Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Laurels in Highland Creek
Address: 6101 Clarke Creek Parkway, Charlotte, NC 28269
County: Mecklenburg
License Number: HAL-060-161
II. Date(s) of Visit(s): 07/03/23,07/13/23, 07/26/23, and 08/01/23
Purpose of Visit(s): Complaint Investigation

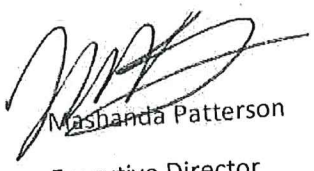
Instructions to the Provider ***(please read carefully)*****:**
Exit/Report Date: 08/23/23

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or 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(c) Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	☑ POC Accepted trp *DSS Initials*	
Level of Non-Compliance: Type A1 Violation	The Laurels and Haven in Highland Creek 6101 Clarke Creek Parkway HAL-060-161 Sept 13 2023	lease velop a n of rection th a ecific te of
Findings: Based on observations, interviews and record reviews, the facility failed to respond to immediately in the case of an accident for 2 of 5 sampled residents (Resident #2 and Resident #3) resulting in a delay in care and intervention to th residents. The findings are: Observations of call bell response time on 07/13/23 from 2:44pm to 2:53pm revealed: -The emergency pull cord in the public bathroom across a hallway from the reception offices was pulled at 2:44pm. -A beeping sound was heard from inside the office space. -Staff members were inside the office and in the hallway around the corner from the public bathrooms.	Rule/ Statue # 10A NCAC 13F .901c Personal Care and Supervision Facility plans to correct/ prevent: Facility will run call (momentum) report weekly and review call times. Facility nursing management team will times	ifteen (15) working ...s from ... date of receipt of e ...rrective Action

-The observation was 9 minutes, and no staff members checked inside the bathroom for anyone in distress. Interview with Director of Resident Care (DRC) on 07/13/23 at 2:53pm revealed: -No staff answered the call bell, because they knew that no one was in the bathroom. -Residents' call buttons located where they were in the facility. Observation of call bell response time on 07/26/23 from 10:58am to 11:23am revealed: -A resident's call button was pressed multiple times. -The resident's apartment door was open. -A Medication Aide (MA) was standing at the medication cart across the hall from the resident's bedroom. -The MAs walkie-talkie did not sound. -At 11:07am, two staff members were seen going into another resident's room that was two doors down from this resident's room. -The MA spoke to the resident as she passed by the room. -At 11:21am, two Personal Care Assistants (PCAs) came into the resident's room and asked if he needed help. -At 11:23am, the Director of Resident Care (DRC) and a nurse came to the doorway and asked if everything was okay. -There was a wait time of 23 minutes after pressing the call button multiple times. Interview with a resident on 07/26/23 at 10:55am revealed: -He lived at the facility for about nine months on the second floor. -He fell in the bathroom about two weeks ago. -He rang his call button "a hundred times" and no one came to help. -He crawled on the floor and got himself up. -"They don't come. It's been that way just about the whole time I've been here." -The only staff with a pager were on the first floor. Interview with a PCA on 07/26/23 at 11:21am revealed: -She was not assigned to work on the second floor. -She and her teammate came from the first floor to the second floor to check on the resident. -She was answering the resident's call bell from the centralized call system at the first floor office. -Two other staff members were assisting another resident on the second floor.	issue corrective action plans and host in services for call response Facility purchased new walkies and efficient manner and pagers for all care team members so answer calls in a more timely  Mashanda Patterson Executive Director	Report

A copy of the call bell and emergency response policy was requested on 07/14/23 at 10:53am and on 08/02/23 at 12:12pm but was not provided. 1. Review of Resident #3's FL2 dated 11/08/22 revealed: -Diagnoses included multiple myeloma, essential hypertension, unspecified systolic (congestive) heart failure, chronic kidney disease, and generalized muscle weakness. -Resident #3 was semi-ambulatory. -Resident #3 had sight limitations. -Resident #3 was prescribed Eliquis Tablet 5mg by mouth two times a day (used to prevent stroke and blood clots and increases the risk of bleeding). Review of Resident #3's care plan dated 05/10/23 revealed: -She required supervision from staff with eating, toileting, ambulation, grooming, personal hygiene, and transferring. -She required limited assistance from staff with bathing and dressing. Review of the facility's call bell event report revealed: -On 06/20/23 at 9:10pm, Resident #3's call bell was unanswered for 58 minutes. -On 06/20/23 at 10:13pm, Resident #3's call bell was unanswered for 35 minutes. -On 06/20/23 at 11:21pm, Resident #3's call button was unanswered for 25 minutes. Review of facility accident report dated 06/21/23 revealed: -There was no time documented. -Resident #3 was found on the bathroom floor facedown with a laceration to the mouth. -Resident #3 dentures were broken. -Resident #3 was alert and oriented x4. -A predisposing situation factor for Resident #3 was the need for staff assistance with ambulation. -Resident #3 was transported to the hospital. -Resident #3's responsible person was notified on 06/21/23 at 11:50pm. Review of Resident #3's facility progress note dated 06/20/23 revealed: -A facility staff member heard Resident #3 screaming from her room. -Resident #3 was lying face down in the shower with a laceration to the oral area and slight bleeding. -Emergency Medical Service (EMS) was called for hospital transport.		

Review of the Emergency Medical Services (EMS) report dated 06/20/23 revealed: -On 06/20/23, the emergency response unit was called at 11:25pm and was dispatched at 11:28pm. -Emergency response personal arrived at the facility on 06/20/23 at 11:39pm. -Resident #3 was evaluated at 11:44pm, which revealed a laceration to the left side of the lip and mild swelling to the left cheek and around the left eye. -Resident #3 was transported to the hospital emergency department (ED) at 11:54pm and arrived on 06/21/23 at 12:08am. -Resident #3 had multiple episodes of vomiting upon arrival at the hospital. Review of Resident #3's ED records dated 06/21/23 revealed: -Resident #3 arrived at the ED on 06/21/23 at 12:14am. -Resident #3 was admitted and evaluated by an ED staff at 12:21am. -She was admitted for a fall when she attempted to transfer from her wheelchair to the toilet. -She had a cut inside the upper left lip and pain and swelling to the left side of the face. -A Computed Tomography (CT) Scan was obtained on 06/21/23 at 12:49am, which revealed a left convexity acute subdural hematoma that measured 2.5 cm in thickness. -Resident #3 was discharged to a trauma hospital on 06/21/23 at 2:56am. Review of Resident #3's trauma hospital records dated 06/21/23 revealed: -Resident #3 was admitted to the Surgical Trauma Intensive Care Unit (ICU) on 06/21/23 at 4:42am from transport from the ED. -Resident #3 was transferred to a surgical unit at 8:41am where a left-sided craniotomy for the evacuation of an acute subdural hematoma was performed. -She was transported from the surgical unit to the surgical unit ICU on 06/21/23 at 12:03pm. Review of a hospital discharge summary for Resident #3 dated 07/20/23 revealed: -Resident #3 remained in the surgical trauma ICU until 06/27/23 at 9:23pm, when she was transferred to an inpatient room. -Resident #3's diagnoses at discharge included:		

-The principal problem of critical polytrauma and active problems of anticoagulated and subdural hemorrhage. -Resident #3's diagnoses history included pulmonary hypertension, hypertension, obesity, cognitive deficit, multiple myeloma on chemotherapy, hyperlipidemia, chronic kidney disease, tobacco abuse, physical education on Eliquis, congestive heart failure, and emphysema. -Resident #3's hospital course was complicated by altered mental status due to her Traumatic Brain Injury (TBI) and poor intake by mouth. -The therapy evaluation recommended a Skilled Nursing Facility (SNF) placement. -A palliative care consult was recommended -The oncologist consult recommended to hold chemotherapy for multiple myeloma during Resident #3's hospital stay. -Resident #3 was admitted to the hospital on 06/21/23 and discharged on 07/20/23 at 2:30pm for a total of 30 days. Interview with Resident #3 at a local hospital on 07/17/23 at 2:27pm revealed: -She was mainly independent, but she needed help getting her legs in the bed. -She went to bed on 06/20/23 at about 9:00pm, but she got up shortly afterwards to use the bathroom. -She needed help after she got into the bathroom. -She pushed the call button pendant on her wrist, but no one came to help. -She was able to transfer from her wheelchair onto the toilet. -When she attempted to transfer off the toilet, she fell between the toilet and wheelchair and pushed her call button when she was falling. -She fell backwards, hitting her mouth on the sink and her head on the bathroom floor. -She was screaming for help, but no one came for a long time. -She had to have emergency brain surgery the next day. -She had issues in the past with getting help from the facility staff. -When her responsible person complained to management, Resident #3 was treated worse by staff. Interview with Resident #3's responsible person on 07/17/23 at 12:30pm revealed: -She received a telephone call on 06/20/23 between 11:15pm-11:30pm from the second shift Medication Aide (MA) to report that Resident #3 fell. -The MA heard Resident #3 yelling for help. -Resident #3 was lying on the bathroom floor, and her mouth was bleeding.		

-The MA was unaware how Resident #3 fell or how long she was on the floor. -Resident #3 told her she was going to the restroom when she fell. -When Resident #3 fell, she hit her face on the bathroom sink and again on the bathroom floor. -Resident #3's dentures broke and cut her mouth. -Resident #3 pushed her call bell twice for assistance, but no one came to assist her. -The MA came into the room when Resident #3 was screaming for help. -Resident #3 refused to go to the hospital. -She requested for Resident #3 to go to the hospital, because she was bleeding. -Resident #3 had a brain bleed and required emergency brain surgery on 06/21/23. -Resident #3 was in the hospital trauma unit for four weeks. -Resident #3 had a great memory before this injury, but now she had sundowning. -Resident #3 was able to walk and feed herself before this injury, but now she could hardly do anything on her own. -Resident #3 was expected to be discharged to a higher level of care because of her injuries. -Resident#3 previously complained about staff not answering the call bells. -She reported the call bell issues to the Assistant Director of Resident Care (ADRC), but nothing changed. Telephone interview with the Licensed Practical Nurse (LPN) on 08/02/23 at 2:21pm revealed: -She recalled that she heard Resident #3 yelling toward the end of her shift. -She went to assist Resident #3, who she found lying on the bathroom floor. -She did not recall the date. -Resident #3 asked to get up, but she told her that she could not be moved since her fall was unwitnessed. -Resident #3 was bleeding from her mouth, and her dentures were broken. -She called 911, but Resident #3 refused to go the emergency room. -She called Resident #3's responsible person, who asked that Resident #3 go the ED. -She stayed with Resident #3 until she left with EMS. -She understood that the call bell system had pagers, and a notification and beeping noise came through a central screen in the central office on the first floor. -The PCAs had pagers, and the MAs had walkie-talkies.		

-She did not have a pager since she was hired about a week ago. -She did not remember having a walkie-talkie when she worked on second shift on 06/20/23. Telephone interview with Resident #3's physician on 07/31/23 at 11:40 revealed: -He was aware that Resident #3 had surgery for a subdural hematoma due to a fall. -He was aware that Resident #3 was found by facility staff lying on her bathroom floor. -He was unaware of how long Resident #3 waited for staff's assistance after falling. -He expected an immediate response from facility staff for an emergency with a resident. - When bleeding from an injury, to wait for assistance for over thirty minutes was extravagant. -In his acute care setting, he expected call bells to be answered within 30 seconds. -He understood that Resident #3 transferred to a skilled nursing facility from the hospital. Attempted telephone interview with Resident #3's surgeon on 08/03/23 at 4:33pm and 08/04/23 at 9:00am was unsuccessful. Refer to telephone interview with second shift Personal Care Aide (PCA) on 08/04/23 at 4:41pm. Refer to telephone interview with another second shift Personal Care Aide (PCA) on 08/04/23 at 4:41pm. Refer to interview with the Director of Resident Care (DRC) on 07/13/23 at 2:53pm.		
Refer to telephone interview with the facility's Regional Director on 08/02/23 at 12:12pm. Refer to telephone interview with Executive Director (ED) on 07/14/23 at 10:53am. 2. Review of Resident #2's FL2 dated 10/12/22 revealed: -Diagnoses included Alzheimer's/Dementia, Orthostatic hypotension, Iron Deficiency Anemia, Synope, Coronary Artery Disease without stent, Emphysema, and Diabetes Type II. -Resident #2 was semi-ambulatory. Observations of Resident #2 on 07/13/22 at 12:04pm revealed:		

-He was sitting in his wheelchair in his room. -The tops of both of his hands were bruised. Review of Resident #2's care plan dated 12/12/22 revealed: -He was totally dependent on staff for ambulation. -He required extensive assistance from staff with toileting, bathing, dressing, and transferring. -He required limited assistance from staff with grooming and personal hygiene. Review of the facility's call bell event report revealed: -On 06/26/23 at 7:00pm, Resident #2's call bell was unanswered for 1 hour and 48 minutes. -On 06/26/23 at 10:12pm, Resident #2's call bell was unanswered for 1 hour and 0 minutes. Review of facility accident report dated 06/26/23 revealed: -There was no time documented. -Resident #2 was observed in a seated position in his room. -He had a 3-inch skin tear on his right arm. -He fell in the bathroom getting off the toilet. Review of Resident #2's facility progress notes dated 06/26/23 between 3:00pm and 11:00pm revealed: -He had 2 unwitnessed falls. -Resident #2 stated he slid out of his chair and "army" crawled into his room. -He had a skin tear on his right forearm. Review of Resident #2's facility progress notes dated 06/26/23 at 10:00pm revealed paramedics assessed Resident #2, and he did not want to go to the hospital. Interview with Resident #2 on 07/13/22 at 12:04pm revealed: -He fell a couple of weeks ago and bruised his hands. -He did not recall how long he waited for assistance from staff when he fell. -He did not want to go the hospital after he fell. -He knew he waited about one-half hour this morning for assistance when he had diarrhea. Interview with Resident #2's responsible person on 08/01/23 at 4:40pm revealed: -He assisted Resident #2 onto the toilet just before this interview, where Resident #2 was now. -At times, he was at the facility when staff took 20 minutes to respond to Resident #2's call button being pressed.		

-Long wait times for staff to respond was an ongoing problem at the facility. Telephone interview with second shift PCA on 08/04/23 at 4:51pm revealed: -She worked second shift on 06/20/23. -She did not work with Resident #3 on 06/20/23 nor heard her yelling for help. -Residents pushed their call buttons when they needed assistance. -The call button alarmed on a pager or staff called on a walkie-talkie to assist a resident. -There were not enough pagers or walkie-talkies for all staff. -Some days, staff did not have a pager or walkie-talkie at all. -She checked on residents every 2 hours. Telephone interview with another second shift PCA on 08/04/23 at 4:58pm revealed: -She worked second shift on 06/20/23. -She did not work with Resident #3 on 06/20/23 nor heard her yelling for help. -Residents were supposed to have call buttons, but not all residents had one. -Batteries were not in all residents' call buttons, or they were not changed when the batteries were dead. -There were only four walkie-talkies and two pagers for staff to know if a resident had used their call button. -She had heard residents calling out for assistance. -Management was not following up on concerns about the call bell issues. Telephone interview with a Licensed Practical Nurse (LPN) on 08/02/23 at 2:21pm revealed: -She understood that the call bell system had pagers, and a notification and beeping noise came through a central screen in the central office on the first floor. -The PCAs had pagers, and the MAs had walkie-talkies. -She did not have a pager or remember having a walkie-talkie when she worked. Interview with the Director of Resident Care (DRC) on 07/13/23 at 2:53pm revealed: -When a resident pressed a call button, it rang to a pager and a central call system in the office. -PCAs carried pagers that sounded when call buttons were pressed. -They were able to tell where a resident was located on the pager.		

-Staff were expected to respond when the call button was pressed by a resident. -There were pendants that cleared the call when the PCA entered a resident's room. -Residents were able to call by phone directly to the front desk. -Front desk staff called MAs on walkie-talkies to report the residents' needs if residents called them. -MAs called or found PCAs on the floor to go assist residents when they were called on the walkie-talkie. -The central call system noted "urgent" for the bathroom pull cord alert on 07/13/23 at 2:44pm. -Staff did not respond to the urgent call report, because they knew that no one was in the bathroom. Telephone interview with the facility's Regional Director on 08/02/23 at 12:12pm revealed: -There was no facility policy specific to call bells or response time to a resident accident. -The expectation when faced with a resident emergency was for staff to react urgently. Telephone interview with Executive Director (ED) on 07/14/23 at 10:53am revealed: -There was a call button in every resident apartment. -Some residents did not want to use their buttons; they used cell phones to call the front desk. -When a call button was pressed by a resident, a wireless signal was triggered to a monitoring system. -If a staff member heard the call alert from the central office, they called a MA on a walkie-talkie to check on the resident. -The central system chimed after 15 minutes if staff did not answer the alert. -The call button alert signal also went to pagers that the PCAs wore.		
-At times, the PCAs pagers were turned off or the volume was turned down, which was addressed at stand-up meetings. -The expectation was to try to answer call button alerts or resident phone calls within 15 minutes. -If a call button was pressed twice, the second press cancelled the call. -If a call button was pressed repeatedly, the expectation was for staff to check on the resident right away. -It was not acceptable for a call button alert to not be answered after 30 minutes. -Staff received a write-up when calls button alerts were not answered. -There were no staff write-ups recently.		

-The system equipment was battery powered, and there was no indicator of low battery power. -The expectation was to change batteries in the call buttons every six months. --- The facility failed to provide an immediate response for an accident to Resident #3 whose call button alert was not answered by staff. A staff member heard Resident #3 yelling for help and found lying in the bathroom floor bleeding from the mouth and with swelling to the left cheek and around the left eye. As a result, there was a delay of 1 hour and 12 minutes in emergency response from the time Resident #3 pressed her call button at 10:13pm and 911 was called at 11:25pm. Subsequently, Resident #3 required emergency surgery to evacuate an acute subdural hematoma and was hospitalized for 30 days. This failure resulted in serious neglect and physical harm which constitutes a Type A1 Violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 22, 2023. --- The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 07/26/23.		

Facility Name: The Laurels in Highland Creek

IV. Delivered Via:	Hand delivery	Date: 8/23/23
DSS Signature:	Karen Phillips	Return to DSS By: 9/14/23

V. CAR Received by:	Administrator/Designee (print name): Mashanda Patterson	
	Signature:	Date 8/23/23
	Title: Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name): Mashanda Patterson	
	Signature:	Date: 9-12-2023

VII. Agency's Review of Facility's Plan of Correction (POC)

☐ *POC Not Accepted*	By:	Date:
Comments:		
☑ *POC Accepted*	By: Karen Phillips	Date: 09/21/23
Comments:		

VIII. Agency's Follow-Up	By: Karen Phillips		Date: 11/16/23
	Facility in Compliance: ☑ Yes ☐ No		Date Sent to ACLS: 11/17/23
Comments:			

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*

The Laurels and Haven in Highland Creek

6101 Clarke Creek Parkway

HAL-060-161

Sept 13 2023

Rule/ Statue #

10A NCAC 13F .901c Personal Care and Supervision

Facility plans to correct/ prevent:

Facility will run call (momentum) report weekly and review call times.

Facility nursing management team will issue corrective action plans and host in services for call response times

Facility purchased new walkies and pagers for all care team members so answer calls in a more timely and efficient manner

Mashanda Patterson

Executive Director

The Laurels and Haven in Highland Creek

6101 Clarke Creek Parkway

HAL-060-161

Sept 13 2023

Rule/ Statue #

10A NCAC 13F .901c Personal Care and Supervision

Facility plans to correct/ prevent:

1. Facility will run call (momentum) report weekly and review call times. (ED and DRC)
2. Call light report will be reviewed every Thursday. (ED and DRC/ ADRC)
3. Any call light that was not answered within 15 minutes will be investigated. (Sharon DRC, Tamica Monroe ADRC) team will issue corrective action plans and host in services for call response times
4. 9-21-23 Med-tech in service: shift reporting/ call lights/ response times (Instructor ED and DRC)
5. Facility purchased new walkie talkie and pagers for all care team members so answer calls in a more timely and efficient manner.
6. Call system will be explained thoroughly with all new residents.

Mashanda Patterson

Executive Director