Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Brookdale South Park
Address: 5326 Park Road, Charlotte, NC 28209
County: Mecklenburg
License Number: HAL-060-085

II. Date(s) of Visit(s): 05/30/25 and 06/24/25
Purpose of Visit(s): Monitoring
Exit/Report Date: 07/24/25

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(b) Personal Care and Supervision	☑ POC Accepted kp *DSS Initials*	____
Rule/Statutory Reference: (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	1. The Health and Wellness Director (HWD), Executive Director (ED), or designee conducted staff re-training on 7/17/2025 that included: a. Elopement Risk screening prior to admission b. Identifying early signs of exit-seeking c. Best practices regarding potential elopements d. Best practices to help identify root cause and interventions to reduce potential for elopements. 2. The ED or designee will review the shift-to-shift report daily to verify completion of the tasks that include checking the working order of any gates, locks, and alarms for each door leading to the outside or an unsecured area of the community.	
Level of Non-Compliance: Type A1 Violation		
Findings: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for 1 of 5 sampled residents (Resident #1) who eloped from the Special Care Unit (SCU) without staff's knowledge. Review of the facility's Missing Resident Policy dated April 1997 and revised March 2025 revealed: -An elopement was defined as any incident where a resident left the secured memory care area of the community or the secured courtyard, unescorted, with or without injury.		

-If associates discovered a resident's whereabouts were unknown, associates were supposed to immediately begin to follow the procedures of the Missing Resident Policy. -Staff were supposed to conduct a thorough interior and exterior search of community and immediate grounds. -The supervisor on duty was supposed to call the police and contact the Executive Director (ED) or designee. -The ED or designee was supposed to contact the resident's family or responsible party. Review of Resident #1's FL2 dated 04/04/25 revealed: -Diagnoses included unspecified dementia of unspecified severity with agitation. -Resident #1 was ambulatory, constantly disoriented, and continent of bowel and bladder. Review of Resident #1's Resident Register revealed that she was admitted to the facility on 04/07/25. Review of Resident #1's Pre-admission Assessment dated 04/09/25 revealed: -She was able to ambulate independently. -She was able to transfer independently. -She required set-up and supervision with Activities of Daily Living (ADLs). -Her behaviors included difficulty with orientation to person, place, and time. -She demonstrated anxious, compulsive, disruptive or obsessive behavior requiring additional staff attention. -A goal was to manage her behaviors with staff assistance. -Interventions included using a positive approach with a calm and gentle voice to direct or redirect her. Review of Resident #1's Care Plan dated 05/08/25 revealed: -She was able to ambulate independently. -She was able to transfer independently. -She required set-up and supervision with Activities of Daily Living (ADLs). -Her behaviors included difficulty with orientation to person, place, and time. -She demonstrated anxious, compulsive, disruptive or obsessive behavior requiring additional staff attention. -A goal was to manage her behaviors with staff assistance. -Interventions included using validation and responding to her "emotions behind anxious behavior, (e.g. looking for mother may mean they need comfort, security, and a sense of belonging)."	3. The ED will designate an evening shift associate, as well as the maintenance director, to verify, daily for three (3) weeks, all gates, locks, and alarms are operating as required. a. Any identified issues with egress doors/gates will be reported to the maintenance technician or designee for follow-up. 4. All interventions will be implemented by 8/23/2025.	

Review of Resident #1's SCU profile dated 04/09/25 revealed: -Her behavior patterns included anxious, disruptive, or obsessive behaviors that required additional attention. -She required set-up of supplies and safety devices as needed. -She demonstrated reluctance to accept medication assistance. -Interventions included to use a "positive physical approach (e.g. go slow, make eye contact, and get down low)". Review of Resident #1's SCU profile dated 05/08/25 revealed: -Her behavior patterns included anxious, disruptive, or obsessive behaviors that required additional attention. -She required set-up of supplies and safety devices as needed. -She demonstrated reluctance to accept medication assistance. -Interventions included to use a "positive physical approach (e.g. go slow, make eye contact, and get down low)". Review of Resident #1's incident report dated 05/28/25 revealed: -She was exit-seeking after she returned from the hospital, which was shortly before she eloped on 05/28/25. -She was found on the property, but outside the secured building. -She fell in the grass and had no apparent injuries. -There was documentation she may have exited the facility behind an employee who did not notice her presence. Review of Resident #1's progress notes dated 05/28/25 at 3:20pm revealed: -She returned to the facility via hospital transport following a hospitalization. -She was very agitated. -She did not want to return to the facility and wanted to go home. -She would not get up from the transport chair and attempted to hit the transport driver. -It took several attempts for her to get up from the transport chair. -She began walking around the facility. Review of Resident #1's progress notes dated 05/28/25 at 5:35pm revealed: -When Resident #1 returned from the hospital, she was upset that she was not taken to her home. -Between 4:00pm and 4:20pm, she was located outside the facility. -She was found on the premises near the main road in front of the facility. -She fell and was sitting on her buttocks with no injuries noted.		

-She was assisted to standing and ambulated independently. -Staff redirected her back into the facility. -Staff were unable to determine how she exited the facility. -It was believed she exited through a kitchen door that was used by staff. -Her Guardian of Person (GOP) was looking for her when she eloped. -Her Primary Care Physician (PCP) was notified. Observation of the SCU on 05/30/25 at 9:49am revealed: -There was an unalarmed service entry/exit door that had a key-code lock. -The door did not always completely close if it was not physically pulled shut. -The door led to the fire alarm control panel, electrical panel, furnace room, kitchen entry door, utility room door, and facility entry/exit door. -To the left, past the control panels and kitchen entry, was the facility entry/exit door. -The facility exit/entry door was not alarmed or locked from the inside. -The facility exit/entry door locked from the outside when pulled shut. -The facility exit/entry door was ajar to the outside of the facility. Observation on 06/17/25 at 9:38am of Resident #1's exit route between the facility exit and where Resident #1 was located by facility staff revealed: -The approximate distance from the facility and where Resident #1 was found was 449 feet. -There was a sidewalk in front of the facility extending from the exit door across the length of the facility. -From the sidewalk extending the front length of the facility, there was a grassy section that led to a grassy slope below the sidewalk that lined a 5-lane road. -The posted speed limit was 35mph on the 5-lane road. Review of a 911 report dated 05/28/25 revealed: -Law enforcement was dispatched on 05/28/25 at 5:26pm to the facility address. -The call was closed on 05/28/25 at 5:31pm. -Another law enforcement officer was driving by when he observed Resident #1 on the grass off the sidewalk struggling to get up. -She told the officer she was going home, but she was unsure where home was.		

-Staff from the facility arrived and explained who Resident #1 was. -Emergency Medical Services (EMS) and the fire department arrived because she fell in the grass. Review of Resident #1's EMS report dated 05/28/25 at 5:31pm revealed: -EMS was dispatched by law enforcement at 5:31pm to the parking lot of the facility for a female who fell. -Upon arrival, Resident #1 was in the care of facility staff. -Facility staff were actively trying to coax Resident #1 back into the facility with EMS assistance. -Facility staff did not intend for Resident #1 to be transported to the hospital. -EMS did not obtain any resident demographics. Telephone interview with Resident #1's Responsible Person (RP) on 06/13/25 at 2:03pm revealed: -She received a call from the facility on 05/28/25 at about 3:00pm when Resident #1 returned from a hospital stay in an agitated state. -When she arrived at the facility, Resident #1 was not in her room. -She and the Health and Wellness Director (HWD) looked for Resident #1. -When she was not located, the HWD initiated elopement procedures. -The concierge reported she received a telephone call from a passerby about a potential resident being outside. -She went outside with the HWD. -A law enforcement officer, who observed Resident #1 on the grassy slope near the sidewalk of the 5-lane road, had stopped to investigate. -Resident #1 had fallen and was sitting on the grassy slope. -Facility staff were able to redirect Resident #1 back into the facility. -EMS responded to the incident, but Resident #1 was not transported to the hospital. -She stayed at the facility for about an hour to complete a wellness check. Telephone interview with a Medication Aide (MA) on 06/25/25 at 11:32am revealed: -She became aware Resident #1 eloped when the elopement procedure was initiated on 05/28/25. -When she went outside to look for Resident #1, several other staff were also outside looking for her.		

-A law enforcement officer who was driving by stopped to check on Resident #1. -The officer got out of his truck to talk to Resident #1. -Resident #1 was on the grassy slope trying to scoot up the slope on her buttocks. -Resident #1's Responsible Person, the HWD, and another MA attempted to redirect her back into the facility. -Staff assisted her onto her feet and began walking on the sidewalk along the 5-lane road toward the facility. -Resident #1 was agitated and did not want to go back to the facility. -A MA was able to redirect her back to the facility. Interview with a second MA on 6/25/25 at 1:08pm revealed: -Resident #1 came back from the hospital at 3:20pm upset because she did not want to be there. -Resident #1 walked around the SCU and the secured patio from the time she arrived back from the hospital. -She heard that staff were looking for Resident #1 on the walkie-talkie at 5:50pm. -Staff were unable to find her. -The concierge reported that someone called to report a woman was seen on the slope at the sidewalk of the 5-lane road in front of the facility. -When she went outside, a law enforcement officer was talking to Resident #1. -Multiple staff went outside to get her. -She was able to redirect Resident #1 back into the facility. -EMS was onsite and tried to talk to her, but she was not transported. Interview with Resident #1's Nurse Practitioner (NP) on 06/24/25 at 9:41am revealed: -Facility staff informed her that Resident #1 eloped from the facility on 05/28/25. -Resident #1 wanted to leave the facility since she was admitted. -Resident #1 carried her purse and would say she was leaving. -She completed a body check and consulted with Resident #1. -Resident #1 was not injured from falling outside. -Resident #1 had multiple hospital admissions for chronic medical conditions since she was admitted to the facility and would become agitated and exit seeing after each return from the hospital. -Resident #1 was unable to adjust to her new home. Interview with the HWD on 05/30/25 at 10:46am revealed:		

-Resident #1 returned from a hospital stay on 05/28/25 at 3:20pm. -Resident #1 was very restless and wanted to walk. -Resident #1 was seen through the doorways walking restlessly back and forth in the secured courtyard. -Staff were trying to bring Resident #1 inside since her Responsible Person was expected to come for a post-hospitalization visit. -When the responsible person arrived, staff were unable to locate Resident #1. -Resident #1 was not in the courtyard, and all of the courtyard gates were secured. -Facility doors leading to the courtyard were left unlocked for residents to have access to the secured courtyard. -She initiated elopement procedures. -A facility staff member reported that a passerby called to report that a female was scooting on her buttocks on the hill beside the facility property. -Multiple facility staff and Resident #1's Responsible Person went outside to find Resident #1 on the slope scooting toward the sidewalk that lined the 5-lane road in front of the facility. -A law enforcement officer had also arrived. -Resident #1 was very agitated. -A MA was able redirect Resident #1 back into the facility where she continued to walk and check doors until she was tired. -EMS was onsite, but did not transport Resident #1. -Resident #1 was hospitalized several times for chronic medical complications and was always agitated and exit seeking when she returned from the hospital. -After Resident #1 settled down for the evening, she checked all egresses in the facility. -She noted that the unalarmed service entry/exit door with a new key-code lock did not latch unless it was physically pulled or pushed shut. Interview with the Administrator on 05/30/25 at 9:49am revealed: -He was briefly out of the facility when Resident #1 eloped. -Resident #1 was back in the facility when he returned. -Staff were looking for Resident #1 before she was found. -Resident #1 was found on a grassy hill on the property where she had fallen. -Resident #1 was on the edge of the facility property line, and she was not hurt. -Resident #1 had just returned from the hospital and said, "this is not my home."		

-He believed Resident #1 exited the facility by following a staff member through the service door. -A new keypad was recently installed on the service door through the control panel room. -The service door leads to the facility egress, which was not locked from the inside. --- The facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) who had a history of exit seeking behaviors, resulting in her eloping from the Special Care Unit without staff knowledge when a service door was left unalarmed and would not close completely unless the handle was physically pulled to. Staff were unaware Resident #1 eloped and was observed by a passerby to be sitting on a grassy slope near the 5-lane highway that ran parallel to the facility. This failure resulted in serious neglect which constitutes a Type A1 Violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 23 2025. --- The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 05/30/25.		

Facility Name: Brookdale South Park

IV. Delivered Via:	Hand delivered	Date: 07/24/25
DSS Signature:	Karen Phillips	Return to DSS By: 08/14/25

V. CAR Received by:	Administrator/Designee (print name): Cynthia Jackson	
	Signature: Cynthia Jackson	Date: 7-24-25
	Title: BOM	

VI. Plan of Correction Submitted by:	Administrator (print name): Brad A. Burge	
	Signature: BAB	Date: 8/14/2025

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		
☑ *POC Accepted*	By: Karen Phillips	Date: 08/18/25
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.*		