Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Caremoor Retirement Center
Address: 4876 Caremoor Place Concord, NC 28081
County: Cabarrus
License Number: HAL-013-052

II. Date(s) of Visit(s): 07/18/25, 07/23/25, 08/11/25
Purpose of Visit(s): CI #20963
Exit/Report Date: 09/17/25

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 .0902(b)/Health Care	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.		
Level of Non-Compliance: Type A2 Violation		
Findings: This rule is not met as evident by: Based on record reviews, observations and interviews, the facility failed to ensure referral and follow-up for 1of 3 sampled residents (Resident #1), who had orders for physical therapy (PT), occupational therapy (OT), wound care and speech therapy (ST), upon discharge from the hospital that were discontinued upon return to the facility, without notifying the Primary Care Provider (PCP). The findings are: Review of the facility's policy "Referrals" revealed: - When a provider made a referral, employees were to fax the referral to the designated office and keep a copy of the original in the resident's chart.		

- If the facility did not receive a call back after 2 business days, a supervisor was supposed to reach out to the referral office and confirm receipt of the referral.
- After confirmation of receipt of the referral, this document and follow-up was to be put in the resident's chart.
- Once an appointment was established, appropriate transportation, if required was to be coordinated.
- Any follow-up from the referral must be followed, and any new medication must be faxed to the pharmacy immediately so that they could be added to the resident's medication administration record (MAR).
- If the resident or the responsible party (RP) refused said referral, this must be documented, the referring provider must be notified, and the order discontinued.

Review of Resident #1's current FL2 dated 07/01/25 revealed his diagnoses included vascular dementia, diabetes mellitus type 2, dysphagia, muscle spasm of back, hypertension, muscle weakness, anxiety, depression and other seizures.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 04/23/25.

Review of Resident #1's current care plan dated 07/01/25 revealed the resident required assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring.

Review of Resident #1's hospital ED note dated 06/16/25 revealed he was evaluated after an episode of unresponsiveness at his facility and was admitted.

Review of Resident #1's hospital Discharge Summary dated 06/20/25 revealed:
- There was an order for PT and OT and the document noted services would be resumed by the previous home health agency.
- There was an order for home health skilled nursing and the document noted services would be resumed by the previous home health agency.
- Home health services for skilled nursing wound care were to include observation and assessment with medical education and management, education on wound care, monitoring for healing.

Review of Resident #1's record revealed there was no documentation of PT, OT, or skilled nursing service being provided upon return to the facility on 06/20/25.

Telephone interview with Physical Therapist Assistant (PTA) with home health agency on 08/19/25 at 3:00pm revealed that on 06/26/25, he went to the facility to complete an assessment to resume services, and the Resident Care Director (RCD) turned him away and told him the home health agency's services were not needed.

Review of Resident #1's hospital admission note dated 07/05/25 revealed:
- Resident #1 was admitted with multiple chief complaints, including sepsis, hypothermia, acute hypoxemic respiratory failure, and lower left lobe pneumonia.
- Resident #1 was observed to have a left toe wound, a right heel ulcer, and a stage III sacral wound.
- A speech therapy consultation was referenced to rule out aspiration.

Review of Resident #1 hospital Discharge Summary dated 07/09/25 revealed:
- There was no order for skilled nursing services for wound care.
- There was an order for speech therapy to "address swallowing deficits".
- Rehabilitation potential was fair and documented complexity/comorbidities as pulmonary compromise (a condition where the lungs ability to function properly was compromised), severity of condition, and oropharyngeal dysphagia (a swallowing disorder that involves difficulty moving food and liquid from mouth to throat).
- A no textured diet was documented.
- Resident #1's family requested comfort feedings.

Review of Resident #1's record revealed there was no documentation of home health ST services being provided upon discharge from the facility on 07/09/25.

Review of Resident #1's hospital ED provider note dated 07/21/25 revealed:
- Resident #1 was evaluated in the ED due to altered mental status for 2 hours and decreased responsiveness and hypotension (low blood pressure).
- The provider documented Resident #1's left heel ulcer was "quite malodorous" (smelling very unpleasant) and they swabbed it for culture.

Review of Resident #1's hospital progress note dated 07/23/25 revealed:

- Resident #1 had cellulitis of left heel, which had a stage III pressure injury (a wound with full thickness skin loss). - Resident #1's left lateral foot had a non-stageable injury, and Resident #1 was being seen by wound care for treatment. Review of Resident #1's hospital discharge summary dated 07/30/25 revealed: - Resident #1 was admitted for pneumonia of left lower lob due to infectious organism. - Resident #1 experienced an episode of aspiration on 07/26/25 during comfort feeding with associated decreased responsiveness. - An inpatient consult was made for wound care assessment. - There were no orders written for any home health services at the time of discharge. - Resident #1 was sent back to his facility on 07/30/25 with hospice services in place. Telephone interview with the Scheduler Coordinator with Resident #1's home health agency on 08/19/25 at 2:30pm revealed: - Between 06/20/25 and 07/30/25, no home health services were provided to Resident #1. - On 06/21/25, resumption of care orders for Resident #1 were received for PT and OT and an initial order was received for skilled nursing for wound care. - On 06/24/25, a telephone call was made to the facility to discuss resumption of services and the RCD refused resumption of care and stated Resident #1 started services with the facility's preferred home health agency. - The RCD told her that Resident #1 was disoriented times three and dependent with all mobility and self-care at that time. - On 06/26/25, a new PTA from the agency went to the facility to resume services for PT with Resident #1, because he was not aware the facility had refused all services to the agency. - The RCD informed the physical therapist that Resident #1 had been assessed and started services with their preferred home health agency and directed him to leave the facility. - The home health agency never received a referral for ST. - No other orders were received after 06/21/25. - The home health agency did not receive any physician's orders to discontinue any of the services (PT, OT or skilled nursing services for wound care) that they had orders to provide to Resident #1. -The agency closed all services for Resident #1 after the RCD refused services on 06/26/25.		

- Skilled nursing services for wound care were never implemented due to the RCD's refusal of services on 06/26/25, and no initial evaluation for wound care was completed. Telephone interview with hospital Case Manager, on 07/24/25 at 10:20am revealed: - On 06/21/25, the hospital submitted a referral to the same home health agency that had previously worked with Resident #1, to resume for physical therapy and occupational therapy, and, to initiate wound care services for the first time. - On 07/05/25, Resident #1 was readmitted to the hospital and discharged on 07/09/25 with orders for speech therapy. - A referral was made to the same home health agency that had previously provided therapy to Resident #1, but this time the referral was for speech therapy; there were no orders for PT, OT or wound care on 07/09/25. - On 07/21/25, Resident #1 was readmitted to the hospital and was currently still inpatient. Telephone interview with the Clinical Care Coordinator of the facility's preferred home health agency on 08/21/25 at 2:15pm revealed: - The agency did not provide any home health services to Resident #1 between 06/20/25 and 07/30/25. - On 06/01/25, the hospital sent referral information for PT and OT; skilled nursing services were not included. - The referral was declined because it appeared that the hospital was seeking information regarding if Resident #1 was current with the home health agency, and the agency notified the hospital that Resident #1 was not receiving services from them. - The agency did not hear anymore from the hospital and service was not initiated for Resident #1. -On 07/02/25, at 9:02am a note was entered that the facility contacted the agency and explained that Resident #1 had been receiving services from another home health agency, but the facility wanted to switch his service to their agency. - On 07/02/25 at 9:57am, there was documentation in their system that the facility said they would have a face to face with the facility doctor and send the demographic sheet to the agency to initiate services. - The facility stated that they only wanted to work with their home health agency. - The agency received two orders from the facility: the first order documented change diet to soft mechanical while waiting on ST evaluation, and the second order was for ST for evaluation to assess and treat, due to Resident #1 having difficulty swallowing and frequent coughing.		

- The agency asked the facility for additional information but never received the information. -On 07/07/25, the agency followed protocol by closing the referral after 5 days due to the facility's failure to send the additional information. - They did not receive a referral for ST on 07/09/25. Telephone interview with a medication aide supervisor on 08/11/25 at 11:00am revealed: - In June 2025, Resident #1 returned from the hospital with orders for a home health agency to provide PT for Resident #1, but the facility did not use the agency to which the referral was made, because they only dealt with one preferred home health agency. - She recalled on 06/26/25, she was told by the RCD that a representative came to provide home health services to Resident #1, from the home health agency to which the hospital made the referral. - The RCD directed the representative to leave because a referral had been made to the facility's preferred agency, and they were waiting on that agency to begin services. - After the RCD told the original home health company they could not return to the facility, she reached out to the facility's preferred home health agency on several occasions and faxed a face sheet for Resident #1 and progress notes, to start the process of getting their services implemented for PT, OT, ST and wound care; however, Resident #1 kept going back to the hospital before they could begin services. - She did not have any documentation of fax confirmation of attempts to start service with the facility's preferred home health agency, documentation of what she faxed, or documentation of the dates she sent the order to the agency. -She spoke with a case manager at the preferred agency several times after making the referral for Resident #1 and was told that more information was needed. - The facility's preferred home health agency said they could not use progress notes from the facility to implement services and must have documentation from the most recent hospitalization to implement services because he was admitted for more than 5 days in the hospital. - She had not been successful in obtaining the documentation needed from the hospital because Resident #1 was in and out of the hospital so much. - She thought the home health referral the facility made for Resident #1 was for wound care and ST to address his swallowing, but she was not certain.		

- In total, Resident #1 went back and forth to the hospital "4 or 5 times between June and July" while the facility was waiting on the preferred agency to initiate services for Resident #1.
- When residents returned to the facility from the hospital, she was responsible for reviewing the discharge summary and sending the summary to the pharmacy to review medication changes and following up regarding any home health services.
- It was her responsibility to ensure any new orders were implemented.
- Around the time Resident #1's home health services were discontinued by the RCD, there was a new nurse practitioner (NP) who started seeing residents in the facility.
- Since the NP had not yet seen Resident #1, it slowed down the process of being able to get new orders written for home health services by the facility's preferred home health agency.
- When Resident #1 was discharged from the hospital, the NP was on vacation that week, and she saw him the following week and made a referral for home health, but he went right back to the hospital that week, before the order could be implemented.
- She communicated with the facility's Registered Nurse (RN) and the NP regarding Resident #1's skin breakdown and informed them that a referral had been made to the facility's preferred home health agency, and they were waiting on them to open services to assess him.

Interview with RCD on 07/23/25 at 11:00am revealed:
- About one month ago, a physical therapist provider from Resident #1's original home health agency came to the facility to provide therapy to Resident #1.
- She informed the physical therapist the facility did not use their agency for services and that Resident #1 already received services from another agency, and informed him he was not to return to the facility to provide services to Resident #1.
- She spoke with a supervisor of the home health agency, and they informed her that they had provided services to Resident #1 for about a month.
- She was not aware the home health agency had been providing services to Resident #1 at the facility.
- She informed the supervisor their services were no longer needed because the facility had a preferred home health agency, and this was the only agency they allowed to provide services to residents of the facility.
- She thought she recalled after the original home health company discontinued services, they had reached out to the NP for a new order for home health services for Resident #1, but by the time it came, he was in the hospital again and the order was no longer valid.

- She did not know the date of when the facility may have reached out to the NP for a new order. - She did not follow up with the MA supervisor to ensure a new order was obtained from the facility's NP, or that the facility's preferred home health agency received an order to initiate services. - She was unaware that the facility's preferred home health agency never received an order from the facility NP to initiate services for Resident #1. - The facility MAs and the MA supervisor provided wound care for Resident #1 during incontinence care. - She was not aware Resident #1 was sent home with an order for a condom catheter to help keep his sacral area dry, until the Adult Home Specialist asked about it on 07/18/25. - The pharmacy should have received an order for the condom catheter and sent it to the facility. - The condom catheter should have come in from the pharmacy last night, but it had not yet arrived. - Resident #1 had been in and out of the hospital so much since June 2025, which prevented home health services from being initiated. Interview with the Resident Care Director on 09/15/25 at 11:40 am revealed: -The home health agency that the facility used was the only agency utilized because in past experiences people had walked into the facility pretending to be home health staff trying to get residents social security numbers. - The main purpose of utilizing the same home health agency was for the safety of the residents. - She had seen home health agencies walk in the facility for 5 minutes and walked out saying they did physical therapy with a resident, but the resident was in their room asleep. - Resident #1's physical therapist never signed in on the kiosk, nor made themselves known to staff, which was an example of why she preferred to only deal with one home health agency. - The facility did not have a formal process of switching providers. - There was no policy regarding which home health agencies were allowed to provide services, but the facility tried to keep it small for the sake of the residents. - If a doctor from outside wrote an order and wanted a specific provider, they would go with that provider. - The facility notified families when providers were changed or switched via phone call, mail or email. - One of the two MA supervisors were supposed to follow up on home health referrals by faxing the order along with a face		

sheet and documentation from the provider explaining why the resident needed the service.
- The home health agency would usually call to acknowledge receipt of the order within a day or two, and then they would send someone out to complete an evaluation.
- Because Resident #1 was in and out of the hospital so much in June 2025 and July 2025, it made getting a different home health provider involved more challenging.

Interview with facility Registered Nurse (RN) on 08/19/25 at 11:05am revealed:
-She conducted a body assessment when Resident #1 was admitted to the facility in April 2025 and observed he had a couple abrasion from falls, wounds on his right and left heels with skin missing, that were possibly a stage one or two.
- His big toe and the toe next to it had been amputated.
- She did not assess any major skin concerns on his buttock at admission.
-When Resident #1 returned from hospitalizations, she assessed his wounds.
- She assessed his buttock each time he returned to the facility to make sure there was no skin breakdown.
- After his 3rd or 4th hospital visit in June 2025 and July 2025, she assessed the wound on his buttock to be worsening.
-She reported staff at the facility got him up "a few times" and turned him and propped him up with pillows.
- Resident #1's arms and legs were always very stiff.
- She noticed the wound on Resident #1's buttock was larger and opened.
-She recalled she asked staff about an order for wound care, and they told her the MA supervisor had informed them they "made an order" and were waiting for the home health agency to begin services.
- The MA supervisor reported she had sent the required documentation to the home health agency to implement services, but then Resident #1 would end up back in the hospital and they would have to start the whole process over.
-She was aware that initially, Resident #1 had another home health agency involved and the RCD told them their services were not needed, but she did not know the specifics of this.
-Her job was to assess residents and make recommendations on how to address their needs.
- She never documented her recommendations in writing when she assessed residents and instead informed the MA supervisor and RCD when she had recommendations.
- She did not review orders for home health services or other physician's orders and relied on the MA supervisors and RCD to do this.

- Initially, she recommended PT, OT, and wound care for Resident #1's feet and the heels of his feet as well as ST because he was aspirating.
- It was not until June 2025 or July 2025 that she recommended to staff to have home health assess the residents' buttock to determine if there was something more they should be doing.

Telephone interview with NP at 08/26/25 at 11:29am revealed:
- On 07/01/25, the RCD called her and informed her that the hospital referred Resident #1 for home health for PT and OT, but home health never came to the facility to assess him.
- She was new to providing services to the facility and 07/01/25 was her first face to face visit with Resident #1.
- On 07/01/25, she read Resident #1's hospital discharge summary in detail but did not have access to his hospital records, which covered much more than the discharge summary.
- On 07/01/25, staff asked her to write an order for home health for PT and OT for increase strength and mobility following an acute hospital stay.
- She also wrote an order for ST because she was most concerned about Resident #1's risk of aspiration.
- Resident #1 was too weak to manage his inhaler, so she was very concerned about the risk of aspiration.
- She did not realize he had a wound until a later hospitalization, and staff never asked her for a referral for wound care.
- It was her expectation, that once she wrote an order for home health services, the facility staff were supposed to fax it to the home health agency, and home health should see the resident within a week, and if not, the facility should follow up with the home health agency.
- It was her expectation that when facility staff observed wounds, they should notify her immediately, by phone.
-If she had been aware Resident #1 had wounds, she would have ordered home health for nursing and wound care to evaluate and treat Resident #1.
- Resident #1 was at risk for having worsening wounds by not having skilled nurse service involved to treat the wounds accordingly.
- Because she had not seen Resident #1's wounds and he was a new patient to her, she was unsure if, or how much, the wounds had progressed.
- She received a call on or about 07/11/25 from a MA stating that Resident #1 needed a condom catheter.
- The MA stated Resident #1 was released from the hospital without a condom catheter and requested a verbal order for the

condom catheter and she signed it upon her return to the facility.
- She was unclear regarding who would be responsible for providing the condom catheter; would it be the pharmacy, a company, or home health once they got involved.
- When residents returned to the facility from a hospitalization, she determined what home health services were needed based on her own assessment, input from staff and their observations and from the resident's discharge summary.
- Resident #1 returned from the hospital on 07/29/25 with hospice services in place, so she did not see him again after his return.

Interview with the Administrator on 09/15/25 at 11:55am revealed:
-Working with the preferred home health agency was a preference because they had an established working relationship with them for years, even prior to her employment with the facility.
-The preferred home health agency communicated well, their documentation was good, and they delivered supplies timely.
-The preferred home health agency responded to the facility and residents' needs, and they did not allow things to fall through the cracks.
-The facility did not have a formal policy to address switching providers.
-If there was a resident that had a third-party vendor that was not meeting the needs of the resident and it resulted in a resident care issue, the facility would contact the resident's responsible party to see if they could switch.
- If the family said no, the facility would follow up with the third-party vendor and ask that they meet the needs of the resident in the way that the facility's provider felt was medically acceptable.
- The facility had experienced third party vendors who came into the facility, would not announce themselves, and would try to open services for other residents in the facility.
- Working with a preferred provider allowed them to have better control over who was coming and going in the facility, as the preferred provider always communicated that they were coming to the facility, announced when they were in the facility, and communicated the needs of the residents.
- When a change in vendors was made at the facility's request, the facility would notify residents' responsible parties.
- Whenever the facility's NP made a referral to the preferred home health agency, they would follow up on the referral without delay.

- When a referral was made at request of the facility, staff would reach out to the preferred home health agency to confirm receipt of the referral, follow up with the provider, and communicate if the provider had not been to see the resident within 2 business days.

Interview with the Administrator on 09/17/25 at 5:03pm revealed:
- She was unaware Resident #1 had orders for physical therapy, occupational therapy, speech therapy and skill nursing services.
- She was unaware the RCD had stopped Resident #1's original home health agency from providing services to him, resulting in a lapse in services for Resident #1.
- She was unaware of the timeframe of when the home health agency stopped providing services to Resident #1 and when a new order was requested from the facility's NP.
- Typically, she would not be informed of orders for each resident and she "did not know" every resident need, care, or order, and she "did not have the capacity to keep up" with this.
- There had never been an issue in the past with a resident changing providers and there being a lapse in the transition process.
- There was no policy in place that outlined a process for changing home health agencies while services were being provided to a resident.

Attempted telephone interviews with Resident #1's hospitalist on 08/25/25 at 3:49pm, 08/29/25 at 10:15am and 09/02/25 at 12:00pm were unsuccessful.

The facility failed to ensure Resident #1's healthcare needs were met by not ensuring a new home health agency was implemented after terminating his services with the original home health agency, for OT, PT, skilled nursing wound care for multiple wounds, and speech therapy to address swallowing deficits. This failure resulted in Resident #1 experiencing worsening wounds, including on 07/07/25, a "deep tissue injury" wound to his right heel, a non-stageable wound to his left heel, wound on his lateral left foot left toe wound, and a stage III sacral wound, present on admission; on 07/23/25, Resident #1 was diagnosed with cellulitis of left heel, which had a stage III pressure injury; and during hospitalization from 07/21-25 -07/30/25, Resident #1 was diagnosed with pneumonia and aspiration into respiratory tract. This failure resulted in substantial risk of injury and neglect of a resident and constitutes an A2 Violation.

CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 17, 2025. The facility provided a plan of protection in accordance with G.S. 131-34 on 07/23/25.		

IV. Delivered Via:	Certified mail and hand delivery	Date: 09/19/25
DSS Signature:	Rosalend Brown	Return to DSS By: 10/10/25

V. CAR Received by:	Administrator/Designee (print name): Madison Scarborough
	Signature: Madison Scarb Date: 9-19-202
	Title: Administrator

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.*		