Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Phoenix Assisted Care
Address: 201 Westhigh St. Cary, NC 27513
County: Wake County
License Number: HAL-092-131
II. Date(s) of Visit(s):
07/11/2023,07/19/2023,07/25/2023,07/26/2023,
08/15/2023
Purpose of Visit(s): Complaint Investigations

Instructions to the Provider ***(please read carefully)*****:** Exit/Report Date: 09-11-23

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. 0901 (b)	☑ POC Accepted MMcA *DSS Initials*	
Rule/Statutory Reference: Personal Care and Supervision 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		
Findings: This rule is not met as by: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#4) who had a diagnosis of dementia resulting in the resident eloping from the facility.		

Facility Name:

The findings are: Review of facility's Missing Residents policy revealed: -"A resident will be considered missing when he/she is not in the facility and we cannot verify their whereabouts; and in addition , there is a reason to be concerned for the resident's safety." -"If the facility discovers a resident missing, we will: Notify the supervisor and all other staff immediately, Perform a hasty search of the building and the immediate areas outside the building, Notify Project Life Safety." -"If the resident is not found we will immediately notify Law enforcement-call 911, the residents family member/ responsible person, the County Department of Social Services." Review of Resident #4's FL-2 dated 03/08/23 revealed: -The resident had a diagnosis of dementia. -The resident was intermittently disoriented and ambulatory. -Recommend level of care was Assisted Living (AL). Review of Resident #4's Resident Register Revealed: -The resident was admitted to AL on 04/04/22. -The resident was forgetful and needed reminders. Review of Resident #4's Care Plan signed by the physician 03/18/23 revealed: - The assessment date and reassessment date were not documented. -The resident required no assistance with transferring. -The resident required supervision with eating and ambulation. -The resident required limited assistance with toileting, bathing, dressing, and grooming. Review of Resident #4's Wandering Risk Assessment dated 03/30/22 revealed, based on questions answered, the resident was not at risk for wandering. Review of the local emergency medical services (EMS) report for Resident #4 dated 06/21/23 revealed: -A bystander found Resident #4 walking down the street, confused, and thought that he might have wandered away from a nearby facility. The bystander walked the resident to that address; he did not reside at that facility. EMS was summoned. The resident was able to communicate his name but not his age, address, date, etc. The local police department was contacted for assistance and advised they	Resident exhibited a new onset of impaired decision-making (wandering) signaling a significant change in his condition of which the facility immediately contacted the physician to seek referral for locked special care unit. 6/21/2023 Facility will respond immediately in the case of an accident or incident involving a resident to provide care according to the needs of the residents, (such as obtaining assistive devices, increased supervision, seeking advice from physician/OT/PT/ST, etc.) RCC/Designee will identify any needed interventions for residents exhibiting a need for supervision and ensure staff are trained on each individual residents needs. Administrator/Designee will conduct stand up meeting 5 days/week with staff to follow up on resident supervision concerns/issues and other medical/physical conditions. Administrator will monitor supervision provided to residents based on need identified in the care plan x 5 days per week	10/23/2023

Facility Name:

were unaware of any missing persons. EMS began to call assisted living facilities in the area to inquire if there were any residents missing. This facility had a resident that matched the description but was unaware he had left the property. The staff was advised the resident was with EMS; they needed to send someone with medical records and face sheet before he could be released to them. After staff from this facility arrived, EMS contacted the resident's/ Power of Attorney (POA) who was notified the resident wandered away from the facility without staff's knowledge. The POA was advised of the resident's vital signs and offered transport to the emergency department (ED) for further evaluation.

Interview with the Executive Director (ED) of the other assisted living facility 7/25/23 at 1:30pm revealed:
- The resident was dropped off by a person in the community who observed him walking down the street and confused.
- The resident had no identification but was able to provide his name.
-EMS was called for assistance about 2:15pm.
-EMS stated local police department had no missing persons reported.
-She suggested EMS call neighboring assisted living facilities an inquire about missing residents.
- At approximately 2:38pm this facility verified Resident #4 was missing from the facility. They were unaware he had left.
-At approximately 3:00pm staff arrived to return resident to this facility.

MapQuest search completed 8/14/23 revealed:
-The distance from the facility Resident #4 resided and the facility he was found was .09 miles.
Route was as follows:
-Facility driveway 285ft.
-Turn right and continue for 118ft.
-Bear right and continue for 0.2 mile.
-Turn left and continue for .05 mile.
-Turn left and continue. for 0.1 mile.
-Turn left and go 79ft.
-Turn left and go 59ft.
-There was a four-lane highway divided by a median; the posted speed limit was 45 miles per hour.
-A large creek ran between the two facilities.

A request for the incident report for Resident #4's elopement on 06/21/23 was not provided by the facility.

Facility Name:

Interview with a family member of Resident #4 on 07/11/23 at 9:25am revealed: -She observed the front door was often unlocked when she arrived to visit Resident #4. -The staff reported the front door was left unlocked for smokers; she never observed any staff outside when the door was unlocked. -Resident #4 had been hallucinating and had sundowners; so, walked the halls most nights. -On 06-21-23 she received a call from EMS and was informed Resident #4 left this facility; he was found by a stranger and mistakenly taken to a nearby facility. -At her next visit the resident told her he did not know how he got there but he would not do that again. -Because of the incidents with the staff, (eloping and his aggressive behavior), the resident was transferred to the special care unit the same day. -He did not like being in the SCU and made a couple of attempts to leave but staff was able to intercept him. Observation of front entrance to the facility on 07/25/23 at 12:55pm revealed: -There were two doors at the entrance into the facility. -The first door was unlocked with no alarm system in operation. -The second door was locked, contained a keypad and an emergency lock shutoff switch that would not alarm if activated. -There was a note above the second door instructing visitors to ring the bell for entrance. -The bell was located outside of the first door in the top left corner of the door.		
Observation of the front entrance to the facility on 07/26/23 at 12:30pm revealed: -Both doors were unlocked. -There was no staff monitoring the front entrance. The administrator and business office manager offices were located at the front of the facility; doors were closed upon AHS arrival. -Interview with facility staff in the dining room on 7/26/23 revealed the entrance doors were unlocked because a new resident was currently moving in.		

Facility Name:

Review of Resident #4's Care Notes Revealed: -On 06/15/23 at 4:05am the resident had a behavioral occurrence; he became very aggressive trying to fight staff. 911 was called and resident was transported to the ER for evaluation. -On 06/15/23 (time undocumented) the resident returned from hospital with a new order of Quetiapine 25mg for agitation. Take one table by mouth nightly for 14 days. -On 06/19/23 at 12:00am the resident had an episode of aggressive behavior and charged staff down the hallway. Resident was transported to ER for evaluation. -On 06/19/23 at 9:00am resident returned to facility. The resident refused breakfast and morning medication. Staff made the resident comfortable; the resident was in room lying down. -On 06/19/23 at 10:05pm the resident showed signs of aggression, ran fast down the hall yelling. As needed clonazepam for combative behavior was administered and effective. -06/21/23- The resident left the facility and did not sign out. He walked to neighboring facility. The neighboring facility called and made them aware the resident was there. The staff brought the resident back to the facility. The primary care provider (PCP) family were all notified. PCP gave the order to move the resident the Special Care Unit (SCU). -06/21/23 at 10:13pm Resident #4 was moved to SCU today. The resident had several episodes of exit seeking. The resident was resting in his new room. Staff will continue to monitor him. Interview with the Supervisor on 08/15/23 at 6:23 PM revealed: -On 06/15/23 about 4:00am the resident came on the hall where he was sitting, pushed the chair and stated someone was in his room trying to fight him. - He went with resident to investigate; verified room was empty. -The resident then grabbed his shirt, pushed him inside the room, shut the door and began to wrestle him. - He was able to get free and exit through the bathroom that adjoined room next door. -The resident followed him through the neighboring room, down the hall, and grabbed the supervisor again. He then asked the personal care aid (PCA) on duty to call 911. -The resident was transported to the ED.		

Facility Name:

-On 06/19/23 about12:00am resident #4 had another episode where he thought someone was trying to get him. - Resident #4 walked the halls and tried to grab the supervisor and PCA. Attempts at redirection were unsuccessful. - He and the PCA ran, hid, and called 911. The resident was transported to the ED. Review of Resident #4's Emergency Department (ED) Discharge Instructions dated 06/15/23 revealed: -Reason for visit was multiple medical complaints. -Diagnoses were agitation, Alzheimer's dementia with other behavioral disturbance, unspecified dementia severity, unspecified timing of dementia onset. -"Start taking quetiapine for agitation, 25MG-1 tablet by mouth nightly for 14 days." -"Continue taking donepezil for mood stabilization- 10MG-1 tablet by mouth nightly." Review of Resident #4's Emergency Department Discharge Instructions dated 06/19/23 Revealed: -Diagnoses were agitation, Alzheimer's dementia with other behavioral disturbance, unspecified dementia severity, unspecified timing of dementia onset. -Medication given was olanzapine for schizophrenia at 4:36am. -"Continue taking donepezil for mood stabilization -10MG-1 tablet by mouth nightly." -"Continue taking quetiapine for agitation, 25MG-1 tablet by mouth nightly for 14 days." Interview with Supervisor on 7/25/23 at12:45pm revealed: -She worked the first shift on the assisted living side of facility on 6/21/23. -She could not recall the last time Resident #4 was seen. -She was unaware Resident #4 had left the facility. -Another staff answered the call regarding missing resident and handed the phone to the supervisor. - EMS inquired about the missing resident and, she informed the administrator who immediately went to pick up the resident. -Resident #4 was moved to the SCU same day. Interview with the Administrator on 7/25/23 revealed: -She was unaware Resident #4 was missing until EMS called. -Resident #4 left facility without signing out. -No search of the facility was necessary.		

Facility Name:

-She was certain the front door was locked on this date. The facility failed to ensure 1 of 5 sampled residents (#4), with a diagnosis of dementia, and recent significant change in mental status, was supervised according to the resident's assessed needs and walked away from the facility without the knowledge of staff through an unsecured exit door. The resident was found almost a mile away from the facility near a busy highway by a bystander . The facility remained unaware of the elopement. This failure of the facility resulted in substantial risk of serious injury to the resident and constitutes a Type A2 Violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED October 11, 2023		

IV. Delivered Via:	In-Person	Date: 09-11-2023
DSS Signature:	Marsha W. McAstor	Return to DSS By: 10-2-2023

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name): Constantina Duth	
	Signature: Constantina Duth	Date: 10/3/23

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

☐ *POC Not Accepted* | By: | Date:

Comments:

☑ *POC Accepted* | By: Marsha McAstor | Date: 10/3/2023

Comments:

VIII. Agency's Follow-Up	By: Marsha McAstor	Date: 1/5/2024
	Facility in Compliance: ☑ Yes ☐ No	Date Sent to ACLS: 1/8/2024

Comments:

Facility met all correction by deadline 10/11/2023

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