Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Brookdale Cary
Address: 7870 Chapel Hill Rd, Cary, N.C. 27511
County: Wake
License Number: HAL-092-023
II. Date(s) of Visit(s): 10/10/22, 10/24/22, 11/28/22, 11/30/22, 12/01/22, 12/5/22, 12/9/22
Purpose of Visit(s): Complaints, Elopements

Exit/Report Date: 3/23/2023

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: Personal Care & Supervision, 10A NCAC 13F .0901 (b) 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: Based on observations, record reviews and interviews, the facility failed to provide supervision for 2 of 5 residents (Residents #1 & #2) residing in the Special Care Unit (SCU), including a resident with myasthenia gravis (autoimmune, neuromuscular disease) and a history of constant exit-seeking, who eloped twice into busy roadways and parking lots (#1), and a hospice resident with a history of 5 falls within 2 months who suffered significant intracranial (brain) swelling and bleeding after a 6th fall on a facility patio, and then sustained 4 subsequent falls and subsequent death (#2). The Findings are: Review of the facility's *Falls Management Policy* dated 2/2023 revealed:	☐ POC Accepted _____ *DSS Initials*	

-Fall Definition: A fall referred to the witnessed, or unwitnessed, unintentional coming to rest on the floor, ground, or other lower level, with or without injury. -A fall risk evaluation was to be completed at admission and after. -Resident falls were to be noted in the resident's record. -A post fall evaluation was to be completed after a fall and entered into the facility's electronic system. -Provide first aide to the resident and follow 911's instructions. -Information on the fall, the resident's response, and interventions taken were to be documented in the facility's PointClickCare system. -The resident's care plan was to be reviewed and falls preventions added or updated within the plan. -Review the fall at the next facility Stand Up (staff) meeting. -Resident falls were discussed at the next resident care review. -Resident's providers and responsible party were to be notified. -Resident falls, injuries, response, and interventions taken were to be documented in the resident record. -Change of conditions were to be documented. 1.) Review of Resident #2's current FL-2 dated 09/22/22 revealed: -Level of physician recommended placement was Special Care Unit (SCU). -Diagnoses included Alzheimer's Dementia, attention and communication deficit, psychomotor deficit, hypertension, and atrial fibrillation with heart failure. -The resident was constantly disoriented. -Resident #2 had an unsteady, abnormal gait, needed assistance to ambulate, and was a falls risk. -Resident #2 had a pacemaker. Review of Resident #2's facility record revealed: -An Emergency Room (ER) discharge summary dated 08/29/22. -The resident had advanced dementia and nerve damage weakness to his legs. -Resident #2 was transported to the ER on 08/29/22 due to multiple falls and hospitalized until 09/06/22. -Resident #2 had an unwitnessed fall with systolic and diastolic congestive heart failure exacerbation. Review of Resident #2's Resident Register dated 08/31/22 revealed Resident #2 was admitted to the facility on 09/06/22, and the resident forgot how to use his walker.		

Review of Resident #2's Care Plan dated 09/07/22 revealed: -The resident was disoriented to person, place, & time. -Resident #2 had heart failure, cardiac arrythmia, and a pacemaker. -Resident #2 required a walker and physical assistance to ambulate. -The resident had wandering behaviors and attempted to exit the facility (date/s not documented). -Staff were to be alert Resident #2 was a heightened risk for falling. a.) Review of Resident #2's progress notes by a Medication Aide (MA) dated 09/07/22 at 9:17pm revealed Resident #2 fell while ambulating out of the dining room. Attempted review of Resident #2's 09/07/22 Incident/Accident (I/A) report revealed no I/A report for the resident 09/07/22. Telephone interview with the Health Wellness Nurse (HWN) on 02/02/23 at 2:25pm and on 03/10/23 at 11:45am revealed: -The HWN did not know the details of the resident's 09/07/22 fall. -Hospice was notified of his 09/07/22 fall. -Hospice evaluated him on 09/09/22. -Hospice found bruising to both his arms on 09/09/22. -Hospice was put in place for Resident #2 since his heart issues caused fainting and falls. -Resident #2's supervision was not increased upon admission or after the resident's 9/07/22 fall. -A one-on-one staff or sitter was not assigned to Resident #2 after these falls. Interview with the HWN on 11/28/22 at 3:30pm and 03/07/23 at 3:52pm revealed Resident #2 did not appear to have injuries after his fall, so an emergency evaluation and an I/A report was not completed. Telephone interview with Resident #2's Hospice Director of Professional Services (HDPS) on 02/08/23 at 2:52pm revealed hospice services began for Resident #2 upon his admission on 09/07/22, due to dementia and a history of heart failure and stroke.		

Review of Resident #2's hospice nursing documentation dated 09/07/22 at 3:12pm revealed: -Resident #2 had an unwitnessed fall with head injury on 09/07/22. -Resident #2 was transported to a local ER. -Hospice services began on 09/07/22 when he discharged from the hospital back to the facility. -Bruising was observed to both his forearms. Telephone interview with a Personal Care Aide (PCA) on 03/09/23 at 10:37am revealed: -Managers instructed this PCA and on-duty staff in morning staff meetings, Resident #2 was on 2-hour checks when in bed and to be kept in common rooms with staff 9/20/22-11/11/22. -Resident #2 constantly took off his top and moved around in his bed. -Most of his falls occurred on 3rd shift; not all 3rd shift staff checked on residents every 2 hours. Interview with Resident #2's Power-of-Attorney (POA) on 03/08/23 at 4:25pm revealed: -Resident #2 suffered severe heart failure on 08/29/22 at her home and was not the same since; afterwards, he leaned to one side, and he forgot to use his walker. -The facility allowed Resident #2 to be admitted on 09/07/22 after hospital discharge on condition Resident #2 could independently transfer himself in/out of bed and with toileting. -Physical Therapy (PT) was ordered and began for Resident #2 in September 2022 since he had balance issues and needed a walker. Attempted review of Resident #2's hospice nursing note dated 09/09/22 was not successful. Review of Resident #2's hospice nursing note dated 10/04/22 revealed: -Resident #2 had symptoms of exacerbated congestive heart failure (lethargy, leg swelling, and decreased oxygen intake). -Staff were to closely (unspecified) monitor the resident and report any changes to hospice. Interview with a Medication Aide (MA) on 11/28/22 at 11:00am and on 2/02/23 at 6:58pm revealed: -Resident #2 had confusion and muscle weakness. -The resident was dependent on staff for wheelchair ambulation and transfers.		

-Resident #2 became increasingly more bed-bound after admission in September 2022.

b.) Review of Resident #2's progress note by the Resident Care Coordinator (RCC) dated 10/18/22 at 11:51am revealed:
-Resident #2 had an unwitnessed fall to the floor (time, injuries, or nature of fall were not documented).
-Hospice and the family were notified.
-There was no documentation of fall preventions.
-Management did not instruct Resident #2's supervision to be increased from 2-hour checks after his September or October 2022 falls.

Attempted telephone interview with Resident #2's hospice physician on 01/27/23, 02/02/23, and 02/07/23 was unsuccessful in reaching the physician.

Review of Resident #2's hospice progress note dated 10/18/22 revealed:
-Resident #2 had an unwitnessed fall to the floor 10/18/22 (time not documented) and was found on his knees by his bed by facility staff.
-Resident #2 was unable to stand and get up.
-The resident appeared to have no visible injuries.
-Resident #2 reported to staff he fell.
-Resident #2's PT evaluated Resident #2's leg for extreme leg weakness in October 2022, after his 10/18/22 fall.

Telephone interview with Resident #2's Hospice Nurse (HN) on 02/08/23 at 10:55am revealed:
-Resident #2 was able to ambulate short distances in September-October 2022.
-The resident declined even more and had more unconscious episodes.
-Resident #2 continued getting out of bed unassisted and falling in October 2022.
-Resident #2 fell 10/18/22 trying to get out of bed.
-Resident #2 could not stand up on his own 10/18/22.
-Resident #2 did not appear to have any visible injuries from his 10/18/22 fall.
-Hospice ordered a wheelchair for Resident #2 in early October 2022, due to leg weakness and dementia.
-She reminded the HWN, lead MA, and PCAs working that day (names not recalled) to check Resident #2 more frequently (unspecified) than 2 hours.

Attempted review of hospice nursing notes or care plan were unsuccessful. Telephone interview with a PCA on 03/08/23 at 7:35pm revealed: -The HWN instructed the PCA and other staff to check on Resident #2 every 2 hours 9/2022-11/11/22 since he had 2-3 falls from 9/2022-11/11/22. -One of Resident #2's September 2022 falls happened when he tried to walk to his walker (date not recalled). -She and other staff often found him sliding out of bed, feet first, onto the floor 09/2022-11/2022. -Only MAs were required to document resident supervision checks. -The HWN and Executive Directors (ED) told the PCA, only 2 PCAs and 1 MA was required for their low census. (Total census: 44). -It was not possible to care for 19 memory care residents in her unit needing 1-2 person assist with Activities of Daily Living (ADLs), falls risk residents, sundowning and aggressive behaviors, since several residents required 2-staff physical assistance, which took staff away from the other residents' needs. Interview with a PCA on 11/28/22 at 11:55am revealed: -Management (manager not recalled) instructed her, and other on duty staff, to check Resident #2 every 2-hours 9/2022-11/101/22, due to the resident's falls. Telephone interview with a 2nd PCA on 03/09/23 at 10:37am revealed: -Managers instructed her and on-duty staff in morning staff meetings, Resident #2 was on 2-hour checks 09/2022-11/11/22. -Resident #2 constantly took off his top and moved around in his bed. -Most of his falls occurred during evening shifts, so not all evening staff checked on residents every 2 hours. -A fall mat began beside Resident #2's bed when hospice began services with him at the end of October 2022. Telephone interview with a MA on 11/28/22 at 11:00am and on 03/09/23 at 9:50am revealed: -Due to Resident #2's September 2022 falls, management (manager not recalled) him and PCAs on duty in an October 2022 staff meeting to start checking Resident #2 every 30 to 60-minutes. -Management instructed the MA and PCAs in an October 2022 staff meeting to assure Resident #2's bed was in low		

position and his fall mat was beside his bed when the resident was in bed. -He found Resident #2's bed low and the fall mat beside his bed when Resident #2 was in bed. Interview with the POA on 03/08/23 at 4:25pm revealed: -The facility discussed a fall mat, low bed, and wheelchair sometime in October-November 2022 as falls precautions with the POA. -A one-on-one staff or a sitter for Resident #2 was not suggested or implemented by the facility. Interview with the Resident Care Coordinator (RCC) on 02/03/23 at 3:35pm revealed: -Resident #2 began declining in September and October 2022 and slept a lot so staff would get him out of bed. -Resident #2 fell 1-2 times before November 2022. -Resident #2 was not walking before November 2022 but would stand up from his wheelchair and try to walk. -Two-hour checks continued with Resident #2 after each of his falls September-November 2022. -She was not instructed to increase the frequency of Resident #2's checks. Telephone interview with the HWN on 02/02/23 at 2:25pm and 02/08/23 at 10:55am revealed: -Resident #2 was able to ambulate short distances in September 2022 with his walker. -Hospice nursing began 09/07/22 for dementia and heart disease. -Resident #2 continued trying to get out of bed unassisted and falling in September 2022. -The HN educated the HWN, the lead MA, and the PCAs who worked those days (names not recalled) to check Resident #2 more frequently than 2 hours. -The HWN did not know the details of the resident's 10/18/22 fall. -Per internal facility documentation, Resident #2 had an unwitnessed fall to the floor at bedside on 10/18/22 at 10:10am. -Resident #2 could not stand; 2 staff were needed to put him back to bed. -Hospice evaluated Resident #2 on 10/18/22 and found no visible injuries. -The resident was found with increased leg weakness, so his PT evaluated his leg around 10/18/22. -A low bed was put in place as a falls intervention on 10/17/22. -A sitter was not put in place for Resident #2 to increase the resident's supervision.		

-Resident #2 continued to be checked every 2 hours. Review of Resident #2's updated care plan dated 10/24/22 revealed: -Resident #2 had wandering behaviors and required staff redirection. -Resident #2's fall preventions: assure the resident's wheelchair was locked. -Resident #2 had 1 fall (date not documented) with (unspecified) injury. -Resident #2 then had 2 subsequent falls (dates unspecified) with resulting skin tears. -Two-hour checks continued on Resident #2. Telephone interview with the HWN on 02/02/23 at 2:25pm and on 03/10/23 at 11:45am revealed: -Two-hour checks on Resident #2 after the resident's 3 falls in one week on 10/18/22, 10/23/22, and 10/30/22 since hospice services were in place with him. -A one-on-one staff or sitter was not assigned to Resident #2 after these 3 falls in October 2022. Telephone interview with Resident #2's Hospice Director of Professional Services (HDPS) on 02/08/23 at 2:52pm revealed a fall mat was ordered by hospice and placed on 10/31/22. c.) Review of Resident #2's progress note by a MA at 8:24pm dated 11/03/22 revealed Resident #2 had an unwitnessed fall to the floor on 11/03/22 (time not documented) while trying to get out of bed. (Any injuries were not documented.) Telephone interview with the HWN on 02/02/23 at 2:25pm and 02/08/23 at 10:55am revealed: -Resident #2 would have unresponsive episodes before and when he was admitted to the facility. -Falls precaution added after his September 2022 falls: a fall mat was ordered and placed on 10/31/22. -The resident began declining more, had more unconscious episodes and became unable to verbalize his needs, prior to 11/10/22. -The HN educated the HWN, the lead MA, and the PCAs who worked those days (names not recalled) to check the resident more frequently than 2 hours, and to position the fall mat at the side of his bed when the resident was in bed. -Per facility internal documentation, Resident #2 had an unwitnessed fall from his bed to the floor on 11/03/22 at 5:30pm.		

-Resident #2 had no visible injuries, so the facility did not seek emergency evaluation of Resident #2. -Hospice or the PCP did not evaluate Resident #2 on 11/03/22. -A sitter was not put in place for Resident #2 to increase the resident's supervision. -Resident #2 continued to be checked every 2 hours. Telephone interview with a PCA on 03/09/23 at 10:37am revealed: -The PCA did not know the details of Resident #2's 2-3 times in November 2022 on 2nd or 3rd shift. -Resident #2's fall mat was beside his bed in November 2022. -The PCA always found his fall mat in place in November 2022 and his bed in low position, on 1st shift, when his low bed arrived 11/11/22. d.) Telephone interview with Resident #2's HDPS on 02/08/23 at 2:52pm revealed: -The facility notified hospice 11/05/22 Resident #2 had an unwitnessed fall to the floor from bed on 11/05/22. -The HN observed Resident #2's fall mat was not by his bed, when Resident #2 was in bed, when the HN arrived to evaluate the resident on 11/05/22. -Resident #2 sustained small abrasions and swelling to his left temple. -The hospice physician ordered wound care; then the HN provided wound care for Resident #2 for his head. Attempted review of Resident #2's 2nd fall I/A report on 11/03/22-11/05/22 was not successful. Telephone interview with the HWN on 02/02/23 at 2:25pm revealed: -Supervision was not increased from 2-hour checks. -A one-on-one staff or sitter was not assigned to Resident #2. e.) Review of Resident #2's I/A Report by the HWN dated 11/10/22 revealed: -The resident had an unwitnessed fall on 11/10/22 at 2:30pm outside on the facility patio. -The MA immediately responded to the resident. -Emergency Medical Services (EMS) was called and transported Resident #2 to the ER. -Resident #2 suffered from a skull fracture and brain bleed. -Hospice and the family were notified.		

-The family declined hospital surgery to treat Resident #2's brain bleed.
-Resident #2 returned to the facility with orders to resume hospice nursing care.

Review of Resident #2's progress note dated 11/10/22 at 3:11pm revealed:
-Resident #2 had an unwitnessed fall on to the patio on 11/10/22.
-Resident #2 was bleeding from his ear.
-Resident #2 was sent to the ER.

Review of Resident #2's Emergency Medical Services' (EMS) run report dated 11/10/22 revealed:
-EMS was called by the facility at 2:09pm.
-EMS arrived at the facility on 11/10/22 at 2:22pm.
-The EMT found the 92-year-old Resident #2 lying on his back on the cement patio ground.
-Staff reported Resident #2's fall was unwitnessed.
-Staff last saw the resident in his wheelchair in the living room 10 minutes before he fell.
-Resident #2 was found unconscious and unresponsive.
-Resident #2 was bleeding from the back of his head and his right ear.
-The resident's eyes were closed, and he had minimal verbal or motor response.
-Resident #2's pupils were pinpoint and non-reactive to light.
-Trauma notification was made to the hospital ER.

Telephone interview with an EMS paramedic on 02/02/23 at 11:20am revealed:
-The paramedic was greeted by a facility staff member and a MA.
-He observed no staff with Resident #2 on the patio or in the living room.
-The resident's wheelchair was inside the living room.
-A pronounced threshold lip was observed in the patio doorway.
-Resident #2 was found lying on his back, on the cement patio floor, with his feet closest to the facility patio door with his head in the opposite direction.
-Resident #2 appeared to have fallen hard, due to the significant laceration and amount of blood coming from his right ear and the back of the resident's head.
-Resident #2 was found unconscious and unresponsive upon arrival.
-Resident #2 became more lucid during transport to the ER.
-A trauma alert was called to the hospital ER, so surgeons and other emergency staff were ready to urgently treat Resident #2.

Review of Resident #2's hospital discharge summary dated 11/10/22 revealed: -Resident #2 suffered a large laceration to the back of his head, a traumatic brain injury, due to a blunt force impact. -The force of impact caused swelling to the brain, which resulted in blood hemorrhaging into the front of the brain (which causes unrecoverable loss of function and is the most severe type of secondary traumatic brain injury. -Resident #2's temporal bone was fractured (the thickest bone in the skull requiring significant force to fracture). -Resident #2's sphenoid bone (temporal skull area) was fractured, with small hemorrhage, extending to the back of the resident's ear. (Sphenoid fractures have a high morbidity rate.) -Resident #2 was in a coma. -Resident #2 had a DNR order, so the family opted for facility end-of-life care. Review of Resident #2's HN progress note dated 11/11/22 revealed: -The HN provided end-of-life care for Resident #2 after his hospital discharge. -Blood was observed oozing from Resident #2's right ear and dried blood in his nostrils. Telephone interview with Resident #2's HN on 02/08/23 at 10:55am revealed: -Resident #2 had blood oozing from his ears, dried blood in his nostrils, and skin tears on his arms. -End-of-life medications began due to bleeding in his brain. -Resident #2 declined rapidly after his 11/10/22 fall. -Resident #2 was non-ambulatory and bedbound after his 11/10/22 fall. -She instructed the HWN, lead MA, and PCAs on duty 11/11/22 to check on Resident #2 more frequently than every 2 hours. Interview with a MA on 11/28/22 at 11:00am and on 02/02/23 at 6:58pm revealed: -She, Resident #2, and 4 other SCU residents were in the living room after lunch around 1:30pm on 11/10/22. -He was not aware which PCA was assigned to Resident #2 on 11/10/22. -A 2nd resident was in a wheelchair, a 3rd resident who needed a walker to ambulate sat in a chair, and 4th ambulatory resident sat in a chair in the living room. -The MA was at the medication cart, beside the patio door. -Resident #2 sat in his wheelchair behind the MA.		

-The MA left the living room to administer a scheduled medication to another resident in their room and to speak with that resident's hospice nurse. -When the MA left the room, there was no other staff in the living room. -When the MA returned to the living room 10 minutes later, Resident #2 was not in his wheelchair. -No staff other was in the living room or on the patio when he returned to the living room. -The living room door to the patio was open. -He found Resident #2 lying on his back outside, on the cement enclosed patio, with his feet toward the doors. -The resident had a large pool of blood under his head and coming from his right ear. -He immediately shouted for help. -Managers responded to Resident #2 and called EMS. -EMS transported Resident #2 to a local ER. -Resident #2 returned via ambulance the next day 11/11/22, with a significant amount of blood still coming from his right ear. -He was not aware if Resident #2 had any falls after 11/10/22. -After each of Resident #2's November 2022 falls, management instructed and reminded this MA to check Resident #2 every 30-60 minutes for 1-2 days; then every 2 hours after 11/12/22. -Resident #2 died a week after his 11/10/22 fall. Interview with a PCA on 11/28/22 at 10:45am revealed: -This PCA did not know which staff was assigned to Resident #2 on 11/10/22. -A fall mat was placed beside his bed in November 2022. -The resident did not have a sitter before or after his 11/10/22 fall. -When Resident #2 returned from the hospital 11/11/22, 2-hour checks resumed on the resident with no new interventions. Interview with a 2nd PCA on 11/28/22 at 11:55am revealed: -She did not know which staff was assigned to Resident #2. -A fall mat was placed beside his bed in November 2022. -Management instructed staff to check on Resident #2 every 2 hours after each fall before and after his 11/10/22 fall. -The resident did not have a sitter. -After his 11/03/22 and 11/10/22 falls, she decided to keep Resident #2 with them in common rooms and check him every hour when his was in bed, so she could supervise him closer. -She was not informed Resident #2 fell on 11/05/22.		

Telephone interview with Resident #2's HPDS on 2/08/23 at 2:52pm revealed:
-The facility did not notify hospice of Resident #2's 11/10/22 fall, the hospital notified hospice.
-Resident #2 did not require end-of-life care, until after his 11/10/22 fall and hospitalization.

Review of Resident #2's hospice nursing progress note dated 11/16/22 revealed staff were ordered to check on Resident #2 more frequently than every 2 hours, assure his fall mat was in place when he was in bed, and his wheelchair was locked.

Telephone interview with the HWN on 02/02/23 at 2:25pm revealed:
-The hospital called later 11/10/22 at 10:55pm to discharge the resident back to the facility.
-Upon return to the facility, Resident #2 was agitated, trying to get out of bed, and had blood dripping from his right ear onto his clothes.
-The HN told the HWN, the lead MA, and PCAs working that day to check Resident #2 every 30-60 minutes after his 11/10/22 fall, assure the bed was positioned low and locked, his wheelchair was locked, and fall mat were bedside when he was in bed.
-The hospice nurse began palliative care for Resident #2 on 11/11/22 at 1:00am.
-Supervision was not increased from 2-hour checks, and a one-on-one staff was not assigned to Resident #2.

Interview with the Resident Care Coordinator (RCC) on 2/03/23 at 3:35pm revealed:
-Resident #2's supervision was not increased from 2-hours checks after each fall in November 2022.
-The RCC was not instructed to check Resident #2 every 30-60 minutes September-November 2022.
-Resident #2 had no sitter September-November 2022.

Telephone interview with Resident #2's POA on 11/30/22 at 1:15pm revealed:
-The POA was notified of his 11/10/22 fall at the facility.
-The POA did not know why he was on the patio without a walker or wheelchair, undetected, and without staff supervision on 11/10/22.
-Resident #2 sustained a skull fracture and brain bleed when he fell backwards on the facility patio on 11/10/22.
-The hospital physician did not expect him to survive his head injury.

Telephone interview with Resident #2's HN on 2/08/23 at 10:55am revealed Resident #2 was non-ambulatory and bedbound after his 11/10/22 fall.

Telephone interview with Resident #2's Hospice Director of Professional Services (HDPS) on 2/08/23 at 2:52pm and 03/09/23 at 12:30pm revealed:
-Resident #2's HN evaluation on 11/15/22 found Resident #2 had a scab on the back of his head with no signs of infection and bruises around both ears.
-The HN did not find Resident #2's fall mat beside his bed when she arrived on 11/15/22.
-The bed's position was not documented by the HN.

e.) Telephone interview with Resident #2's HDPS on 02/08/23 at 2:52pm and 03/09/23 at 12:30pm revealed:
-The facility notified hospice of 2 falls on 11/16/22: Resident #2 had an unwitnessed fall to the floor by the foot of his bed at 4:29am.
-Resident #2's HN went out to evaluate him upon receipt of this call.
-The HN evaluated Resident #2 and found no new skin wounds, bleeding, or bruising at that time.

f.) Review of Resident #2's progress note dated 11/16/22 at 6:15am by a MA revealed Resident #2 had 1 unwitnessed fall (time, nature of fall, and injuries were not documented).

Telephone interview with Resident #2's HDPS on 2/08/23 at 2:52pm and 03/09/23 at 12:30pm revealed:
-The facility notified hospice at 11:26pm of a 2nd unwitnessed fall Resident #2 sustained on 11/16/22.
-Resident #2 was found in bed on 11/16/22 without his fall mat at the side of his bed.
-The resident was not responsive.
-The HN documented Resident #2 had facial bruising from a fall after 11/11/22 (date not documented).
-A low bed was ordered and put by hospice on 11/16/22 to replace his hospital bed.

Review of Resident #2's progress note by the HWN dated 11/16/22 at 12:29pm revealed:
-The HWN expected staff to stay with Resident #2 and the other residents when in the living room.
-The HWN expected staff to lay Resident #2 down in bed if he appeared lethargic; then check on Resident #2 every 2 hours.

Telephone interview with the HWN on 02/02/23 at 2:25pm revealed:
-Resident #2 had a subsequent fall from bed on 11/16/22 at 4:15pm.
-The HWN did not know why Resident #2's fall mat was not beside his bed at the time of his 11/16/22 fall.
-The resident did not appear to have visible injuries, so Resident #2 was not sent to the hospital, hospice evaluated him 11/16/22, and an I/A report was not completed.
-Hospice found Resident #2 to have no apparent new injuries on 11/16/22.
-The facility did not increase his supervision or start a one-on-one staff or sitter with Resident #2.

g.) Review of Resident #2's hospice nursing progress note dated 11/17/22 revealed:
-The hospice nurse performed a follow-up evaluation of Resident #2 after a fall the morning of 11/17/22 (time and nature of fall was not documented).
-The resident lay unresponsive in bed.
-Injuries to Resident #2 were not documented.
-Resident #2's death was imminent.
-Staff were expected to check Resident #2 every 30-60 minutes and assure his fall mat was beside his bed when he was in bed.

Attempted review of I/A reports, progress notes, and physician evaluation notes for Resident #2's 2 falls on 11/17/22 were unsuccessful.

h.) Telephone interview with Resident #2's HDPS on 02/08/23 at 2:52pm and 03/09/23 at 12:30pm revealed:
-Hospice was notified by the facility, Resident #2 had an unwitnessed fall to the floor on 11/18/22.
-The HN evaluated him on 11/18/22 and found no new visible new injuries.
-A scoop mattress for Resident #2's bed was ordered as a falls precaution on 11/18/22. (Date scoop mattress was placed was not recalled or documented.)

Telephone interview with Resident #2's Primary Care Physician (PCP) on 2/08/23 at 9:10am revealed:
-She treated Resident #2 prior to his facility admission 3/2022 and 8/2022.
-Resident #2's cognitive and physical decline escalated in early 2022, due to dementia, coronary artery disease, and congestive heart failure.
-Resident #2 was shaky on his feet and a high risk for falls.

-She expected the facility to provide close (unspecified) supervision of Resident #2, especially with ambulation. Telephone interview with a PCA on 03/09/23 at 10:37am revealed: -Resident #2 fell 2 subsequent times sometime (dates not recalled) during 3rd shift, after his 11/10/22 fall with head injury. -She thought Resident #2's fall precautions included a fall mat and low bed that began in November 2022. -She found the fall mat beside Resident #2's bed when he was in bed during 1st shift in November 2022. -Management instructed staff to keep him in the living room with staff September-November 2022. -Management did not increase Resident #2's supervision from every 2 hours after his falls September-November 2022. -A one-on-one staff was not put in place for Resident #2 after his falls September-November 2022. Telephone interview with the ED on 12/05/22 at 10:30am and 03/09/23 at 11:30am revealed: -Two, previous EDs worked at the facility September-November 2022. -She began as ED at the facility on 11/28/22. -When a resident started to fall, she would immediately assure the facility's *Fall Management Policy* was implemented. -She communicated the falls and supervision precautions with staff at morning staff meetings. -After a resident fall, she expected staff to check the resident every 30 minutes for 48 hours; then check the resident every 1 hour thereafter, unless the PCP and HWN's consultations resulted in a change of supervision and care planning. -A sitter would be quickly put in place with a subsequent fall. -She expected the HWN to consult with the physician for change of condition evaluations and falls care planning, including PT and equipment. -She expected staff to supervise all residents every 2 hours. -She expected staff to check residents every 30-60-minute for residents with these directives. -She expected staff to check on residents on patios every 30 minutes if staff were not on the patio running an activity. -She expected staff to radio for supervision help if they were busy. -She expected staff supervising residents inside facility common areas to replace themselves before leaving the area.		

Telephone interview with the HN on 02/02/23 at 2:25pm revealed: -The HN told the HWN and on-duty staff to check Resident #2 every 30-60 minutes after each of his November 2022 falls. -The HN told the HWN and on-duty staff to assure the bed was positioned low and locked, his wheelchair was locked, and fall mat was bedside when he was in bed after each fall in November 2022. -The HR noted Resident #2's supervision and falls precautions in resident's hospice nursing notes. Review of Resident #2's hospice nursing notes dated 11/18/22 and 11/21/22 revealed: -Resident #2 was bedbound, unresponsive, and his death was imminent. -The HR instructed the HWN and staff on-duty to check Resident #2 every 30-60 minutes and continue his falls precautions. Telephone interview with Resident #2's HDPS on 02/08/23 at 2:52pm and 03/09/23 at 12:30pm revealed: -The HN found Resident #2 to be in the final stage of end-of-life on 11/21/22 with shortness of breath and unresponsiveness. Telephone interview with Resident #2's HDPS on 02/08/23 at 2:52pm and 03/09/23 at 12:30pm revealed: -The facility notified hospice on 11/22/22, Resident #2 died on 11/22/22. 2.) Review of the facility's *Alzheimer's and Dementia Care Exit Alarms & Wanderguard System* policy dated 11/2020 revealed: -The alarms were to be activated at all times. -It is the responsibility of the staff to respond when an alarm sounded. -When an alarm sounded, staff were to check the alarm display to see which door was breached/alarming. -The staff will not silence the alarm until the location of the activation was identified. -The responding staff was to go to the door(s) breached to investigate. -Staff was to redirect residents away from exits, view the immediate area outside the door, locate any residents who exited, and escort any exited resident back inside. -A resident head count was to be done to assure all residents were accounted for.		

-If a resident was missing, the Resident Sign-Out Log was to be checked and the *Missing Resident Policy* begun, completing the *Missing Resident Response Worksheet.* -Staff were to report residents who repeatedly triggered alarms to the ED, HWD, or designee. -New staff were to be trained on the exit door policies by the ED or Manager on Duty (MOD) the first day of employment. -The new staff will sign they have read and understand the exit door policies. Review of the facility's *Guidelines for Elopement Risk Interventions* dated 11/2020 revealed: -When a resident increased pacing, agitation, or restlessness, watched or stood near doors or exits, checked (pushed on) doors, or was awake at night, staff were to: Review for change of condition, implement specific interventions to engage the resident, update family, initiate a physician appointment, begin 1 hour or 15-minute checks, with 15-minute checks for newly admitted residents. -If a resident walked towards an exit or walked out of the facility with others, staff were to: Redirect the resident away from the exit, update the family, consult with the regional corporate team, and begin a 1:1 staff, or consider a 1:1 staff for at least 48 hours, or start 15-minute checks. -When a resident walked through an exit door, followed someone out a door, or climb out a window or over a fence, the staff were to: Begin a 1:1 staff for at least 48 hours or until other appropriate, alternate placement could be arranged. Review of Resident #1's current FL-2 dated 4/22/22 revealed: -Diagnoses included myasthenia gravis, sepsis, and fever. -The resident was constantly disoriented and was semi-ambulatory (need for assistive devices was not documented). -Physician-recommended level of care was not documented. (This facility is a dementia care facility.) Review of Resident #1's Resident Register dated 11/04/2020 revealed: -Resident #1 was admitted to the facility on 11/04/22. -Resident #1 had significant memory loss, so she needed direction. Review of Resident #1's Primary Care Physician (PCP) documentation dated 4/25/22 revealed staff should continue (unspecified) supervision of Resident #1 since she had muscle weakness, due to myasthenia gravis.		

Review of Resident #1's September 2022 Medication Administration Record (MAR) revealed: -An order to check Resident #1 every 30 minutes was listed on the MAR. -30-minute checks were not documented as being done in September 2022. Telephone interview with Resident #1's PCP on 1/27/23 at 3:45pm revealed: -Resident #1 had muscle weakness and had a history of falls, due to myasthenia gravis and dementia. -Resident #1 had a facility history of elopements and constant exit-seeking behaviors. -The PCP ordered 30-minute checks of Resident #1 in September 2022, after Resident #1's elopement in September 2022, her constant exit-seeking, and as a falls precaution. -The PCP's electronic order system changed in August/September 2022, so the PCP did not have access to the September 2022 30-minute check order in the old system. a.) Review of Resident #1's Incident/Accident (I/A) Report dated 10/10/22 revealed: -Resident #1 eloped from the facility on 10/10/22. -Resident #1 exited the employee entrance at the back of the facility through a broken dining room-staff room door (at an undocumented time) and exterior exit door propped open by a contractor. -Resident #1 was found (at unspecified time) by an unnamed person in the back, facility parking lot. -Resident #1 had no visible injuries. -The dining room-staff room door was immediately (date not documented) repaired. Review of Resident #1's progress note by a Medication Aide (MA) dated 10/10/22 at 8:00pm revealed: -Resident #1 eloped from the facility on 10/10/22. -She eloped through a broken door that was disabled by contractors repairing a 2nd door. Interview with a MA on 10/24/22 at 3:15pm revealed: -Resident #1 constantly checked and pushed on all exit doors. -Resident #1 was on 2-hour checks prior to her 10/10/22 elopement. -The alarm company had been working on one of the doors on 10/10/22 and deactivated the alarm on the exit doors.		

-Staff did not know the exit door locks and alarms were deactivated, so staff did not hear an alarm when Resident #1 exited the A-Hall door. -The A-Hall door was found open. -She last saw Resident #1 sometime before 5:00pm before dinner. -A staff arriving to work found Resident #1 in the facility parking lot and returned her back inside to the SCU. -Resident #1's supervision checks did not change from 2-hours after her 11/06/22 elopement. -She did not know 30–60-minute checks on Resident #1 were on the MAR. -This MA decided to check Resident #1 every 30-60 minutes if the MA did not hear the alarm go off since she constantly tried to exit, activating the door alarms. Interview with a 2nd MA on 10/24/22 at 3:50pm revealed: -Management instructed staff in morning meetings October-November 2022 to check Resident #1 every 2 hours. -He was not instructed by management to provide different care or precautions. -He did not know 30-minute checks of Resident #1 were on the MAR. -He decided to check on Resident #1 every 30 minutes, since she had constant exit-seeking behaviors. Interview with a Personal Care Aide (PCA) on 10/25/22 at 5:10pm revealed: -She arrived to work as another resident's sitter on 10/10/22 at 6:30pm. -She saw Resident #1 walking around the front of the facility on the sidewalk in front of her car. -She was shocked and concerned to see her outside. -Resident #1 had a plastic bag or adult incontinence brief in her hand. -Resident #1 told her, she had been outside a very long time, so she was tired. -She tried to lead Resident #1 away from the parking lot, but Resident #1 attempted to step down off the sidewalk curb into the parking lot. -The PCA led Resident #1 to the facility front door, where another agency PCA led Resident #1 inside the facility. -The staff on duty were not aware she was missing. -The MA on duty was frantic, trying to figure out how Resident #1 got out of the facility. -Staff could not recall the last time they saw Resident #1 before she was returned to the facility. -She observed staff redirect Resident #1 away from exit doors prior to 10/10/22, but no one instructed her how often to check Resident #1.		

-She was not instructed to check on Resident #1 more frequently than every 2 hours after the resident's 10/10/22 elopement. Interview with a 3rd MA on 10/24/22 at 3:15 and on 3/10/23 at 11:00am revealed: -Resident #1's supervision checks did not change after her 10/10/22 elopement, but he decided to check her every 30-60 minutes. -If he was busy when it was time to check her, he radioed a PCA to check Resident #1 before he documented her 3-60-minute check was done on the MAR. -The corporate office and management always stressed the importance of running to alarming exit doors and seeking the resident who activated the alarm. -In October 2022 some facility and agency staff did not show urgency in running to alarming exit doors or redirecting residents who were exit-seeking. Interview with a 2nd PCA on 11/28/22 at 11:25am revealed: -The dining room door to the staff break room door broke (date unknown) sometime prior to September 2022. -Staff were told to increase supervision of Resident #1 while the door was broken by keeping her with staff in common rooms. -The resident dining room and staff breakroom pass-through door was repaired, and a keypad was added, sometime in September 2022. Telephone interview with a 3rd PCA on 11/30/22 at 11:25am revealed the pass-through door had been broken for 2 months but was repaired sometime in November 2022. Interview with a 2nd MA on 11/28/22 at 11:15am revealed: -Staff were instructed to respond immediately to alarming exit doors or residents pushing on exit doors. -Resident #1 had constant exit-seeking behaviors. -Management instructed staff to check alarms and redirect Resident #1 away from exit doors prior to September 2022. Interview with the facility's Maintenance Coordinator (MC) on 11/30/22 at 11:05am revealed: -He was hired in September 2022. -He was not familiar with the residents' supervision needs or plans. -PCAs and MAs reported the dining room-staff room door's lock was not working for 1 year.		

-The contractors who repaired the pass-through door, propped the pass-through door and exterior doors open on 10/10/22 (duration not known). -Staff informed him afterwards, Resident #1 eloped out the propped open staff break room exit door on 10/10/22. -He did not know it was facility policy for him to provide direct supervision of outside contractors. Telephone interview with Resident's hospice PCP on 1/27/23 at 3:45pm revealed: -She was notified of only 1 of Resident #1's elopements, the resident's mid-September 2022 elopement into the facility parking lot. -This PCP ordered 30-minute checks for Resident #1 in September 2022. -Her colleague physician documented, Resident #1 had no injuries from her 10/10/22 elopement. -This PCP ordered one-hour checks on Resident #1 some-time at the end of October, due to Resident #1's 10/10/22 elopement (date of order not accessible). Resident #1's October 2022 PCP order for Resident #1's 30-minute-checks was not available for review. Review of Resident #1's October 2022 MAR revealed: -An entry for 1-hour visual checks of Resident #1. -1-hour checks were not documented from 10/01/22-10/26/22 until 5pm. -It was documented Resident #1 had exit-seeking behaviors on 10/10/22 from 8:00am-6:00pm. -1-hour checks were documented hourly on 10/26/22 from 5:00pm-7:00pm. -1-hour checks were not documented on 10/26/22 from 12:00am-5:00pm. -1-hour checks were not documented 10/26/22 from 8:00pm, 9:00pm nor 10:00pm. -1-hour checks were not documented as done on 10/27/22 at 9:00pm. Telephone interview with Resident #1's PCP on 1/27/23 at 4:15pm revealed: -Her evaluations of Resident #1 in August-December 2022 found Resident #1 significantly confused. -She and staff observed Resident #1 constantly push on exit doors from June–December 2022. -She expected staff to keep Resident #1 in their eyesight at all times, due to the resident's dementia, exit-seeking, and elopements.		

-Resident #1 eloped from the facility into the facility's parking lot in October 2022. -Due to change of the PCP's clinic order system, she did not have access to her intervention/orders prior to October 2022. Interview with the Health & Wellness Nurse (HWN) on 10/24/22 at 2:30pm revealed: -She was not on duty when the resident eloped at approximately 6:38pm on 10/10/22. -Staff was posted at the broken door, until it was repaired on 10/10/22. -The HWN initially arranged a sitter; then the sitter was canceled by an unknown manager, and 2-hour checks on Resident #1 resumed. -1-hour checks on Resident #1 began later in October 2022. Review of Resident #1's care plan update on 10/12/22 revealed: -Resident #1 was not oriented to time or place. -Resident #1 required physical assistance to stand and was a falls risk due to impaired gait. -Resident #1 needed redirection due to exit-seeking behaviors. -Resident #1 eloped through an open door on 10/10/22, so Resident #1 needed close (unspecified) supervision. Review of Resident #1's progress note by a MA dated 10/20/22 at 2:46pm revealed Resident #1 was observed to be unsteady on her feet. Review of Resident #1's progress notes dated by the Resident Care Coordinator (RCC) on 10/31/22 at 9:18am revealed: -Resident #1 attempted to exit a facility door but was redirected by the MA from the exit. -One-hour checks began on Resident #1 on 10/31/22. b.) Review of Resident #1's I/A Report by the HWN dated 11/06/22 revealed: -Resident #1 was witnessed by 2 visitors at 1:30pm on 11/06/22 trying to get into cars in the facility's parking lot. -Resident #1 exited out the A-Hall exit door on 11/06/22 (time not documented) and walked around to the front of the building. -Resident #1 was retrieved within 15 minutes (time not documented). -One-on-one supervision for Resident #1 was immediately placed after her 11/06/22 elopement for 72 hours.		

Review of Resident #2's progress notes dated 11/06/22 revealed: -An entry, increased monitoring of Resident #2 every 1 hour. -Resident #2 was documented as actively exit-seeking 4 times in 6 hours on 11/06/22 from 7:00am-12:44pm: 9:34am, 9:36am, 11:44am, and 11:51am. -Resident #2 was not documented as checked at from 12:00pm-2:16pm, before her elopement reported as 1:30pm. -Resident #2 was not documented as checked every 1 hour on 11/06/22 from 2:30pm-4:30pm, and 5:16pm-7:42pm. -Resident #1 eloped out the facility's A-hall door at approximately 1:30pm. -Resident #1 was found (by undocumented person) trying to get into visitors' cars in the parking lot. Review of Resident #1's progress note by a MA dated 11/06/22 at 9:39pm revealed: -Resident #1 eloped out of the facility through the A-Hall exit door at 1:30pm on 11/06/22. -The concierge returned Resident #1 back into the facility 15 minutes later. -Resident #1 had no visible injuries. -Supervision precautions were not documented as increased. Review of Resident #1's November 2022 MARs revealed: -An entry dated 10/25/22 to 'provide increased monitoring of Resident #1 every 1 hour to lay eyes on the resident to assure she is not exit-seeking"', starting 10/26/22. -Resident #1 had exit-seeking behaviors 11/05/22-11/30/22. -Resident #1 had documented exit-seeking behaviors on 11/06/22 from 8:00am-6:00pm. -Resident #1 was not documented as checked hourly from 12:00am-6:00am on 11/06/22. Interview with a MA on 10/24/22 at 3:15 and on 3/10/23 at 11:00am revealed: -The last time she saw Resident #1 on 11/06/22 was after dinner, around 6:30pm. -The staff were transitioning residents from the dining room to the living room. -In November 2022 some facility and agency staff did not show urgency in running to alarming exit doors or redirecting residents who were exit-seeking. -Agency staff relied on facility staff to assure exit alarms were set and reactivated. -A sitter was assigned to Resident #1 sometime in 2023, and management and the MAR instructed staff to check her every 1 hour.		

-He checked Resident #1 every 1 hour in November 2022 as ordered and directed by management.
-If he was busy when it was time to check her, he radioed a PCA to check Resident #1 before he documented she was checked.
-The new Executive Director (ED) quickly changed staff, began routine training and drills on elopements, exit door alarm checks and activation, and elopement drills when she arrived at the end of November 2022.

Interview with a 2nd MA on 10/23/22 at 3:50pm revealed:
-Resident #1 was on 2-hour checks before and after her 10/10/22 elopement.
-Management then instructed staff to check on her every 1 hour after her 11/06/22 elopement.
-He checked Resident #1 every 1-2 hours as directed in October 2022.

Interview with a 3rd MA on 11/28/22 at 1:04pm revealed:
-Resident #1 was on 2-hour checks prior to 11/10/22.
-Resident #1 was placed on 1-hour checks after her 11/06/22 elopement.
-She checked Resident #1 every 1-2 hours, as directed by management and on the MAR, unless staff already intervened with her for exit-seeking.

Telephone interview with Resident #1's PCP on 1/27/23 at 4:15pm revealed:
-She observed staff in October 2022 not immediately go to alarming exit doors or look for exited residents.
-She expected the facility to inform her of any elopements.
-She was not informed of Resident #1's 11/10/22 elopement.
-She expected staff to keep Resident #1 in their eyesight at all times, due to the resident's dementia, exit-seeking, and elopements.

Telephone interview with Resident #1's hospice PCP on 1/27/23 at 3:45pm revealed:
-The PCP was not notified of Resident #1's 11/06/22 elopement.
-One-hour checks on Resident #1 were in place in November 2022 by this PCP.

Interview of the HWN on 2/02/23 at 1:30pm revealed:
-Resident #1 was on 1-hour checks prior to 11/06/22.
-Resident #1 exited out of the A-Hall exit door at 1:30pm on 11/06/22 after depressing and holding the exit door's crash bar until the lock released.

-The door alarmed when she opened the A-Hall door. -Staff turned the alarm off before looking for the resident who activated the alarm. -Two visitors found Resident #1 outside, in the front of the facility, trying to get in cars. -The concierge went out and brought Resident #1 back inside. -The HWN immediately placed a sitter for 72 hours with Resident #2 after the 11/06/22 elopement. -Resident #1 continued 1-hour checks after 11/09/22. Interview with the concierge on 11/06/22 at 1:00pm revealed: -The concierge worked on 11/06/22. -One visitor reported Resident #1 was in the front parking lot around 12:30pm, trying to get into cars. -A 2nd reported seeing her at the side of the facility parking lot as the visitor parked her car. -The concierge observed Resident #1 in the circle drive in the front of the facility, walking in the parking area, toward the back of the facility. -Resident #1 was in sweatpants and sweatshirt, and it was a very hot day. -The concierge attempted to retrieve Resident #1 but was unsuccessful in getting the resident to come back to the facility with her. -The concierge sought a PCA, who guided Resident #1 back into the facility (at an unrecalled time). Observation of Resident #1 on 10/24/22 at 3:50pm revealed: -Resident #1 was unsteady when ambulating and when she pushed on exit doors. -Resident #1 attempted to open every door and activated one exit door alarm. -A PCA came upon alarm activation and redirected Resident #1 away from the exit door. Observation of Resident #1 on 10/24/22 at 3:00pm and 3:50pm and on 11/28/22 at 11:30am revealed: -Resident #1 was unsteady when ambulating and when she pushed on exit doors. -Resident #1 attempted to open every door. Telephone interview with the new ED on 12/05/22 at 10:30am and 03/09/23 at 11:30am revealed: -She began working at the facility 11/27/22. -She reviewed PCA and MA positions and dismissed all agency staff and ineffective facility staff December 2022-present. -She expected staff to supervise all residents every 2 hours.		

-She expected staff to check residents every 30 or 60-minutes for residents with these directives. -She expected staff to check on residents on patios every 30 minutes if staff were not on the patio running an activity. -For residents who elope, she would put a one-on-one staff with the resident for 24 hours or longer, or begin 1- hour checks after 24 hours, depending on the resident's exit-seeking and elopement history. -She expected staff to radio for supervision check help if they are busy. -She expected staff supervising residents in common areas to replace themselves before leaving the area.			
The facility failed to provide supervision for 2 of 5 residents residing in the Special Care Unit. One resident (Resident #2) who had multiple falls with injuries, suffered blunt force head trauma after falling outside which resulted in skull fractures, brain swelling and bleeding, and blood hemorrhaging into the brain causing traumatic brain injury and coma, who discharged back to the facility on end-of-life care and then sustained 4 additional falls and subsequently died; and a resident with a history of neuromuscular leg weakness, falls, and exit-seeking, and elopement behaviors, eloped twice without staff knowledge into facility parking lots and roadways. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation.			
The facility provided a Plan of Protection in accordance with 10A NCAC 13F .0901 (b) on 11/28/22.			
CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED: ***4/23/23***.			

IV. Delivered Via:	Electronic Delivery	Date: 3/23/23
DSS Signature:	*Roberta Schmidt-Beebe*	***Return to AHS By: 3/23/23*** ***POC Due: 4/13/23***

V. CAR Received by:	Administrator/Designee (print name): Charisse Fair RN Area Nurse Manager	
	Signature: Charisse Fair RN, Area Nurse Manager	Date: 3/23/23
	Title: Area Nurse manger	

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.*		