# Adult Care Home Corrective Action Report (CAR)

**I.** Facility Name: Cuthbertson Village
Address: 3800 Shamrock Drive Charlotte, NC 28215
County: Mecklenburg
License Number: HAL-060-059

**II.** Date(s) of Visit(s): 12/07/22, 01/06/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 02/08/23

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

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

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

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

| **III (a). Non-Compliance Identified**<br>*For each citation/violation cited, document the following four components:*<br>• *Rule/Statute violated (rule/statute number cited)*<br>• *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)*<br>• *Findings of non-compliance* | **III (b). Facility plans to correct/prevent:**<br>*(Each Corrective Action should be cross-referenced to the appropriate citation/violation)* | **III (c). Date plan to be completed** |
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| Rule/Statute Number:<br>10A NCAC 13F .0901(b)/Personal Care and Supervision<br><br>Rule/Statutory Reference: (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. | ☐ POC Accepted<br>_____<br>*DSS Initials* | ____ |
| Level of Non-Compliance: Type A2 Violation | | |
| Findings:<br>Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 5 residents (Resident #1) who had dementia and required special care unit (SCU) level of care.<br><br>Review of facility's missing resident policy dated 01/2021 revealed:<br>- When a resident was missing staff would check with the sign-out register to verify the resident did not check out to leave the building or campus with family or other authorized staff.<br>- Nurse would check with the community's transportation staff to verify that the resident did not leave for any unexpected appointments.<br>- Staff would immediately notify the nurse supervisor to report the missing resident. | | |

- Notify staff to begin a thorough search of the entire facility. This search would begin in the resident's room and expand out to other areas of that floor. The search area should include checking all areas on the floor, common areas, closets, stairwells, resident rooms, beds (verifying who is in each bed), and bathrooms. Nursing staff would increase the search area to include other areas.
- Nurse supervisor would contact administrator and care coordinator and would notify security of the missing resident.
- If a resident was not located during the initial search of the building and immediate grounds, the following notification procedures would be followed: the administrator/designee would contact the president of the company and the senior leadership team; the care coordinator would contact the resident's family/primary contact; the president of the company/designee would contact the chairperson of the board of directors and regulatory agencies; the director of risk management would contact 911 to report missing resident and request assistance once authorized by administration, and would also serve as a liaison to first responders throughout the elopement incident.
- The facility's incident commander on scene would coordinate the search for the missing resident/s on campus with first responders and other emergency personnel.
- The president or their designee would make daily reports until the resident has been located.

Review of Resident #1's current FL-2 dated 02/14/22 revealed:
- Diagnoses included dementia, transient cerebral ischemic attack, osteoarthritis, Vitamin D deficiency, hyperglycemia, Vitamin B deficiency, anemia, personal history of transient ischemic attack, and Gastro-esophageal reflux disease.
- Resident #1 was ambulatory and intermittently disoriented.
- Resident #1's level of care was a SCU.

Review of Resident #1's SCU profile dated 04/07/22 revealed:
- Resident #1 ambulated with a rolling walker.
- Her vision and hearing were adequate, and she was able communicate clearly.
- Resident #1 was alert and oriented to person only.
- Resident #1 required reminders and was "pleasantly confused."
- Resident #1 was usually awake by 8:00am, enjoyed activities as well as being outside.
- There was no additional documentation related to Resident #1 going outside.

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| Review of Resident #1's care plan dated 07/02/21 revealed she required limited assistance with ambulation and was independent with transferring.<br><br>Review of Resident #1's Licensed Health Professional Support task dated 07/11/22, revealed she required assistance with ambulation and used an assistive device.<br><br>Review of Resident #1's progress note dated 06/04/22 revealed:<br>- The License Practical Nurse (LPN) was made aware that Resident #1 was not in her room in the SCU at shift change.<br>- The LPN notified the Administrator, who notified risk management, security, the Executive Director and the care coordinator.<br>- The LPN was directed to search all areas of the SCU, courtyards, and external areas.<br>- Resident #1 was found in an enclosed courtyard within the SCU on the ground near a rocking chair, with a small hematoma to the back of head.<br>- Resident #1 was assisted back inside to the SCU, assessed thoroughly by the nurse, and given food and drink.<br>- Neurological checks were put in place for 72 hours to monitor Resident #1.<br>- Resident #1's family was made aware she was found outside and said they would be in to visit the next day.<br><br>Review of physician communication note dated 06/04/22 revealed:<br>- Resident #1 was observed lying in supine position on ground on the porch in the enclosed courtyard of the SCU.<br>- Resident #1 had a hematoma to left back of her head.<br>- Neurological checks were initiated, and Resident #1's family was notified.<br><br>Telephone interview with Medication Aide (MA) on 01/31/23 at 9:00am and 02/01/23 at 8:53am revealed:<br>- On 06/04/22, she went to work at the beginning of her shift at 3:00pm.<br>- The MA she was relieving was in a rush to leave due to family emergency.<br>- After staff from first shift left, she conducted a head count of residents and observed Resident #1 was not in the SCU.<br>- She immediately informed the other MAs and Personal Care Aides (PCAs) in the SCU, including the person who Resident #1 was supposed to be assigned to for second shift. | | |

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| - Staff conducted a search of the SCU including all resident rooms and other areas that she could have been within the facility.<br>- Staff did not search in the courtyard.<br>- She attempted to call the nurse supervisor to alert her that Resident #1 could not be located, but the line was busy.<br>- Around 4:00pm, the LPN came to the unit and she informed her Resident #1 could not be located.<br>- The LPN was dealing with another situation and said she would check to see if Resident #1 had gone out with family or to an appointment and she would let staff know.<br>- Around 5:00pm, she attempted to follow-up with LPN by phone when it was time for dinner, but there was no answer.<br>- The LPN came back to the unit around 9:00pm, and she asked if she had found out where Resident #1 was, the LPN seemed surprised because she had forgotten to check with the resident's family.<br>- The LPN immediately contacted Resident #1's family, who reported Resident #1 was not with them.<br>- Staff began an additional search of the facility, including all courtyards, and Resident #1 was found outside in the SCU courtyard.<br>- Resident #1 had a bump on the back of her head but seemed to be okay and was able to get up with assistance.<br>- Resident #1 had no complaints of pain.<br>- Resident #1 was soiled but her clothing was not wet. She did not appear to have any insect bites.<br>- She was assisted inside the facility to the dining room where she was given something to eat and drink.<br>- "Neurochecks" which consisted of checking her vitals were implemented every 15 minutes for an hour, and then were conducted hourly for three days.<br>- Resident #1's vitals remained in the normal range.<br>- She was not sure what Resident #1's normal routine was, or if she usually went outside alone.<br>- The courtyard door was locked and required a code to open.<br>- Residents were not supposed to go outside without a staff member, which was why she had not initially checked the courtyard.<br>- The facility sign-out logs and transportation logs are kept in the office, so the LPN would have been the one to check to see if Resident #1 had signed out to go anywhere.<br><br>Telephone interview with the first shift PCA (7-3pm) on 02/01/23 at 9:15am revealed:<br>- On 06/04/23, Resident #1 asked to go into the secured courtyard. | | |

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| - She scanned her badge to open the door and allowed Resident #1 into the courtyard.<br>- She did not recall exactly what time Resident #1 asked to go out, but it was after lunchtime.<br>- She had a family emergency and was in a hurry to leave at 3:00pm when second shift came in and she forgot to report that Resident #1 was in the courtyard.<br>- Resident #1 was ambulatory with the assistance of a walker and could transfer independently.<br>- Resident #1 regularly asked to go into the courtyard throughout the day.<br>- Staff were not required to remain with residents who went into the secured courtyard because the courtyard was visible from the dining room and kitchen.<br>- The door to the courtyard automatically locked from both the inside and outside when it closed.<br>- When residents who were outside were ready to come inside, they would come to the door on the screened in porch and a staff member would scan their badge to allow them back into the facility.<br><br>Observation of SCU on 01/06/23 at 11:30am revealed:<br>- The exit door from the SCU into the secured courtyard was secured and required a staff member to scan their badge to go outside or come inside.<br>- From inside the facility, staff could see into the courtyard, but the rocking chairs on the porch in the secured courtyard area were difficult to see unless staff opened the secured door and looked outside the door onto the porch.<br><br>Attempted telephone interview with the LPN on 02/01/23 was unsuccessful.<br><br>Review of weather history report of 06/04/22 revealed:<br>- A high temperature of 84 degrees Fahrenheit and a low of 63 degrees Fahrenheit, peaking at 84 degrees from 3:00pm to 4:00pm.<br>- There was no precipitation on 06/04/22.<br>- Wind speeds ranged from 0 to 14 miles per hour (mph), with gusts up to 25mph on 06/04/22.<br><br>Telephone interview with Resident #1's physician's assistant (PA) on 02/01/23 at 1:20pm revealed:<br>- She recalled reviewing documentation on Monday, 06/06/22 from the facility that Resident #1 had been found on the ground in the secured courtyard and had apparently been outside for a while before she was discovered. | | |

- She did not know if facility staff had reached out to the wellness clinic on call staff over the weekend since the incident occurred on 06/04/22.
- She saw Resident #1 on 06/06/22 to assess her and to specifically look at the hematoma on her head and to evaluate her hip, as she had been complaining of pain.
- She ordered an x-ray, which did not show any fractures on Resident #1's hip, ordered acetaminophen to treat the hip pain.
- When a resident had a fall, the LPN was the first person to assess the resident for injury.
- If there was a concern a resident may have an injury requiring medical intervention, they would be sent out to the hospital to be evaluated and treated.
- If there was no concern for serious injury, residents were often placed on neurochecks, which included vitals, for a period of time or until the resident could be assessed by their physician.
- A hematoma did not necessarily warrant a resident being sent out to the hospital for evaluation if the resident was otherwise at their baseline.
- She recalled, Resident #1 appeared to be at her baseline after the incident, from the information she received.
- Resident #1 was eating and drinking normally after the incident, she was able to be assisted up off of the ground without issue and was able to ambulate as usual.
- While being outside without food or drink for an extended period would put her at an increased risk for dehydration, she was drinking normally following the incident, so she was not overly concerned about this.

Telephone interview with former Care Coordinator on 02/01/23 revealed:
- She was on vacation at the time the incident occurred.
- The Administrator had conducted retraining for staff related to the missing resident policy after the incident occurred.
- There was no policy in place that addressed resident's access to the secured courtyard.
- Residents were permitted access to the courtyard as desired.
- Staff were supposed to routinely check on residents in the courtyard, and to check the courtyard during snack time at 10am, 2pm, and 8pm.
- There was no specific time period in which residents in the courtyard were supposed to be checked on.
- Staff were not required to stay in the courtyard with residents who were independent with ambulation.
- Residents who were allowed into the courtyard without supervision were capable of coming to the door and knocking when they were ready to come back inside.

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| - When residents were assisted with access to the courtyard, the staff that let them into the courtyard should inform the MA assigned to the resident for the day so they knew of their whereabouts.<br>- The whereabouts of all residents should be discussed during shift-to-shift report.<br><br>Interview with Administrator on 12/07/22 at 11:30am revealed:<br>- On 06/04/22 a first shift staff member assisted Resident #1 outside to the courtyard, where the resident enjoyed spending time each day.<br>- She was not sure what time Resident #1 was assisted outside to the courtyard.<br>- When second shift came in, staff were unable to locate Resident #1 during rounds after first shift left.<br>- Staff notified the LPN when they could not locate Resident #1 around 4:00pm, when she went to the unit for rounds.<br>- The LPN said she had forgotten to follow-up with Resident #1's responsible party to see if the resident went out with them.<br>- Resident #1 was later found in the secured courtyard, lying on the ground.<br>- Staff were not required to stay with residents when they went into the secured courtyard, since the courtyard was visible from the kitchen and dining room area, where staff could see the porch and courtyard.<br>- She did not recall Resident #1 having any serious injuries and she did not require any medical treatment from the fall.<br><br>The facility failed to provide supervision for one resident, (Resident #1), who had a diagnosis of dementia and required Special Care Unit level of care, who was allowed into the secured courtyard area, fell and was unable to get up, and was not found until 7 hours later. This failure resulted in substantial risk for physical harm and neglect and continues a Type A2 Violation.<br><br>CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 03/12/23.<br><br>The facility provided a plan of protection in accordance with G.S. 131-34 on 12/09/22. | | |

Facility Name: Cuthbertson Village

| IV. Delivered Via: | certified mail / hand delivery | Date: 2/10/23 |
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| DSS Signature: | Denise Baideman | Return to DSS By: 3/6/23 |

| V. CAR Received by: | Administrator/Designee (print name): Elise Swanger | |
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| | Signature: Elise Swanger | Date: 2/10/23 |
| | Title: Director of Assisted Living | |

| VI. Plan of Correction Submitted by: | Administrator (print name): | |
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| | Signature: | Date: |

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

| ☐ *POC Not Accepted* | By: | Date: |
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| Comments: | | |

| ☐ *POC Accepted* | By: | Date: |
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| Comments: | | |

| VIII. Agency's Follow-Up | By: | Date: |
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| | Facility in Compliance: ☐ Yes ☐ No | Date Sent to ACLS: |
| Comments: | | |

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