Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Bethamy Retirement Center
Address: 909 N. Salisbury Avenue Spencer, NC 28159
County: Rowan
License Number: HAL-080-032
II. Dates of Visits: 07/24/24, 08/09/24, 08/12/24, 08/14/24, 08/15/24, 09/04/24, 09/16/24
Purpose of Visit(s):Complaint Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date:9/16/24

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: 10A NCAC 13F .0901 Personal Care and Supervision Rule/Statutory Reference: (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. Level of Non-Compliance: A1 Violation This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to respond immediately when a resident (Resident #1) reported difficulty breathing and chest pain. The staff waited between 30-40 minutes to contact EMS, who initiated cardiopulmonary resuscitation (CPR) in the ambulance in route to the emergency room. The findings are: Resident #1's current FL2 dated 12/21/22 documented diagnoses of atrial fibrillation, anemia, hypertension, diabetes, hypertrophy of the prostate, major depression, alcohol abuse in remission, obesity, end stage renal disease, above the knee amputation of the left leg and cellulitis.	☑ POC Accepted KCH *DSS Initials* All staff will be trained on the facility's medical emergency procedures by the Regional Director of Operations or designee. The procedures detail that anyone who is aware of an emergency has a duty to call 911 immediately and it is not necessary to obtain prior approval. The medical emergency procedures also implement the use of walkie talkies to communicate emergencies among staff so that other staff can assist while waiting for emergency medical services (EMS) to arrive. For the next 30 days, the Administrator or designee will follow-up with all staff who were on duty during emergencies to ensure that emergency medical procedures were followed. Re-training and disciplinary action will occur as needed.	10/16/2024

Review of Resident #1's Resident Register revealed he was admitted to the facility on 04/18/2024. Observation of Resident #1 in the Intensive Care Unit (ICU) of a local hospital on 07/24/24 at 5:22pm revealed the resident was intubated and could not speak. Interview with Resident #1 on 07/24/24 at 5:22pm revealed: -The resident was asked about the allegation that the facility staff waited 40 minutes before calling 911 for help when he complained of difficulty breathing and chest pains. -The resident wrote on the notepad, "at least 30 minutes." -The resident wrote, "thank you" for the visit. Interview with the ICU nurse on 07/24/24 at 5:35pm revealed: -The resident had arrived at the hospital on 07/23/24 at 4:20am with CPR in progress. -The Paramedic reported the resident coded in the ambulance and they started CPR before reaching the hospital. -The nurse reported CPR was done three times in the emergency room before his condition stabilized enough to move him to intensive care. -The nurse reported he would soon be moved to another hospital for possible heart surgery. Interview with Resident #1 on 08/09/24 at 2:34pm revealed: -He had been feeling bad the evening of 07/23/24 and knew something was wrong. -He felt very cold and was sweating profusely in the middle of the night. -He was having trouble breathing and rolled to the desk in his motorized chair. -He told the personal care aides (PCAs) he was having trouble breathing, was cold and sweating and needed an ambulance. -He told them he might be having a heart attack and needed an ambulance now. -He reported he wanted to scream and let them know how serious it was but he could not get his breath and at one point was unable to speak. -He was in this condition for at least 30 minutes prior to the ambulance's arrival. -The next thing he remembered was waking up in the hospital. -Interview with the PCA on 08/14/24 at 12:40pm revealed: -He had completed CPR training the month before and knew how to perform CPR. -The PCAs were told to contact the Supervisor on call to get permission to send a resident out.	After the initial 30 days of review of emergencies, the Administrator or designee will conduct quarterly reviews of 10% of the emergencies that occurred during that quarter to ensure that emergency procedures continue to be followed. Re-training and disciplinary action will occur as needed.	

-Between 1:00-2:00am on 07/23/24, the resident came to the nurse's desk in his electric scooter and was sweating profusely.
-He could tell something was "off" because the resident was sitting slumped over and was gasping for air.
-The resident was holding his hand over his heart and asked them to call an ambulance.
-He thought the resident might be having a heart attack.
-The resident rolled his scooter back to his room and a second PCA went to the room with the resident.
-He called 911 Emergency Medical Services (EMS) within 10 minutes of the resident coming to the desk to report the problem.
-He called the Supervisor on call right after he called 911 and got no answer.
-He called the Supervisor on call multiple times and did not get an answer.
-He asked the second PCA to go to the Supervisor's house at the back of the property and report the situation.

Interview with the second PCA on 09/04/24 at 5:05pm revealed:
-She was told to always call the Supervisor on call and report what was going on when there is a problem.
-The procedure was to get vital signs on the resident and call the Supervisor on call and tell them what was going on and wait for instructions.
-The night of 07/23/24, the resident came to the desk on his scooter, wearing only an adult incontinent brief.
-The resident was hunched over and said he could not breathe.
-He was slinging his arms and trying to talk.
-She followed him to his room and was unable to get his vital signs.
-The resident was gasping and could not even talk.
-She asked the other PCA if he was going to call 911.
-He told the PCA he was not going to call 911 yet and was going to try to reach the Supervisor on call.
-She tried to reach the Supervisor she thought was on call based on the posted schedule that night but the Supervisor never answered.
-She called the Supervisor she thought was on call at least 4 times and waited for the Supervisor to call back.
-She tried to call the other Supervisor who lived in a house on the property and this Supervisor did not answer.
-She tried to reach the Administrator by telephone and did not get an answer.
-The schedule had been changed and the initial Supervisor she and the other PCA were trying to reach was not on call

and neither was the Administrator.
-The Supervisor living in the house on the property was the Supervisor on call and she did not respond to the phone calls.
-She called 911 and reported the difficulty breathing.
-She went to the Supervisor's home and knocked on her door and woke her up to report the situation.
-The Supervisor on call arrived at the facility but by then the fire department and EMS had arrived.

Review of the EMS call log revealed:
-At 3:36am on 07/23/24, the second PCA called 911 to report a male resident was having trouble breathing and was sweating.
-He was not alert and was not responding appropriately.
-EMS arrived at 3:44am.

Interview with the Supervisor on 08/12/24 at 12:25pm revealed:
-She was the Supervisor on call the night of 07/23/24.
-A PCA called her around 3:00am and reported the resident was freezing and they could not get a blood pressure.
-He told her he had already called 911 before calling her.
-When she arrived at the facility five minutes later, the ambulance was already in the facility.
-The Paramedics could not get a blood pressure or blood sugar reading.
-The resident's legs were extremely cold and he was coughing and gasping for air.
-The resident was placed in the ambulance and taken to the hospital.
-On evenings when the Supervisor on call was not in the facility, PCAs were to call to get permission before calling 911.

Interview with Supervisor on call on 08/14/24 at 12:10pm revealed:
-The schedule for Supervisors on call had been changed and the PCAs had the wrong information as to who was on call the night of 07/23/24.
-The first Supervisor the PCA called was not on call and was not responsible for answering the phone.
-The Administrator was not on call and was not responsible for answering the phone.
-She was the person on call and remained adamant she responded as soon as she was called to come to the facility.
-The Supervisor denied the report of the second PCA knocking on her door to awaken her and get assistance.

Interview with the local Fire Department Chief on 08/15/24 at 9:33am revealed:
-On third shift the evening of 07/23/24, the facility had two staff working.
-The fire department was called to the facility related to a report of difficulty breathing at 3:36am.
-He was told the staff reported waiting for 30-40 minutes to call 911 because they had trouble getting in touch with the on call Supervisor for permission to send the resident out.
-He expressed concern the staff did not call 911 sooner to get help for the resident.
-He agreed to provide a written statement from his fire engineer who responded to the call.

Review of the fire department's written report dated 09/03/24 revealed:
-On 07/23/24, the fire department arrived at the facility to respond to a difficulty breathing call. No time was noted in the report.
-The fire engineer found two employees on duty when he arrived.
-The male employee told him the resident came to the staff approximately 30-40 minutes prior to calling 911 and reported not feeling well.
-The staff said the resident presented to them as cold, clammy, pale, with difficulty breathing and chest discomfort.
-The engineer assessed the resident and reported his whole body was ice cold, he was flailing his body around and presenting as if he was going to throw up.
-The engineer was unable to get any vital signs.
-The resident told the engineer he had been feeling this way for over an hour.
-Both staff told the engineer they were unable to get vital signs and per their protocol they were to call the Supervisor if they needed assistance.
-The staff reported being unable to reach the Supervisor during the 30-40 minute time frame.
-The engineer determined the resident was having a heart attack.
-EMS arrived on scene and the supervisor finally arrived (no time given in the report) and was unable to answer their questions.
-The resident was placed in the ambulance and defibrillator pads were placed on the resident.
-The paramedic asked the engineer to drive the ambulance to the hospital for them due to the patient's deteriorating status.
-The defibrillator had to be used to shock the resident during the transport and CPR was in progress upon arrival at the

emergency room.

Interview with a paramedic with EMS on 08/15/24 at 12:05pm revealed:
-He responded to the call to the facility for difficulty breathing on 07/23/24.
-The resident told him he had awakened during the night and was having trouble breathing and had been that way for about an hour.
-The resident looked in pretty bad shape and was to the point he could not speak and could only communicate by shaking his head yes and no.
-Staff reported the resident had been that way for an hour and did not explain why they delayed in calling 911.
-They loaded the resident into the ambulance and he coded about 2 minutes before they got to the hospital.
-CPR was initiated and continued with his arrival at the hospital.

Interview with the Administrator on 09/16/24 at 2:25pm revealed:
-The facility does not have a policy or procedure that required a PCA to get permission from the medication aide (MA) or Supervisor before call 911 for a resident.
-Anyone who felt a resident needed to be sent to the hospital should call 911 and then report to the Administrator or Supervisor what has been done.
-She had never told anyone they must get their Supervisor's permission before they can call for help for a resident.
-She did not understand why anyone would say it was the facility policy because it had never been a policy.
-Residents were to be sent out if there was any question there was something wrong and they need assessment.

The facility failed to respond immediately when a resident (Resident # 1) reported difficulty breathing and chest pain. The staff waited 30-40 minutes to contact EMS, who initiated CPR in the ambulance in route to the emergency room. This failure resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-24 on 09/16/24 for this violation.

THE CORRECTION DATE FOR THE TYPE A 1 VIOLATION SHALL NOT EXCEED OCTOBER 16, 2024.

[redacted]

Facility Name:

IV. Delivered Via:	Hand Delivery	Date: 09/23/24
DSS Signature:	Lisa Holshouser, AHS Lisa Holshouser	Return to DSS By: 10/14/24

V. CAR Received by:	Administrator/Designee (print name): Dana Brooks	
	Signature: [signature]	Date: 10/11/2024
	Title: Administrator	

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:		

Facility Name:

☑ POC Accepted	By: Lisa Holshouser	Date: 10/14/24
Comments:		

VIII. Agency's Follow-Up	By: Lisa Holshouser	Date: 11/18/24
	Facility in Compliance: ☒ Yes ☐ No	Date Sent to ACLS:
Comments:		

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