Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Four Oaks Senior Living
Address: 565 Boyette Rd.
County: Johnston
License Number: 051-060

II. Date(s) of Visit(s): 09/29/22, 11/17/22, 12/16/22
Purpose of Visit(s): Death Investigation
Exit/Report Date: 05/11/23

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 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 Personal Care and Supervision	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: (c)Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	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.	
Level of Non-Compliance: Type A2 Violation		
Findings: Based on record reviews and interviews, the facility failed to ensure that staff responded immediately for 1 of 1 resident sampled (Resident #1) who required cardiopulmonary resuscitation (CPR) according to facility's CPR policies and CPR training after the resident became unresponsive and her pulse and respirations were absent. The findings are: Review of the facility's Emergency Training and CPR policy revealed: -The facility shall designate a staff person to respond in emergencies if the Executive Director was not available.	To be in compliance with Rule 10A NCAC 13F.0901(c), the Area Clinical Director (ACD)/ Care Managers(CM) in-serviced staff on policy for emergency training and CPR. The ED/CM will train new hires on Emergency Training and CPR during orientation process. RCC/SCC will implement a system on current assignment sheets to identify staff members on duty that are CPR certified. The ED will monitor the schedule weekly. ED/Care Managers will ensure a minimum of one person per shift is CPR cerified to ensure resident safety.	05/15/2023 Ongoing

Facility Name:

-Each community must have at least one staff member trained in CPR and choking management on duty and on the premises at all times. -If the resident did not have a valid "Do Not Resuscitate Order" an appropriately trained community staff shall initiate CPR. Review of Resident #1's FL-2 dated 04/20/22 revealed: -Diagnoses included dementia with behaviors, atrophy of thyroid, and acquired hyperlipidemia unspecified. -Resident was designated as constantly disoriented. -The resident had wandering behaviors. Review of the Report of Death for Resident #1 dated 09/23/22 revealed: -The resident was discovered non-responsive in the resident lobby at 7:10pm on 09/17/22. -Staff called emergency services (EMS). -The call was received at 7:10pm and EMS was en route at 7:13pm. -EMS started their assessment at 7:18pm. -EMS pronounced resident deceased at 7:19pm. Review of the 5 day investigation report dated 09/22/22 completed by the facility revealed: -Staff A discovered resident non-responsive in the resident lobby. -Staff A's CPR certification had expired. -Resident #1 was a full code. -Staff A stated she was not putting her mouth on the resident. -Staff B who was CPR certified was in another resident's room. -Staff A failed to alert Staff B who was CPR certified. -The Administrator completed an investigation by conducting interviews with the witnesses and staff. -Staff A said she was aware the resident was full code. -Staff A resigned at the start of the investigation. Review of Staff A's employee record on 10/21/22 revealed: -Staff A did not have current CPR certification. -The facility had completed a Health Care Personnel Registry (HCPR) check on staff A dated 12/28/21 that showed no substantiated findings of resident abuse, resident neglect or misappropriation of resident property. Review of Staff B's employee record on 10/21/22 revealed: -Staff B was certified in CPR on 09/14/21.		

-The facility had completed a HCPR check on Staff B on 10/07/20 with no substantiated findings of resident abuse, resident neglect or misappropriation of resident property.

Review of Emergency Services report dated 10/07/22 revealed:
-They received a call at 7:10pm to respond to the facility.
-The EMS team was dispatched at 7:12pm to the facility.
-They arrived on the scene at 7:15pm.
-The EMS was directed towards Resident #1's room.
-The resident was laying supine on the bed, "obviously not breathing and without pulse".
-EMS noted the resident had rigor mortis in mandible and was pale and cold to touch.
-Staff told EMS that Resident #1 had only been in her room for approximately 30 minutes before they noticed she wasn't breathing.
-Resident was pronounced dead at 7:19pm.

Interview with Administrator on 11/17/22 at 2:15pm revealed:
-The incident occurred on 09/17/22.
-They Administrator received notification of the death in the facility on 09/17/22.
-The Administrator received the additional details on 09/19/22 and initiated the investigation on 09/19/22.
-Staff A resigned as soon as the investigation started.
-Staff A was the medication aide for the memory care unit that night.
-Staff B was the supervisor for the building that shift and was certified in CPR.
-Staff B was in another resident's room at the time of the incident.
-Two other staff were present in the room with the resident but were not CPR certified.
-Staff moved the resident from the lobby to her room after finding her unresponsive to prevent the other residents from observing the incident.
-Staff were trained on the facility's CPR policy upon hire.
-An in-service on CPR policies and procedures was completed on 11/17/22.

Interview with Staff B on 11/17/22 at 3:10pm revealed:
-She was on the assisted living side of the facility on the date of the incident.
-Staff A came up to the assisted living side to ask how to print EMS reports but did not mention the incident.
-Staff B did not find out about the death until 09/18/22.

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Attempted telephone interview with staff C on 10/21/22 at 2:40pm and 10/24/22 at 3:15pm was unsuccessful. The facility failed to ensure CPR was initiated by a CPR qualified staff for one resident who was found not breathing and without a pulse. The resident was pronounced dead at the facility by EMS shortly after their arrival. This failure resulted in substantial risk for serious harm which constitutes a Type A2 violation. This facility provided a plan of protection in accordance with G.S. 131-D on 11/17/22.		

IV. Delivered Via:		Date: 5/11/23
DSS Signature:	Teresa Hartley	Return to DSS By: 6/1/23

V. CAR Received by:	Administrator/Designee (print name): Roslin Wheeler	
	Signature: Roslin Wheeler	Date: 5/11/23
	Title: Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name): Roslin Wheeler	
	Signature: Roslin Wheeler	Date: 5/17/23

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:		Date:
	Facility in Compliance: ☐ Yes ☐ No		Date Sent to ACLS:
Comments:			
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*			