2 but did acknowledge they offered to allow Resident# 2 to move in with them.
- They told Resident #2 they could move in together "if DSS allowed it".
- Resident #2 was "like a younger sibling" to them.

Interview with Resident #2 on 08/23/23 at 10:55 am revealed they did tell the Administrator they were in love with Staff A on 08/03/23 but they were only friends with Staff A.

Interview with Administrator on 09/05/23 at 11:20 am revealed:
- Resident #2 moved into a new facility 08/28/23.
- Staff A asked for directions to Resident #2's new facility because the facility housekeeper wanted to visit Resident #2.
- She did not believe that the housekeeper was planning to visit Resident #2.
- She did not provide directions to Resident #2's new facility to Staff A.
- An internal investigation was completed and substantiated.
- The 24-hour and 5-day reports were completed and faxed to the Health Care Personnel Registry on 08/03/23 and 08/16/23 regarding Staff A and this incident.
- Staff A was still actively employed by the facility.

Telephone interview with the facility medical provider on 09/05/23 at 3:56 pm revealed:
- They were not the facility provider when Resident #2 was admitted to the facility.
- They were not sure if Resident #2 was an appropriate candidate for assisted living at admission.
- Resident #2 was often witnessed helping at the facility by answering the phone and providing information to the caller at Staff A's request and direction.
- Resident #2 needed supervision with bathing, dressing and personal hygiene due to schizophrenia or schizoaffective disorder.

Telephone interview with Resident #2's mental health

provider on 09/05/23 at 4:15 pm revealed:

- They didn't think Resident #2 moving in with Staff A was a great idea, but the facility didn't ask their opinion and they did not offer an opinion.
- Resident #2 needing an assisted living facility or family care home could be debatable.
- They were not aware that Resident #2 had an IQ of 50.
- Based on the IQ of 50, resident would require at least a family care home level of care.
- They would not have been supportive of Resident #2 having a relationship with Staff A, but it wasn't really any of their business.

Telephone interview with the weekend Supervisor on 09/08/23 at 5:03 pm revealed:

- There was one night that Resident #2 left the facility with Staff A and when the nurse arrived the next morning to draw blood, they had to tell the nurse that Resident #2 spent the night away from the facility with the Staff A.
- There were "a couple more nights prior" that they knew of when Resident #2 spent the night away from the facility.
- Resident #2 continued to spend nights away from the facility even after the nurse came.
- Staff A would often bring Resident #2 back to the facility on the weekends for medications and then would leave again with the resident.
- Resident #2 had been spending almost every weekend away from the facility since the nurse's visit date.
- The only weekend they can remember when Staff A didn't take Resident #2 away from the facility was the weekend after DSS visited on 08/03/23.
- Resident #2 started spending nights with Staff A sometime in May 2023.
- They mentioned this situation to the Administrator prior to 06/26/23.
- The Administrator said they were not getting involved in it and they didn't know anything was happening between Staff A and Resident #2.
- The Administrator knew prior to the AHS social worker visit on 08/03/23 that this was happening.
- Some of the other facility residents were also aware Resident #2 was leaving the facility with Staff A for overnight visits.
- Resident #2 could have easily locked their bedroom door and left out the front entrance without anyone knowing.
- Staff A did not come to the facility the weekend of 09/02/23 and 09/03/23, which was out of the ordinary,

Do to the fact that Resident 2 was checking themselves out the assumption was they were with Staff A.

They were mistaken in their assumptions.

Not true.

because Staff A had previously visited the facility every weekend while not working.

- They would often see Resident #2 "huddled up against" Staff A when medications were being passed.
- After AHS social worker visited 08/03/23, Resident #2 started walking down the road and was picked up by Staff A away from the facility.
- Resident #2 and Staff A would spend a great deal of time in Staff A's car in the facility parking lot.
- The Administrator "loves Staff A to death" and always "takes up for them" whenever anyone brings something up.
- The nighttime Supervisor and most of the residents were also aware of Resident #2 leaving the facility and spending nights away with Staff A.

A quiet space Staff A could help build Residents 2 self esteem. Without interruptions.

They were mistaken in their assumptions.

The facility failed to ensure Resident #2, who had a diagnosis of schizoaffective disorder and an IQ of 50, was free from exploitation by Staff A resulting in Resident #2 leaving the facility overnight on multiple occasions and becoming involved in a relationship with Staff A. The Administrator was made aware of the allegations but did not complete appropriate protective measures to protect Resident #2. The failure resulted in serious exploitation and neglect which constitutes a Type A1 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/05/23.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 11/06/23.

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IV. Delivered Via: hand delivered	Date: 10/13/23
DSS Signature: [signature]	Return to DSS By: 11/3/23

V. CAR Received by:	Administrator/Designee (print name): Sylvia Virginia McCullough	
	Signature: Sylvia V. McCullough	Date: 10/13/23
	Title: Adm.	

VI. Plan of Correction Submitted by:	Administrator (print name): Sylvia Virginia McCullough	
	Signature: Sylvia Virginia McCullough	Date: 11/3/2023

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

☐ ***POC Not Accepted*** | By: | Date:

Comments:

Facility Name: McCullough's Rest Home

☒ *POC Accepted* | By: [signature] | Date: 11/13/2023

Comments:
DSS did not request that resident be moved from the facility.

VIII. Agency's Follow-Up | By: [signature] | Date: 12/20/23

Facility in Compliance: ☒ Yes ☐ No | Date Sent to ACLS: 12/20/23 CB

Comments:
Facility is in compliance at this time.

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