Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Parc at Sharon Amity
Address: 4025 N. Sharon Amity Rd. Charlotte NC 28205
County: Mecklenburg
License Number: HAL-060-125

II. Date(s) of Visit(s): 10/29/23, 11/01/23, 12/01/23, 12/14/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 01/02/24

Instructions to the Provider *(please read carefully)*:

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

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

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Resident' Rights, are maintained and may be exercised without hinderance.	☐ POC Accepted _____ *DSS Initials*	___
Level of Non-Compliance: Type A1 Violation		
Findings: Based on record reviews and interviews the facility failed to ensure one resident (Resident #1) was free from physical and mental abuse related to a shower refusal which resulted in a fractured vertebra with mild loss of height requiring seventeen days of hospitalization. The findings are: Review of the facility's Workplace Rules dated 08/26/2019 revealed Residents have the right to select their provider of choice, and they have the right to decline services. Review of the facility's Guidelines for Supervision of Residents who Exhibit Difficult Behaviors dated September 2021 revealed:		

-At risk behaviors included agitation, aggression, and physical or verbal assault.
-Staff shall be trained in methods of recognizing and managing at risk behaviors.
-Staff shall utilize redirection, recognizing escalating behaviors, maintaining safety, using activities, intervention list, room change, as interventions for residents with difficult behaviors.

Review of Resident #1's FL2 dated 09/27/23 revealed:
-Diagnoses included dementia, congestive heart failure, coronary artery disease, anemia, hypertension, gastroesophageal reflux, and hyperlipidemia.
-The resident was ambulatory and intermittently disoriented.
-There was no documentation of behaviors.
-Resident #1's recommended level of care was Special Care Unit (SCU).

Review of Resident #1's Resident Register revealed she was admitted to the facility on 09/22/23.

Review of Resident #1's SCU Resident Profile and Care Plan dated 10/13/23 revealed:
-She was cooperative, social, and aggressive.
-She exhibited behaviors related to anger and wanting to leave the facility.
-Interventions to address Resident #1's behaviors included 'letting her cool off' and 'taking her outside letting her walk around.'
-She was independent with ambulation without devices.
-She required limited assistance with bathing, dressing, and grooming.
-Intervention for Resident #1's bathing needs documented staff would assist her with bathing to ensure safety.
-Intervention for Resident #1's dressing and grooming needs documented staff would continue to provide assistance.
-There were no additional interventions documented related to Resident #1's behaviors.

Review of Resident #1's record revealed:
-Resident #1 was assessed on 10/19/23 and did not have any Licensed Healthcare Professional Tasks (LHPS).
-Resident #1 was assessed by a physical therapist on 10/26/23.
-Resident #1 was ordered a rolling walker for mobility.
-There were no documented skin assessments.

Review of Resident #1's SCU Resident Profile and Care Plan dated 11/30/23 revealed:

-Resident #1 was cooperative, social, and aggressive. -Resident #1 exhibited behaviors related to anger and wanting to leave the facility. -Interventions to address Resident #1's behaviors included 'letting her cool off' and 'taking her outside letting her walk around.' -Resident #1 required a walker for locomotion. -Resident #1 required limited assistance with bathing, dressing, and grooming. Review of Resident #1's October 2023 progress notes revealed: -On 10/29/23 at 7:50am, Resident #1 was sent to the hospital related to pain. -There was no addition documentation related to Resident #1's complaint of pain. -On 10/27/23 at 9:03pm, Resident #1 refused a shower. -On 10/27/23, there was no documentation related to interventions for Resident #1's refusal to shower. -On 10/27/23 at 6:50am, Resident #1 slapped staff. -On 10/27/23, there was no documentation related to interventions for Resident #1's behaviors. -There was no additional documentation related to Resident #1's behaviors. Review of Resident #1's incident report dated 10/29/23 revealed: -Resident #1 required medical observation due to complaint of back pain. -Resident #1 was sent to the emergency department (ED). -Resident #1 sustained a lumbar fracture and was admitted to the hospital. Review of Resident #1's Emergency Medical Technician (EMS) record dated 10/29/23 revealed: -EMS began an assessment of Resident #1 for lower back pain on 10/29/23 at 8:06am. -Resident #1 stated she had verbalized to staff that she did not need or want a shower on 10/29/23. -Resident #1 stated two staff "threw her" in the bathtub and "forcefully" showered her and proceeded to "threw her" into bed after the shower. -Resident #1 had been in pain ever since the incident. -Resident #1 was transported to the emergency department (ED) for further evaluation and treatment. Review of Resident #1's hospital discharge report dated 11/14/23 revealed:		

-Resident #1 was admitted to the hospital on 10/29/23 due to complaint of lower back pain related to an injury sustained while staff provided personal care. -An x-ray was performed on 10/29/23 which identified a lumbar one (L1) vertebra superior endplate fracture with mild loss of height. -Resident #1 required a kyphoplasty (a minimally invasive procedure to inject bone cement) procedure to treat her spine injury. -Resident #1 was discharged from the hospital on 11/14/23 back to the facility.		
Interview with Resident #1 on 12/01/23 at 4:30pm revealed: -She was involved in an incident at the facility which involved two staff: a male and a female staff. -She did not know the staffs' names. -She did not recall the date of the incident, but it occurred early in the morning. -Staff told her she needed to take a shower to get ready for family to take her out of the facility. -She did not want staff, specifically male staff, to provide her with a shower. -The staff made her get into the shower, and she was crying and told them to repeatedly "stop, I don't want you to give me a shower." -During the shower, she ended up on the floor. -After the shower, the two staff dressed her and "threw me on the bed." -Shortly after the shower and getting dressed, she complained of back pain and was sent to the hospital. -She was nervous that staff would harm her again if she declined assistance with a shower. Telephone interview with a local law enforcement official on 11/08/23 at 11:37am revealed: -He interviewed staff related to Resident #1's incident on 10/29/23. -Staff said Resident #1 sustained some type of fall while she resisted staff providing shower assistance to her on 10/29/23. -Criminal charges would not be filed. Telephone interview with Resident #1's responsible party on 10/30/23 at 11:45am revealed: -Resident #1 required assistance with toileting, dressing, and showering. -Resident #1 had a history of resisting assistance with care. -On 10/28/23, she requested staff prepare Resident #1 for an out of facility visit.		

-Resident #1 was scheduled for an out of facility visit at 7:15am on 10/29/23. -On 10/29/23, facility staff notified her regarding Resident #1 complaining of lower back pain after receiving a shower and getting dressed related to staff providing the resident with a shower. -On 10/29/23, she met Resident #1 at the ED, and Resident #1 described staff forcibly giving her a shower which resulted in her experiencing severe lower back pain. Telephone interview with Resident #1's responsible party on 12/05/23 at 4:15pm revealed: -Resident #1 required lumbar spine surgery as a result of the incident which occurred on 10/29/23 at the facility. -Resident #1 was re-admitted to the facility on 11/14/23 because she was unable to identify any alternative facilities that she felt comfortable with to provide care to Resident #1. -Since Resident #1's re-admission to the facility, she continued to require constant re-assurance that staff would not harm her again. Telephone interview with Resident #1's family member on 12/12/23 at 11:46am revealed: -Facility staff had been instructed to prepare Resident #1 to be ready for church by 7:15am on 10/29/23. -On 10/29/23 between 7:15am and 7:30am, she arrived at the facility to transport Resident #1 to church. -On 10/29/23 between 7:15 and 7:30am, Resident #1 stated two staff members handled her roughly in the shower and had thrown her onto her bed, resulting in pain to her back. -Resident #1 winced in pain when she touched Resident #1's back. -Resident #1 was unable to standup due to the back pain. -The facility requested Resident #1 be sent to the emergency department (ED) for evaluation. Telephone interview with Resident #1's primary care provider on 12/07/23 at 1:10pm revealed: -Resident #1 had a diagnosis of intermittent dementia. -Resident #1 required assistance with bathing, toileting, and dressing. -On 10/29/23, he was notified by the facility related to Resident #1 having an incident at the facility. -On 10/29/23, if Resident #1 had verbalized not wanting to take a shower, staff should not have continued to proceed with giving a shower. -Resident #1 had a right to refuse a shower.		

-During Resident #1's shower on 10/29/23, it was likely that she sustained some type of physical trauma resulting in a vertebra fracture due to the resident expressing back pain shortly after the incident. -Residents with dementia occasionally require encouragement, re-attempts, or engagement from family members to participate in ADL care. Telephone interview with a third shift PCA on 11/01/23 at 12:00pm revealed: -She was responsible for providing ADL care to Resident #1 on 10/29/23 during her shift. -On 10/29/23, the third shift medication aide (MA) informed her she was responsible for getting Resident #1 up and ready to take out of the facility. -On 10/29/23, she attempted to encourage Resident #1 to take a shower, but she refused. -On 10/29/23, she asked the MA for assistance to get Resident #1 ready and was instructed to get an additional PCA to assist with Resident #1's care. -On 10/29/23, she requested an additional PCA to assist her in giving Resident #1 a shower and getting dressed. -On 10/29/23, she and the additional PCA were able to get Resident #1 into the shower, on a shower chair. -During Resident #1's shower, Resident #1 was yelling, scratching, hitting, and kicking her. -During Resident #1's shower, the additional PCA tried to calm Resident #1 down and prevent her from hitting her by holding Resident #1's arms by her sides, while she proceeded to soap, wash, and rinse Resident #1. -After Resident #1's shower, the PCAs dressed Resident #1 and escorted her back to her bed to wait for her family to arrive. -During Resident #1's personal care, she did not sustain a fall, injury, or complain of pain. -Resident #1 needed to be ready for a family visit on 10/29/23, and she wanted to ensure she completed the tasks necessary to have her ready. -Upon hire, she had been trained to encourage residents to participate in ADL's, re-attempt a few minutes later if a resident refused care, or request additional staff to assist with resident care. Telephone interview with a second third shift PCA on between 2:50pm and 5:20pm time revealed: -He worked as a PCA on 10/29/23. -On 10/29/23, Resident #1's assigned PCA requested his assistance with a shower and getting Resident #1 dressed for a family outing.		

-On 10/29/23, Resident #1 did not want staff to give her a shower. -He did not recall how Resident #1 eventually entered the shower stall. -During Resident #1's shower, the resident was sitting on a built-in shower bench while Resident #1's assigned PCA entered the shower to wash Resident #1. -During the shower, Resident #1 was yelling, hitting, and kicking at the PCA because she did not want the shower or help from staff. -He tried to verbally encourage Resident #1 to remain calm and held her arms by her side to prevent her from hitting the assigned PCA continuously while getting washed. -After Resident #1's shower, he and the additional PCA were able to get Resident #1 dressed and escorted her back to her bed to wait for Resident #1's family to arrive. -During Resident #1's ADL care, he did not think she had a fall, and she did not complain of any pain. -He attempted to assist Resident #1's assigned PCA with Resident #1's ADL care because the third shift MA had instructed the PCA to ensure Resident #1 was clean and dressed during their shift. -Upon hire, he had been trained to encourage residents to participate in ADL's, re-attempt a few minutes later if a resident refused care, or request additional staff to assist with resident care. Telephone interview with a third shift medication aide (MA) on 12/12/23 at 10:54am revealed: -She worked as a MA on third shift on 10/29/23. -She was responsible for instructing PCAs on which residents needed early morning ADL care and ensure residents' needs were met throughout the shift. -Resident #1 was known to be resistant to staff assisting her with ADL care. -On 10/29/23, she instructed Resident #1's assigned PCA to ensure Resident #1 was awake and ready for family to pick up the resident early on 10/29/23. -Around 6:00 am on 10/29/23, Resident #1's assigned PCA notified her that the PCA needed assistance to get Resident #1 ready. The PCA did not tell her why she needed assistance with Resident #1. -She instructed the PCA to request an additional PCA to assist with Resident #1's ADL care. -Resident #1's assigned PCA must have determined Resident #1 required a shower on 10/29/23 as part of getting her ready for a family visit.		

-On 10/29/23, she was unaware Resident #1 had declined staff assisting with a shower or sustained any injuries during ADL care. -If a resident refused ADL care, PCA's were to notify the MA, and provide stand-by encouragement to the resident to re-attempt ADL care. -If a resident continued to refuse care after three attempts, staff were expected to notify the MA of the refusal and the MA documented the refusal in the resident's progress notes. -On 10/29/23, staff should not have continued to provide Resident #1 with a shower when she was verbally and physically refusing care. -On 10/29/23, third shift PCAs did not notify her of Resident #1's refusal to have a shower. -On 10/29/23 at 6:50am, she observed Resident #1 lying in her bed, and the resident would not reply to any of her questions and did not complain of being in pain. Telephone interview with a first shift MA on 12/12/23 at 11:33am revealed: -On 10/29/23, she worked on third shift and first shift. -On 10/29/23, at 7:15am she observed Resident #1 crying in bed and complaining of back pain and sore arms. -Resident #1 stated two staff had given her a shower and 'attacked her' and "They hurt me." -On 10/29/23, around 7:20am, Resident #1's family had arrived and were present in Resident #1's room while she completed a body observation of Resident #1. -On 10/29/23, she had Resident #1 stand while she checked her for injuries, Resident #1 was unbalanced and continued to cry and complain of lower back pain, she did not observe any bruising. -On 10/29/23, she contacted 911 for assistance. -On 10/29/23, EMS and local law enforcement arrived at the facility. -On 10/29/23, Resident #1 was transported to the ED for evaluation. Telephone interview with the Special Care Coordinator (SCC) on 10/29/23 at 3:04pm revealed: -Resident #1's responsible party had requested staff provide Resident #1 with a shower and prepare the resident for an out-of-facility visit in the morning of 10/29/23. -Resident #1 alleged two staff assaulted her on 10/29/23. -PCA staff reported Resident #1 was physically combative with staff during a shower on 10/29/23.		

Interview with the Administrator on 11/01/23 between 9:40am and 2:00pm revealed: -On 10/29/23, she was notified of an incident which involved two staff assisting Resident #1 with ADL care during third shift on 10/29/23. -She initiated interviews with staff related to the incident and determined Resident #1 refused a shower on 10/29/23, but staff proceeded to shower the resident regardless. -On 10/30/23, she submitted an Initial Allegation Report to the NC Department of Health and Human Services the two PCAs involved in Resident #1's shower incident which occurred on 10/29/23. -She did not know exactly how Resident #1 sustained an injury to her spine. -Third shift staff were instructed by the third shift MA to provide Resident #1 with a shower and get her dressed and groomed. -She did not expect staff to continue a shower with Resident #1 if she was combative and refused care. -She expected staff to attempt, encourage, and re-attempt residents to participate in ADL care and request additional staff to assist if necessary. -Staff were trained upon hire that residents had a right to refuse care and to report refusals to the MAs. Based on record reviews and interviews the facility failed to ensure Resident #1 was free from physical and mental abuse related to a shower refusal, which resulted in a fractured vertebra with mild loss of height requiring a spinal procedure. This failure resulted in serious physical harm which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/09/23 for this violation. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED 02/01/24.		

IV. Delivered Via:	Certified Mail + Secure Delivery Email	Date: 01/04/24
DSS Signature:	A Hoymeister	Return to DSS By: 01/19/24

* **V. CAR Received by:**	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

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.*