Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Americares Adult Homes #1
Address: 101 Annie Parker Circle, Smithfield NC
County: Johnston
License Number: HAL-051-070

II. Date(s) of Visit(s): 10/30/23
Purpose of Visit(s): complaint investigation
Exit/Report Date: 12/28/23

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 RESIDENTS RIGHTS**	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: An adult care home shall assure that the rights of all residents guaranteed under G.S. 131-D-21, Declaration of Resident Rights, are maintained and may be exercised, without hindrance.		
Level of Non-Compliance: **TYPE A2 VIOLATION**		
Findings: This Rule is not met by: Based on observations, interviews and record reviews, the facility failed to protect 1 of 1 residents (#1) from physical abuse by a staff member (Staff A) who physically assaulted Resident #1. The findings are: Review of the facility's undated policy for Abuse, Neglect, Exploitation, and Misappropriation of Property on 10/30/23 revealed: -Definition of abuse is a deliberate act that results in physical harm, pain, or mental anguish; it can be physical, verbal, sexual or mental; abusers can be staff, residents, or visitors. -The facility is required to provide individualized care to support or improve each resident's well-being; have policies and procedures to prevent and address abuse, neglect, exploitation; screen, train, and supervise employees;		

investigated allegations of abuse and take correct action; protect residents during and after an investigation; report allegations to the state licensing and certification agency and/or adult protective services.

Review of Resident #1's current FL-2 dated 10/12/23 revealed:
-Diagnoses included schizoaffective and bipolar disorder.
-The resident was ambulatory and was continent of bowel and bladder.

Review of Resident #1's care plan dated 10/18/23 revealed:
-The resident was oriented.
-The resident needed supervision with eating, toileting, ambulation, and transferring.
-The resident needed limited assistance with bathing, dressing and grooming,

Interview with a Detective from the local police department on 10/30/23 at 8:25am:
-He was dispatched to the facility this morning (10/30/23) around 7:30am for an assault between a staff and a resident.
-Resident #1 was observed with a bloody nose.
-Staff A had visible scratch marks on her face and chest area.
-He was unable to get any information about the altercation from Resident #1 or Staff A.
-There have been no criminal charges filed at this time.
-There was no on-going investigation at this time.

Interview with Staff A on 10/30/23 at 8:42am revealed:
-She had worked at the facility since 09/01/23 as a live-in personal care aide (PCA).
-Resident #1's roommate knocked on the bathroom door in the staff bedroom around 7:10am and told her that Resident #1 was being loud and threatening her.
-She went to their room and asked Resident #1 what was going on.
-Resident #1 told her she did not do anything and then walked up to Staff A and "bum-rushed" her by pushing her body into hers.
-She told Resident #1 to calm down and Resident #1 then slapped her in the face and grabbed her hair.
-Resident #1 would not let go of her hair so she hit her in the face.
-She was not sure if she hit Resident #1 with a closed fist or the palm of her hand because she was just trying to get away from her.

investigated allegations of abuse and take correct action; protect residents during and after an investigation; report allegations to the state licensing and certification agency and/or adult protective services.

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Interview with a Detective from the local police department on 10/30/23 at 8:25am:
-He was dispatched to the facility this morning (10/30/23) around 7:30am for an assault between a staff and a resident.
-Resident #1 was observed with a bloody nose.
-Staff A had visible scratch marks on her face and chest area.
-He was unable to get any information about the altercation from Resident #1 or Staff A.
-There have been no criminal charges filed at this time.
-There was no on-going investigation at this time.

Interview with Staff A on 10/30/23 at 8:42am revealed:
-She had worked at the facility since 09/01/23 as a live-in personal care aide (PCA).
-Resident #1's roommate knocked on the bathroom door in the staff bedroom around 7:10am and told her that Resident #1 was being loud and threatening her.
-She went to their room and asked Resident #1 what was going on.
-Resident #1 told her she did not do anything and then walked up to Staff A and "bum-rushed" her by pushing her body into hers.
-She told Resident #1 to calm down and Resident #1 then slapped her in the face and grabbed her hair.
-Resident #1 would not let go of her hair so she hit her in the face.
-She was not sure if she hit Resident #1 with a closed fist or the palm of her hand because she was just trying to get away from her.

Interview with Resident #1's roommate on 10/30/23 at 8:57am revealed:
-Resident #1 woke her up around 7:00am when she turned the lights on and was going through her closet.
-She told Resident #1 to turn the lights off so she could sleep.
-Resident #1 got angry and started yelling at her.
-Resident #1 unplugged her oxygen machine from the wall and told her "if you need it bad enough then you can plug it back in."
-Resident #1 was hitting a bag against the wall and threatening her so she went to get Staff A.
-When Staff A came in the room and asked Resident #1 what was going on, Resident #1 pushed Staff A and grabbed her hair.
-They fell against the wall and the bed and Resident #1 was still holding on to Staff A's hair.
-She saw Resident #1 slap Staff A several times but was not sure if Staff A hit Resident #1 because there was a lot going on.
-She heard Staff A say "you are not going to push me around."
-The medication aide (MA) came in and tried to break them up but then called the police.
-She thought the door might have been shut at some point but she could not remember.
-She and Resident #1 did not get along because she was young and always played her music too loud.
-Resident #1 did not respect her at all.

Interview with Resident #1 on 10/30/23 at 9:22am revealed:
-She got up around 7:00am and turned on the lights in her room.
-She was cleaning out her closet and her roommate got mad and wanted her to turn off the lights.
-Staff A came into their room and accused her of being too loud.
-Staff A shut the bedroom door so she could not get out and that made her angry.
-When she tried to open the door, Staff A grabbed her wrists and punched her in the face.
-She had to "defend" herself to get out of the room.
-She did not like people to bother her for no reason.

Interview with the MA on 10/30/23 at 9:45am revealed:
-She witnessed part of the incident with Resident #1 and Staff A.
-She heard yelling coming from Resident #1's room and found Resident #1 holding onto Staff A's hair.
-She saw Resident #1 and Staff A swinging their arms and

falling onto the bed.
-She saw Staff A swing her hand but was not sure if it was a closed fist or the palm of her hand.
-She called the police because she needed help to break them up.

Review of Staff A's personnel record on 10/30/23 revealed:
-There was verification of a healthcare personnel registry (HCPR) check completed on 8/15/23.
-There was verification of a criminal background check completed on 8/15/23.
-There was no documentation of a 2-step tuberculin (TB) skin test completed for Staff A.
-There was no documentation of a drug screening completed for Staff A.

Interview with the Administrator on 10/30/23 at 10:25am revealed:
-She was called about the altercation between Staff A and Resident #1 this morning.
-She was in the process of doing her investigation so she could complete the 24hr Health Care Personnel Registry (HCPR) report.
-She was told that Resident #1 got defensive when Staff A went in her room and asked her a question.
-Resident #1 pushed Staff A, scratched her face and chest and grabbed her hair.
-Resident #1 would not let go of Staff A's hair no matter what was said.
-Staff A swung her arm and either slapped or hit Resident #1 in the face.
-Staff A could not remember if she hit her with a closed fist or the palm of her hand.
-Staff A had not received any training on how to deal with aggressive residents.
-She would have Staff A leave the facility until further notice.
-Staff A was still at the facility to complete her documentation of the incident and to find a place to go because she was homeless.
-She was going to have Resident #1 sent out to be evaluated for the bloody nose and her mental health.

There were no reports by other residents of Staff A being abusive or disrespectful.

REFER TO 10A NCAC 13F .0901(b) PERSONAL CARE AND SUPERVISION

falling onto the bed.
-She saw Staff A swing her hand but was not sure if it was a closed fist or the palm of her hand.
-She called the police because she needed help to break them up.

Review of Staff A's personnel record on 10/30/23 revealed:
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-There was verification of a criminal background check completed on 8/15/23.
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-Resident #1 pushed Staff A, scratched her face and chest and grabbed her hair.
-Resident #1 would not let go of Staff A's hair no matter what was said.
-Staff A swung her arm and either slapped or hit Resident #1 in the face.
-Staff A could not remember if she hit her with a closed fist or the palm of her hand.
-Staff A had not received any training on how to deal with aggressive residents.
-She would have Staff A leave the facility until further notice.
-Staff A was still at the facility to complete her documentation of the incident and to find a place to go because she was homeless.
-She was going to have Resident #1 sent out to be evaluated for the bloody nose and her mental health.

There were no reports by other residents of Staff A being abusive or disrespectful.

REFER TO 10A NCAC 13F .0901(b) PERSONAL CARE AND SUPERVISION

The facility failed to ensure 1 of 1 residents (#1) was safe from physical abuse by a staff member (Staff A) who physically assaulted Resident #1 resulting in a bloody nose. The facility's failure resulted in abuse and physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 27, 2024		
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Rule/Statute Number: Level of Non-Compliance:	☐ POC Accepted _____ *DSS Initials*	

IV. Delivered Via:	Visit	Date:	12/28/23
DSS Signature:	Ragavitam	Return to DSS By:	1/27/24

V. CAR Received by:	Administrator/Designee (print name):	
	Signature: Anjali Reddi	Date: 12-28-23
	Title:	

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:	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.*		

Comments:

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