Adult Care Home Corrective Action Report (CAR) Amended

I. Facility Name: Somerset Court Assisted Living
Address: 401 W. Academy St. Cherryville NC 2021
County: Gaston
License Number: HAL-036-034

II. Date(s) of Visit(s): 2/18/25, 3/7/25, and 4/9/25
Purpose of Visit(s):Complaint Investigation
Exit/Report Date: 4/9/25

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 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 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 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. 0702 Discharge of Residents	☑ POC Accepted GM *DSS Initials*	5/9/25
Rule/Statutory Reference: 10A NCAC 13F. 0702 Discharge of Residents (c) The facility administrator or their designee shall assure the following requirements for written notice are met before discharging a resident: (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be completed and hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms. The Adult Care Home Notice of Discharge shall include the following: (A) the date of notice; (B) the date of transfer or discharge; (C) the reason for the notice; (D) the name of responsible person or contact person notified; (E) the planned discharge location; (F) the appeal rights; (G) the contact information for the long-term care ombudsman; and (H) the signature and date of the administrator. (2) A copy of the completed Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form shall		

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be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated. For the purposes of this Rule "responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications. The Adult Care Home Hearing Request Form shall include the following: (A) the name of the resident; (B) the name of the facility; (C) the date of transfer or discharge; (D) the date of scheduled transfer or discharge; (E) the selection of how the hearing is to be conducted; (F) the name of the person requesting the hearing; and (G) for the person requesting the hearing, their relationship to the resident, address, telephone number, their signature, and date of the request.	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law. POC expanded to include specific terminology on 5/8/2025 Training and guidance provided to the facility Executive Director, Resident Care coordinator and the Business Manager on 10A NCAC 13F .0702 Discharge of Residents. Training included, but not limited to; 1) Level of care changes requiring a notice of discharge to be issued. 2) DMA-9052, Notice of Transfer/Discharge Form and how to completed. 3) DMA-9052, Hearing Request Rights and Form. Requirements to include with Notice of Transfer/Discharge and section to be completed by the facility. 4) Notice of Transfer/Discharge and Hearing Request Rights acceptable methods of delivery to include HAND DELIVERY to the resident, obtain RECEIPT BY DOCUMENTING DELIVERY OF THE DISCHARGE NOTICE ON THE RESIDENT REGISTER TO INCLUDE SIGNATURE OR MARK and a copy provided to the responsible party or legal representative (if applicable). 5) Guidance and training provided on issuing the required Notice of Transfer/Discharge and Hearing request rights based on the facility ASSESSMENT or a medical professional's determination or RECOMMENDATION that a resident needs can no longer be met at the facility or current level of care to include a FL-2 indicating a new level of care. 6) Guidance provided on maintaining copies and documentation of level of care changes, Notices of Transfer/Discharge including the hearing Request Form. 7) Training provided on reasons for discharge per rule 10A NCAC 13F .0702 and the NCGS 131D Discharge of Residents.	
Level of Non-Compliance: Type A1 Violation		
Findings: Based on record reviews and interviews the facility failed to ensure the notices of discharge and appeal rights were made by the facility for 1 of 1 sampled resident whose medical needs could not be met by the facility (Resident #1) who was discharged to a local hospital. Review of Resident #1's previous FL-2 dated 7/9/24 revealed: -Diagnoses included chronic respiratory failure with hypercapnia (inability to remove excess carbon dioxide), type II diabetes mellitus, chronic peripheral venous insufficiency, paroxysmal atrial fibrillation on (AFib) (an irregular often rapid heart rate that causes poor blood flow)], chronic obstructive pulmonary disease (COPD). -The level of care was Domiciliary (Rest Home). -The FL-2 was signed by Resident #1's primary care provider (PCP). Review of Resident #1's current FL-2 dated 1/30/25 revealed: -Diagnoses included chronic respiratory failure with hypercapnia, type II diabetes mellitus, chronic peripheral venous insufficiency, COPD, morbid (severe) obesity, and paroxysmal AFib. -The level of care was skilled nursing facility. -The FL-2 was signed by Resident #1's PCP.	Training provided by Regional Vice President of Operations in coordination with the Clinical Nurse Consultant. QUALITY ASSURANCE: 1) Guidance and support will be provided by the Regional Vice President of Operations and/or Clinical Nurse Consultant when the facility administrative personnel issue a Notice of Transfer/Discharge based on a facility assessment and/or a medical professionals determination/recommendation for a different level of care. 2) RVPO and Clinical Consultant will review residents at risk of discharge during conference calls and site visits to ensure discharge procedures and documentation are maintained.	Training Completed 4/30/2025 4/30/2025 Ongoing

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be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated. For the purposes of this Rule "responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications. The Adult Care Home Hearing Request Form shall include the following: (A) the name of the resident; (B) the name of the facility; (C) the date of transfer or discharge; (D) the date of scheduled transfer or discharge; (E) the selection of how the hearing is to be conducted; (F) the name of the person requesting the hearing; and (G) for the person requesting the hearing, their relationship to the resident, address, telephone number, their signature, and date of the request.	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law. POC expanded to include specific terminology on 5/8/2025 Training and guidance provided to the facility Executive Director, Resident Care coordinator and the Business Manager on 10A NCAC 13F .0702 Discharge of Residents. Training included, but not limited to; 1) Level of care changes requiring a notice of discharge to be issued. 2) DMA-9052, Notice of Transfer/Discharge Form and how to completed. 3) DMA-9052, Hearing Request Rights and Form. Requirements to include with Notice of Transfer/Discharge and section to be completed by the facility. 4) Notice of Transfer/Discharge and Hearing Request Rights acceptable methods of delivery to include HAND DELIVERY to the resident, obtain RECEIPT BY DOCUMENTING DELIVERY OF THE DISCHARGE NOTICE ON THE RESIDENT REGISTER TO INCLUDE SIGNATURE OR MARK and a copy provided to the responsible party or legal representative (if applicable). 5) Guidance and training provided on issuing the required Notice of Transfer/Discharge and Hearing request rights based on the facility ASSESSMENT or a medical professional's determination or RECOMMENDATION that a resident needs can no longer be met at the facility or current level of care to include a FL-2 indicating a new level of care. 6) Guidance provided on maintaining copies and documentation of level of care changes, Notices of Transfer/Discharge including the hearing Request Form. 7) Training provided on reasons for discharge per rule 10A NCAC 13F .0702 and the NCGS 131D Discharge of Residents.	
Level of Non-Compliance: Type A1 Violation		
Findings: Based on record reviews and interviews the facility failed to ensure the notices of discharge and appeal rights were made by the facility for 1 of 1 sampled resident whose medical needs could not be met by the facility (Resident #1) who was discharged to a local hospital. Review of Resident #1's previous FL-2 dated 7/9/24 revealed: -Diagnoses included chronic respiratory failure with hypercapnia (inability to remove excess carbon dioxide), type II diabetes mellitus, chronic peripheral venous insufficiency, paroxysmal atrial fibrillation on (AFib) (an irregular often rapid heart rate that causes poor blood flow)], chronic obstructive pulmonary disease (COPD). -The level of care was Domiciliary (Rest Home). -The FL-2 was signed by Resident #1's primary care provider (PCP). Review of Resident #1's current FL-2 dated 1/30/25 revealed: -Diagnoses included chronic respiratory failure with hypercapnia, type II diabetes mellitus, chronic peripheral venous insufficiency, COPD, morbid (severe) obesity, and paroxysmal AFib. -The level of care was skilled nursing facility. -The FL-2 was signed by Resident #1's PCP.	Training provided by Regional Vice President of Operations in coordination with the Clinical Nurse Consultant. QUALITY ASSURANCE: 1) Guidance and support will be provided by the Regional Vice President of Operations and/or Clinical Nurse Consultant when the facility administrative personnel issue a Notice of Transfer/Discharge based on a facility assessment and/or a medical professionals determination/recommendation for a different level of care. 2) RVPO and Clinical Consultant will review residents at risk of discharge during conference calls and site visits to ensure discharge procedures and documentation are maintained.	Training Completed 4/30/2025 4/30/2025 Ongoing

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Review of Resident #1's facility's progress notes dated 1/20/25-2/12/25 revealed: -Resident #1 was sent to the Emergency Department on 1/20/25 for shortness of breath. -Resident #1 was admitted to the hospital on 1/21/25. -The facility spoke with Resident #1's "specialty" nurse at the local hospital on 1/24/25 and Resident #1 was not ready for discharge due to the doctor changing his mind. -On 1/27/2,5 the facility Resident Care Coordinator (RCC) went to the hospital to assess Resident #1 for mobility and wounds. -On 1/27/25, the hospital case manager informed them that the doctor decided to change Resident #1's medications again and it would be a least another 24 hours before discharge. -On 1/28/25, the facility spoke with Resident #1's hospital nurse who stated the cardiologist changed more of Resident #1's medication and would be doing a cardioversion (a procedure requiring sedation and electrodes placed on the patient's chest to deliver an electrical shock to restore their heart to a regular heart rate) and would be staying another 24-48 hours before returning to the facility. -On 1/30/25, the Business Office Manger (BOM) went to see Resident #1 who was visibly weak and on two liters of oxygen. -Upon assessment Resident #1 let the BOM know she felt like "crap", and she knew she was too weak to try and stand, walk, or transfer. -On 1/30/25, the hospital nurse said Resident #1 had two cardioversion treatments and was still in atrial flutter (a condition in which the hearts upper chamber (atria) beats too quickly) and AFib. -On 1/30/25, the hospital nurse was told by the facility that Resident #1 could not be accepted back to the facility without "therapy". -On 1/31/25, the facility's in-house home health nurse stated while Resident #1 was in AFib/ Atrial flutter Resident #1 needed to be somewhere she could be closely monitor and she did not think it was a good idea for her to return to the facility. -On 1/31/25, the RCC called the hospital to inform the case manager Resident #1 would not be admitted back to the facility. -On 1/31/25, the hospital nurse let the RCC know the AFib, and atrial flutter would not just go away on their own. -On 1/31/25, the hospital nurse recommended skilled nursing if the facility could not care for AFib. Review of Resident #1's Resident Register revealed: -Resident #1 was admitted on 8/11/21.	Additional Training on Resident Rights provided by the Regional Vice President of Operations in coordination with the Clinical Nurse Consultant. Please note: The facility spoke with the case manager not a 'specialty" nurse. Please note: On 1/30/25, it was the case manage, not a hospital nurse who referenced the cardioversion treatments. Please note: The conversations with the hospital from 1/28-1/31/2025 were conducted by the Business Office Manager per the progress notes, not the Resident Care Coordinator.	4/30/2025

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-There was no documentation for discharge/transfer information related to reason for discharging the resident. -There was no signature or date by the Administrator /representative. Review of Resident #1's Physician's orders dated 1/30/25 revealed: -The resident's level of care was congestive heart failure (CHF) (a chronic condition in which the heart doesn't pump blood as well as it should). -Resident was to be upgraded to skilled care due to uncontrolled AFib. -Resident #1 was at high risk due to multiple comorbidities with possible complications due to diabetes, COPD, hypertension, and CHF. Attempted telephone interviews with Resident #1 on 3/19/25 at 9:37am and 3/19/25 at 2:04pm were unsuccessful. Telephone interview with Resident #1's responsible party (RP) on 3/7/25 at 11:58am revealed: -Resident #1 was never given a written discharge notice or appeal rights. -She was told the hospital's case manager attempted multiple times to contact the facility, but no one from the facility returned the hospital case manager's call. Review of Resident #1's hospital records dated 1/20/25-3/7/25 revealed: -Resident #1 was brought into the ED on 1/20/25 with shortness of breath. -Resident #1 was admitted to the hospital on 1/21/25 with a chief complaint of shortness of breath. -On 1/24/25, Resident #1 was not medically stable for discharge. -On 1/27/25, the RCC completed a bedside assessment of Resident #1 and determined the patient was able to return to the facility. -The Resident #1 went back into atrial flutter on 1/29/25 after she received a cardioversion. -On 1/31/25 the clinical case manager spoke with the BOM and was informed she would not allow patient to return today or this weekend (1/31/25). -The BOM voiced concerns Resident #1 was no longer considered to need assisted living level of care and her continued issues with AFib.		

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-The clinical case manager explained to the BOM Resident #1 was evaluated by the therapy department and Resident #1 was at her baseline for assisted living level of care. -The clinical case manager informed the BOM the cardiologist cleared Resident #1 for discharge today (1/31/25). -The BOM stated she would need to complete another face-to-face visit, but not today (1/31/25). -The Administrator and RCC maintained Resident #1 could not return to their building until the resident completed rehabilitation, per Resident #1's PCP recommendation. -The facility denied the hospitals request and discharged resident #1 on 1/31/25. -The case manager requested to speak with someone other than the RCC, as the hospital had no other options, than to look for an alternative assisted living bed. -On 2/12/25, the hospital nurse reached out again to speak with Administrator, but the Administrator was out of the building. -On 2/12/25, the RCC contacted the Administrator for confirmation of whether or not the patient would be considered for re-evaluation back to the facility. -On 2/13/25, the hospital's clinical case manager expected day notice for discharge to be delivered but it was not. Telephone interview with the hospital's clinical case manager on 3/6/25 at 11:38am revealed: -Resident #1 was going to be discharged back to the facility on 1/25/25 but was not released because the cardiologist changed her medication. -Resident #1 was cleared on 1/31/25 by the cardiologist. -Resident #1 was given the second hospital discharge on 2/4/25. -On 2/12/25, the facility declined to take Resident #1 back because they could not meet her needs. Telephone interview with the hospital's clinical case manager on 3/18/25 at 1:47pm revealed: -The resident was officially ready for discharge on 1/31/25. -The facility said they were not going to take her back on 2/12/25 and the search began to find another facility. -There was an approximate 40-day delay in discharge because the resident did not have another facility to go to. -There was two FL-2s in the medical records dated 2/5/25, assisted living and 3/3/25, skilled nursing. -A blister on top of Resident #1's foot had formed at the end of February 2025, which made her level of care skilled nursing. -The hospital was looking for both placement at adult care homes (ACH) and skilled care facilities simultaneously		

because ACH facilities were saying that on paper Resident #1 was skilled nursing level of care.
-Resident #1 discharged yesterday 3/17/25 to skilled care facility.

Telephone interview with Resident #1's PCP on 3/18/25 at 12:35pm revealed:
-He decided she needed skill nursing before this hospitalization but "put it on paper" on 1/30/25.
-She has been to the hospital multiple times for AFib and shortness of breath.
-On a previous hospital visit in January 2025 the hospital said she needed skill, but the hospital changed their mind.
-He decided Resident #1 was not appropriate for assisted living because she needed continuous monitoring.
-Resident #1 had multiple comorbidities that he felt Resident #1 would benefit from being in a facility with a nurse on duty 24 hours a day and not medication aides who are not qualified to manage Resident #1 complex needs.
-She was going into AFib more often, experiencing shortness of breath, prescribed 3 types of insulin, had 20 wounds, required possibly 2 person or more assistance, he felt she was suitable for rehab or a skilled nursing facility.
-Resident #1 was not at her baseline and needed a higher level of care.
-He never received a notification for discharge or an FL-2 from the hospital.
-The hospital said Resident #1 needed rehab and then would discharge her back to the facility but changed their minds, and she did not need rehab.
-Staff informed him when the hospital assessed Resident #1 it did not match up with what the facility would assess Resident #1.
-Resident #1 would be more dependent on staff than before she left.
-Since the medication aides were not nurses, therefore a skilled level would better manage her medical conditions.
-Skilled nursing staff were more trained to look for signs and symptoms of Resident #1's complex comorbidities.

Interview with the RCC on 2/18/25 at 10:50am revealed:
-The facility was not able to readmit Resident #1 because the hospital would not discharge her because a change of medication on 1/28/25.
-The facility could not meet Resident #1's needs which included two or more persons assist, issues with AFib, a pure wick catheter (a urinary catheter used to collect urine in a canister), and she was not at baseline.

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- She determined Resident #1 could return to the facility after completing the assessment on 1/27/25. -The hospital case manager called the facility on 1/27/25 to inform her Resident #1 had a medication change and was not ready for discharge. -The facility tried on multiple times (1/27/25, 1/30/25, and 2/4/25 to bring Resident #1 back. -She informed the hospital case manager on 2/12/25 the facility would not take Resident #1 back due AFib issues, diet, transferring, and wounds. -She intended to give Resident #1 a discharge notice. -She informed the case manager at the hospital she would send a discharge notice, but she was the only manager facility and was not able to go right away. Telephone interview with the RCC on 4/4/25 at 1:50pm revealed: -She received the FL2 for an upgrade to skilled on 1/31/25 but did not discharge immediately because she thought Resident #1 would go to rehabilitation and then Resident #1 could be readmitted. -She had to have the updated FL-2 whether she was going to rehabilitation or going to skilled. -She told the social worker at the hospital that Resident #1 would not be coming back to the facility on 2/12/25. Interview with the Administrator on 3/7/25 at 2:20pm revealed: -When staff went to the hospital to complete an assessment the resident was experiencing intromittent AFib. -Resident #1 was admitted to the hospital multiple times in the past few weeks for the same condition and this was the reason why the facility could not readmit. -The facility was not able to meet Resident #1's needs, but the hospital tried to get them to readmit her. -She was told on 2/3/25 by the facility's home health nurse the facility could not meet Resident #1's needs to be closely monitored. -She was told on 2/3/25 by the home health nurse that Resident #1 needed to go to rehab or skilled because home health could never do anything for her AFib. -Resident #1's PCP upgraded Resident #1 to skilled nursing on 1/30/25. -The PCP discussed Resident #1 by phone with the hospital nurse and received medical records to make his decision that Resident #1 needed skilled nursing. -She did not think a discharge would need to be completed if Resident #1 was upgraded.		

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-The social worker from the local hospital called to see if the facility would come and complete another assessment. -The RCC informed the hospital by phone Resident #1 would be discharged. -The RCC had no one to deliver the discharge notice to Resident #1 in person.		
Telephone interview with the Administrator on 3/13/25 at 2:10pm revealed: -Resident #1 was hospitalized on 1/20/25 leading up to the time the facility intended to discharge the resident on 2/12/25. -She had not delivered a discharge notice with appeal rights. -She intended to deliver a discharge notice on 2/12/25 but due to an emergency she was not able to do so. -She did not feel the need to deliver a discharge notice today since so much time passed. The facility failed to ensure a discharge notice and appeal rights were issued and delivered to Resident #1 while the hospital, resident and responsible party thought the facility was going to take the resident back. The failure resulted in the resident staying in the hospital unnecessarily for two additional weeks and is serious neglect and constitutes a Type A1 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on March 7, 2025. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED May 9, 2025.		

*** This is an amended copy of the CAR dated 4/9/25 which was amended after delivery on 4/9/25.

IV. Delivered Via:	Hand delivered	Date: 4/11/25
DSS Signature:	Mandi Moore	Return to DSS By: 5/1/25

V. CAR Received by:	Administrator/Designee (print name): Leslie Jackson	
	Signature: Leslie Jackson	Date: 4/11/25
	Title: ED	

VI. Plan of Correction Submitted by:	Administrator (print name): Leslie Jackson ED

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	Signature: Leslie Jack Sr - ED	Date: 5-8-25

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		
☑ *POC Accepted*	By: Jessi Moore	Date: 5-8-25
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.*		