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 _____ *DSS Initials*	
Level of Non-Compliance: Type A1 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 Action
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 the 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.		

-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.		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):	
	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.*