Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Pines on Carmel Senior Living
Address: 5820 Carmel Road Charlotte, NC 28226
County: Mecklenburg
License Number: HAL-060-168

II. Date(s) of Visit(s): 8/8/23, 8/23/23, 09/15/23
Purpose of Visit(s): Complaint Investigation and follow up visit
Exit/Report Date: 09/19/23

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)* • *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) Personal Care & Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	☐ POC Accepted _____ *DSS Initials*	
Level of Non-Compliance: Unabated Type A2 Violation		Please develop a plan of correction with a specific date of completion submitted within fifteen (15) working days from the date of receipt of the
Findings: Based on interviews, observations, and record reviews the facility failed to supervise 1 of 5 sampled residents (Resident #1) who had a known history of exit seeking behaviors and wandering, which resulted in the resident eloping from the facility without staff's knowledge. Review of facility's Wandering and Elopement Prevention Plan program, dated 03/14/2022 revealed: -Definitions: Elopement -when a resident (who is cognitively or physically impaired) leaves the community/secured area without necessary authorization (i.e., an order for discharge or leave of absence) and/or necessary supervision to do so.		

-If a resident is determined to be at risk of wandering and or elopement, educational material will be available concerning the risk for elopements and specific interventions are provided to the resident and family. Interventions are included in the individualized services plan/care plan in the resident's record. -Residents with cognitive deficits that reside in memory care or assisted living will be evaluated for elopement risk by member of the clinical team to identify their individual level of risk for wandering/elopement. The evaluation is completed: Before the resident moves in to help determine whether the community is capable of safely and adequately meeting the needs of the resident. -Staff are instructed to maintain a visual line of sight of exit doors, particularly during shift change, mealtimes, and emergencies, as these are times when residents may be able to exit the community unnoticed while staff attention is diverted. Review of Resident #1's pre-admission screening dated 07/24/23 revealed: -Resident #1 was diagnosis with Bipolar affective disorder. -Resident #1 was ambulatory without assistive device. -Resident #1 needed verbal cueing in the event of an evacuation. -Resident #1 had a recent hospitalization for a medical or psychiatric illnesses prior to admission. -Resident #1 was not independent in daily decision making. -Resident #1 had a low risk during the elopement evaluation results. -Resident #1 scored a 20-24 mild cognitive impairment on the mental status evaluation tool. -Resident #1 required daily reminders for care, meals and activities. -Resident #1 was a fall risk. -Resident #1 required daily reminders for grooming, shaving, dressing and bathing. -Resident #1 was independent with toileting. -Resident #1 had an order for the community to assist with medications. Review of Resident #1's current FL-2 dated 06/22/23 revealed: -Diagnosis included Bipolar Affective Disorder. -Resident #1 was intermittently disoriented. -Resident #1 had wandering behaviors. -Resident #1 was ambulatory and continent of bowel and bladder. -Resident #1 was verbal. -Resident #1 level of care was Assisted Living (AL). Review of Individual Service Plan dated 07/24/23 revealed:		Corrective Action Report

-Resident #1 was diagnosed with Bipolar Affective disorder. -Resident #1 was ambulatory with no assistive devices. -Resident #1 was reminded to attend meals for optimal nutrition. -Resident #1 was reminded to attend activities to promote social engagement and quality of life. -Resident #1 needed assisted with dressing to present a clean and neat appearance and promote independence. -Resident #1 needed assisted with grooming and shaving to optimize hygiene and appearance. -Resident #1 required assistance with was to have staff assist with resident's medication administration needs routinely and as needed. Review of Resident #1's Resident Register revealed he was admitted to the facility on 07/24/23. Record reviews on 08/23/23 revealed Resident #1's did not have an elopement risk evaluation completed. Review of the facility's door alarm system dated 08/04/23 revealed between the times 8:29pm – 9:40pm showed the front door of the facility was opened 22 times for at least one minute each time. Observations of the AL building on 08/08/23 at 11:00am revealed: -The entrance door did not require a code to enter the front door or any of the exit door. -All the exit doors throughout the facility were locked on the outside, but the doors were able to be opened by anyone from the inside of the building. -The AL building had a walking path around the entire AL building. -The AL had several surveillance cameras throughout the building. Interview with the Administrator on 08/07/2023 at 1:00pm revealed access to the video surveillance footage from 08/04/2023 was denied. Review of Resident #1's incident reported dated 08/04/23 at 10:40pm revealed: Resident #1 left the facility without signing out. -While doing rounds staff realized he was no longer in the building. -Staff began searching the building and community around the building.		

-Resident #1 was found by law enforcement, extremely disoriented and confused. Review of the local weather history report revealed the temperature outside on 08/04/23 at 9:00pm was 79 degrees Fahrenheit and with no precipitation. Observation of the route Resident #1 took from the facility on 08/23/23 at 10:55am – 11:15am revealed: -Resident #1's was found at address located 0.5 miles away from the facility. -There were sidewalks in route to the address where he was found. -There was a four-lane road directly in front of the facility with a posted approximately speed limit of 45mph (miles per hour). -There was a four-way street in which Resident #1 had to cross to get to the address where he was found. -The property was in a community with over 100 other homes. -There were new homes being built on the four-lane road directly in front of the facility. -There was a gas station on the road as well. -There was more than one stoplight along the route to where Resident #1's was found. -From 10:55am until 11:15am the roadway was frequented by 90 passenger vehicles, several school buses, motorcyclists and 4 construction vehicles. Review of Resident #1's progress notes dated 08/05/23 at 3:08am revealed: -Resident #1 left the facility on 08/04/23 and was last seen around 8:30pm. -A caregiver went into his room after 9:00pm to check on him and collect trash when she noticed he was not there. -The staff members immediately gather all staff in the building and started searching. -The staff searched the inside of the building and outside the facility's perimeter. -A Medication Aide (MA) got in her car to and went searching up and down the road in front of facility, but she did not locate Resident #1. -The facility nurse was contacted, who contacted the Administrator, who contacted the Director of Maintenance (DOM) who came to the building to help search for Resident #1. -The DOM drove up the street and saw the local police and local EMS.		

-The DOM asked if Resident #1 was the person located in the ambulance and Resident #1 Power of Attorney (POA) was present as well. -The POA reported Resident #1 had a high fever and low blood pressure according to EMS and was transported to local hospital. Telephone Interview with homeowner on 08/24/23 at 10:09am revealed: -He had a video doorbell camera on the front door of the home. -On 08/04/23 at 9:28pm, Resident #1 walked onto the front porch of the home and tried to open the door. -Resident #1 continued to try and open the front door of the home until he stopped and sat down on the front porch for a while until the police arrived at the home. -He called 911 at the time Resident #1 arrived at the home because he tried to open the door. -The local police arrived at the home at 9:48pm. -Resident #1 told the police "It was his home and he drove to the house". -Resident #1 gave the police an address in another city as his home address. -Resident #1 appeared to be confused. -The street was very busy and had lots of traffic. Interview with Resident #1 on 08/23/23 at 12:59pm revealed: -He had been at the facility for a while. -He left because he wanted to go home. -He went out the front door. -He was unsure why he left but he liked taking walks. -He still wanted to go for a walk. -He did not have much freedom in the facility. -He talked about his past. -He did not remember what happen on the late-night walk. Review of Medic Emergency Medical Services report dated 08/04/23 at 10:01pm revealed: -Resident #1 was found, ambulatory in a driveway, in the care of local fire department and local police. -The local police reported they were called to the scene by the homeowner. -Resident #1 was found because Resident #1 kept trying to jiggle the door handle and tried to open the door. -He sat on the front steps on the home. -Resident #1 was not complaining of pain or complaints but kept talking about people and things that didn't pertain to anything going on. -Resident #1 was flushed and hot to the touch.		

-Resident #1 POA arrived at the scene. -A history look up was completed and found Resident #1 lived at the AL facility up the street. -The local police officer was headed to the facility when the maintenance worker arrived at the scene. -Resident #1 vitals where heart rate was 98, respiration rate was 18, blood pressure was 102/60, blood glucose levels were 116 and temperature was 100.2 Fahrenheit, and he may be septic. -The patient was given 500 milliliters of normal saline and transported to local hospital. Review of Resident #1's emergency room (ER) provider note dated 08/05/23 revealed: -Resident #1 had an altered mental status and was found wandering down the street yesterday from the facility. -Resident #1 had a baseline of some confusion. -Resident #1 was currently taking Xanax (used to treat anxiety disorders and anxiety caused by depression) and valium (used to treat anxiety, seizures, muscle spasms or twitches) every day and was taken off all antianxiety medications on Tuesday of this week. -Resident #1 now presented with increased confusion and has been anxious. -Resident #1 had a past medical history of dementia and was currently residing in an assisted living facility. -Resident #1 was accompanied by family with complaints of increased altered mental status with for the past several days. -The family reported that Resident #1 was currently on Seroquel and Lithium (medications used to treat mental/mood conditions) at baseline, and he was recently placed on Valium and Xanax (medications used to treat anxiety) but overdosed a couple of times at the assisted living facility and was seen in the emergency department. -After, Resident #1 was removed from the medications, he began to experience increased confusion and anxiety and left the facility. -He was found by police knocking on doors outside the facility. -Resident #1 was admitted to inpatient services for further work-up, management and observation. Review of Resident #1's hospital records for Psychiatry inpatient visit notes dated 08/05/23 revealed: -Resident #1 was diagnosis with a neurocognitive disorder, hypothyroidism and bipolar affective disorder since 2007. -Resident #1 reported "trouble with bipolar depression caused by emotional stress being treated for depression.		

-Resident #1 reported occasionally feeling anxious when dealing with organizations that are unfair and unjust. -Resident #1 was taking Xanax 0.5mg 3 times daily and as needed that was started on 06/08/23, increased on 07/10/23 to 1 mg 3 times daily and discontinued on 08/01/23. -Resident #1 was taking Valium 10mg 3 times daily on 07/22/23. -Resident #1 was taking Prozac 10mg on 06/06/23 and increased on 07/22/23 to 20mg. -Resident #1 was taking Zoloft until it was discontinued on 06/06/23, because it was not helping, Resident #1 was moaning, in a manic state, having trouble distinguishing reality, not eating, pacing was diagnosed with bipolar disorder in 2007 and has been on lithium and Seroquel for many years. Telephone Interview with Resident #1's Power of Attorney (POA) on 08/25/23 at 9:15am revealed: -Resident #1 was admitted into the facility in July 2023 and had been there less than two weeks. -He received a call at 10:00pm on 08/04/23 from a police officer saying they had found Resident #1 trying to break into someone house. -Resident #1 eloped from the facility on 08/04/23 and went to an address located down the street from the facility. -Resident #1 had a history of mental health issues in the past few months and had several hospitals stays to address the concern. -Resident #1 was staying with him for 3 weeks until he wandered away from his home twice prior to being admitted into the facility. -Resident #1 was placed at the facility because he needs 24-hour supervision because of his mental health concerns. -Resident #1 had not been eating or sleeping well at the facility. -Resident #1 had been sent to the hospital a few weeks ago because he was not acting like himself. -The EMS staff members remember Resident #1 because they had pick him up from the facility before. -Resident #1 was on a lot of medication and not acting like himself at the facility. -The facility's doctor had recently changed all of Resident #1's medications and discontinued several narcotics which cause resident #1 to be confused. -Resident #1 had been acting different for the past few months. -He and his sister informed the facility of Resident #1 past behaviors and mental health concerns. -He was not sure how long Resident #1 was gone from the facility when the police found him.		

-Resident #1 was able to have a full conversation but he was still confused and talks about thing that had not happened. Telephone Interview with a personal care aide (PCA) on 08/24/23 at 11:23am revealed: -She was assigned Resident #1 on the day he eloped from the facility, 08/04/23. -She reported to MA that Resident #1 was not in his room. Telephone Interview with personal care aide (PCA) on 08/24/23 at 11:25am revealed: -She was working at the facility at the time Resident #1 eloped on 08/04/23. -Resident #1 had been acting different all day and saying he was going to leave the facility. -The facility nurse and administrator were informed of Resident #1's behavior, but they did not do anything to address the issue. -The staff were not told to watch Resident #1 closely. -The facility management did not put any interventions in place for Resident #1. -The MA said someone needed to monitor Resident #1, but no one had been assigned to him. -The staff members had training on elopements. Telephone Interview with a MA on 08/24/23 at 10:57am revealed: -She was the assigned MA for Resident #1 on the evening, shift (3:00pm-11:00pm) of the elopement on 08/04/23. -She had last seen Resident #1 around 8:30pm during her medication pass. -She was informed by the assigned PCA around 9:00pm that Resident #1 was not in his room when she went to check on him and empty the trash can in his room. -Resident #1 was known to constantly walk the AL hallways since being at the facility. -Resident #1 was wandering around the facility all day and going in and out of other resident's room. -She re-directed him to his room several times during the shift. -Resident #1 had been having behavior issues for the past few days. -The facility was aware of Resident #1's behaviors, but there were no interventions in place. -There were concerns with his medication being reported by Resident #1 family. -The facility did not have any precaution in place for Resident #1.		

-The facility did not have any additional staff to supervise Resident #1 after the concerns regarding for medication. -The staff started looking for him but could not find him. -She did not call the police to report Resident #1 missing. -She called the facility nurse to report Resident #1 missing. -The facility maintenance director found Resident #1. -There was no communication from management that Resident #1 had any interventions or additional supervision in place on 08/04/23. -She believed Resident #1 walked out the front door of the facility during his elopement. -The doors are only locked from the outside but can be open from the inside with no problem. Interview with the facility's Director of Maintenance (DOM) on 08/08/23 at 2:18 pm revealed: -On 08/04/23, he received a telephone call about the elopement after 10:00pm and returned to the facility to help search for Resident #1. -He was in his car driving up the street located in front of the facility when he saw EMS and police cars, so he stopped and asked if Resident #1 was the person inside the vehicle and the officer said yes. -He returned to the facility and told the MA were Resident #1 was, he gave her a ride to the location and then returned home. -He was not sure of who the staff member was who called him about the elopement. -Resident #1 was able to elope from the facility by walking out of any door of the facility but he was not sure which door he used. -The facility doors are not locked from the inside. -The facility doors alarms go to the beeper, but staff must be wearing the beepers to see the alarm go off. -He has informed the caregiver staff they should be wearing the beeper when at work. -He was not responsible to inform the staff they should be wearing beeper to monitor the door alarms. -The facility had security cameras and he did not review the security cameras when the resident left the building. Interview with facility corporate nurse on 08/23/23 at 12:00pm revealed: -She completed the pre-screening assessment on Resident #1, who was admitted to the AL. -He was admitted on 07/24/23, and she was not in the building on that day. -Resident #1 did not have any concerns when he moved into the building and was engaging with services.		

-Resident #1 was appropriate for AL until he got sick. -She was unsure what cause his sickness. -Resident #1 had not been doing great since he got sick. -Resident #1 seen the physician and was taking off some medication and given new medication. -Resident #1 was adjusting to the medications and did not appear to have any issues. -She checked on Resident #1 several times throughout the day of the elopement and did not find any concerns. -Resident #1 was seen walking around the facility several times on the day of his elopement on 08/04/23. -She was not aware Resident #1 FL-2 stated he had wandering behaviors or disoriented intermittently. -She was not at the facility when the elopement happened. -On 08/04/23, she received a telephone call from the MA informing her that Resident #1 had eloped from the facility. -The staff were aware to watch Resident #1 because of his sickness. -She and MCC made the staff aware to watch Resident #1. -The staff was responsible for checking on Resident #1 every 30 minutes. -The facility did not have any records of Resident #1 being checked every 30 minutes. -The expectation was for staff to make sure the residents are safe and breathing.		
Interview with Facility Administrator on 08/08/23 at 2:47pm revealed: -Resident #1 was admitted to the assisted living facility on 07/24/23. -Resident #1 was independent with all ADL's, constantly walked the AL halls, and engaging with activities. -On 08/04/23, Resident #1 eloped from the facility and walked down the street to someone home and found by the police. -Resident #1 exited the facility out the front door. -She was not sure how long Resident #1 had been gone from the facility. -Resident #1 had been given new medication from the doctor to help with his anxiety. -Resident #1 was taken to the hospital because he had a high fever. Interview with facility Administrator on 08/28/23 at 11:45am revealed: -She was aware of Resident #1 history of mental illness. -She was not aware Resident #1 FL-2 stated he had a history of wandering behavior or a history of intermittent disorientation. -She was not aware of any medication changes for Resident #1.		

-She reported the facility nurse would know more regrading Resident #1 medications. -She was not aware of what time Resident #1 left the facility. -The facility had security camera, but she did not review the video. -She was not allowed anyone outside the facility staff to review the facility video monitor system without an approval from corporate office. -She was not aware of any policy which stated she was required to review the cameras. -The facility staff did not call the police. -She did not know why the facility did not call the police. -She was going to complete a training with staff. -The staff was responsible for supervising every resident. _____ The facility failed to provide supervision to Resident #1 who had a known history of wandering behaviors and mental health diagnosis, which resulted in the resident eloping from the facility, walking 0.5 miles, and crossing a busy multiple-lane highway without staff's knowledge that resulted in the resident missing for almost 2 hours. This failure resulted in substantial risk for serious harm and neglect and constitutes a Unbated Type A2 Violation. _____ CORRECTION DATE FOR THIS UNBATED TYPE A2 VIOLATION SHALL NOT EXCEED 10/25/23. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/23/23.		

Facility Name: The Pines on Carmel Senior Living

IV. Delivered Via:	hand	Date: 9/25/2023
DSS Signature:	Jonyn R. Wright	Return to DSS By: 10/16/2023

V. CAR Received by:	Administrator/Designee (print name): Shannon McCullough	
	Signature: Shan McCu	Date: 9/25/2023
	Title: Health Services Specialist	

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.*