Submitted by: Robert Taylor 6/23/2025 8:51:12 AM

Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Somerset Court of Goldsboro
Address: 603 Lockhaven Court, Goldsboro, NC 27534
County: Wayne
License Number: HAL-096-047

II. Date(s) of Visit(s): 04/24/2025, 05/13/2025, 05/15/2025, 05/19/2025, 05/21/2025, 05/22/2025, 05/29/2025, 05/30/2025
Purpose of Visit(s): Complaint Investigation

Exit/Report Date: _____

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(c) Personal Care and Supervision	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: 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: Type A1 Violation		
Findings: Based on record reviews and interviews, the facility failed to respond immediately to 1 of 1 sample resident (Resident #1) who was discovered unresponsive without a pulse and failed to administer cardiopulmonary resuscitation (CPR) to the resident who had a full code status. The rule was not met as evidenced by: Review of the facility's Accident/Incident Policy dated 09/2021, revealed:		

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- When an accident or incident occurs, staff should remain calm and not panic.
- Staff should remove the resident from danger, if possible, if resident is in immediate danger.
- Staff should send for or call for help.
- Staff should evaluate the situation.
- Staff should call 911 or have someone else call 911.
- Staff should check the resident for injuries.
- If severe injury is apparent or possible, staff should not move resident until Emergency Medical Services (EMS) arrive.
- Staff should determine if the resident is breathing, conscious and check for pulse.
- Staff should administer CPR as appropriate.
- Staff should first check Do Not Resuscitate Status.
- Staff should administer first aid as appropriate.
- Staff should continue emergency intervention until EMS arrives.
- A staff member must remain with the resident until EMS arrives.
- Staff should send the appropriate information with the resident.
- Staff should notify the residents' physician and responsible party.
- If injury, staff should complete the report of accident and incident form.
- If the incident requires intervention greater than first aid, the accident and incident report form should be sent to the local county department of social services within 48 hours.
- If the incident results in the death of the resident, complete the death reporting form and assure notification to agencies as required per state regulation.

Review of Unresponsive Protocol Training dated 04/17/2025, revealed:
- If a resident is found unresponsive staff should immediately check their code status for DNR.
- Code status can be found in matrix, the DNR binder in the medication room and the sticker on the resident's name plate.
- Staff should begin CPR if not DNR.
- Staff should call 911.
- Staff should contact the Administrator and Resident Care Coordinator.
- Staff should continue CPR until EMS arrives.

Review of Resident #1's current FL-2 dated 01/06/2025, revealed:
- Diagnoses included: Lack of coordination, Essential Hypertension, Autistic Disorder, Acute Respiratory Failure,

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Dysphasia Orophagnagul Phase, Other Abnormalities of Gait and Mobility, and Muscle Weakness.
- Resident #1 was ambulatory.
- Resident #1 was continent with bladder and bowel.
-Resident #1 had no orientation listed.
-Resident #1 did not reside on the Special Care Unit.
- Resident #1 was able to communicate his wants and needs verbally.

Review of Resident #1's Care Plan dated 03/10/2025, revealed:
- Diagnoses included: Vascular Dementia unspecified severity without behavioral disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, Acute Respiratory Disease and Intracranial Injury without loss of consciousness initial encounter admission.
- Resident #1 was full code status.
- Resident #1 was independent with toileting, ambulation, and transfers.
- Resident #1 required limited assistance with eating, bathing, dressing, and grooming.

Review of the hospital After Visit Summary dated 04/16/2025, revealed:
- Resident #1 had a kidney stone removed.
- Resident #1 was prescribed Cipro, Norco and Pyridium (an antibiotic, controlled substance pain medication used to treat pain in the urinary track and bladder.
- Resident #1 was ordered to continue all other medications.
- Resident #1 did not have any special treatment or care orders prescribed.
- Resident #1's next follow up appointment was scheduled for 04/29/2025 at 09:10am.
- If redness, tenderness, or signs of infection arise, contact MD.
- If resident's temperature was greater than 101.3 Fahrenheit, contact MD.
- Resident #1 should follow-up in 1 week for stent string removal.

Review of Resident #1's Incident and Accident Report dated 04/17/2025, revealed:
- The time of the incident was documented at 7:30 am.
- The location of the incident was Resident #1's bedroom.
- The description of the incident was documented as Resident #1 lying in bed unresponsive.
- The type of incident documented was medical unresponsive.
- Staff did not document any vital signs.
- Staff contacted 911.

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- The description of the call documented as advised not to move him and emergency medical services (EMS) was on the way.

Review of the local Wayne County 911 Event Report dated 04/17/2025, revealed:
- A call was received on 04/17/2025 at 7:46 am by the PCA.
- Dispatch arrived at the scene at 7:54 am.
- The caller stated a resident passed away this morning.
- Staff reported they walked in to check on him and he was unresponsive and blue.
- The notes stated, "obviously dead", "the patient is cold and stiff in a warm environment," and "the patient is unquestionably dead."
- Medic noted that the resident was dead upon arrival at 07:58 am.

Review of EMS Report dated 04/17/2025, revealed:
- EMS received the call at 7:46 am.
- EMS was dispatched at 7:48 am.
- Upon arrival Resident #1 was found lying on his right side.
- Facility stated Resident #1 was last seen 30 minutes prior to calling 911.
- Resident #1 had absent radial and carotid pulses and no heart tones could be heard.
- The time of death was called at 07:58 am for Resident #1.
- Care was transferred back over to the facility at time of death.
- The level of consciousness was documented as unresponsive.
- Impression documented as Cardiac Arrest.
- Initial Patient Acuity documented as dead without resuscitation efforts.

Review of PCA Employee Training Record on 05/22/2025, revealed the PCA did not have any current CPR certification in her employee record.

Review of the Supervisor Employee Training Record on 05/22/2025, revealed:
- The Supervisor was current in CPR.
- The Supervisor received CPR/First Aide certification on July 23, 2023.

Interview with a Personal Care Aide (PCA) on 05/15/2025 at 01:49 pm, revealed:
- She worked first shift.
- All DNR residents had a red heart sticker on the outside of their bedroom door.

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-Resident #1 did not have a red heart sticker on the outside of his bedroom door.
-Resident #1 was a full code.

Interview with a Medication Aide (MA) on 05/15/2025 at 02:17 pm, revealed:
- She works first shift.
-She had taken CPR when first hired at the facility on 7/23/24.
- All DNR residents had a red heart on their bedroom door.
- If an unresponsive full code resident was discovered, they were to call 911 and initiate CPR.
- Resident #1 lived at the facility for a long time and was like the mascot of the facility.

Interview with a PCA on 05/15/2025 at 2:39 pm, revealed:
- She works first shift.
- She had been working at the facility for almost 2 years.
- She had been given CPR when first hired at the facility.
- Staff must call 911 if they walk into a resident's bedroom and discover they are unresponsive.
- Staff would start CPR if they walked in and found an unresponsive full code resident.
- The residents that do not have a big red heart sticker on their bedroom door are full code.
- The resident's code status can be found on the resident's face sheet.
-She was working on the other side of the building and did not know what was happening.
-Resident #1 did not have a big red heart sticker on his bedroom door.
-Resident #1 was a full code.
-Staff members that were working that morning did not follow the policy and initiate CPR.

Interview with the Business Office Manager (BOM) on 05/15/2025 at 03:59 pm, revealed:
- When she arrived at work, the EMS truck was in the parking lot.
- Several staff members were witnessed crying in the hallway.
- Staff members were witnessed yelling out and very distraught.
- The Administrator had to send the PCA home who discovered Resident #1 because she could not stop crying.
- She did not know why staff did not initiate CPR.
- The Administrator had made everyone that worked at the facility retake CPR, even the staff who had recently taken it.
- Staff should know who full codes are because were provided with training.

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- Staff that worked directly with residents must know this. Interview with MA on 05/19/2025 at 7:48 pm, revealed: - She worked second shift. - She was working on 04/17/25, when Resident #1 was discovered. - She was not on that side of the building at the time Resident #1 was discovered. - The Supervisor and PCA were overheard yelling for help and crying. -She went down the hall to see what was happening and witnessed the Supervisor and PCA standing at Resident #1 bedroom door crying. - She was unsure why CPR was not initiated. - Everyone looked as if they were in such shock and disbelief that Resident #1 has expired. - Resident #1 was a full code resident. - Resident #1 never had a red heart on his door. - The red heart indicated a resident had a DNR order. - If there were no red heart then the resident is full code. - She had been trained in CPR by the facility. - She had been provided training on how to respond to an unresponsive resident. Interview with the Supervisor on 05/29/2025 at 2:51 pm, revealed: - She was working in the other hall passing out morning medications. - Resident #1 was last observed around 5 am fully conscious and asleep in his bed. - The aides were working in the halls doing their morning rounds. - She heard the PCA yell out somebody help me. - She locked up the medication cart and proceeded to the hall to where the PCA was standing. - The PCA was standing in the hall outside Resident #1's bedroom clearly upset. - When she asked the PCA what was going on, the PCA stated that Resident #1 expired. - When she looked in the room, Resident #1 was unresponsive. -She was CPR certified. - She had been trained annually in CPR. - She knew that CPR should have been initiated. -She knew that she should have initiated CPR. - Everyone was in such disbelief. - The PCA called 911.		

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- Resident #1 was very close to the staff members of the facility which caused everyone to be overtaking with so much grief that they could not think clearly in that moment.
- She has been trained on unresponsive protocol.
-She understood that she should have taken a pulse and checked for signs of life.
-She was unable to process what was happening.
- She was required to retake her training in both CPR and

Interview with Resident #1's Primary Care Provider (PCP) on 05/29/2025 at 3:17 pm, revealed:
- She received a call from the Administrator stating Resident #1 had passed away the morning of 04/17/25.
- She asked the Administrator if anyone attempted CPR.
- The Administrator stated that the staff could not get their emotions together and was too in shock to think clearly.
- She told the Administrator that CPR should have been attempted.
- Resident #1 had a minor procedure completed 24 hours before passing.
- Resident #1 did not have any type of increased monitoring following the procedure.
- She advised the Administrator that all staff members should be retrained on unresponsive protocols.
-She did not sign the death certificate because the medical examiner has to be the one to do it.

Interview with a PCA on 05/29/2025 at 03:33 pm, revealed:
- She was in the middle of making rounds.
- She went to Resident #1's bedroom to wake him up for breakfast.
- When she approached Resident #1's bedroom door and looked in, Resident #1's skin was observed to be a pale color.
- She could observe that Resident #1 had expired.
- She was in shock at what was observed.
- She went back out into the hall and started yelling out for help.
- She called 911 and told them that Resident #1 had expired.
- She explained to the 911 dispatch that Resident #1 was unresponsive and blue.
- She is certified in CPR.
- She knew Resident #1 code status was full code.
-She knew she should have checked Resident #1 for a pulse and sings of life.
- She knew that she should have initiated CPR.
- She was saddened and in shock over observing adult expired.
-She was unable to check for a pulse or initiate CPR because she was in shock at witnessing a expired body.

Interview with the RCC on 05/29/2025 at 4:19 pm, revealed:
- She received a telephone call at 09:00 am from the Supervisor stating Resident #1 had passed away.
- She was on the road in route to the facility at the time of the call.
- When she arrived at the facility, Resident #1 had already expired and was being prepared for transport to the local hospital morgue by EMS.
- She was unsure why staff did not initiate CPR.
- She understood how shock and grief can affect the staff's decisions that morning.
-The supervisor was CPR certified.
- All facility staff must take CPR and First Aid training when hired for employment.
- All facility staff must take unresponsive protocol training when hired for employment.
- The 911 dispatcher never instructed or verbally prompted the CNA to begin CPR.
-The facility staff had been trained to check for signs of life and if none found initiate CPR.
-It was not the job of the 911 dispatcher to tell staff members to start CPR.
-It would have helped if 911 had reminded the staff members.
- Staff on duty knew Resident #1 was a full code.
-Staff on duty should have checked for possible signs of life.
- Staff on duty should have initiated CPR.
- Every resident has a face sheet with their code status information listed.
- The status code was listed on the resident's bedroom door.
- A red heart on the resident's bedroom door means Do Not Resuscitate (DNR).

Interview with the Administrator on 04/24/2025 at 11:05 am, revealed:
- Resident #1 had kidney stone removal procedure completed on 04/16/2025.
- Resident #1 did not have any special restrictions.
- Resident #1 did not have any changes in diet.
- Resident #1 ate dinner and then went for a walk around the community.
- Resident #1 took all evening medications with no complaints.
- The Supervisor called her on 04/17/2025 and stated that Resident #1 had passed
- Staff reported to the administration that Resident #1 was last seen at 5:00 am.

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- 911 was contacted and staff were informed to leave the adult where he was.
- The staff was transferred to a non-emergency number.
- Once the paramedic arrived, Resident #1 was pronounced deceased.
- Resident #1's emergency contact was contacted.
- Resident #1 was a full code.
- Staff members were in shock and 911 failed to prompt them to begin resuscitation.
-She understood that it was not the job of the 911 dispatch to instruct her staff on what to do.
-Staff members knew that they are to check for pulse and signs of breathing when a unresponsive resident is discovered.
-Staff members knew that if the resident has no DNR and is discovered without signs of life, CPR should be imitated.
- Staff members had 3 different ways to know if a resident was full code or not.
- DNR residents had a heart sticker on the outside of their bedroom door.
- An in-service on unresponsive protocol steps was completed the next day, 04/17/2025.
- Staff were distraught due to Resident #1 being a long-time resident.
- Staff did not initiate CPR as they should have.
- The Administrator understood how the staff felt witnessing Resident #1 deceased and why they were too upset to initiate CPR.

The facility failed to provide CPR for a resident was a full code in accordance with their policy and procedures for an unconscious resident who subsequently expired. This failure resulted in serious neglect and constitutes and Type A, Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on <month> <date>, 2025, for this violation.

The correction date for the Type A1 Violation shall not exceed **** , 2025.

IV. Delivered Via:	Hand Delivered	Date: 6/20/25
DSS Signature:	Robert J. Taylor, SCIII, AHS	Return to DSS By: 8/4/25

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- 911 was contacted and staff were informed to leave the adult where he was.
- The staff was transferred to a non-emergency number.
- Once the paramedic arrived, Resident #1 was pronounced deceased.
- Resident #1's emergency contact was contacted.
- Resident #1 was a full code.
- Staff members were in shock and 911 failed to prompt them to begin resuscitation.
-She understood that it was not the job of the 911 dispatch to instruct her staff on what to do.
-Staff members knew that they are to check for pulse and signs of breathing when a unresponsive resident is discovered.
-Staff members knew that if the resident has no DNR and is discovered without signs of life, CPR should be imitated.
- Staff members had 3 different ways to know if a resident was full code or not.
- DNR residents had a heart sticker on the outside of their bedroom door.
- An in-service on unresponsive protocol steps was completed the next day, 04/17/2025.
- Staff were distraught due to Resident #1 being a long-time resident.
- Staff did not initiate CPR as they should have.
- The Administrator understood how the staff felt witnessing Resident #1 deceased and why they were too upset to initiate CPR.

The facility failed to provide CPR for a resident was a full code in accordance with their policy and procedures for an unconscious resident who subsequently expired. This failure resulted in serious neglect and constitutes and Type A, Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/01/2025, for this violation.

The correction date for the Type A1 VIOLATION SHALL NOT EXCEED 08/04/, 2025.

IV. Delivered Via:	Hand Delivered	Date:	6/20/25
DSS Signature:	Rebecca Lyles, SCOIII, AHS	Return to DSS By:	8/4/25

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Facility Name: Somerset Court of Goldsboro

V. CAR Received by:	Administrator/Designee (print name):	
	Signature: Susie Buckland	Date: 6/20/25
	Title: DOC	

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:		
☐ *POC Accepted*	By:	Date:
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.*		

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AHS Facility Report

Purpose of Visit:

☑ **Monitoring** ☑ **Complaint Investigation** ☐ **Complaint Investigation Summary** *(see Attachment B))*

☐ **Deliver CAR** ☐ **Follow Up to CAR issued on:** _____ ☐ **Technical Assistance**

☐ **Deliver Correspondence** ☐ **Death Investigation** ☐ **Other:** _____

Date Onsite: 05/20/2025 **Time:** 12:30 PM **Previous Onsite Date:** 05/15/2025

County: Wayne	**Facility:** Somerset Court of Goldsboro	**License #:** HAL-096-047

Address: 603 Lockhaven Court Goldsboro, NC 27534

Administrator/Designee: Kristen Lynn

Section A: **Current Census:** **Sample Size:** ☒ **Unannounced Visit**

Section B: *Complete this section during onsite visit*

Rule Number: 10A NCAC 13F .0901 Unknown Death **Description:** Personal Care and Supervision	☑ Observations	☑ Interviews	☑ Record Reviews
	☐ No Deficiency	☐ Deficiency	☑ CAR to be Issued
	☐ Plan _____		
Rule Number: **Description:**	☐ Observations	☐ Interviews	☐ Record Reviews
	☐ No Deficiency	☐ Deficiency	☐ CAR to be Issued
	☐ Plan _____		
Rule Number: **Description:**	☐ Observations	☑ Interviews	☑ Record Reviews
	☐ No Deficiency	☐ Deficiency	☐ CAR to be Issued
	☐ Plan _____		

Section C: *Brief Description of Visit/Discussion With Staff in Charge*

Based on Observations, Interviews, Record Reviews the facility failed to assure that staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This constitutes an TYPE A Violation.

Section D: *Signatures*

Administrator/Designee: Susie Strickland	**Date:** 05/21/2025
Adult Home Specialist: Robert J. Taylor, SW III, AHS	**Date:** 05/21/2025

Check if Attachment: _____