Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Charlotte Assisted Living
Address: 9120 Willow Ridge Road, Charlotte, NC 28210
County: Mecklenburg
License Number: HAL-060-158

II. Date(s) of Visit(s): 06/04/25 and 06/25/25
Purpose of Visit(s): Monitoring
Exit/Report Date: 07/24/25

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0901(b) Personal Care and Supervision	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.		
Level of Non-Compliance: Type A2 Violation		
Findings: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for 1 of 5 sampled residents (Resident #1) who eloped from the facility without staff's knowledge. Review of the facility's Elopement Policy and Procedure policy effective July 2020 revealed: -The purpose of the policy was to ensure the assessment, identification, and supervision of at risk residents who may wander due to a confused state. -"High At-Risk" residents were required to wear an electronic "roam alert" device.		

-Staff were supposed to direct special attention to all "High At-Risk" residents who had Alzheimer's disease or other related disorders.
-All available facility staff were supposed to respond immediately to a missing resident alert.
-Facility staff were supposed to perform a quick and careful search.

Review of the facility's Emergency Procedure – Missing Resident policy effective August 2018 revealed residents at risk for wandering and/or elopement were supposed to be monitored, and staff were supposed to take necessary steps to ensure their safety.

Review of Resident #1's current FL2 dated 12/04/24 revealed:
-Diagnoses included metabolic encephalopathy, unspecified arterial fibrillation, essential hypertension, cardiac pacemaker, and Alzheimer's disease.
-Resident #1 was ambulatory, intermittently disoriented, and continent of bowel and bladder.
-His recommended level of care was Assisted Living (AL).

Review of Resident #1's Resident Register revealed that he was admitted to the facility on 12/05/24.

Review of Resident #1's Pre-admission Assessment dated 11/27/24 revealed:
-Resident #1 was able to ambulate independently with a walker.
-He had long-term memory deficits.
-He had difficulty finishing his thoughts and was not oriented to place.
-He required set up and cues for all Activities of Daily Living (ADLs).

Review of Resident #1's Care Plan dated 06/02/25 revealed:
-He was able to ambulate independently with a walker.
-He was able to transfer independently.
-He had intermittent confusion.
-He was forgetful and required reminders.
-He wore a roam alert bracelet due to prior elopement history at a previous facility.

Review of Resident #1's physician order dated 04/05/25 revealed placement of a roam alert bracelet on the right lower extremity for increased wandering behavior and safety concerns.

Review of Resident #1's Accident and Incident Report dated 06/03/25 revealed: -He exited the rear service door of the facility at 5:50pm. -He walked down the street toward a bus stop. -He was interceded by a passerby who notified the facility of his location at 6:15pm. -Staff immediately took him back to the facility after the call from the passerby was received. -He did not have any visible injuries. -"He stated, I left the same door the workers leave. I thought I had an appointment." -His roam alert on the right ankle was intact. Review of the facility's roam alert report dated 06/03/25 revealed: -Resident #1's roam alert activated an alarm at the facility's rear service exit on 06/03/25 at 5:50pm. -The alarm was turned off by staff in 5 minutes. Observation of the facility access to the back service egress from the residents' dining room on 06/04/25 from 1:44pm to 1:57pm revealed: -There was an elevator to the left of the dining room exit doors. -Beyond the elevator was a staff service door to the left. -The service door opened into a hallway that led to the back service egress door. -The distance between the two service doors was approximately 47 feet. Observation of Resident #1's exit route between the facility and where he was located by a passerby on 06/04/25 between 3:08pm-3:32pm revealed: -The exit from the back service door led to a sidewalk-lined parking lot on the side of the facility. -Turning left from the exit led to 2-lane, dead-end road facing the facility. -Both sides of the 2-lane road were lined with sidewalks and business complexes. -The distance between the facility back service door exit and where Resident #1 was found was approximately 742 feet. Based on observations, interviews, and record reviews it was determined that Resident #1 was not interviewable. Telephone interview with Resident #1's Responsible Person (RP) on 07/02/25 at 4:51pm revealed:		

-Facility staff called him on 06/03/25 to report that Resident #1 left the facility and was on a sidewalk away from the facility parking lot. -A passerby who was leaving work for the day saw Resident #1 on the sidewalk and called the facility staff to come get him. -Staff took Resident #1 back to the facility. -He talked to Resident #1 on the phone. -Resident #1 told him that he was going to a medical appointment. -Resident #1 told him that he left the facility through the back door that staff use. Telephone interview with a passerby, who stopped to assist Resident #1 on 06/13/25 at 2:35pm revealed: -She was leaving work when a man walking on the sidewalk with a walker yelled out to her. -Resident #1 asked for directions to get home. -Resident #1 was wearing an ankle monitor. -Resident #1 had a facility activity calendar with him. -She called the phone number on the activity calendar to report Resident #1's location. -Resident #1 was standing near the entrance of business complex several yards from the facility. -She and a coworker got a chair and some water for Resident #1. -A facility staff walked up the sidewalk, and another staff drove to Resident #1's location. -Facility staff assisted Resident #1 into their car and returned him to the facility. Review of historical weather data for 06/03/25 at 6:00pm revealed the temperature was 84 degrees Fahrenheit. Interview with a Cook on 06/04/25 at 1:37pm revealed: -On 06/03/25 at 5:50pm, he went toward the rear service door from the kitchen to take the garbage to the dumpster. -He heard the roam alert alarm sounding when he arrived at the door. -He did not hear the alarm when he was in the kitchen. -He turned the alarm off and looked outside in the immediate area. -He did not see anyone outside the door and went back into the kitchen. -He did not alert any other facility staff. Interview with the Maintenance Assistant on 06/04/25 at 1:25pm revealed:		

-A roam alert alarm alerted at a computer screen at the concierge's desk. -There were roam alert signal boxes at each of 3 staircase doors, at 2 back egress doors, and at the front entrance of the facility. -The roam alert alarm did not register on staff's work pads or telephones. -The alarm was visible on a monitor at the concierge's desk. -The concierge alerted staff to the location of a roam alert alarm by walkie-talkie. Interview with a Concierge on 06/25/25 at 4:15pm revealed: -There were two types of alarm alerts she monitored. -A yellow-coded alert displayed on the computer screen when a roam alert alarm was activated. -She did not see a yellow alarm display on the computer screen on 06/03/25 at 5:50pm. -She did not think the alert system was working properly. -She received a call from a bystander reporting that a resident was located on a sidewalk away from the facility. -She called a MA on the walkie-talkie to report an elopement. -The MA and another staff member brought Resident #1 back to the facility. Telephone interview with a Medication Aide (MA) on 06/27/25 at 4:49pm revealed: -On 06/03/25, she was working in the Special Care Unit when the concierge called on the walkie-talkie that Resident #1 was "up the road". -She called the person who called the facility and was told Resident #1's location. -She walked up the road and picked up Resident #1. -Resident #1 was sitting in a chair on the sidewalk with two bystanders. -Resident #1 said his legs were tired. -A coworker drove up to assist Resident #1 back to the facility. -She was working in the SCU on 06/03/25. -The roam alert alarm came across her pager with the location at the back service door. -Resident #1 was a resident in Assisted Living (AL). -All of the SCU residents were present, so she did not respond to the alert. Interview with a second MA on 06/25/25 at 2:43pm revealed: -She worked in the AL on 06/03/25 and was assigned to Resident #1. -At 5:20pm, she walked with Resident #1 to the dining room for dinner.		

-Resident #1 knew how to return to his room from the dining room. -She did not check out a beeper on 06/03/25. -She did not receive a call on the walkie-talkie from the Concierge about a resident who eloped. Interview with a third MA on 06/25/25 at 4:09pm revealed: -She worked in the AL on 06/03/24. -Her pager was on the medication cart while she was assisting a resident. -She saw the roam alert on the pager when she returned to the medication cart, but it had been cleared. -A cleared roam alert alarm signaled that the alarm was answered and residents were safe. -She was not alerted to respond to the elopement by the Concierge. Interview with Resident #1's Family Nurse Practitioner (FNP) on 06/04/25 at 2:55pm revealed: -He was aware that Resident #1 eloped from the facility on 06/03/25. -He was aware that Resident #1wore a roam alert device. -He ordered a urinalysis to rule out an urinary tract infection as a contributing factor for Resident #1's increased confusion. -Resident #1's dementia was progressing, but he appeared to be at his baseline when he visited him today. -He wrote an order for Resident #1 to be monitored in the Special Care Unit while awaiting lab results. Interview with the Administrator on 06/04/25 at 10:55am revealed: -Resident #1 wore a roam alert. -Prior to 06/03/25, the facility's management team was considering having Resident #1's roam alert removed. -Resident #1's exit seeking behaviors had subsided since he moved there in December 2024. -Resident #1 was consistent with a routine of going to the onsite gym to exercise, participating in facility activities, and going to dinner unescorted. -Resident #1 routinely went outside to sit on the front porch of the facility, but he did not attempt to leave the campus. -On 06/03/25, Resident #1 went to the dining room for dinner. -Resident #1 later exited the facility through a service door used by staff that was near the dining room. -The dining room staff heard the roam alert alarm after 5 minutes and checked outside the door. -There were no residents seen outside, and dining staff turned off the roam alert alarm.		

-Turning off the roam alert alarm signaled to other staff that the no further staff response was needed.
-At 5:50pm, a bystander called the facility to report a facility resident up the road from the facility and was trying to go home.
-A MA went to get Resident #1 and brought him back to the facility.
-Staff were expected to investigate the alarm and ensure that residents who wore roam alerts were present in the facility.

Interview with the Administrator on 06/04/25 at 2:05pm revealed:
-The roam alert keypad system was mounted beside facility exit doorways.
-The monitor beeped and sent a signal to staff pagers and the concierge's computer monitor when it was activated by a resident wearing a roam alert device.
-The MAs carried pagers on their assigned shifts.
-The alarm was disarmed at the exit keypad manually by staff.
-All facility staff received training in how roam alerts work and how to respond to an alarm in orientation.
-The expectation on 06/03/25 was for staff to be alerted by walkie talkie that a roam alert alarm was activated at the back service door.
-Staff were expected to initiate elopement policy and procedures to ensure all residents were present in the facility.

The facility failed to provide supervision for 1 of 5 sampled residents (Resident #1), who was diagnosed with cognitive deficits, had a history of exit seeking behaviors, and wore an ankle monitor to track location resulting in Resident #1 leaving the facility unnoticed. Staff did not investigate the roam alert alarm, but instead silenced it. Staff were unaware Resident #1 was not in the facility until a passerby found him on the sidewalk approximately 742 feet away from the facility saying he was trying to get home. This failure resulted in substantial risk for physical harm which constitutes a Type A2 Violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 23 2025.

The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 06/04/25.

Facility Name: The Charlotte Assisted Living

IV. Delivered Via:	Hand delivered	Date: 07/24/25
DSS Signature:	Karen Phillips	Return to DSS By: 08/14/25

V. CAR Received by:	Administrator/Designee (print name): Jazmyne Montgomery	
	Signature: [signature]	Date: 7/24/25
	Title: RCS	

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.*