Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Pines on Carmel Senior Living
Address: 5820 Carmel Road, Charlotte, NC 28226
County: Mecklenburg
License Number: HAL-060-168

II. Date(s) of Visit(s): 05/16/25; 05/19/25; and 06/17/25
Purpose of Visit(s): Monitoring
Exit/Report Date: 07/10/25

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 _____ *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.	This plan of correction is not to be interpreted as an admission of or agreement with the findings and conclusions in the statement of deficiencies dated 7/10/2025 . It is a submission of our ongoing efforts to comply with regulatory requirements. We have outlined specific actions in response to identified issues. We remain committed to the delivery of quality health care services and will continue to make changes and improvements in line with that objective.	
Level of Non-Compliance: Type A2 Violation		
Findings: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for 1 of 7 sampled residents (Resident #1) who eloped from the Special Care Unit (SCU) without staff's knowledge. The findings are:		

facility without authorization or necessary supervision, but without a high immediate danger of harm if successful. -Resident #1 required redirection greater than 12 times daily. -Safety instructions were documented as "offer resident a snack or take him to the restroom." Review of Resident #1's SCU profile dated 02/03/25 revealed: -Resident #1's behavior patterns included wandering. -Resident #1 was independent with ambulation and transfers. -Resident #1 liked to walk the hallways. -There were no interventions documented on the form. -Resident #1 was not oriented to place and time. Review of Resident #1's SCU profile dated 05/02/25 revealed: -Resident #1's behavior patterns included wandering and sundowning. -Resident #1 was independent with ambulation and transfers. -Resident #1 liked to walk the hallways. -There were no interventions documented on the form. -Resident #1 was not oriented to place and time. Review of Resident #1's Elopement Risk Evaluation form dated 05/05/25 revealed: -Resident #1 scored with potential risk regarding 2 questions: 1) "Does the resident wander aimlessly or no-goal oriented (i.e., Confused, moves without purpose, may enter other's rooms and explore others' belongings)?" 2) "Is the wandering behavior a pattern, goal-directed (i.e., specific destination in mind, going home, seeking someone they can't find, hovering by staff and the door, going to work)?" -Resident #1 was considered "moderate risk" for elopement. -There were no interventions documented to prevent elopements. Review of Resident #1's incident report dated 05/15/25 revealed: -Resident #1 was witnessed in the parking lot of the community. -Staff immediately went to the resident and redirected him back to the SCU. -Resident #1's vitals were taken, and the family and physician were notified. -Resident #1 was placed on one-on-one care for 24 hours. Review of Resident #1's progress notes dated 05/15/25 revealed: -Resident #1 was witnessed in the parking lot at 5:00pm by staff.	Health Services Director or designee to conduct Personal Care and Supervision training specific to Wandering and Elopement for all staff. Training to be complete by 7/31/25. Health Services Director or designee will conduct monthly audit for Elopement Risk evals for 3 months to include reviewing ISP and Elopement risk evals on all residents in the MCU to ensure interventions are still appropriate. Executive Director or designee to audit process completion for 3 months.	

Interview with a Medication Aide (MA) on 05/16/25 at 5:02pm revealed: -She worked in the AL at the facility. -Her coworker was cleaning dining room tables after dinner when she saw Resident #1 in the parking lot. -Her coworker called staff in the SCU and the Administrator. -She and her coworker went outside to check on the resident. -Resident #1 was "out of sight" when they arrived in the parking lot. -They located Resident #1 walking on the sidewalk along the main road away from the facility. -Resident #1 was on the sidewalk at the street sign at a neighborhood adjacent to the facility. -She asked Resident #1 his name and where was he going. -Resident #1 stated his name correctly and that he was going home. -The MA redirected him back to the SCU without incident. Interview with a Personal Care Aide (PCA) on 6/17/25 at 4:18pm revealed: -She was coming down the hallway at the dining room when she saw a man walking toward the end of the parking lot. -She was unaware he was a SCU resident. -She called the MA in the SCU and the Administrator. -She and a coworker went outside to check on the resident walking in the parking lot. -She asked him his name, to which he responded. -Resident #1 stated he was "going home." -He was easily redirected back to the SCU. -The MA from the SCU was outside to take Resident #1 back into the facility. Interview with another PCA on 05/16/25 at 4:02pm revealed: -On 5/15/25, she was cleaning residents' dinner plates in the dining room. -She later learned that Resident #1 was in the parking lot. -She did not hear a door alarm. -The MA went outside to look for Resident #1. Interview with a second PCA on 05/16/25 at 4:06pm revealed: -On 05/15/25, she was feeding a resident her dinner in her room. -She finished feeding the resident and went into the SCU kitchen. -She learned that Resident #1 was in the parking lot. -When she went to the front door of the facility, Resident #1 was being escorted back to the facility.		

-Staff called her to report that Resident #1 was outside of the SCU on 05/15/25.
-Staff from the AL went to bring the resident back to the SCU.
-Staff did not report how Resident #1 was able to leave the SCU.

Interview with the Administrator on 06/17/25 at 10:55am revealed:
-When a PCA from the AL called her about Resident #1 eloping, she returned to the facility.
-After staff escorted Resident #1 back to the SCU, the MA reset the emergency exit button that engaged the magnetic lock on the SCU front door.
-She interviewed staff on the SCU about the elopement.
-Staff was expected to check the facility doors if an alarm sounded.
-She understood that staff working on the SCU did not hear the screamer from the emergency exit button.
-Staff needed to be reeducated about residents' exit seeking behaviors.

The facility failed to provide adequate supervision for 1 of 7 sampled residents (Resident #1) who eloped from the Special Care Unit (SCU) and had a history of wandering and exit seeking behaviors, resulting in the resident exiting the SCU before staff were made aware he was not present and being found by staff on a sidewalk adjacent to a city street. This failure resulted in substantial risk of harm and neglect which constitutes a Type A2 Violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 09 2025.

The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 05/19/25.

Facility Name: The Pines on Carmel Senior Living

IV. Delivered Via:	Hand-delivered	Date: 07/10/25
DSS Signature:	Karen Phillips	Return to DSS By: 07/31/25

V. CAR Received by:	Administrator/Designee (print name): Samantha Glass	
	Signature: Samantha Glass	Date: 7/10/25
	Title: Administrator	

VI. Plan of Correction Submitted by:	Administrator (print name): Samantha Glass	
	Signature: Samantha Glass	Date: 7/31/25

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

☐ *POC Not Accepted*	By:	Date:
Comments:		
☑ *POC Accepted*	By: Vida Sandero	Date: 8/1/25
Comments: The facility has 30-days to get in compliance		

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.*