Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Wickshire Creeks Crossing
Address: 8398 Fayetteville Road Raeford NC 28376
II. Date(s) of Visit(s): 03/30/23, 04/18/23, 05/04/23, 05/18/23

County: Hoke
License Number: HAL-047-015
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 05/30/2023, 06/02/2023

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)* • *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) Rule/Statutory Reference: Personal Care and Supervision/Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	☑ POC Accepted AM *DSS Initials*	
Level of Non-Compliance: Type A2 Violation Findings: Based on observations, interviews and record reviews, the facility failed to provide supervision based on the residents' assessed needs and current symptoms that led to the elopement of Resident #7. The Findings are: Review of Resident #7's FL-2 dated 10/19/22 revealed: -Resident #7's diagnoses included vascular dementia, psychotic disturbance, Vitamin D deficiency history of hip fracture, history of nondisplaced fracture vertebra. -Resident #7 was intermittently disoriented and wandered. Review of Resident #7's Resident Register revealed she was admitted to the special care unit (SCU) side of the facility on 10/28/2022.	The community shall continue to provide personal care to residents according to the residents care plans and attend to any pesonal care needs residents may be unable to attend to for themselves. Staff shall provide supervision of residents in accordance with each residents assessed needs, care plan and current symptoms. The Community has added an additional alarm (Sounding device) stop sign (visual)	6/30/23

Facility Name: Wickshire Creeks Crossing

<table>
<tr>
<td>
Review of Resident #7's care plan dated 03/27/2023 revealed:
-Resident #7 required supervision when eating.
-Resident #7 required extensive assistance with toileting, bathing and dressing.
-Resident #7 required limited assistance with grooming/personal hygiene.
-Resident #7 was independent when she ambulated and transferred.
-Resident #7 wandered.

Interview with a personal care aide (PCA) on 05/04/2023 at 10:30am revealed:
-On 03/11/23, the day of the elopement, there were only two PCAs working on the SCU side of the facility.
-The PCA had never been trained on how the exit doors worked, or what needed to be done once a resident set the alarm off on the SCU exit doors.
-Resident #7 was very busy and continued to mess with the plastic panel over the red lock/unlock switch beside the door on the SCU.
-The PCA informed the medication aide (MA) that the Resident continued to mess with the exit doors on the SCU.
-The PCA felt the last time Resident #7 pushed on the door it was not locked and the resident got out.
-A call came into the facility and a MA who answered the phone was asked if a resident from the facility was missing.
-The PCA was not sure exactly what time Resident #7 had gotten out of the facility, however it was after lunch as the resident had eaten and lunch was served between 12:00 - 12:30 pm.
-No one at the facility knew Resident #7 had gotten out of the SCU side of the facility.
-A MA from the facility went and picked Resident #7 up from the apartment complex down from the facility.
-The PCA was not sure what the facility elopement protocol was.
-There had not been anything different put in place since Resident #7 eloped from the facility.

Interview with a MA on 05/04/2023 at 11:15am revealed:
-Someone from the community called the facility on 03/11/23, and asked was the facility missing a resident, because there was an elderly lady by the apartment complex walking and stumbling around.
-The MA was not sure of the time of the call.
-A head count was done on both sides of the facility and then it was realized Resident #7 was not in the facility.
</td>
<td>
to all Memory Care exit doors that in the in the event the red switch has been flipped to the off position, if and when the door is opened, there is a continuos alarm that will sound and can not be silenced and reset without a key and physical acknowledgement of the sounding alarm.
This action is designed to either deter the resident from walking out of the exit door and or allow the staff time to come and prevent the resident from going outside of the door and or eloping.
It shall be the process of each staff member who works on Memory Care to complete exit door checks at the beginning of each shift, every 2 hours and at the end of their shift and document those checks.
The MCD/Designee will review these checks weekly and as needed to ensure the checks are being completed and residents are alway safe.
The Executive Director/designee will complete monthly documentation checks for 6 months to ensure residents
</td>
<td>
6/30/23

6/30/23

6/30/23

6/30/23

6/30/23
</td>
</tr>
</table>

are provided supervision in

Facility Name: Wickshire Creeks Crossing

- The MA looked around the perimeter of the facility but did not see Resident #7. -The MA got in her car and drove to the apartment complex down from the facility and located Resident #7 leaning against the fence that surrounded the apartments. -Resident #7 was there by herself, cold and shivered. -Resident #7 was fully dressed but it was cold outside that day. Interview with the Resident Care Coordinator (RCC) on 05/04/23 at 11:30am revealed: -She was the supervisor on duty the day [03/11/23] Resident #7 eloped from the facility. -The facility elopement protocol was followed: an incident report was completed, the Executive Director (ED), Resident #7's family and primary care provider (PCP) were notified of the elopement. -Resident #7 was placed on 30-minute checks only after the resident had eloped from the facility. -The MA on the SCU would have the 30-minute check logs for Resident #7. Interview with another MA on the SCU on 05/04/23 at 11:45am revealed the MA had no idea that Resident #7 was on 30-minute checks, therefore the MA did not know anything about the logs. Review of incident report for Resident #7 dated 03/11/23 received on 03/13/23 revealed: -Resident #7 had flipped the switch on the door alarm and left out the facility. -Resident #7 was brought back to the facility and had an abrasion to her face. -Resident #7 was not transported to the local hospital. -Resident #7 wandered. Interview with Resident #7's family member on 04/18/2023 at 1:45pm revealed: -On 03/11/23 at 2:02pm, she was contacted by a MA from the facility and was informed Resident #7 had gotten out of the SCU. -The family member went to the facility and was informed by the RCC that Resident #7 had gotten out the SCU sometime after the resident ate lunch around 12:40pm. - Around 1:10pm, a MA received a phone call from someone outside the facility that a resident from the facility may have gotten out.	accordance with their assessed needs, care plan and current symptoms. The Environmental Services Director/MCC/Designee will complete quarterly training on elopement and dementia residents in conjunction with our quarterly elopement drills. The ED/Designee will review the quarterly dementia and elopement training and the elopement drills to ensure that all associates understand and that residents remain in a safe environment and recieve supervision in accordance to their assessed needs, care plan and current symptoms.	6/30/23 6/30/23

-The MA drove to the nearby apartment complex and picked Resident #7 up with her car and transported the resident back to the facility.
-Resident #7 had noticeable bruises on her left cheek, chin, back and top of her left eye.
-The family member along with the RCC checked the door on the SCU that Resident #7 left out of.
-It was discovered the red-light switch connected to the locked doors on the SCU was in the off position and this caused the alarm to disactivate.
-The family member was informed by the ED that it was reported by staff that Resident #7 had been messing with the plastic panel that was over the exit door switch that morning.
-Staff had only replaced the plastic panel and had not switched the red switch to the on position when replacing the plastic panel.
-Staff was unaware the red switch needed to be switched to lock, once a resident had set the alarm off.
-Staff did not know Resident #7 had left the facility or was missing until a MA had gotten a call from someone outside the facility.
-The family member was informed by the ED that Resident #7 would be put on 15-minute checks and that staff were to check all exit doors every hour until further notice after the resident eloped from the facility.

Interview with the ED on 05/04/23 at 12:06pm revealed:
-The ED was notified by telephone on 03/11/23 that Resident #7 had eloped from the facility.
-The ED had not been informed prior to the elopement that Resident #7 had messed with the exit door alarm system.
-The ED was informed by the staff that Resident #7 had messed with the plastic cover over the red switch all morning.
-The staff had not recognized that Resident #7 had flipped the red switch to the off position, the up position which disarmed the mag lock.
-After Resident #7 eloped from the facility staff, where to check the doors on the SCU the beginning and end of the shift and every two hours daily.
-Resident #7 was very busy and wandered around the SCU.
-The ED thought supervision for Resident #7 had been increased after the resident eloped from the facility, but the ED was not sure.

Review of the facility Alzheimer's Care Disclosure Statement revealed residents were monitored closely for safety related incidents for potential wandering.

Review of the facility's elopement policy and procedures for the SCU effective 10/01/20 revealed: -All residents were to be assessed for elopement by a licensed health care professional prior to moving into the SCU and such would be included in the care plan. -Residents who displayed searching behaviors shall be reported to the ED, health services director or manager on duty. -Then safety measures would be implemented to allow the resident to wander safely on the SCU, such as having a structured, supervised walking schedule. -The staff would be notified if a resident was at risk and the appropriate interventions would be put in place to minimize eloping. -If a resident eloped from the facility, once returned the resident would undergo a complete physical assessment for trauma or injury. -The environmental services manager would conduct an elopement drill at least quarterly, all shifts will participate and the drills are to be documented on the elopement/missing resident form. The facility failed to provide for 1 of 1 sampled resident (Resident #7) who had a history of dementia, was intermittently disoriented and wandered by not supervising the resident after the resident had displayed exit seeking behaviors which resulted in the resident eloping from the facility and sustaining bruises to the back, left cheek, chin, and top of the left eye. Their failure resulted in substantial risk of physical harm, and constitutes a Type A2 violation. ________________________ The facility provided a plan of protection in accordance with G.S. 131-D34 on 05/23/23. The correction date for this Type A2 violation shall not exceed 6/30/23. __________ Rule/Statue Number: 10A NCAC 13F.0703(a) Rule/Statutory Reference: Tuberculosis Test, Medical Examination and Immunizations. Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A.0205 Level of Non-Compliance: Standard Deficiency		

Facility Name: Wickshire Creeks Crossing

Findings: Based on interviews and record reviews the facility failed to ensure that 3 out of 8 residents sampled (Resident #4, #7) received subsequent TB skin test after being admitted to the facility and resident (#2) received an initial or subsequent TB skin test. The findings are: 1. Review of Resident #2's current Fl-2 dated 08/31/22 revealed: -Resident #2's diagnoses included: Alzheimer's disease, essential hypertension, other specified disorders of bone density, unspecified protein- calorie malnutrition. -Resident #2 was intermittently disoriented. -Resident #2 was admitted to the facility on 10/29/21. Review of Resident #2's facility record on 03/30/23 revealed: -There was no documentation that Resident #2 had an initial TB skin test before being admitted to the facility. -There was no documentation in Resident #2's facility record that the resident had gotten a subsequent TB skin test. 2. Review of Resident # 4's Fl-2 dated 02/01/23 revealed: -Resident 4's diagnoses included: Type II diabetes, primary hypertension, chronic kidney disease, congested heart failure, dry eyes, glaucoma, constipation and anemia. -Resident #4 was intermittently disoriented. -Resident #4 was admitted to the facility on 10/27/22. Review of Resident's #4's facility record on 04/20/23 revealed: -Resident #4 had an initial TB skin test on 09/20/22 that read negative on 09/22/22. -There was no documentation in Resident #4's facility record that the resident had gotten a subsequent TB skin test. 3.Review of Resident #7's current FL-2 dated 10/19/22 revealed: -Resident #7's diagnoses included: vascular dementia, psychotic disturbance, Vitamin D deficiency history of hip fracture, history of nondisplaced fracture vertebra. -Resident #7 was intermittently disorientated and wandered. Review of Resident #7's resident register she was admitted to the special care unit (SCU) side of the facility on 10/28/2022. Review of Resident's #7's facility record on 04/20/23 revealed:		

Facility Name: Wickshire Creeks Crossing

-Resident #7 had an initial TB skin test on 10/26/22 that read negative on 10/28/22. -There was no documentation in Resident #7's facility record that the resident had gotten a subsequent TB skin test. Interview with the facility ED on 05/18/23 at 12:15pm revealed: -The facility RCC and the facility MCD are responsible for ensuring the residents have gotten the initial and subsequent TB skin test completed. -At this point the facility has no checks and balances in place to ensure the TB skin test are completed, but the ED is working on it. Rule/Statue Number: 10A NCAC 13F. 0903 Rule Statutory Reference: Licensed Health Professional Support. The facility shall ensure that participation by a registered nurse, occupational therapist, or physical therapist in the onsite review and evaluation of the residents' health status, care plan and care provided as required in Paragraph (a) of this rule is completed within 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter. Level of Non-compliance: Standard Deficiency Findings: Based on interviews and record reviews the facility failed to ensure 4 of 8 residents sampled (Residents #2, #4, #7 and # 8) had an onsite review and evaluation within 30 days of admission or developing a licensed health support task. 1. Review of Resident #2's current Fl-2 dated 08/31/22 revealed: -Resident #2's diagnoses included: Alzheimer's disease, essential hypertension, other specified disorders of bone density, unspecified protein- calorie malnutrition. -Resident #2 was intermittently disoriented. -Resident #2 was admitted to the facility on 10/29/21 Review of Resident #2's care plan dated 03/20/23 revealed the resident was totally dependent on the facility staff for transfers. Review of Resident #2's facility record on 03/30/23 revealed there were no initial or quarterly licensed health professional support (LHPS) reviews in the resident's chart. 2.Review of Resident # 4's current Fl-2 dated 02/01/23 revealed:	The Community shall request a T.B skin test or documentation of a T.B skin test within the last year upon admission. If a T.B skin test within a year isn't available, the Community will allow a chest x-ray that indicates no disease present. It is the responsibility of the RCC/MCC/Designee that once a resident moves in, they began tracking 14 days from admission in order for the resident to obtain their second step T.B skin test as applicable. After the 14th day, the RCC/MCC/Designee will have the T.B skin test placed by the Community PCP and or the RN consultant and then read within 48 to 72 hours. The Executive Director will complete weekly and as needed checks to ensure that all residents receive initial and second step T.B skin test.	6/30/23 6/30/23 6/30/23 6/30/23

Facility Name: Wickshire Creeks Crossing

-Resident #4's diagnoses included: Type II diabetes, primary hypertension, chronic kidney disease, congested heart failure, dry eyes, glaucoma, constipation and anemia. -Resident #4 was intermittently disoriented. Review of Resident #4's resident register revealed the resident was admitted to the facility on 10/27/22. Review of Resident #4's medication administration report (MAR) dated 02/01/2023 – 02/28/2023 revealed: -Resident #4 was to be injected with 5 units of insulin subcutaneously in the morning for diabetes. -Resident #4 was to have her blood sugars checked 4 times daily before meals and at bedtime. -Resident #4 was on a sliding scale insulin injection subcutaneous four times a day for diabetes. Review of Resident #4's facility record on 03/31/23 revealed there were no initial or quarterly LHPS reviews in the resident's chart. 3.Review of Resident #7's current FL-2 dated 10/19/22 revealed: -Resident #7's diagnoses included: vascular dementia, psychotic disturbance, Vitamin D deficiency history of hip fracture, history of nondisplaced fracture vertebra. -Resident #7 was intermittently disoriented and wandered. Review of Resident #7's resident register revealed the resident was admitted to the special care unit (SCU) side of the facility on 10/28/2022. Review of Resident #7's medication administration report (MAR) dated 02/01/2023 – 02/28/2023 revealed: -Resident #7 was prescribed a rectal suppository every 6 hours as needed for pain/fever. -Resident #7 was prescribed rectal suppository every 24 hours as needed for constipation. Review of Resident #7's facility record on 04/18/2023 revealed there were no initial or quarterly LHPS reviews in the resident's chart. 4.Review of Resident #8's current FL-2 dated 03/23/23 revealed: -Resident #8's diagnoses included: congestive heart failure, unspecified heart failure, Type II diabetes, Late onset Alzheimer's dementia without behavioral disturbance, hypoglycemia and acute hypoxemic respiratory failure.	The community has acquired an RN Consultant who comes to the community to complete initial LHPS and quarterly. The RCC/MCC/ Designee will contact the RN Consultant once a resident moves in to schedule the initial LHPS assessment. Once assessed the resident will be placed on the annual LHPS list or quarterly assessment list. Once the resident is placed on the quarterly list, the RCC/MCC/ Designee will be responsible for contacting the RN Consultant to complete the quarterly assessments. The RN Consultant will also be contacted by The RCC/MCC/ or Designee to complete any additional initial assessments, significant change assessments and any annual assessments that have become due. This process will be Monitored Monthly and as needed by the Executive Director/ Designee for 6 months to ensure that the process is followed and residents recieve onsite review and evaluation of their health Status, care plan and care provided 7/4/23 7/4/23

-Resident #8 was intermittently disoriented. Review of Resident #8's resident register revealed the resident was admitted to the SCU side of the facility on 09/30/21. Review of Resident #8's medication administration report (MAR) dated 04/01/23 – 03/30/23 revealed the resident was ordered to have 100 units of insulin injected per sliding scale four times a day for diabetes. Review of Resident #8's facility record on 04/18/2023 revealed there were no initial or quarterly LHPS reviews in the resident's chart. Interview with the facility executive Director on 04/18/23 at 2:50pm and on 05/18/23 at 12:15pm revealed: -When asked for the residents LHPS reviews the ED stated, "there were no initial or quarterly LHPS reviews because the residents did not have any identifiable tasks." -Ongoing the RCC and the MCD will be the ones responsible for ensuring the nurse is notified when a resident has a task or develops a task. -A new registered nurse (RN) has been hired by the facility but is currently completing training with the facility staff. -Next week the ED will ask the RN if she could complete the LHPS reviews for the residents.	within 30 days of admission, or within 30 days from the date a resident develops the need for a task and at least quarterly thereafter.	7/4/23
Rule/Statue Number: 10A NCAC 13F. 1307 Rule/Statutory Reference: Special Care Unit Resident Profile and Care Plan (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities and degree of cognitive impairment. Level of Non-compliance: Standard Deficiency Findings: Based on observations, interviews and record reviews the facility failed to ensure that 3 of 4 residents sampled (Residents #3, #7 and #8) had a written resident profile completed within 30 days of admissions and quarterly thereafter. Interview with the facility ED on 05/18/23 at 12:06pm revealed the facility became a SCU in August 2021.	The community has completed all Special Care unit Profiles. The MCC/Designee will be responsible for completing all initial and quarterly Special Care unit profiles. The Executive Director will review all initial	7/4/23

Facility Name: Wickshire Creeks Crossing

Review of the facility Alzheimer's Care Disclosure Statement revealed:
-Within 30 days of admission to the memory care and quarterly thereafter, a written resident profile will be developed.
-The resident profile will contain assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and abilities, and degree of cognitive impairment.

1.Review of Resident #3's current Fl-2 dated 10/17/22 revealed:
-Resident #3's diagnoses included: Alzheimer's Disease, unspecified anxiety disorder, unspecified dementia, Type II diabetes, intracranial hypertension and unspecified systolic heart failure.
-Resident #3 was intermittently disoriented.
-Resident #3 wandered

Review of Resident #3's resident register revealed the resident was admitted to the locked side of the facility on 01/29/19, which later became licensed as a SCU.

2. Review of Resident #7's current FL-2 dated 10/19/22 revealed:
-Resident #7's diagnoses included: vascular dementia, psychotic disturbance, Vitamin D deficiency history of hip fracture, history of nondisplaced fracture vertebra.
-Resident #7 was intermittently disorientated and wandered.

Review of Resident #7's resident register revealed the resident was admitted to the special care unit (SCU) side of the facility on 10/28/2022.

Review of Resident #7's facility record on 04/18/2023 revealed there were no initial resident profile completed within 30 days of admissions and quarterly thereafter in the resident's chart.

3.Review of Resident #8's current FL-2 dated revealed:
-Resident #8's diagnoses included: congestive heart failure, unspecified heart failure, Type II diabetes, Late onset Alzheimer's dementia without behavioral disturbance, hypoglycemia and acute hypoxemic respiratory failure.
-Resident #8 was intermittently disoriented.

Review of Resident #8's resident register revealed the resident was admitted to the SCU side of the facility on 09/30/21.

and quarterly Special Care Unit Profiles Monthly and as needed for the next 90 days to ensure that they are completed and according to each resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities and degree of cognitive impairment.

7/4/23

Facility Name: Wickshire Creeks Crossing

Review of Resident #8's facility record on 04/18/2023 revealed there were no initial resident profile completed within 30 days of admissions and quarterly thereafter in the resident's chart.		

IV. Delivered Via:	Electronic Mail & Certified Mail	Date: 06/02/2023
DSS Signature:	Antoinette McMillian Smith	Return to DSS By: 6/26/23

V. CAR Received by:	Administrator/Designee (print name): Myra J. Sinclair	
	Signature: Myra J. Sinclair	Date: 6/02/23
	Title: Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name): Myra J. Sinclair	
	Signature: Myra J. Sinclair	Date: 7/3/23

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By: Antoinette McMillian	Date: 07/03/2023
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.*