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): 05/02/23, 05/22/23, 06/09/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 6/28/23

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 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:	☐ POC Accepted	
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.	*DSS Initials*	
Level of Non-Compliance: 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 Corrective
Findings: This Rule is not met as evidenced by: Based on interviews, observations, and record reviews the facility failed to supervise 1 of 5 sampled residents (Resident #4) 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: A. Before moving in to help determine whether the community is capable of safely and adequately meeting the needs of the resident. -Instruct staff 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 #4's current FL-2 dated 02/07/23 revealed: -Diagnosis of acute Metabolic Encephalopathy (a problem in the brain) caused by chemical imbalance. -Resident #4 required SCU level of care and was constantly disoriented. -Resident #4 was ambulatory and continent of bowel and bladder. Review of Resident #4's Resident Register revealed she was admitted to the facility on 02/08/23. Review of Resident #4's elopement risk evaluation completed on 02/13/23 revealed: -There was no documentation that the resident was recently admitted. -Resident #4 was documented as cognitively impaired with poor decision-making skills. -Pertinent diagnoses included dementia, organic brain syndrome, Alzheimer's, delusions, hallucinations, anxiety disorder and manic depression. -Resident #4 was able to ambulate independently, without the use of assistive device. -Resident #4 had a history of wandering and exit seeking behaviors. -Resident #4 was in the early stages of memory loss. -Resident #4's family and staff voiced concerns the resident had wandering tendencies and would try to leave the facility. -Resident #4 had attempted to elope from the community. -Resident #4 was upset she was in the community and wanted to go home. -Resident #4 had a high-risk score of 26 of eloping from the facility.		Action Report

Observations of the Special Care Unit (SCU) on 05/02/23 at 11:00am revealed: -The SCU required entrance via code entry through a keypad at each exit door. -All SCU exit doors and courtyard door locking mechanisms unlocked and locked using the keypad system. -The SCU had a fenced-in patio area with a locked gate and a keypad requiring a code to exit. -The SCU had several cameras throughout the building. Interview with the Administrator on 05/02/2023 at 10:40am revealed access to video surveillance footage on 04/21/2023 was denied. Review of Resident #4's incident reported dated 04/21/23 at 1:20pm revealed: -Technicians with a fire protection company were at the facility from 7:30am-2:00pm on 04/21/23, working on the maglock system. -The maglock system was disabled during this time which allowed Resident #4 to walk out the front door of the facility. -At 1:20pm, Resident #4's Responsible Party (RP) called the facility and asked if Resident #4 had been seen. -The RP stated a neighbor called her and stated the resident was sitting on the porch of Resident #4's previous address. -At 1:30pm, Memory Care Coordinator (MCC) and Medication Aide (MA) staff completed a head count and Resident #4 was not located. -The Administrator was notified on 04/21/23 at 1:30pm. -At 1:35pm, the MCC and MA drove to Resident #4's previous address. -The facility contacted local law enforcement on 04/21/23 at 1:40pm. -The facility Health Services Director was notified on 04/21/23 at 2:00pm. -At 1:55pm, Resident #4 was located at her previous address sitting on the front porch. -At 2:00pm, the MCC completed a quick assessment of Resident #4, and found no injuries. -At 2:05pm, Resident #4 was assisted into the car for transport back to facility. -At 2:35pm, the MCC, the MA and Resident #4 arrived at the facility. -At 2:45pm, Resident #4 was showered. -Resident #4 voiced no complaints, pain or discomfort. -At 2:55pm, the facility called Emergency Medical Services (EMS) for a non-emergency transfer.		

-Resident #4's primary physician was notified on 04/21/23 at 3:00pm. -At 4:00pm, Resident #4 was transported to the local hospital for evaluation and treatment by EMS. -Resident #4 vitals were taken by facility staff. -The RP was not notified; she was the one who notified the facility. -At 10:45pm, Resident #4 was returned to the facility after completing medical evaluation. Review of Resident #4's emergency room (ER) provider note dated 04/21/23 revealed: -Resident #4 was assessed after wandering away from her facility and found at her previous address. -She was gone from the facility for 2 1/2 hours. -Resident #4 had no medication at that time. -Her vitals were taken. -She was awake, alert and with no acute distress. -Resident #4 was able to tolerate food and liquids. -Resident #4 was able to stand and walk. -The ER provider could not definitively rule out a life-threatening cause of the presenting symptoms during an emergency department visit; therefore, required to follow-up with a physician to further assess risks of life-threatening causes of her symptoms. -If she could not follow-up as an outpatient within a reasonable time period, Resident #4 should return to the ER to facilitate follow-up. Observation of the route to Resident #4's previous address on 05/02/23 from 3:40pm - 4:30pm revealed: -Resident #4's previous address was 6.8 miles away from the facility. -There were no sidewalks in route to Resident #4's previous address. -The property was on a golf course with over 100 other homes. -There were more than five stoplights along the route to Resident #4's old property. -There were several wooded areas along the walkway to Resident #4's address. -There were several medium sized lakes along the walk to the property. -There was a four-lane road directly in front of the facility with a posted approximately speed limit of 45. -From 3:40pm until 4:30pm the roadway was frequented by 80 passenger vehicles, several school buses, motorcyclists and 5 construction vehicles.		

-There were several parts of the roadway under construction for repairs during the day.

Review of the local weather history report revealed the temperature outside on 04/21/23 at 2:00pm was 81 degrees Fahrenheit and with no precipitation.

Review of the facility fire watch documentation dated 04/21/23 revealed four fire watches were completed at 11:30am, 12:00pm, 12:30pm and 1:00pm by MA on 04/21/23 before staff found out Resident #4 had eloped.

Review of Resident #4's progress notes dated 04/21/23 at 3:22pm revealed Resident #4 "went for a walk" outside the facility. Resident #4 was located and returned by a staff member with no injuries, no complaint of pain or discomfort. Resident #4 was sent to ER for evaluation and treatment.

Review of Resident #4's progress notes dated 04/22/23 at 6:29am revealed Resident #4 was returned to the facility from ER at 10:45pm. Resident #4 was to be checked every 30 minutes.
-There was no documentation of Resident #4 was checked on every 30 minutes.
-There was no documentation of a follow up interventions put in place to address her exit seeking behaviors after the elopement on 04/21/23.

Telephone Interview with a representative with the fire protection company on 05/16/23 at 12:34pm revealed:
-The facility requested work on the fire panel system on 04/14/23.
-It was found the facility had two damaged fire panel system that needed to be replaced and would need to come back later.
-The technicians reported to the Director of Maintenance (DOM) when they arrived onsite at the facility.
-The DOM was responsible for ensuring all staff at the facility were aware of the doors being unsecure for the repair.
-The fire protection company technicians were not responsible for supervising any resident.

Interview with Resident #4's physician assistant on 05/02/23 revealed:
-She did not have any documentation the facility notified her concerning Resident #4's elopement, which occurred on 04/21/23.
-She expected staff to supervise Resident #4 to prevent possible elopement.

-Resident #4 could have sustained serious injury or death by crossing busy roadways on 04/21/23 when she eloped from the SCU. Observations of Resident #4 on 05/02/23 at 11:02am revealed: -Resident #4 was observed playing basketball on the back patio of the SCU unsupervised. -Resident #4 engaged in a game of basketball while having a full conversation. -There was no facility staff outside with Resident #4. -There was a staff member sitting at the locked back door of the facility that exited in the fenced patio area. Interview with Resident #4 on 05/02/23 at 11:02am revealed: -She had been at the facility a few months. -She left the facility because the door was opened, and she wanted to go home. -She walked out the front door of the facility. -She walked to her home after she left the facility. -Her home was not that far away from the facility. -She walked down a local busy street by using the cross walks to cross the streets safely to get home. -The facility staff were sitting in the common area of the unit when she left the facility on 04/21/23. -Two staff members came to her home to pick her up and took her back to the facility. -She did not want to be at the facility and had plans to leave the facility again. -She could climb the fence located in the back of the facility used to enclose the SCU. Telephone Interview with Resident #4's second RP on 05/24/23 at 2:20pm revealed: -Resident #4 was admitted into the facility in February 2023. -Resident #4 eloped from the facility on 04/21/23 and returned to her previous address located over 6 miles from the facility. -Resident #4's primary RP received a telephone call from a friend who lived in the community reporting Resident #4 was sitting on her old porch. -The primary RP then called another friend to go to the previous address and watch Resident #4 until she could get in touch with staff at the facility. -The primary RP called and informed the facility staff of the elopement. -The facility staff had no knowledge Resident #4 was not in the building. -Resident #4 was gone for over 2 1/2 hours and had walked over 6 miles to her previous address.		

-The family was told work was being completed on the lobby and the front doors were opened and that was how Resident #4 eloped from the building. -The family had a meeting with management at the facility and agreed to intervention being put into place to keep Resident #4 safe. -The facility was requesting the family pay for Resident #4 to have a one-to-one staff to supervise Resident #4 or she be discharged from the facility. Interview with a SCU first shift personal care aide (PCA) on 05/02/23 at 11:07 am revealed: -Resident #4 was very mobile and active, constantly walking the hallways of the SCU. -She was aware Resident #4 wanted to return to her former home. -Prior to Resident #4's elopement on 04/21/23, staff was instructed by MCC to perform every two-hour observation on Resident #4. -She did not work on 04/21/23 when Resident #4 eloped from the facility. -On 04/22/23, she was instructed to supervise Resident #4 any time Resident #4 was in the SCU courtyard and perform hourly checks when Resident #4 was in the SCU. Interview with a second SCU first shift PCA on 05/02/23 at 11:15 am revealed: -Resident #4 was known to constantly walk the SCU hallways and be active in the courtyard. -Resident #4 occasionally asked staff when she could return home. -Resident #4 was different from the other SCU residents due to her age, degree of mobility and activity level. On 04/21/23, two contracted repair man were working on the front exit doors and fire suppression system due to the storm damage sustained about one week ago. -On 04/21/23, during first shift, three care staff were working. -On 04/21/23, she was engaged with some SCU residents in the SCU living room for activities while the other PCA was doing laundry, and the MA was passing medications. -On 04/21/23, she was unaware if Resident #4 had attended lunch service. -On 04/21/23 between 1:00 pm and 2:00 pm, the MCC entered the SCU and asked where Resident #4 was. -On 04/21/23, the SCU staff performed a search for Resident #4, and she was unable to be located. -On 04/21/23, the MCC and MA drove to Resident #4's home to retrieve her.		

Interview with a MA on 05/02/23 at 11:13am revealed: -She was working at the facility on 04/21/23 when Resident #4 eloped. -She was aware Resident #4 was very active, alert and independent. -Resident #4 was not prescribed any medication since being at the facility. -She reported there were 3 staff members assigned to work the SCU unit on 04/21/23 on first shift (7am-3pm). -There was no communication from management that the doors were not working on 04/21/23. -She was aware a local company was at the facility working on panel for the doors, but she did not know the doors were unlocked at that time. -She was aware the facility had problems with the doors last week when lighting hit the building after a storm knocking out the fire systems causing the doors to be unsecure. -She thought the doors were fixed because management did not have anyone watching the doors anymore. -When the doors were unlocked, staff were told by the MCC to sit at each exit door on the unit. -The MAs were responsible for completing the fire watch every 30 minutes. -She was unaware if Resident #4 was present at lunch on 04/21/23. -The person completing the fire watch had to ensure all residents who were assigned to the facility seen every 30 minutes and documented. -She was responsible for completing the fire watch every 30 minutes on 04/21/23. -She was unaware Resident #4 eloped from the facility until MCC came and asked where she was. -She checked for Resident #4, but she was not on the unit. -She was told by the MCC that Resident #4 had eloped. -She and MCC went to Resident #4's old address to look for her. -The local address was a long drive that took about 12 - 20 minutes by car. -Resident #4 was returned to the facility around 2:30pm by MA and MCC. -She was aware Resident #4 did not want to be at the facility. -The staff was aware Resident #4 must be watched. -She reviewed the cameras and saw Resident #4 walked out the front door of the facility at 11:17am on 04/21/23. -She was unaware of any interventions put in place for Resident #4.		

Interview with MCC on 05/02/23 at 1:30pm revealed: -She was working on 04/21/23 during the elopement, but she was in the assisted living (AL) building at the time. -She received a telephone call on 04/21/23 at 1:20pm from Resident #4's responsible party asking where Resident #4 was. -She then went to go look for Resident #4 in the SCU and asked the 3 staff members if they knew where the resident was. -The staff members went to look and could not locate Resident #4. -She went back to the telephone and explained to Resident #4's RP that she could not locate her. -Resident #4's RP reported the elopement and provided an address on where Resident #4 could be found. -Staff were not aware Resident #4 had eloped prior to the RP calling. -On 04/21/23, two contracted repair employees were working on the front exit doors and the fire suppression system due to storm damage sustained about one week prior. -While the two contracted employees were working on the fire suppression system, the front doors of the building were opened and unlocked. -On 04/21/23, SCU lunch was served at 12:00 noon. -She was unaware Resident #4 was not present at lunch. -She informed staff the doors were not locked because of the services being performed by the contracted employees. -The staff were told to keep all the residents in the back of the building, but Resident #4 was walking around the building. -She was aware Resident #4 did not want to be at the facility. -She was aware Resident #4 was able to climb on a table to climb over the fence in effort to leave the facility. -The three staff members were assigned and present on the SCU on 04/21/23 with a census of 24 residents. -The facility did not have an extra staff person assigned to the building for the fire watch or to secure the doors of the SCU. -Due to the damage to the facility, the staff were completing fire watches every 30 minutes. -The fire watches included observing every resident in the building. -The staff were responsible for supervising every resident. -She reviewed the security camera for the facility and saw Resident #4 walked out the front door of the building at 11:17am. -She and MA went to pick Resident #4 up from her pervious address which was about 30 minutes from the facility. -Resident #4 was found sitting on the porch of her old address with no injuries and transported back to the facility by car. -Resident #4 was returned to the facility around 2:30pm.		

Interview with the facility Director of Maintenance (DOM) on 05/02/23 at 10:25am revealed: -He was aware of the elopement on 04/21/23. -Resident #4 was able to elope from the facility by walking out of the front door of the facility. -The facility had security cameras and he was able to see when the resident left the building. -The facility had been hit by lighting on 04/14/23 that caused damage to the fire panel system. -The facility had ongoing contractors working on the fire suppression system and fire panels on 04/21/23. -The SCU fire suppression system and exit doors were worked in conjunction with the exit doors releasing when the fire suppression system initiated an alert. -The facility sustained storm damage on 04/14/23 which disabled the fire suppression system and SCU door locks. -He informed the administrator, MCC and SCU staff members that the doors would be unlocked to decrease chance of an elopement. -He was not in SCU when the contractor employees were working on the fire suppression system. Interview with facility Administrator on 05/02/23 at 10:40am revealed: -On 04/14/23, the facility sustained storm damage which disabled the fire suppression system, call bell response system, and SCU magnetic door locking mechanisms. -On 04/21/23, a contracted vendor was performing maintenance on the SCU fire suppression system and had notified the DOM and SCU staff that the exit doors were disengaged during the work. -Resident #4 was independent with all ADL's, constantly walked the SCU halls, and played basketball in the courtyard. -On 04/21/23 at approximately 1:30 pm, the MCC received a telephone call from Resident #4's RP concerning Resident #4's current location. -On 04/21/23, Resident #4's RP notified the facility that Resident #4 was currently seven miles away from the facility, at Resident #4's former address. -On 04/21/23, the MCC picked up Resident #4 from her previous address and returned Resident #4 to the facility at approximately 2:30 pm. -A review of facility's video monitor system recordings, determined Resident #4 had walked out of the SCU front door at 11:17am and proceeded to walk off the facility grounds. -She was not allowed anyone outside the facility staff to review the facility video monitor system without an approval from corporate office.		

-The staff assigned to the unit on 04/21/23 were responsible for supervising Resident #4. The facility failed to provide supervision to Resident #4 who had a known history of exit seeking behaviors and wandering, which resulted in the resident eloping from the facility, walking 6.8 miles, and crossing a busy multiple-lane highway without staff's knowledge that resulted in the resident missing for approximately 3 hours, and the facility was notified by Resident #4's RP of her whereabouts. This failure resulted in substantial risk for serious harm and neglect and constitutes a Type A2 Violation. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 07/28/23. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/02/2023 and 6/23/23.		

Facility Name: The Pines on Carmel Senior Living

IV. Delivered Via:	HAND	Date: 6/29/2023
DSS Signature:	Tonya R. Wright	Return to DSS By: 7/20/23

V. CAR Received by:	Administrator/Designee (print name):	
	Signature: Vemelia Rowe	Date: 6/29/23
	Title: Executive Director	

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.*