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): 12/20/24, 01/02/25, 01/06/25, 01/14/25, 01/17/25, 01/28/25
Purpose of Visit(s): Complaint Investigations and Death Investigations
Exit/Report Date: 2/13/25

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)* • *Rule/Statutory Reference (text of the rule/statute 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(a)/Personal Care and Supervision	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	Response to 10A NCAC 13 F .0901(a) Personal Care and Supervision	Completion Date: 3/14/25
Level of Non-Compliance: Type A1 Violation	Initial training began when new Administrator became aware of issues cited in this report and was completed on 1/15 25 at staff meeting.	Initial Completed 1/7/25 – Scheduled 1/15/25 & Completed and additional training will be completed by 3/14/25. Ongoing training quarterly for 4 quarters and then annually.
Findings: Based on observations, record reviews and interviews, the facility failed to provide care and services to 1 of 5 residents (Resident #2), a resident who required assistance with transfers with the aid of a slide board, according to her care plan. 1. Review of Resident #2's current FL-2 dated 12/10/24 revealed: - Diagnoses included cerebral infarction, dysphagia, cognitive communication deficit, heart failure, muscle weakness, atrial fibrillation, polyneuropathy, and hyperlipidemia.		

Christie Ogles

- EMS arrived at the facility on 01/04/25 at 12:35am. - Resident #2 reported that on 01/02/25 a male worker, who's name she did not recall, attempted to transfer her by grabbing under her arms and was unable to transfer her properly by himself. - During the transfer, she felt an injury occur in her shoulder. - Medic observed visible swelling in her left shoulder, she had weak grip strength and "virtually no mobility" in her left arm. - There was no obvious deformity observed in the arm. - She reported her pain was an 8/10. - She had baseline weakness in her legs due to a previous fracture. Review of Resident #2's Emergency Department discharge note dated 01/04/24 at 1:33am revealed: - Resident #2 complained of left shoulder pain and reported that while staff was transferring her on 01/02/25 at 1:30pm she heard a pop in her shoulder and had pain since that time. - She had limited range of motion and swelling to her upper left extremity. - An x-ray was completed and revealed a possible fracture of the humerus (the upper arm bone). - Resident #2's arm was placed in a sling and she was discharged back to her facility, with a referral to an orthopedic surgeon. Review of Resident #2's Orthopedic physician's notes dated 01/08/25 revealed: - Resident #2 was seen for evaluation related to a closed nondisplaced fracture of proximal end of left humorous. - Her left shoulder was tender, and motion was painful, with minimal swelling and edema. - He recommended conservative treatment with immobilization in a shoulder immobilizer. - There were instructions that staff should be careful with transfers and not manipulate the left shoulder. Review of facility's Care Plan book revealed there was no care plan in the book for Resident #2. Interview with Resident #2 on 01/06/25 at 10:50am revealed: - She had a slide board that was supposed to be used when staff transferred her. - She had the slide board "a long time" and most staff were familiar with using it. - On Thursday (01/02/25) a male Personal Care Aide (PCA) who did not usually provide care to her, came in to transfer her from her chair to her bed for incontinence care.	Administrator or Designee will facilitate training related to Service Plans and Providing Resident Care Service Plan books will be updated with most recent service plans AHWD responsible to update service plans in the books daily. DHW responsible to audit compliance ED responsible to audit compliance monthly	Completed on 1/15/25 Additional training to be completed by 3/14/25, quarterly for 2 quarters and annually. To be completed by 3/14/25. then quarterly for 6 months To be completed by 3/14/25. Compliance will be completed by 3/14/25 Monitoring of compliance will be monthly for 6 months and then quarterly for 6 months Monitoring for compliance will be monthly for 6 months and then quarterly for 6 months

Christine Megan

wanted to use her slide board to transfer to the bed, but he insisted he could transfer her without it. - Resident #2 reported the staff member picked her up from the chair and transferred her to the bed without incident and provided incontinence care. - Resident #2 reported to her that the staff member "picked her up" to put her back in her chair and "sort of tripped" and had to readjust his grip on her because he almost dropped her and grabbed under her arm, which was when she first felt pain in her shoulder. - Resident #2 did not think her shoulder was seriously injured because of the failed transfer and thought the soreness would feel better after a day or two, but the pain increased. - The next day, when staff put her in bed, she complained of worsening pain, and she was sent out to the ED for evaluation. Interview with the PCA on 01/06/25 at 3:10pm revealed: - He usually worked at a sister facility located next door but sometimes picked up shifts at this facility on second shift. - He had been assigned to care for Resident #2 on many occasions and was familiar with her needs. - He was aware that Resident #2 had right side paralysis because of a stroke. - He had been trained on how to properly use a slide board, but he had never used a slide board alone. - Often when Resident #2 needed to be transferred, he and the MA would transfer her together, and they would use a slide board. - On 01/02/25, he went into Resident #2's room to assist her in transferring from her wheelchair to her bed. - He asked her if she could stand, to which she responded she "thought she could". - He assisted Resident #2 in standing up by holding under her arms and observed Resident #2 was weaker than usual and could not bear weight. - He was holding under her arm and due to her unexpected weakness, he had to quickly assist her back onto the chair to keep her from falling to the ground. - After allowing Resident #2 to rest for a few minutes, he again attempted to transfer her to bed by holding under her arms and was able to get her into bed that time. - Resident #2 never asked to use the slide board, and she never said she was in pain. - He was aware Resident #2 had a stroke in the past and that her left side was her "weak side" because of the stroke, so he always tried to be on that side of her during transfers to provide more support on her weak side.		

Christine McOgden

- To her knowledge, all staff used a slide board to transfer Resident #2. - There was a care plan book in the clinic on each floor of the facility that contained the care plans for each resident, and staff were supposed to review the book to learn about the needs of the residents. - When new staff started, she directed them to refer to the care plan book. - She did not review the care plan book often because she had worked at the facility so long she felt she was familiar with the residents and their needs. - She preferred to learn the needs of the residents, she usually asked new residents when they moved into the facility what assistance they needed from staff, and she also observed residents to learn their needs. Interview with second shift MA on 01/06/25 at 12:05pm revealed: - On 01/02/25, Resident #2 reported she had pain in her shoulder but said she didn't think she needed any pain medication. - Resident #2 did not report to her what had happened to cause her shoulder to hurt, and it was not uncommon for her to have "aches and pains" so she did not think the pain was out of the ordinary for Resident #2. - Resident #2 required assistance with transfers, and she always used a slide board to assist her. - When using the slide board, she would slide the board under her hip and then the resident would grab the side of the board and pull herself over to the other side of the board. - She recalled when she was first trained as a PCA in the facility, other staff members had shown her how to use a slide board. - She always used the slide board when assisting Resident #2 with transfers and would "be afraid not to use it" because it "didn't seem safe" for Resident #2. - She was unsure what assistance Resident #1's Care Plan reflected she needed and did not recall ever seeing the resident's care plan. Telephone interview with a second shift MA on 01/22/25 at 3:50pm revealed: - On 01/03/25, she recalled Resident #2 complained of shoulder pain and said that she was planning to try to see a doctor the next day to have her shoulder evaluated. - Resident #2 did not want to be sent out for evaluation on second shift on 01/03/25 for evaluation.		

- Since she seemed to be experiencing a good deal of pain, she strongly recommended Resident #2 go to the hospital for evaluation, and she agreed to go.
- Because her shoulder was hurting so much, she did not try to pull up her sleeve to assess the area.
-EMS came and transported her to the ED.
- Resident #2 required assistance with incontinence care, dressing and transfers.
- She had never assisted Resident #2 with transfers because she was always already in bed by the beginning of 3rd shift and was still in bed at the end of 3rd shift.
- She had been trained on using slide boards and was comfortable with using them.
- She learned about the needs of residents through shift-to-shift report, usually, and by reviewing the Care Plan books as necessary.
- She was unsure if she seen Resident #2's care plan.

Interview with Physical Therapist on 01/14/25 at 11:30am revealed:
- She was not currently working with Resident #2 but had previously worked with her on building strength prior to fracturing her knee several months ago.
- Resident #2 required assistance with all transfers.
- Resident #2 had a slide board that could be used for assistance with transfers.
- To use a slide board, staff would slide the board under a resident's bottom when the resident was in the sitting position and then the resident would hold on to the edge of the board and "scoot" themselves over onto the board and onto another surface.
- Prior to Resident #2's knee injury, she was working with her to try build strength so that she could squat pivot.
- At the time she stopped working with her several months ago, Resident #2 was sometimes able to successfully squat and pivot to transfer, and sometimes also used a slide board.
- She had worked with several staff on utilizing slide boards with residents, when a staff member happened to be in a resident's room during a transfer of a resident who used a slide board.
- For residents who have had a stroke resulting in paralysis, they were at a greater risk of fractures because the joints were weak and there was no muscle tone around the joint to help hold it in place.

and the staff member stated he "thought he could move her" without the slide board. - Staff were responsible for reviewing the care plan book and for providing care according to resident's care plans. - The PCAs did not document each instance of personal care assistance provided to residents. Interview with Regional Operations Specialist on 01/17/25 at 10:10am revealed: - She was aware that Resident #2's care plan documented a slide board should be used for transfers but thought the staff who failed to use the slide board was likely unaware a slide board should be used because he did not typically work in the facility. - Care Plans were supposed to be maintained up to date in the Care Plan book located in the clinic on each floor of the facility for staff review. - The current care plans were also located within their electronic record system, but the PCAs did not have access to this system and should have been referring to the care plan books. - Any time there was a change to a resident's care plan, this should be communicated by the DRC and ADRC to the MAs and PCAs so they were all aware. - The ADRC was responsible for updating the care plans in the books when there were any changes to residents' care plans, and this should be flagged in the shift-to-shift report. - PCAs reviewed the shift-to-shift report to learn of any changes to residents needs at the beginning of each shift. - PCAs did not document each instance of personal care assistance provided to residents. Interview with Resident #2's Physician on 01/14/25 at 9:45am revealed: - Resident #2 had been his patient for about a year and had recently "been through a lot" with the loss of a close family member and she fractured her knee several months ago and had not fully recovered from that injury. - He received communication from the facility that Resident #2 complained of shoulder pain and was sent out to the ED for evaluation and diagnosed with a fracture in her shoulder. - He was aware that Resident #2's most recent care plan he signed included the use of a slide board for transfers, but he was unsure of how long the slide board had been available for the resident's use. - Slide boards were used to make transfers easier for weak residents, as they reduce the risk of injury.		

IV. Delivered Via:	Certified mail/hand delivered Vida Sanders / Jessya Wright	Date: 2/13/25
DSS Signature:		Return to DSS By: 3/6/25

V. CAR Received by:	Administrator/Designee (print name): Christine Ogden
	Signature: Christine M Ogden Date: 2/13/25
	Title: New Administrator effective 1/15/25

VI. Plan of Correction Submitted by:	Administrator (print name): Christine Ogden
	Signature: Christine M Ogden Date: 3/6/25

New Admin effective 1/15/25 Rev 3/12/25

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

☒ *POC Not Accepted* | By: Denise Boudeman | Date: 3/12/25

Comments: More detail needed

☒ *POC Accepted* | By: Denise Boudeman | Date: 3/12/25

Comments:

VIII. Agency's Follow-Up	By: Denise Boudeman	Date: 5/8/25
	Facility in Compliance: ☒ Yes ☐ No	Date Sent to ACLS:

Comments: Violation is now abated.

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

Christine M Ogden