Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Wickshire Creeks Crossing
Address: 8398 Fayetteville Rd. Raeford NC 28376
II. Date(s) of Visit(s): 07/07/23,07/26/23, 08/16/23, 08/21/23

County: Hoke
License Number: HAL-047-015
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 08/29/23, 09/05/2023

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)* • *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(c)	☑ POC Accepted ________ *DSS Initials*	
Rule/Statutory Reference: Personal Care and Supervision/ Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and interventions according to the facility's policies and procedures.		
Level of Non-Compliance: Type A1 VIOLATION		
Findings: Based on observations, interviews and record reviews, the facility failed to respond immediately and provide care and interventions based on the residents' assessed needs and symptoms that resulted in the death of Resident #1. The findings are: Review of Resident #1's FL-2 dated 02/03/23 revealed: diagnoses included idiopathic aseptic necrosis of left femur, paroxysmal atrial fibrillation, unspecified severe protein – calorie malnutrition, hyperlipidemia and muscle weakness.		

Facility Name: Wickshire Creeks Crossing

Review of Resident #1's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) side of the facility on 02/24/23. Review of Resident #1's facility progress notes dated 04/05/23 revealed: -The medication aide (MA) worked on 04/03/23 on the SCU. -At 9:35pm the MA went to Resident #1's room and checked on the resident when she entered the room two personal care aides (PCAs) were comforting the resident. -The MA noticed that Resident #1 was taking short shallow breaths, was mouth breathing and had a wet gargling sound because of this the PCAs were instructed to check on the resident every 15 minutes. -At 9:37pm the MA texted her supervisor, the memory care director (MCD) and informed her that she had placed Resident #1 on 15-minute checks due the resident's current condition. -At 9:38pm the MCD contacted the MA back and informed the MA to inform hospice of Resident #1's condition. -At 9:40pm the MA was unable to get a pulse or oxygen reading on Resident #1, the MA then called the MCD and stated she felt the resident had "expired". -At 9:41pm the MA called a local hospice company and requested a phone call back. -The hospice company called back at 10:08pm and informed the MA that Resident #1 was not one of their clients. -At 10:09pm the MA called the MCD to inform her that the resident was not a hospice client. -At 10:12pm the MCD called the MA back and informed the MA to call 911; therefore, the MA called 911 to come to the facility and assess Resident #1 who she felt was dying. -The MCD arrived at the facility and immediately assessed Resident #1. -At approximately 10:28pm emergency medical services (EMS) arrived to the facility and shortly thereafter EMS confirmed Resident #1 had expired. Review of local EMS report dated 04/03/23 revealed: -Someone from the facility called 911 at 10:18pm. -EMS was dispatched to the facility at 10:21pm and arrived at the facility at 10:29pm. -Upon arrival of EMS to the facility the local fire department was already at the facility and had placed Resident #1 on the floor out of the bed to begin cardiopulmonary resuscitation (CPR) for about 5 minutes. -The local fire department had suctioned approximately 8-10mls of black fluid out of Resident #1's airway.		

-EMS assessed Resident #1 and the resident was found to be apneic and pulseless with black fluid in the airway her jaw was locked in place and resuscitation was ended. -The MA reported that during rounds Resident #1 would not take her medications and gurgling sounds could be heard in the resident's airway. -The MA stated "I knew she wouldn't survive the night" so the staff continued to check on the resident every 15 minutes. -The MA reported that at 9:40pm she attempted to obtain a set of vitals and was unable to get a pulse oximeter reading or blood pressure. -The MA cleaned and redressed Resident #1 due to the resident soiling herself. -The MA then called her supervisor to be advised what to do next, the supervisor advised the MA to call 911. -The MA called 911 at 10:12pm. -EMS asked for any paperwork associated with Resident #1 and the facility staff reported "they didn't have any and they couldn't print anything out". -The MA reported no CPR was administered before the first responders arrived. Interview with a personal care aide (PCA) on 07/07/23 at 12:00pm revealed: -The MA working on 04/03/23, the MCD) nor the executive director (ED) did not know whether Resident #1 was a hospice patient or had a do not rusticate (DNR) in place and that is what caused the delay in getting help for the resident. -The PCA stated there needed to be something in place indicating the residents code status, "the incident with Resident #1 happened in April and there have been no changes yet". -No staff at the facility started CPR on Resident #1 on 04/03/23. Interview with the facility MCD on 08/21/23 at 2:44pm revealed: -She was called to the facility by the MA around 9:20pm and was informed that Resident #1 was taking short shallow breaths. -She arrived to the facility the night of 04/03/23 at approximately 10:15pm. -Upon arrival to the facility the MCD asked another MA if she was CPR certified, the MA was however when they both arrived to Resident #1's room the resident had already passed away. -The MA who worked on 04/03/23 on the SCU called four hospice companies to find out if Resident #1 was a hospice client.		

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-The MA reported that during rounds Resident #1 would not take her medications and gurgling sounds could be heard in the resident's airway.
-The MA stated "I knew she wouldn't survive the night" so the staff continued to check on the resident every 15 minutes.
-The MA reported that at 9:40pm she attempted to obtain a set of vitals and was unable to get a pulse oximeter reading or blood pressure.
-The MA cleaned and redressed Resident #1 due to the resident soiling herself.
-The MA then called her supervisor to be advised what to do next, the supervisor advised the MA to call 911.
-The MA called 911 at 10:12pm.
-EMS asked for any paperwork associated with Resident #1 and the facility staff reported "they didn't have any and they couldn't print anything out".
-The MA reported no CPR was administered before the first responders arrived.

Interview with a personal care aide (PCA) on 07/07/23 at 12:00pm revealed:
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-The PCA stated there needed to be something in place indicating the residents code status, "the incident with Resident #1 happened in April and there have been no changes yet".
-No staff at the facility started CPR on Resident #1 on 04/03/23.

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-She arrived to the facility the night of 04/03/23 at approximately 10:15pm.
-Upon arrival to the facility the MCD asked another MA if she was CPR certified, the MA was however when they both arrived to Resident #1's room the resident had already passed away.
-The MA who worked on 04/03/23 on the SCU called four hospice companies to find out if Resident #1 was a hospice client.

Facility Name: Wickshire Creeks Crossing

-The MCD stated staff not knowing if Resident #1 was a hospice client caused a delay in getting the resident the help needed and that was why CPR was not initiated by the facility staff. -There was a DNR book in place but the MA could not find Resident #1 in the DNR book. -Resident #1 was a full code. Interview with the Executive Director (ED) on 08/21/2023 at 3:57pm revealed: -None of the facility staff started CPR prior to the first responder's arrival to the facility. -The staff would know who was receiving hospice because the resident would have a hospice aide to come to the facility a couple days a week to provide personal care. -The MA on duty called several hospice companies and tried to find out if Resident #1 was a hospice client. -There had been discussion about admitting Resident #1 to hospice services and that was what caused the confusion, the facility staff had not known if the resident had been admitted to hospice or not. -There were at least two staff members who were CPR certified that worked the 2:00pm - 11:00pm shift on 04/03/23. -By the time someone called the MA back from the hospice companies Resident #1 was "gone". Review of the facilities incident reports – state reporting policies and procedures revealed: -If there was a critical/life threatening accident/incident, call 911, perform CPR or perform first aid as indicated. -Notify physician and follow instructions. Attempted interview on 08/22/23 at 3:49pm with the MA who worked on 04/03/23 from 2:00pm to 11:00pm was unsuccessful. Attempted interview with Resident #1's family member on 08/01/2023 at 1:56pm was unsuccessful. _______________ The facility failed to respond immediately and accordingly for 1 of 1 sampled resident (Resident #1) who was actively dying, was a full code and no life saving measures where initiated by the facility staff which resulted in a delay in the resident receiving CPR which contributed to the death of the resident which constitutes a Type A1 Violation	It shall always be the procedure of the community that staff shall respond immediately in the case of an accident or incident involving a resident to provide care and interventions according to the facility's policies and procedures. 9/29/23 The community has placed red dots by the names of each resident that has a golden DNR sheet provided by the physician The community has also placed green dots by the names of each resident that is not a DNR indicating that in the event of any incident or accident that requires CPR, the staff will know to immediately begin CPR until paramedics arrive to take over care. The community has also placed DNR books at both nurses stations, Current DNR Resident lists, current Full code lists and current Hospice that are available and acessible to all staff in the case of an emergency. 9/29/23 The RCC/MCC or designee will responsible for checking

Facility Name: Wickshire Creeks Crossing

The facility provided a plan of protection in accordance with G.S. 131-D34 on 08/21/23 The correction date for this Type A1 violation shall not exceed 09/29/23	The red and green dots, The DNR Book, Hospice list and DNR and Full code lists weekly to ensure that all dots are intact and up to date. They will also check the 9/29/23

DNR book, Hospice list and DNR and Full lists weekly to ensure the lists are updated and accurate for the staff
over →

IV. Delivered Via:	Electronic Mail / Certified Mail.	Date: 9/5/2023
DSS Signature:	Antoinette McMillian Sutton	Return to DSS By: 9/26/23

V. CAR Received by:	Administrator/Designee (print name): Myra Sinclair	
	Signature: Myra J. Sinclair	Date: 9/28/23
	Title: Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name): Myra J. Sinclair	
	Signature: Myra J. Sinclair	Date: 9/28/23

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☑ ***POC Accepted***	By: Antoinette McMillian	Date: 10/4/2023
Comments:		

VIII. Agency's Follow-Up	By: Antoinette McMillian Sutton		Date: 10/26/2023
	Facility in Compliance: ☑ Yes ☐ No		Date Sent to ACLS: 11/07/2023
Comments:			

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

Facility Name: Wickshire Creeks Crossing

9/29/23

The ED/Designee will spot check the Dot system, DNR books, Hospice list DNR lists and Full code lists weekly and as needed to ensure all lists and books, as well as dots are in place and reflect the accurate code system.

This system is put in place to ensure that life saving measures are initiated and clear for all associates in the case of any accident or incident involving residents.