

Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Landings of Rockingham
Address: 2605 Swallow Road, Reidsville, NC 27320
II. Date(s) of Visit(s): 12/15/23, 12/18/23, 12/20/23, 1/25/24

County: Rockingham
License Number: HAL-079-106
Purpose of Visit(s): Death Investigation
Exit/Report Date: 2/13/24

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, 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:

10 A NCAC 13F .0909/Resident Rights

Rule/Statutory Reference:

An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

(4) To be free of mental and physical abuse, neglect, and exploitation.

Level of Non-Compliance:

TYPE A1

Findings:

The rule was not met as evidenced by:

Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 1 resident (#1), who required assistance with bathing and had a history of bathing without staff knowledge, was free from neglect when she was found deceased in the facility's unsecured Spa Room tub.

The findings are:

Review of Resident #1's FL2 dated 4/26/23 revealed:

-Diagnoses include heart failure, chronic obstructive pulmonary disease, chronic kidney disease, history of seizure

POC Accepted

JK

DSS Initials

Responses to the cited deficiencies do not constitute an admission 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

10A NCAC 13F .0909 Resident Rights
 G.S. 131D-21(4) To be free of mental and physical abuse, neglect, and exploitation.

Community ED and/or Care Staff will ensure that residents are free from abuse, neglect and exploitation

3/13/24

Community ED implemented increased checks of all Spa Room areas throughout the community. Completed once new numbered key pad locking system was installed.

12/11/23

ED and Maintenance Tech have changed the locks on Spa Rooms to a numbered key pad locking system to better secure Spa Rooms.

12/11/23

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<p>disorder. -Resident #1 required assistance with bathing.</p>	<p>ED and/or Care Coordinator conducted audit of resident care plans to ensure appropriate level of care is documented</p>	<p>12/30/23</p>
<p>Review of Resident #1's Care Plan dated 5/11/23 revealed: -Resident #1 required limited assistance regarding bathing. -Resident #1 required supervision/set up for grooming/personal hygiene.</p>	<p>ED and Care Coordinator implemented emblem system on resident name plates to reflect code status and fall risk status for residents.</p>	<p>12/11/23</p>
<p>Review of the local Emergency Medical Services (EMS) report dated 12/9/23 revealed: -The facility placed a telephone call to 911 on 12/9/23 at 2:47am.</p>	<p>ED Conducted in-service training on new emblem system located on residents name plates and new locking system located on Spa Room doors.</p>	<p>12/11/23</p>
<p>-EMS arrived to facility on 12/9/23 at 2:55am. -Resident #1 was deceased upon their arrival at 3:00am. -Law Enforcement arrived at the facility on 12/9/23 at 3:13am.</p>	<p>ED conducted in-service training on the following topics: 1. Notification to Emergency Medical services 2. Staff rounds 3. Spa room coded locking system 4. Care planning, including but not limited to, "limited assistance" 5. Reporting changes of residents conditions, to include when and who to report to.</p>	<p>12/22/23</p>
<p>Review of the local Law Enforcement (LE) Report dated 12/9/23 revealed: -There was a call for service for a death investigation from the facility on 12/9/23 at 3:07am. -Resident #1 was found in the bath tub by staff. -Staff stated it was normal for Resident #1 to take baths by herself.</p>	<p>Community Ombudsman conducted in-service training for Resident Rights</p>	<p>2/6/24</p>
<p>Review of photographs revealed: -Resident #1 was in a fetal position sitting upright at the bottom of the bathtub. -Lividity (pooling of blood) was evident on the chest, stomach, legs, and arms area.</p>		
<p>Observation of the facility's Spa Room on 12/15/23 at 10:05am revealed: -There was a keypad lock on the outside of the door of the spa room. -There was a bathtub designed for one individual to bathe in. -There was a call cord attached to the wall wrapped around the cold water faucet.</p>		
<p>Interview with the Resident Care Coordinator (RCC) on 12/15/23 at 10:27am revealed: -She was not on duty in the facility when Resident #1 was found in the spa room. -She received a telephone call from the night shift medication aide/supervisor (MA/S) on 12/9/23 at 1:47am. -The MA/S told her Resident #1 was found deceased in the spa room bathtub. -Resident #1 would bathe alone in the spa room regularly. -Resident #1 would not tell staff when she would bathe. -Resident #1 was told not to bathe alone because for safety</p>		

Facility Name:

purposes.

Interview with a MA/S on 12/18/23 at 3:37pm revealed:

- Resident #1 would try to get in the bathtub on her own.
- Resident #1 would attempt to bathe alone in her shower located in her room.
- She never saw Resident #1 in the spa room unattended.
- Resident #1 was told to inform staff when she wanted to take a bath.
- She knew Resident #1 needed assistance with bathing.
- Resident #1's bathing schedule was on second shift hours between 3:00pm and 11:00pm.
- She was not aware of any other safety measures put in place for Resident #1 to attempt preventing her from bathing independently.

Interview with a Personal Care Aide (PCA) on 12/18/23 at 3:48pm revealed:

- Resident #1 would sometimes bathe on her own independently.
- Staff would tell her to let staff know when she wanted to bathe.
- Sometimes Resident #1 would use the call bell for staff assistance and sometimes she would not.
- She knew Resident #1 needed assistance with bathing.
- There were numerous times Resident #1 would have already taken her bath independently.
- She was not aware of any other safety measures put in place for Resident #1 to attempt preventing her from bathing independently.

Telephone Interview with the night shift PCA on 12/19/23 at 4:20pm revealed:

- She was working on 12/9/23.
- She completed rounds every 2 hours.
- She last saw Resident #1 at 12:00am on 12/9/23 when Resident #1 was putting her clothes basket at her door.
- Resident #1's door was closed at 12:30am.
- She went by Resident #1's door a little after 1:00am and her door was open.
- She thought Resident #1 was in her bathroom in her room.
- Between 1:30am and 1:40am, she opened the spa room to check for towels.
- She saw Resident #1's body floating in the water in the bathtub.
- She knew Resident #1 had at least one time in the past been in the spa by herself on night shift.
- She told Resident #1 to let her know if she was in the spa room.

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- Other staff would report during shift change Resident #1 would be in the spa room by herself.
- Resident #1 would not let staff know she was in the spa tub.
- She knew Resident #1 needed assistance with bathing.
- Resident #1 was told not to bathe alone because it was a safety precaution and she was unsteady on her feet.
- Resident #1 needed assistance with getting in and out of the bathtub.
- She did not know of any other safety measures put in place for Resident #1 to prevent her from bathing in the spa tub independently.

Interview with the RCC on 12/20/23 at 2:58pm revealed:

- Sometimes Resident #1 would not tell staff when she was going to the spa room.
- She did not know what assistance Resident #1 received with bathing from staff.
- Resident #1 would be told to let staff know when she would bathe.
- She knew Resident #1 should have received assistance with bathing.
- She did not know of any other safety measures that were put in place for Resident #1 to attempt preventing her bathing independently.

Telephone Interview with the night shift MA/S on 12/20/23 at 4:47pm revealed:

- She was working on 12/9/23.
- A PCA yelled for help between 1:30am-1:40am.
- She observed Resident #1 to be deceased in the bathtub when she went in the spa room.
- Resident #1 had taken many baths by herself even though she had been told not to do so.
- She knew Resident #1 needed assistance with bathing.
- Resident #1 was told not to bathe alone and needed assistance because she could slip and fall getting in and out of the tub in the spa room.
- To her knowledge, there were no other safety measures put in place for Resident #1 to attempt preventing her from bathing in the spa tub independently.

Telephone Interview with the Regional Director of Operations (RDO) on 12/28/23 at 12:38pm revealed:

- The RDO was acting Administrator at the time of Resident #1's death.
- He was contacted on 12/9/23 at 1:48am and he was informed Resident #1 was found in the bathtub.
- He did not know Resident #1's FL2 and care plan indicated she was to receive assistance with bathing.

Facility Name:

- He was not aware Resident #1 was going to the spa room by herself.
- He did not know of any safety measures that were put in place for Resident #1 to prevent her from bathing in the spa tub independently.
- The expectation was for staff to follow the needs identified on the FL2 and the care plan.
- A keypad lock was purchased for the spa room on 12/9/23.

Telephone Interview with the RCC on 1/30/24 at 3:22pm revealed:

- Resident #1 was told not to bathe alone because it was facility protocol and safety purposes.
- Nothing had occurred in the past to warrant Resident #1 telling staff she was going to bathe alone.
- Resident #1 enjoyed the spa room to soak her legs.
- There was no lock on the spa room door prior to 12/9/23.
- There was no policy in place regarding the door being locked.

Telephone Interview with the night shift MA/S on 1/30/24 at 3:29pm revealed:

- Resident #1 was told not to bathe alone because she could slip and fall getting in and out of the tub in the spa room.
- Nothing had occurred in the past to warrant Resident #1 telling staff she was going to bathe alone.
- Resident #1 enjoyed the spa room to soak her legs.
- The RCC was aware of Resident #1 bathing independently.
- There was no lock on the spa room door prior to 12/9/23.
- There was no policy in place regarding the door being locked.

Telephone Interview with the night shift PCA on 1/30/24 at 4:20pm revealed:

- Resident #1 was told not to bathe alone because it was a safety precaution and she was unsteady on her feet.
- Resident #1 received assistance with getting in and out of the shower.
- Nothing had occurred in the past to warrant Resident #1 telling staff she was going to bathe alone.
- There were no locks on the spa room door prior to 12/9/23.
- She did not believe there was a policy in place regarding the door being locked.

Telephone Interview with a MA/S on 1/31/24 at 1:40pm revealed:

- Resident #1 was told not to bathe alone because of safety, she could get weak, and anything could happen.
- Nothing had occurred in the past to warrant Resident #1 telling staff she was going to bathe alone.
- There was no lock on the spa room door prior to 12/9/23.

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-There was no policy in place regarding the door being locked.

Telephone Interview with a PCA on 1/31/24 at 3:02pm revealed:

- Resident #1 was told not to bath alone because it was not safe for her to bathe on her own.
- Resident #1 received assistance with turning the water on and plugging the water.
- The PCA would sometimes wash her back.
- There was no lock on the spa room door prior to 12/9/23.
- There was no policy in place regarding the door being locked.

Telephone Interview with RDO on 2/1/24 at 10:28am revealed:

- There was no lock on the spa room door prior to 12/9/23.
- There was no policy in place regarding the door being locked.

Telephone Interview with Maintenance on 2/12/24 at 2:42PM

- He put the keypad lock on the door on 12/11/23.
- There was no lock on the spa room door prior to 12/9/23.
- The RDO told him to place the keypad lock on the Spa Room door.
- The lock was placed on the spa room for safety concerns in order to prevent another incident of a resident death.

Based on interviews and record reviews, the facility neglected to maintain the safety of Resident #1 who had a history of using the facility's spa tub while alone and was found deceased in the tub. This failure resulted in serious physical harm and death which constitutes a Type A1 Violation.

The facility provided a Plan of Protection in accordance to G.S. 131D-2.16; 131D-4.3; 143B-165 on 12/18/23 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED, March 13, 2024

Rule/Statute Number:		<input type="checkbox"/> POC Accepted
Rule/Statutory Reference:		DSS Initials
Level of Non-Compliance:		
Findings:		

Facility Name:

IV. Delivered Via:	In Person	Date:	2/15/24
DSS Signature:	Jimm Kemp	Return to DSS By:	3/5/24

V. CAR Received by:	Administrator/Designee (print name): Chelsin Creasey	Date:	2-13-24
	Signature: Chelsin Creasey		
	Title: Business Office Coordinator		

VI. Plan of Correction Submitted by:	Administrator (print name): Donna Brendle	Date:	3/7/2024
	Signature: Donna Brendle		

VII. Agency's Review of Facility's Plan of Correction (POC)	
<input type="checkbox"/> POC Not Accepted	By: _____ Date: _____
Comments:	
<input checked="" type="checkbox"/> POC Accepted	By: Tierra Ross, Adult Home Specialist Date: 3/8/24
Comments:	

VIII. Agency's Follow-Up	By: Tierra Ross, Adult Home Specialist	Date:	4/10/24
	Facility in Compliance: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date Sent to ACLS:	
Comments:			

*For follow-up to CAR, attach Monitoring Report showing facility in compliance.

Facility Name: