Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Gardens of Trent
Address: 2915 Brunswick Avenue, New Bern, NC 28560
County: Craven
License Number: HAL-025-035

II. Date(s) of Visit(s): 04/19/23, 04/24/23, 04/29/23, 05/01/23, 05/13/23, 5/24/23, 05/31/23, 06/01/23, 06/06/23, 06/12/23, 06/13/23, 06/16/23
Purpose of Visit(s): Follow Up/Complaint Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: 06/16/23

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 Type A2 violation**, this agency may prepare an Administrative Penalty Proposal for the violation(s). Please submit any additional information within **5 days** to be considered prior to the preparation of the penalty proposal. If on follow-up survey the violations are not corrected, a civil penalty of up to $1000.00 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 Personal Care and Supervision Rule/Statutory Reference: (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. Level of Non-Compliance: Type A1 Violation Findings: This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#5), who had a diagnosis of dementia and resided in the special care unit (SCU), was ambulatory with a as needed wheelchair, had wandering behaviors and eloped from the facility on 04/16/23. The findings are: Review of Resident #5's current FL-2 dated 02/07/23 revealed: -The recommended level of care was Special Care Unit (SCU). -Diagnoses included dementia and gastroesophageal reflux	☐ POC Accepted _____ *DSS Initials*	

disease.
-The resident was intermittently disoriented.
-The resident was ambulatory.

Review of Resident #5's Resident Register revealed Resident #5 was admitted on 09/07/22 and had a named responsible person.

Review of Resident #5's Care Plan dated 12/28/22 revealed:
-The resident had a mental health and social history that included wandering.
-The resident was receiving medications for mental illness or behavior.
-The Resident had limited ability with ambulation/locomotion.
-The resident had a wheelchair as needed.
-The resident had limited strength in the upper extremities.
-The resident used oxygen 2L nasal cannula as needed for shortness of breath.
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.

Review of the Incident/Accident Report for Resident #5 dated 04/16/23 at 3:20pm revealed:
-The incident type was an elopement where the resident got out of the facility and was located less than a mile from the facility.
-The description of the incident was that the resident was in the parking lot of a different facility.
-The Primary Care provider's after-hours staff was notified at 4:00pm.
-The Resident Representative was notified at 3:50pm on 04/16/23.
-Emergency Services was not sent to the facility.
-The Department of Social Services was notified via email at 8:39pm on 04/16/23.
-The orders were to increase supervision to be monitored at least every hour throughout the shift from 04/16/23-04/19/23.

Review of Resident #5's progress notes dated 04/16/23 at 7:21pm revealed:
-The type of accident was noted as an elopement at 3:20pm.
-The Provider was notified.
-The Responsible party was notified.

Review of Resident #5's progress notes dated 04/17/23-04/18/23 revealed:
-The progress note dated for 04/17/23 at 4:26am was recorded as a late entry in the system on 04/24/23 at 4:28am stating the reason for progress note was listed as other- elopement.
-The progress note dated for 04/17/23 at 2:28pm was recorded as a late entry in the system on 04/24/23 at 4:30am stating the reason for progress note was listed as other-elopement, no issues with attempt to elope during shift.
-The progress note dated for 04/18/23 at 4:30pm was recorded as a late entry in the system on 04/24/23 at 4:31am stating the reason for progress note was an elopement, no issues with attempt to elope during shift.
-The progress note dated for 04/18/23 at 2:31pm was recorded as a late entry in the system on 04/24/23 at 4:34pm stating the reason for progress note was an elopement, no issues with attempt to elope during shift.

Observation of the surrounding area of the facility on 06/04/23 at 02:30pm revealed:
-The facility's front entrance led to an open space of a paved parking lot.
-There was a split parking lot, with 4 rows of parking spaces.
- The distance from the facility to the paved road in front of the facility was 158 feet.
-The street the facility was on had a posted speed limit sign of 25mph.
-There were 2 lanes of traffic on the street the facility was on.
-The parking lots on the street the facility was on had parking blocks separating the different lots.
-There was no sidewalk on the side of street the facility was on until the intersection of the street and the busy city highway.
-There was a wooded area Resident #5 walked past.
-There were 2 sets of stop and go lights with 4-way traffic that Resident #5 walked past.
-The city highway had a posted speed limit sign of 45mph.
-There were 4 lanes of traffic on the city highway.
-The busy city highway had 5 lanes of traffic, 2 lanes on each side going opposite directions, and a middle turning lane.
-At the intersection heading Northbound on the busy city highway, there was a straight or turning right lane, a straight lane, and a turning left lane.
-At the intersection heading Southbound on the busy city highway there was a straight or turning right lane, a straight lane, and a turning right lane.
-The street connected to the busy city highway had 3 lanes of

traffic.
-At the intersection eastbound there was a straight or turning right lane and a turning left lane.
-At the intersection westbound there was a straight or turning right lane, and a turning left lane.
-The intersection had a crosswalk in all 4 directions.
-The intersection had a pedestrian light in all 4 directions.
-The distance from the facility to the location where the resident was picked up from was approximately 1056 yards.
-Approximately 42 vehicles drove past in both left and right directions of the city highway per minute from 2:40pm-3:10pm.

Telephone interview with the Realtor of the wooded area on 06/05/23 at 8:25am revealed:
-The wooded area is 5.09 acres or 221,720 square feet.
-The frontage of the wooded area is 634 feet.
-The depth of the wooded area is 350 feet.

Telephone interview with a Police Officer on 06/06/23 at 4:17pm revealed:
-Dispatch received a call from a good Samaritan stating there was a pedestrian (Resident #5) who appeared distressed and disoriented at 2:59pm.
-The good Samaritan drove Resident #5 to the Bank and waited for the officers to arrive.
-The good Samaritan drove Resident #5 with the officer following to a neighboring facility to see if the resident was part of their community, but she wasn't.
-The neighboring facility called other facilities in the area to try to see if the resident belonged to one of them.
-The neighboring facility found that the resident belonged to the special care unit facility.
The facility staff were going to drive to the neighboring facility to get Resident #5.
-When the facility staff came, they appeared upset, stated the resident's name and took her back to the facility.

Telephone interview with a good Samaritan on 06/05/23 at 4:11pm revealed:
-Resident #5 had crossed the street at the lights going north and was attempting to cross onto the busy city highway.
-She was heading to the bank when they observed Resident #5 attempting to cross the street, they were not aware how long the resident was standing there.
-She finished up with the automated teller machine (ATM)

and saw the resident still attempting to cross the street.
-She did not want to see Resident #5 get hit or hurt.
-She asked Resident #5 to get in the car, so she would be safe.
-She asked Resident #5 where they lived but the resident did not know.
-She called the police after a few minutes of the resident being in the vehicle.
-Two staff from the facility came to get resident.
-She was concerned for Resident #5 because when she found out that the facility picking her up was a secured memory care, she should not have been able to get out of the facility and was concerned, she would have gotten hit by a car.

Telephone interview with a neighboring facility staff on 06/05/23 at 8:12am revealed:
-Two police officers, a good Samaritan, and Resident #5 came to the neighboring facility because the Samaritan saw the resident walking in traffic and looked like she was going to fall.
-The good Samaritan said to the staff she feared for Resident #5's life.
-The good Samaritan knew of the neighboring facility and brought her to see if she belonged to the facility.
-Resident #5 looked confused.
-The neighboring facility staff called the memory care side to see if it was one of their residents.
-The memory care staff came and stated it was not a resident.
-The memory care staff called other facilities nearby to see if they were one of their residents.

Telephone interview with a 2nd neighboring facility staff on 06/05/23 at 1:35pm revealed:
-A good Samaritan brought Resident #5 to the neighboring facility because she assumed Resident #5 was part of the memory care unit there.
-Police were at the neighboring facility with the resident.
-Resident #5 had a bag with them that looked like it was for bingo or an activity.
-She called the facility and asked if they had a missing resident.
-Resident #5 did gave the neighboring facility a fake name, and the facility stated they did not have a resident by that name.
-She asked if the facility was all memory care, and that there was a resident who must have come from a facility nearby as the resident had bilateral edema on her legs that she could see.
-She was put on hold while the facility did a head count.

-Facility staff asked if she could ask the resident what her legal name was, and confirmed it was Resident #5.
-Resident #5 was slightly confused.
-The events happened after the 3pm shift change.
-The facility staff came immediately after being called and were distraught and concerned about Resident #5.
-She was concerned because Resident #5 came from a memory care unit and did not seem like she should have been walking with the edema.

Telephone interview with the Hospice Case Worker on 06/05/23 at 1:19pm revealed:
-She was notified on 04/18/23 of the elopement of Resident #5 when they were at the facility for a scheduled visit.
-Resident #5 was unaware of the elopement on 04/18/23.
-Resident #5 was referred to hospice care for heart failure and significant and extreme edema resulting in severe swelling in her lower legs and feet radiating to thighs.
-There were concerns with her walking around even in the hallway with edema.
-She was not sure how Resident #5 could walk as far as she did.
-Resident #5 used oxygen as needed but used it often when she walked around more.
-The distance Resident #5 walked was concerning, she was at risk for falls, risk of respiratory distress and potential for not being able to catch her breath which could have increased her confusion.

Telephone interview with Resident #5's physician's office assistant on 06/12/23 at 3:16pm revealed:
-A voicemail was left for the on-call physician at 7:06pm on 04/16/23.
-The message was checked at 7:09pm by the on-call physician.
-The voicemail was noted as a "for your information" and stated that Resident #5 eloped from the facility and was found with no injury.
-A call was not returned to the facility by the on-call doctor.

Interview with the physician on 06/13/23 at 2:35pm revealed:
-The facility staff notified the physician on 06/13/23.
-She believed she was found at a fire station nearby.
-She was informed someone found Resident #5 and thought she belonged to another facility.
-Resident #5's legs were always swollen, and the resident

refused treatment.
-She was not aware of a history of wandering and never saw Resident #5 trying to get out of the facility and had not had a report from the facility of Resident #5 exit seeking.
-She was not aware of a suicide risk.
-The resident should not have been out of the facility walking as she was diagnosed with dementia and was in a secure facility.
-She was concerned for any resident who leaves a facility unsupervised, the facility should be locked at all times as it is for dementia residents.
-Resident #5 probably got into the good Samaritans vehicle because she was tired.

Telephone interview with Resident #5's Family Member (FM) on 06/02/23 at 12:58pm revealed:
-The FM was informed Resident #5 left the facility, went to a different facility and was hanging out there.
-The facility told the FM that they did not need to worry because she was already back at the facility.
-Resident #5 had multiple suicide attempts before going to the facility where she would jump in front of moving cars.
-The FM was concerned for Resident #5's safety because Resident #5 had eloped from the hospital before, and she attempted to jump in front of moving cars.
-The FM was surprised that there were no calls that she was in traffic because she had done that multiple times before.
-The reason Resident #5 was brought to the facility was due to her eloping from the hospital and the suicide attempts of jumping in traffic or saying she would.

Interview with a Medication Aide (MA) on 06/06/23 at 9:50am revealed:
-She was working 7:00am-3:00pm shift on 04/16/23.
-Resident #5 was last seen around 2:10pm in the dining room walking around with a cup of water wearing a striped shirt.
-She was concerned because she felt they did something wrong and would get in trouble, was concerned if resident could have gotten hurt.
-Another resident on the same side was between the locked door and the outside door and did not know how that resident got through.
-A head count was conducted when the resident was found between the doors.
-She did not know how Resident #5 got out of the facility but could have been the same way the other resident got past the locked door.

-Resident #5 was smart and she thought she knew what she was doing.
-Resident #5 was always an exit seeker.
-She was doing 2 hour checks on residents.
-She was concerned with Resident #5 having edema.

Interview with a 2nd Medication Aide (MA) on 06/01/23 at 2:41pm revealed:
-She was working on the other side of the facility for first and second shift when Resident #5 eloped.
-The MA on the other side of the facility (3rd MA) received a phone call that Resident #5 was at a neighboring facility.
-The neighboring facility called different assisted living facilities nearby to find out where Resident #5 was supposed to be.
-Both of the MA's left the building to get Resident #5 from a neighboring facility.
-The staff did not know the resident was missing.

Interview with a 3rd Medication Aide (MA) on 06/01/23 at 3:15pm revealed:
-She was late getting to work and arrived at 3:10pm.
-She went down the hall to count medications and received a phone call at 3:20pm from a neighboring facility asking if there was a resident missing from the facility.
-The neighboring facility gave a name that was not Resident #5's first name but was her last name.
-The neighboring facility described the adult and the 2nd MA believed it was Resident #5.
-The facility conducted a head count and found Resident #5 was not in the building.
-Both MA's in the facility took the facility van and drove to the neighboring facility.
-Resident #5 was in a vehicle of an unknown person and police were on scene.
-She was unaware of who the driver of the vehicle was.
-She was concerned and panicked when they received the call, as she had swollen legs and moved slowly.
-She was unaware of how long Resident #5 had been missing as their shift was just starting.
-She called hospice, texted physician, and called the family member.

Second interview with 3rd Medication Aide (MA) on 06/06/23 at 3:03pm revealed:
-When doing the head count when the call came that Resident

#5 eloped, she did a head count and looked at the door switches and saw one of the switches in the back of the facility leading to the dumpster area was flipped down causing the door to be unlocked. -She was unsure how long the switch was flipped allowing the door to be unlocked. -She did not know if an alarm went off when the switch was flipped down. Interview with a PCA on 05/31/23 at 3:41pm revealed: -There had been a problem with the doors being unlocked in the building. -The PCA was surprised Resident #5 was not hit because her legs were swollen, and she would get out of breath when she walked. -She was concerned because it should not have happened. Interview with a 2nd PCA on 06/06/23 at 10:23am revealed: -Resident #5 was a smooth exit seeker and would lean on doors and look out the window to casually see if it would open. -Resident #5 would also sit and watch the doors and residents trying to open them. -Resident #5 was a good walker but their legs were swollen. Interview with the Supervisor on 06/06/23 at 10:55am revealed: -The supervisor was not working the day of the elopement. -The MA on the "blue side" of the building called and said Resident #5 was at another facility. -She informed MA to call the Administrator. -She was concerned after being notified how far resident #5 walked. -Resident #5 had swollen legs but could walk pretty well. -She was not aware Resident #5 was an exit seeker. -She was not aware of how Resident #5 got out of the facility. -She did not remember hearing of a different resident getting between the locked door and the outside door prior to the elopement. Interview with the Facility Nurse on 06/12/23 at 2:37pm revealed: -The facility staff conducted 2-hour checks on residents as it was required, but the facility checked more frequently than every 2 hours.		

-There was no documentation of 2-hour checks being conducted.
-All residents wandered at some point.
-Medication Aides on the floor supervise the PCA's to ensure 2-hour checks are being conducted.
-Medication Aides will assist in the 2-hour checks.
-The Supervisor would also monitor to ensure the 2-hour checks were being conducted.

Interview with the Administrator on 05/31/23 at 12:30pm revealed:
-It was unknown how Resident #5 got out of the facility.
-The facility received a call from a different facility that Resident #5 was there.
-The call came at 3:20pm after shift change.
-She was not concerned as Resident #5 was safe back at the facility.
-She was not concerned with Resident #5 walking because they were not aware of any safety or health diagnosis.
-Resident #5 was last seen in the dining room around 2:00pm wearing smeared lipstick and had on a striped shirt.

Second interview with the Administrator on 06/06/23 at 3:37pm revealed:
-Was not aware that Resident #5 had prior elopements before arriving at the facility.
-Resident #5 was not an exit seeker.
-She did not know why the FL-2 did not have wandering listed but the Care Plan did.

Third interview with the Administrator on 06/06/23 at 2:22pm revealed:
-There was not a written policy on conducting 2-hour checks on the residents.
-The 2-hour checks being conducted was a general rule.
-There was no documentation of 2- hour checks being conducted.
-The facility put a 1-hour check in place for wanderers and fall risks when the plan of protection was put in place on 04/19/23.
-Residents would wander and exit seek all day long, if a resident was knocking on doors, staff would redirect them.

The failure of the facility to provide supervision in accordance

with Resident #5's history of wandering behaviors and care plan which resulted in Resident #5 eloping from the special care unit on 04/16/23 and was found by a good Samaritan driving in the community approximately 1056 yards away on the sidewalk next to a busy city highway. The staff were not aware the resident was missing. This failure resulted in serious neglect which constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/19/23 and amended to 05/24/23 for initiation of follow up with a correction date for this violation of 07/08/23.

CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED _____

Rule/Statute Number: 10A NCAC 13F .0305
Physical Environment

Rule/Statutory Reference:

(h4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff.

Level of Non-Compliance: Type B Violation

Findings:
This Rule is not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to respond to an audible sounding device for the mag lock switch cover when one of the locking switches was disabled on one of "blue" side facility doors in the very back of the building allowing the door to be unlocked.

The Findings are:

Review of the State Licensure of the facility on 06/16/23 revealed:
-The Resident capacity is for 60 beds.
-The facility had a census of 52 residents at the facility on 04/16/23.

-The whole building is a special care unit.

Interview with a Medication Aide (MA) on 06/06/23 at 9:50am revealed:
-There was a resident who was found in-between the locked door and the outside door at the very back of the building earlier on 1st shift on 04/16/23.
-Med Tech and PCA's did not notice the switch flipped down allowing the door to be unlocked when the resident was between the locked door and outside door.
-A head count was conducted, and all residents were in the building.
-She did not know how long the back door was unlocked for.
-She was unaware it was ever unlocked.
-She believes it could have been how another resident eloped from the facility.
-She did not hear an alarm that the switch cover was lifted, or the door opened.
-There were many exit seekers in the secured memory care facility.

Interview with a 2nd Medication Aide on 06/06/23 at 9:26am revealed:
-Over a month ago, all the doors stopped working on 1st shift on both sides.
-A head count was conducted.
-Staff kept the residents together.
-Another day later on 2nd shift the doors stopped working on both sides.
-She had to call the Administrator, but the Administrator did not come out.
-There were zip ties on the door switch covers so the residents do not unlock the door.
-When the cover was lifted an alarm would sound until the cover was put down.
-There were no zip ties for the dining room switches on the "green side", and the alarm chirps are not as loud as the other doors.

Interview with a 3rd Medication Aide (MA) on 06/06/23 at 3:03pm revealed:
-There was a resident who was found between the locked door and the outside door at the very back of the building on the "blue" side earlier on 1st shift on 04/16/23.
-A head count was conducted, and all residents were in the building at that time.
-The MA and the Personal Care Aides did not notice the

switch flipped down allowing the door to be unlocked when the resident was between the locked door and the outside door.
-When the call came about a resident eloping another head count and door check was conducted.
-She noticed the back door leading to the dumpster area was unlocked and the door switch was flipped down.
-She flipped the switch back up and got a zip tie to lock the cover.
-She was concerned because a resident did get out and another resident was between the doors earlier that day.
-She was not working when the alarms would have gone off notifying of someone opening the door.

Interview with a PCA on 06/06/23 at 9:00am revealed:
-The doors have been unlocked before.
-There was a day where the locks were not working, after the elopement on 04/16/23.
-The locks stopped working at night and went through the morning.
-She did not know the reason they were not locking.
-The Administrator was called by the Medication Aide.
-When the doors are unlocked the staff have to stand by the doors and watch the halls until they are fixed.
-When the doors are not working, there always needs to be someone at the very back of the building, as it is out of view from the Med Room and Dining room corner.
- There were not enough staff to watch all the doors and halls when they were not working.
-When staff needed to watch doors, it was harder for staff to do their job of taking care of the residents' needs.

Interview with a 2nd PCA on 06/06/23 at 10:23am revealed:
-About 3 months ago the mag lock system went down.
-Staff had to secure doors and count the residents.
-There were new residents who came around April on the "blue" side who would attempt to mess with the doors all the time.

Interview with the Director of Resident Care on 06/06/23 at 11:33am revealed:
-She did not know how a resident got out of the facility.
-The doors were opened when the PCA's were taking out the garbage.
-There was a resident who was in between the doors when the PCA's were taking out the garbage.

Interview with the Supervisor on 06/06/23 at 10:55am revealed:
-The doors had secondary alarms that when the door was opened it alarmed.
-The secondary alarms were loud.
-The door switches had a plastic cover on them and were zip tied shut so residents could not access the switches.

Telephone interview with the facility physician on 06/13/23 at 2:35pm revealed:
-She was not aware the doors were not always working.
-The staff are doing the best they can but cannot always watch every door.
-She was concerned that a resident was able to get out of the facility.
-She was concerned that the doors were not always working.

Interview with the Administrator on 05/31/23 at 12:30pm revealed:
-It is unknown how Resident #5 got out of the facility.
-Resident #5 got out of the facility around shift change.

Refer to 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).

The facility failed to hear and respond to an audible working sounding device for the mag lock switch cover after one of the locking switches was disabled resulting in a resident eloping from the facility causing potential detrimental risk of safety and the welfare of all residents who are known to wander as it was a SCU.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/01/23.

CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED _____

Rule/Statute Number: 10A NCAC 13F .0909

Resident Rights	
Rule/Statutory Reference: (1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.	
Level of Non-Compliance: Standard Deficiency Findings: This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#4), who was not treated with dignity and respect by a personal care assistant. The findings are: Review of Resident #4's current FL-2 dated 01/16/23 revealed: -The recommended level of care was Special Care Unit (SCU). -Diagnoses included dementia with behavioral disturbances, displaced intertrochanteric fracture, hypothyroidism, mild protein calorie malnutrition, vitamin D deficiency, hyperlipidemia, major depressive disorder, and essential (primary) hypertension. -The resident was intermittently disoriented. -The resident was non-ambulatory. Review of Resident #4's Resident Register revealed the resident was admitted on 03/03/20 and had a named power of attorney. Review of Resident #4's Care Plan dated 05/24/22 revealed: -The resident was receiving mental health services. -The resident was no ambulatory. -The resident used a wheelchair. -The resident had limited strength in the upper extremities. -The resident was sometimes disoriented. -The resident was forgetful and needed reminders. Interview with Resident #2 and Resident #4's primary care provider on 06/13/23 at 2:35pm revealed: -Typically, all falls are reported, the facility staff lets staff know when it happens and if they feel the resident needs to be	

sent to the ER.
-When working with Resident #4, staff need to take a deep breath or walk away when resident is not reasonable or negotiable.
-Resident #4 should have been treated with dignity and respect.
-The facility let the staff go who was not treating Resident #4 appropriately.

Interview with the Administrator on 06/13/23 at 12:25pm revealed:
-She first received a text from a family member of a resident at the facility to call her.
-She was notified that the family member heard yelling between a resident and a staff.
-She called the facility staff who stated they were going to call her and were on the phone with the Director of Resident Care.
-She stated that even if the resident was having a behavior, the staff was inappropriate.
-The resident was upset about medications and the Personal Care Assistant (PCA) did not know what her medications were.
-The resident was pointing her finger and getting in the PCA's face.
-The PCA was telling the resident to get away from her and stated, "get your damn finger out of my face".
-The behavior was normal for the resident, and the resident had good and bad moments.
-The physician was notified of the incident.
-The 24-hour report was sent to the Health Care Personnel Registry because it was reported where a staff yelled and raised their voice to make a resident go away.
-Law enforcement was not notified.
-The Guardian was not notified due to it being a behavior.
-In the past the resident representative was notified for going to the hospital, broken a window, or when a resident hurt someone.
-She stated that she was concerned that she was not treated with dignity and respect and should not have been yelled at.
-She terminated the PCA involved.

Review of the Continuing Education Units sent by Collins Learning via email on 06/01/23 at 10:06am revealed:
-There was a training on Resident Rights in Assisted Living that reviewed residents being treated with dignity and respect, to be free from verbal abuse, and to have a safe and homelike environment.

-There was a training on Ethics in Dementia Care that reviewed behavioral challenges, how residents want to be treated, and humane and compassionate care.
-There was a training on Managing Dementia-Related Behaviors that reviewed compassion for emotionally upsetting circumstances, behaviors being a form of communication, responding to the resident and if it should change, effective approaches, verbal, and physical behaviors, remaining calm, and to take a break or get help.
-The training on Ethics in Dementia Care also discussed how 2/3 of residents in long-term care have some form of psychological disorder including schizophrenia.

The facility failed to treat Resident #4 with Dignity and Respect per the Resident Rights in Assisted Living Facilities.

CORRECTION DATE FOR THIS STANDARD DEFICIENCY SHALL NOT EXCEED _____

Rule/Statute Number: 10A NCAC 13F .1212
Reporting of Accidents and Incidents

Rule/Statutory Reference: (c) The report as required in Paragraph (b) of this Rule shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident. (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect, or exploitation of a resident.

Level of Non-Compliance: Standard Deficiency

Findings:
This Rule is not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to report an abuse allegation within 48 hours for 2 of 5 sampled residents (#2, #4) who had family report the allegations to the administrator.

The findings are:

Review of Resident #1's current FL-2 dated 02/14/23 revealed:
-The recommended level of care was Special Care Unit (SCU).

-Diagnoses included dementia/Alzheimer's disease, vitamin B12 deficiency, and depression with anxiety.
-The resident was constantly disoriented.
-The resident was ambulatory.

Review of Resident #2's current FL-2 dated 03/14/23 revealed:
-The recommended level of care was Special Care Unit (SCU).
Diagnoses included unspecified dementia without behavioral disturbances, chronic obstructive pulmonary disease, hypertension, essential tremors, anxiety disorder, hyperlipemia, unspecified osteoarthritis, and shortness of breath.
-The resident was constantly disoriented.
-The resident was semi-ambulatory.

Review of Resident #2's Resident Register dated 03/30/23 revealed the resident was admitted on 03/30/23 and had a named responsible person.

Review of Resident #2's Care Plan dated 10/11/22 revealed:
-The resident used a walker.
-The resident was receiving medication for mental illness/behavior.
-The resident was semi-ambulatory.
-The resident used a wheelchair as needed.
-The resident was sometimes disoriented.
-The resident had significant memory loss and needed to be directed.

Review of Resident #4's current FL-2 dated 01/16/23 revealed:
-The recommended level of care was Special Care Unit (SCU).
-Diagnoses included dementia with behavioral disturbances, displaced intertrochanteric fracture, hypothyroidism, mild protein calorie malnutrition, vitamin D deficiency, hyperlipidemia, major depressive disorder, and essential (primary) hypertension.
-The resident was intermittently disoriented.
-The resident was non-ambulatory.

Review of Resident #4's Resident Register revealed the resident was admitted on 03/03/20 and had a named power of

attorney.

Review of Resident #4's Care Plan dated 05/24/22 revealed:
-The resident was receiving medications for mental illness or behavior. Missing information!!!!
-The Resident had limited ability with ambulation/locomotion.
-The resident had a wheelchair as needed.
-The resident had limited strength in the upper extremities.
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.

Review of Incident and Accident Report for Resident #2 sent from the facility via email on 04/04/23 at 4:55pm revealed:
-The event date for the report of a fall occurred on 04/02/23 at 8:17pm.
-The name of the staff member or resident who discovered the accident or incident indicates the residents' daughter stated the mother said she fell.
-The description of the incident was the resident was lying in bed.
-The resident complained of pain or injury.
-The location of injury is the back and states pain per the daughter.
-Resident was transported to the hospital at 8:19pm by EMS.
-The resident was diagnosed with a fractured ankle.
-The physician after hours was notified on 04/02/23 at 8:17pm.

Interview with Resident #2's family member on 05/12/23 at 2:00pm revealed:
-Resident #2 fell before lunchtime.
-POA was not notified of a fall.
-POA asked staff what happened and was told there was not a record of a fall.
-An anonymous person in the facility shared a photo taken of Resident #2 laying on ground in the hallway to the POA.
-An anonymous person informed POA that 3 staff had to assist Resident #2 off the floor.
-Resident #2's POA sent the photo of Resident #2 on the ground on 04/02/23 at 11:14pm.

Review of the text message from Resident #2's POA shared on 05/17/23 revealed:
-The POA sent the Administrator a picture of Resident #2

laying on the floor on 04/02/23 at 11:14pm.
-The text attached to the picture states "This was the picture sent to me by the person that saw mama in the floor and went to let the workers know that she had fallen".
-There was no response to the text message.

Review of the incident and accident report for resident #2 on 05/12/23 revealed:
-The date the event occurred was 05/12/23 at 12:45pm.
-The date the event was recorded was 05/16/23 at 3:45pm.
-The date the report was sent to the County Department of Social Services was on 05/16/23 at 5:05pm.
-The event description stated, "Reports of alleged abuse".
-The incident type was labeled as other (not related to a fall) alleged abuse.
-The description that was observed stated "daughter reported the resident reported to her alleged abuse".
-The resident did not go to the hospital and was not seen by a primary care provider.
-The physician was notified on 05/16/23 at 3:45pm.
-The resident representative was notified on 05/12/23 at 12:45.

Email to the administrator on 05/17/23 at 9:02am revealed:
-Law enforcement was not notified of the alleged abuse that was reported on 05/12/23 for Resident #2.

Phone interview with Resident #2's POA on 05/12/23 at 2:00pm revealed Resident #2 informed family member that she was hit in the face near the eye by a staff member.

Review of Incident and Accident Reports for Resident #4 revealed:
-There was no incident or accident report for resident #4 from 05/24/23.

Interview with Resident #4's Guardian on 05/30/23 at 9:25am revealed:
-The guardian was not notified of any issues with Resident #4 having an altercation or behaviors.
-The guardian had not heard of any issues with any staff and Resident #4.

Telephone interview with an anonymous person on 05/23/23 at 11:50am revealed:
-Sunday 05/21/23 at about 8:30/9:00pm there was a staff member yelling and swearing at a resident (Resident #4).
-There were 3 PCA's and 1 Medication Technician trying to keep the staff away from the resident.
-The situation went on for about 20 minutes.
-The staff that was yelling calmed down and went away from the resident.
-The Administrator was notified.

Telephone call with the Nurse Consultant for Health Care Personnel Investigations on 05/17/23 at 8:44am revealed the facility did not call local law enforcement for the allegation with Resident #2.

Telephone call with the Nurse Consultant for Health Care Personnel Investigations on 5/30/23 at 8:27am revealed:
-There was an abuse allegation report for resident #9 dated 05/24/23 sent to the Division of Health Services Regulation.
-Local law enforcement was not notified of the allegation with resident #4.

Telephone call with the local dispatch center on 05/31/23 at 8:26am revealed the last time the facility called to report any alleged abuse was November 2022.

Interview with Resident #2 and Resident #4's primary care provider on 06/13/23 at 2:35pm revealed:
-Typically, all falls are reported shortly after they occur, the facility staff lets staff know when it happens and if they feel the resident needs to be sent to the ER.
-She was notified of Resident #4 and verbal altercation with staff on 05/24/23.

Interview with the Administrator on 05/31/23 at revealed:
-Administrator stated a family member of another resident reported the allegation to her, as well as staff.
-Administrator stated they did not complete an incident report.
-Administrator stated there was no mental or physical abuse.
-Administrator sent both a 24 hour and 5-day report to the Health Care Personnel Registry.
-Administrator terminated the PCA who alleged was verbal to a resident.

-Administrator stated that she did not feel it was abuse, the staff said loudly "Get your damn finger out of my face" multiple times.

Second interview with the Administrator on 06/01/23 at 4:35pm revealed:
The Administrator stated that she did not send the Incident Report from 5/12 on time.

Third interview with the Administrator on 06/13/23 at 12:25pm revealed:
-The incident report with Resident #2 on 4/02/23 at 8:14pm was combined with the fall that occurred earlier that day due to the Medication Aide not knowing that a fall occurred.
-The Personal Care Aides did not notify the Medication Aide that resident #2 fell on 1st shift.
-She forgot to do the incident report 05/12/23 when she was notified of the abuse allegation with Resident #2.
-She worked on the 24-hour report right away and submitted it to the Health Care Personnel Registry.
-She did not notify law enforcement because it was alleged abuse and did not know if it actually occurred.

The facility failed to submit Incident and Accident Reports within 48 hours for 2 residents (#2, #4) and notifying local law enforcement for allegations of abuse.

CORRECTION DATE FOR THIS STANDARD DEFICIENCY SHALL NOT EXCEED _____

IV. Delivered Via:	in person	Date: 6/21/23
DSS Signature:		Return to DSS By: 7/13/23

V. CAR Received by:	Administrator/Designee (print name): Kris Bolen	
	Signature:	Date: 6/21/23
	Title: ED	

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.*		