

## 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.

<b>III (a). Non-Compliance Identified</b> <i>For each citation/violation cited, document the following four components:</i> <ul style="list-style-type: none"> <li>• Rule/Statute violated (rule/statute number cited)</li> <li>• Rule/Statutory Reference (text of the rule/statute cited)</li> <li>• Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)</li> <li>• Findings of non-compliance</li> </ul>	<b>III (b). Facility plans to correct/prevent:</b> <i>(Each Corrective Action should be cross-referenced to the appropriate citation/violation)</i>	<b>III (c). Date plan to be completed</b>
Rule/Statute Number: 10 A NCAC 13F .0909/Resident Rights	<input type="checkbox"/> POC Accepted	<i>DSS Initials</i>
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		

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disorder.

-Resident #1 required assistance with bathing.

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.

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.

-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.

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.

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.

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.

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

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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.

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- 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 constitute 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:	_____ <i>DSS Initials</i>
Level of Non-Compliance:	
Findings:	

