Adult Care Home Corrective Action Report (CAR)

I. Facility Name: East Towne Assisted Living
Address: 4815 North Sharon Amity Rd. Charlotte, NC 28205
County: Mecklenburg
License Number: HAL-060-149

II. Date(s) of Visit(s): 06/30/23, 07/12/23, 07/18/23, 07/21/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 08/14/23

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 .0906(f)(4)/Other Resident Care and Services (f)(4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.	☐ POC Accepted _____ *DSS Initials*	—
Level of Non-Compliance: Type A2 Violation		
Findings: Based on interviews and record reviews, the facility failed to immediately notify law enforcement (LEO) and the county Department of Social Services when 1 of 7 sampled residents (Resident #1) who had a history of leaving the facility without communicating his whereabouts with staff left the facility and staff was not able to find him. Review of the facility's Missing Resident Policy revealed: In the event of a missing resident, staff will: A.) A resident will be considered missing when he/she is not in the facility and we cannot determine his/her whereabouts; and in addition, there is reason to be concerned for the resident's safety. B.) If the facility discovers a resident is missing we will: 1) Notify the	**"Responses to the cited deficiencies do not constitute an admission or agreement 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 f Correction is prepared solely as a matter of compliance with State law."**	

East Towne Assisted Living

supervisor and all other staff immediately. 2) Perform a hasty search of the building and the immediate areas outside the building. C.) If the resident is not found, we will immediately notify: 1) Local Law enforcement - Call 911 2) North Carolina Project Lifesaver 3) The resident's family member/responsible party 4) The County Department of Social Services 5) Management on call. D.) Post notifications, staff will initiate a Level II search (thorough search of the building, grounds, outside structures, dumpsters, storage buildings and vehicles). Staff will assure that required agencies are notified and an accident/incident repot is sent to DSS within 48 hours. DSS is to be called immediately in the event of a missing resident. (As in C above). E.) We will cooperate fully with law enforcement and or authorities in charge of search and rescue. Review of Resident #1's current FL2 dated 05/18/23 revealed: - Diagnoses included a history of primary spontaneous pneumothorax, difficulty in walking, emphysema, essential hypertension, and chronic obstructive pulmonary disease. - Resident #1 had intermittent confusion and was ambulatory. Review of Resident #1's Resident Register revealed he was admitted to the facility on 05/12/22, and he was his own responsible party. Review of Resident #1's Care Plan dated 04/19/23 revealed: - Resident #1 was independent with ambulating and transfers and required limited assistance with all other Activities of Daily Living (ADL). - Resident #1 was forgetful and needed reminders. - Resident #1 was not noted to have any wandering behaviors. Interview with Resident #1 on 07/18/23 at 3:40pm revealed: - Before he came to live at the facility, he lived at the Men's Shelter and could go wherever he wanted, whenever he wanted. - He recalled leaving the facility recently, when he caught a city bus and went "across town" to the bus station, where he transferred buses and went to his old neighborhood to go to the bank and to visit a family member. - He recalled leaving the facility "about lunchtime" after he had eaten lunch. - He went to his bank, took out some money, and then went to visit his family member, with whom he ate dinner. - He called the facility to let them know where he was and "a guy came" and picked him up and brought him back to the facility.	**Facility will implement responses conducted on the POP for immediate trainings and in services provided on 8/15/23** **<u>110A NCAC 13F .0906 (F)(4) Other Resident Care and Services:</u>** **Facility ED/DRC will complete an all staff training/in service to review the following policies:** **1. Resident Community Access- AL** **2. Sign In/Out Policy** **3. Missing Resident/Resident Elopement Policy** **4. Identification and supervision of confused/wandering resident policy** **Facility will ensure that all staff are following the expectations of the policies listed above. If at any point the facility is found to be non compliant with any of the above policies or the rule area below 10A NCAC 13F .0906 (F)(4) Other Resident Care and Services the Facility ED/DRC will immediately retrain staff as necessary.**	8/15/2023 9/14/2023

East Towne Assisted Living

- He planned on leaving the facility again soon and would let a staff member know before he left next time and thought he had told someone before he left last time. - He "did not think" the facility had a sign-out log that he needed to sign before he left the facility. - He did not know the name of the facility or the road on which the facility was located. - He did not know the phone number to the facility and said he used to have it on a piece of paper but it was thrown away recently. - When asked the current month, Resident #1 did not know. - When asked the current year, he asked if it was 1986. - When asked who the current president was he did not know. - Resident #1 could accurately recall his date of birth but was incorrect about his current age. Review of Resident #1's incident report dated 06/29/23 at 6:00pm revealed: - Resident #1 was not located in the community and had not signed out or notified any staff he was leaving. - Upon finding Resident #1, he reported he had visited a family member and was planning to return to the facility. - Resident #1 was not sent to the hospital for evaluation and would see his primary care physician during the physician's next visit. - The report documented the police and the County Department of Social Services (DSS) needed to be notified. - There was no documentation the person in charge of the facility notified the appropriate law enforcement agency and the County Department of Social Services (DSS) when Resident #1 was identified as missing. Review of County DSS facility complaint revealed the Administrator called to notify Resident #1 was missing on 06/29/23 at 10:18pm. Review of Resident #1's progress note dated 06/29/23 at 6:00pm revealed Resident #1 "left facility without informing staff." Review of Resident #1's progress notes from 05/12/23 – 06/28/23 revealed no documentation of other incidents in which Resident #1 left or attempted to leave the facility without supervision. Review of facility's Resident Sign In & Out log revealed Resident #1 had not signed out at any other time between 06/25/23 and 06/30/23.		

East Towne Assisted Living

Review of historical weather data on 06/29/23, revealed a high temperature of 88 degrees Fahrenheit between 2:00pm and 5:00pm. Review of Resident #1's visit notes with his Psychiatric Nurse Practitioner, dated 06/15/23 revealed: - Resident #1 had chronic and progressive dementia. - He was alert and oriented with some intermittent confusion and forgetfulness noted. - His cognition was at baseline. - Staff had no concerns with any behavioral disturbances. - Staff continued to provide supportive care and safety precautions. Review of the local LEO's report dated 06/29/23 revealed: - On Thursday, 06/29/23, LEOs responded to a call for service in reference to a missing person at approximately 9:00pm. - Staff reported to the LEO that Resident #1 had not been seen since 6:30pm. - Staff and residents had observed Resident #1 walking in the parking lot area of the facility before walking down the sidewalk. - Staff reported his only diagnoses was diabetes. - Staff reported that Resident #1 recently talked about visiting his old neighborhood. - A "be on the lookout" alert was sent out to other officers to look for Resident #1 around his old neighborhood. - All hospitals were contacted and did not have Resident #1 as a patient at that time. - The facility provided flyers with Resident #1's name and picture. - Resident #1 was entered into the missing person's database. - The report was amended as the investigation continued to include additional information. - On 6/30/23, a LEO visited the facility and was informed staff had located Resident #1 and he was brought back to the facility and Resident #1 was removed from the missing person's database. Interview with a second shift (3:00pm - 11:00pm) Personal Care Aide (PCA) on 07/18/23 at 3:20pm revealed: - Resident #1 was often confused "about everything" and frequently refused showers saying he had "just had one" that day. - Resident #1 was often in his room in bed or in the enclosed courtyard smoking a cigarette.		

East Towne Assisted Living

- Resident #1 was not allowed to go out the front door of the facility because he had attempted to leave the facility without signing out twice before the incident on 06/29/23. - She recalled once, staff had to chase him on foot down the road and into a nearby apartment complex. He hid behind trees, bushes and air conditioning units from staff during the chase. - On that occasion, staff were able to convince him to return to the facility. - Since then, he was not allowed to go out the front door of the facility. - Resident #1 talked "all the time" about leaving the facility and returning to his old neighborhood to visit a family member and to go to the bank. - She was assigned to Resident #1 on second shift on 06/29/23. - At the beginning of her shift between 3:00pm and 4:00pm, she looked for Resident #1 and he was not in his room or the courtyard. - She asked staff if anyone had seen him and no one had; around dinner time, she searched the entire building, including all closest and bathrooms. - She told the Medication Aide (MA) assigned to Resident #1 that day, that she had not been able to locate him. - She did not notify the RCD, RCC or the Administrator that she was not able to locate Resident #1 because this was the responsibility of the MA. - Sometime after dinner that evening, the MA contacted the Resident Care Director (RCD) and Administrator, who both came to the facility to help search for Resident #1 and then 911 was called. - The police arrived at the facility after staff completed the search outside and around the neighborhood. - Resident #1 was found late that night, after she had left the building at 11:00pm. - When a resident was identified as missing, staff were supposed to immediately report the incident to the administrator and police. - PCAs were not supposed to call 911, because this was a MA responsibility. Interview with a second PCA on 07/18/23 at 3:05pm revealed: - Resident #1 was "a little confused sometimes." - Resident #1 often spent time in the enclosed courtyard or on the screened-in smoking porch. - Resident #1 often said he was going to go back to his old neighborhood to see a family member and go to the bank.		

East Towne Assisted Living

- She did not feel comfortable letting Resident #1 onto the front porch of the facility because she was afraid he would attempt to leave the facility. - She recalled soon after he initially came to the facility a few months ago, there was an occasion one Sunday in which he walked away from the facility. - Staff observed him leaving the facility and quickly followed him down the sidewalk and through the neighborhood. - It took four staff members to catch up with Resident #1 and convince him to return to the facility. - The facility's policy on missing residents required staff to immediately notify management, including the Administrator and the RCD, conduct a quick search of the inside of the facility and around the building and neighborhood. Interview with a third PCA on 07/18/23 at 2:55pm revealed: - Resident #1 often talked about going to his old neighborhood to go to the bank. - Resident #1 was allowed to go outside in the enclosed courtyard and the screened in smoking porch. - Resident #1 was not allowed to go onto the unsecured front porch because he often talked about "leaving the facility and not coming back" and would say he was "going home." - She worked on first shift on 06/29/23 and recalled he ate lunch that day, watched television in the activity room for a while after lunch, and spoke to the Business Office Manager (BOM). - The facility policy regarding missing residents required that the Administrator, RCD or Resident Care Coordinator (RCC) and the police be notified of the missing resident. Interview with a second shift (3:00pm - 11:00pm) Medication Aide (MA) on 07/18/23 at 2:30pm revealed: - Resident #1 had memory problems and was often "a little confused." - Resident #1 would go into the enclosed courtyard or onto the enclosed smoking porch to smoke. - Resident #1 was not allowed to go onto the front porch of the facility without supervision. - She was working on second shift at the time Resident #1 was identified as being missing on 06/29/23, however she was not Resident #1's assigned MA. - The PCA assigned to Resident #1 on 06/29/23 noticed near the beginning of their shift at 3:00pm that Resident #1 was not in his room, as he usually was that time of day. - Later that evening at dinner, around 5:00pm, staff observed Resident #1 did not come to the dining room.		

East Towne Assisted Living

- Resident #1's PCA searched the entire building while the other residents were eating dinner and looked in all closets and bathrooms for him between 5:00pm - 5:30pm. - The PCA assigned to Resident #1 reported to her assigned MA that she had search the entire building and did not find him, and they concluded that Resident #1 was not in the facility and had likely left the facility prior to second shift starting on 06/29/23. - About 8:00pm, the PCA assigned to Resident #1 and another PCA approached her to tell her that Resident #1 had not been seen since the beginning of second shift and that they had reported this to his assigned MA earlier in the shift. - Prior to being notified at 8:00pm, she was not aware Resident #1 was missing. - She immediately, upon becoming aware that Resident #1 was missing at 8:00pm, she contacted the Administrator and the RCD. - The Administrator and the RCD were unaware Resident #1 was missing and soon arrived at the facility along with other staff members, who conducted an unsuccessful search outside of the facility and around the surrounding neighborhood. - Upon not being able to locate Resident #1 in their search around the facility, 911 was notified by either the Administrator or the RCD. - When a resident was identified as being missing, the facility policy required the staff member in charge to immediately contact the Administrator and the RCD, call 911, and prepare the facesheet to provide with the resident's information. - Staff did not need to obtain permission from any management prior to calling 911 in the event of a missing resident. Telephone Interview with a second shift (3:00pm - 11:00pm) MA assigned to Resident #1 on 06/29/23, on 07/21/23 at 12:23pm revealed: - She came in late on 06/29/23, after 4:00pm. - When she came into the facility on 06/23/23, no staff informed her that Resident #1 was not able to be located within the facility. - The first time anything about Resident #1 was mentioned to her, was sometime after dinner, around 5:30pm, when his assigned PCA mentioned he had not come to the dining room for dinner and that they were unable to locate him in the building. - She was busy passing medications to residents at the time and forgot to inform the lead MA. - The PCA later informed the lead MA, who immediately informed management.		

East Towne Assisted Living

- She was unsure of the exact time at which the lead MA was notified. Interview with Resident Care Director (RCD) on 07/12/23 at 12:05pm revealed: - According to her staff interviews, after dinner, Resident #1 left the facility around 6:00pm, when he followed another resident onto the front porch to smoke, without staff's knowledge that he had exited the front doors. - Other residents reported that Resident #1 walked into the parking lot and down the sidewalk. - Resident #1 had sat on the porch on many occasions with other residents and had not left the facility before. - Resident #1 did not sign out before leaving the facility. - Staff identified about 7:00pm that Resident #1 was not in the facility or on the porch and notified management they could not locate him. - She, and other management staff, came to the facility and began a search of the facility, the perimeter of the facility, and split up to search the surrounding neighborhood. - About 9:00pm, after their search of the surrounding area was unsuccessful, they called 911 to report Resident #1 missing, and also notified the company's corporate office. - She had been preoccupied with the search in the neighborhood for Resident #1, she did not think about notifying the police until 9:00pm. - After the police came and completed their report, she and 3 other staff members decided to go to Resident #1's old neighborhood to search for him, as he had recently talked about wanting to go to the bank. - At around 11:30pm, they observed Resident #1 at a bus stop in front of a business in his old neighborhood. - Resident #1 told her he took a city bus to his old neighborhood, where he had dinner with a friend and visited his sick son, before he went to the bus stop where he was eventually located. Interview with the Resident Care Coordinator (RCC) on 07/21/22 at 9:35am revealed: - Resident #1 "kept to himself" most of the time, spending time in his room or in the enclosed courtyard, where he frequently smoked. - Resident #1 spoke of going back to his old neighborhood frequently. - On 06/29/23 at 8:21pm she received a text message from a MA who was working in the facility at that time, that Resident #1 "was gone."		

- She immediately drove to the facility, driving through the surrounding neighborhood on her way there and went into a grocery store, where she had learned he had gone once before when he left the facility, but did not find him. - She went to the facility and assisted in searching for the resident. - Prior to 06/29/23, she was aware of one incident, in which Resident #1 had left the facility. - The first time Resident #1 left, soon after moving into the facility, she recalled the RCC at that time, informed staff that he was no longer allowed to go onto the unsecured front porch without supervision. - Staff should have documented each incident Resident #1 left the facility on an incident report, and there should have also been an observation documented as well upon his return. - She did not see any documentation in the progress notes or incident reports regarding the incidents prior to 06/29/23. - After the incident on 06/29/23, the facility had also requested a consultation with a neurologist to determine if Resident #1 had a diagnosis of dementia. - She was not aware the psychiatric nurse practitioner had documented Resident #1 had chronic and progressive dementia. - Staff should still have been documenting each shift on Resident #1. - New staff should have been informed that Resident #1 was not allowed to go on the porch without supervision when they shadowed other staff. Interview with Resident #1's Psychiatric Nurse Practitioner on 07/21/23 at 11:00am revealed: - Resident #1 had a cognitive impairment and was "forgetful" which had been his baseline, since she first saw him on 07/09/22. - She thought her first visit with Resident #1 was in response to the incident in which he ran down the sidewalk and staff catch up to him and convince him to return to the facility. - She was not sure of an exact date of when resident had ran down the sidewalk. - In the Psychiatric Progress Note from the visit on 07/09/22, she documented that Resident #1 "likes going outside and should not go off premises without supervision." - Resident #1 required supervision anytime he was outside of the facility because he had attempted to leave in the past. - She was not aware that Resident #1 had left the facility and was gone for several hours on 06/29/23 without supervision. - She was unaware of a prior incident in which Resident #1 left the facility unsupervised and went to a local grocery store.		

East Towne Assisted Living

- She believed Resident #1 had enough awareness to cross the street safely, watch out for traffic, and possibly even find his way back to his old neighborhood. - Her main concern with Resident #1 leaving the facility was that it was very "hit or miss" as to whether he would recall the name of the facility in which he lived, at any given time. - She was also concerned about the possibility of him being taken advantage of by others if he was out on his own. - She last saw Resident #1 yesterday, on 07/20/23, and no staff had mentioned to her that he had left the facility unsupervised on 06/29/23. Interview with Administrator on 07/21/23 at 11:05am revealed: - It was her understanding that the first time Resident #1 had eloped from the facility was on 06/29/23. - She recalled one occasion in which he had walked down the sidewalk soon after he was admitted, and staff went after him and were "right behind him" the whole time. - She was not aware that staff had been directed that Resident #1 was not supposed to go on the front porch without supervision. - She was not aware the Psychiatric Nurse Practitioner had recommended in July 2022 that resident not be allowed outside of the facility without supervision. - Her expectation was that the RCD and RCC would inform her of any incidents regarding residents who required increased supervision or who left the facility and were gone for hours. - She also expected if a resident was observed as being confused and was not allowed to leave the facility without supervision, that the RCD would reach out to the physician to have them assessed to see if a higher level of care was needed. - As soon as the lead MA notified her that Resident #1 was missing, she and the RCD immediately came to the facility with other staff and conducted an additional search of the surrounding area. - Upon not being able to locate Resident #1, the county DSS and LEO were notified. - Staff should have called 911 sooner, according to the facility's policy, but she and other staff were so focused on searching for Resident #1 that they did not think to call 911 immediately. - It was her understanding that Resident #1 left the facility after dinner on the evening of 06/29/23 and had only been gone about an hour before staff identified he was missing. - She was not aware second shift staff had not seen Resident #1 at any time during second shift, and he did not eat dinner in the facility on 06/29/23.		

East Towne Assisted Living

The facility failed to immediately notify local LEOs and the County DSS when Resident #1, who was diagnosed with intermittent confusion, was discovered missing and left unreported from the facility sometime after his lunch on 06/29/23. The facility did not contact law enforcement until 9:00pm, which resulted in approximately nine-hour delay of the search for the missing resident. This failure resulted in a substantial risk for serious physical harm and constitutes a Type A2 Violation. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 09/14/2023.		
The facility provided a plan of protection in accordance with G.S. 131-34 on 08/15/23.		

East Towne Assisted Living

IV. Delivered Via:	Certified mail and hand delivery	Date: 8/15/23
DSS Signature:	Denise Boardeman	Return to DSS By: 9/13/23

V. CAR Received by:	Administrator/Designee (print name): Paul Akosah	
	Signature: [signature]	Date: 8/15/23
	Title: Executive Director	

VI. Plan of Correction Submitted by:	Administrator (print name): Paul Akosah	
	Signature: [signature]	Date: 9/5/23

VII. Agency's Review of Facility's Plan of Correction (POC)

☐ *POC Not Accepted* | By: | Date:

Comments:

☒ *POC Accepted* | By: Denise Boardeman | Date: 9/8/23

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.*