Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Brookdale Durham
Address: 4434 Ben Franklin Blvd
Durham, NC

County: Durham
License Number: HAL:032-065

II. Date(s) of Visit(s): 09/18/2025, 09/11/2025, 09/12/2025, 08/29/2025, 08/26/2025, 08/22/2025

Purpose of Visit(s): Complaint Investigation NC 00233107
Exit/Report Date: 10/17/25

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 Corrective Action Plan. 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, Unabated Type B, Citation)* • *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 Rule/Statutory Reference: Personal Care and Supervision (c) 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 A1Violation Based on interviews and record reviews, this facility failed to respond immediately to 1 of 5 sampled Resident #1 after the Resident activated his emergency pendant immediately following a fall, which resulted in the resident being hospitalized and placed in rehabilitation. The Findings are: Review of the facility's Policy on Resident Call System and Door Alarm Response dated 05/2023 revealed: -Staff should respond to resident call system alerts and door alarms in a reasonable and timely manner. 1. Review of Resident #1's current FL-2 dated 06/05/25 revealed:	☐ POC Accepted _____ *DSS Initials*	

-Diagnoses included Type 2 diabetes, hypertension, Alzheimer disease, hyperlipidemia, chronic kidney disease, and GERD.
-Resident #1 was ambulatory, using no devices for assistants.

Review of a local emergency medical services (EMS) report dated 08/22/25 revealed:
-EMS was called to the facility on 07/04/25 at 1:37am by Resident #1's family member.
-EMS arrived at the facility on 07/04/25 at 1:48am but did not see Resident #1 until 2:05am and did not transport Resident #1 to the local hospital until 2:37am.
-EMS was outside of the facility waiting for the facility's staff to come to the front door.
-No one came but the door opened.
-EMS walked into the facility and went to Resident #1's room.
-Resident #1's door was locked but Resident #1 was alert and communicated with EMS through the door.
-He fell and hurt his hip, and he could not get to the door to open it.
-EMS attempted to find facility staff but no staff were found.
-Upon arrival of EMS, a staff came to the lobby and radioed another staff for a key to Resident #1's room.
-Once the key was obtained access was made.
-Resident #1 was found sitting on his bed.
-Resident #1 stated he went to the bathroom and on the walk back to his bed he had a fall.
-Resident #1 was able to crawl to his bed and then tried to use his medical emergency necklace to activate 911 but it did not work.
-Resident #1 then called family and they called 911.
-Resident #1 stated the fall happened at 1:00am.
-Upon full head to toe exam, Resident#1 had no other abnormalities besides left hip pain.
-Resident #1 was assisted onto a stretcher and taken to the ambulance.
-Once inside the ambulance Resident #1 rated his pain a 4/10.
-Resident #1 was offered pain medication but declined.
-Resident #1 was transported to the local hospital.

Review of Resident #1's local discharge summary dated 07/04/25 revealed:
-Resident #1 presented with left hip pain after a mechanical fall in his bathroom overnight.
-He got up to use the bathroom and lost his balance, falling on his left hip.
-He did not have dizziness, chest pain or any other symptoms prior to the fall.

-He did not hit his head and did not lose consciousness.
-He immediately had pain in his left hip and was unable to get up.
-He pressed his alert necklace button but did not get a response from facility staff.
-He crawled back to his bed and called his family on the phone.
-The family attempted to reach staff by phone but was unable to do so, so she called local EMS.
-When the EMS arrived at the facility, they were unable to locate staff for about 20 minutes and were about to break down Resident's door when staff arrived to let them into his room.
-He was transported to the local Emergency Department, (ED)for further care.

Review of Resident #1's discharge summary from the local hospital dated 07/08/25 revealed:
-Resident #1 was admitted to local hospital on 07/04/25 for a left pelvis fracture after mechanical fall.
-He was then discharged on 07/08/25 to a rehabilitation center for physical therapy.

Review of Resident #1's discharge summary from a local rehabilitation dated 08/11/25 revealed Resident #1 was discharged from the local rehabilitation center back to the facility.

Review of facility's progress notes for Resident #1's revealed:
-On 07/04/25 the resident had an unwitnessed fall that occurred at 1:00am in his room, near his bed.
-The first person on the scene following the fall was the EMS.
-Resident #1called his family member while the MA was at the front desk.
-When she came back, EMS staff had arrived and asked if she could open room #101. When MA opened the door of Resident #1's room, he was lying on the bed saying, "he needed help and stated he had fallen".
-EMS checked his vitals and the resident said that he thought he hurt his hip.

Interview with Resident #1's family member on 08/27/25 at 1:57pm revealed:
-The weekend of 07/04/25 at 1:00am Resident #1 had a fall.
-Resident #1 was lying on the floor for an hour pushing his pendant several times and no one responded.
-He was able to crawl to his bed and called another family member who then called EMS.
-He kept her on his telephone while EMS was at his door

talking to him.
-She could hear local EMS tell Resident #1 that they would have to break down the door to get to him.
-EMS called the local law enforcement; they too walked around the building looking for staff.
-She received a telephone call from Medication Aide on that shift informing her that Resident #1 had a fall and that his medical alert button was broken.
-The Administrator informed her the medical alert was not broken and that staff did not have walkie talkies.
-Because of the fall Resident #1 had a fractured hip and was in rehab for a month.

Interview with Resident #1 on 08/22/25 at 1:21pm revealed:
-He was coming from his bathroom when he tripped and fell into his apartment.
-He used his pendant to call for help but no staff responded.
-He was not sure of the time.
-He lay on the floor for an hour pushing his pendant and no one responded.
-He was in a lot of pain in his left hip.
-He finally was able to crawl to his bed and call his family member who then called EMS.
-EMS told him they would have to call the local law enforcement to break down the door.
-Finally, someone unlocked the door, and he was able to get medical service from the local EMS.

Interview with a Medication Aide (MA) on 09/22/25 at 8:50 am revealed:
-She was the MA for third shift working from 11:00pm to 7:00am on 07/03/25 going to the morning of 07/04/25.
-She did not recall any falls on her shift.

Interview with a second MA on 10/09/2025 at 1:45pm revealed:
-Staff members who worked on the floor were assigned a radio.
-Staff members were required to keep the radios with them while they were on the floor.
-There had not been a time when the facility did not have working radios for the staff.

Interview with a Personal Care Aide (PCA) on 09/22/2025 at 8:53am revealed:
-She was a PCA that worked 3rd shift on 07/03/2025 going to the morning of 07/04/2025.
-She always worked on the 2nd floor of the building on the assisting living side.

-The facility would have one MA for the entire facility at night.
-There would be one PCA for second floor, one PCA for 3rd floor and two PCAs' for Special Care Unit.
-She did not know anyone came into the building during 1:00am because she was on the 2nd floor.
-She had her radio, but no calls came through for assistance during 1:00am.

Interview with a second PCA on 09/18/25 at 5:18pm revealed:
-He worked 3rd shift and on the 3rd floor as a PCA.
-He did not recall a fall that occurred during the 3rd shift of 07/03/2025 to 07/04/2025.
-He informed the front desk was supposed to have staff monitoring until someone comes in the next morning.
-The front desk was required to be monitored from 11:00pm to 12:00am by a MA, then from 12:00am to 1:00am
-A PCA from the 2nd floor would then monitor the front desk from 1:00 am to 2:00 am.
-A SCU staff would monitor the front desk from 2am to 3am.
-From 3am to 4am then 3rd floor PCA watches the front desk.
-The third shift MA would do an extra hour at the front desk if needed.

Interview with the Assistant Administrator on 10/09/2025 at 2:25pm revealed:
-The facility had issues with the call bell after 8:00pm every night and on weekends.
-There was no one at the front desk to respond to the pendants and call bells after 8:00pm on the weekdays and weekends.
-She did not know who was supposed to sit at the front desk to get the calls.
-She was not sure if one staff member per shift was supposed to sit at the front until 8:00am when someone came in the next morning.
-The front door was locked at 8:05pm automatically and if someone came after 8:05pm to the front door to get in, they would have to push the outside button.
-The outside button prompted the front desk telephone to ring; therefore, staff at the desk must answer the call and let someone in the front door.

Interview with the Administrator on 08/29/2025 at 5:00pm revealed:
-He only talked to the daughter, but he had not talked to any of the staff who worked third shift that morning when the event occurred.
-He spoke with the daughter by telephone on 07/04/25 at 2:18pm.

-He listened to the family about their concerns. -Staff are supposed to check the front desk call system every 15 minutes to make sure no residents' call bells are not missed. The facility failed to respond immediately to an incident involving 1 of 5 sampled residents (Resident #1) who did not receive prompt and appropriate emergency care after activating his emergency pendant following a fall which resulted in a pelvic fracture. This failure resulted in a delay in EMS being able to examine the resident. The failure of the facility resulted in serious physical harm and neglect, which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 August 29, 2025, for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMEBER 16, 2025.		

IV. Delivered Via:	Emailed	Date: 10/17/25
DSS Signature:	Jo Ann Hooper	Return to DSS by: 11/07/25

V. CAR Received by:	Administrator/Designee (print name):
	Signature: Date:
	Title:

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:	

Facility Name:

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.*		