Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Destiny Family Care Home #4
Address: 5818 Poole Road, Raleigh, NC 27610
County: Wake
License Number: FCL-092-290

II. Date(s) of Visit(s): 1/30/2024, 2/2/2024, 3/6/2024, 4/12/24
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 4/12/2024

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, Unabated Type B, Citation)* • *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** 5/3/24
Rule/Statute Number: **10A NCAC 13G .0901** **Personal Care and Supervision** Rule/Statutory Reference: (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. Level of Non-Compliance: **Type A1 Violation** Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 out of 4 sampled residents (#3) which resulted in six falls between December 2023 and January 2024. One of the falls resulted in broken ribs and, another fall resulted in a broken left arm. The findings are: Review of Resident #3's current FL-2 dated 02/03/23 revealed: -Diagnoses included muscle weakness (generalized), bipolar disorder (Unspecified), chronic obstructive pulmonary disease, generalized anxiety disorder, conversion disorder, unspecified fracture of right femur, cognitive communication deficit. -The resident required assistance with bathing and dressing. Review of Resident #3's current care plan dated 12/09/2023 revealed: -The resident was ambulatory with an aide or device.	☐ POC Accepted *DSS Initials* In compliance with rule 10A NCAC 13G .0901 Personal Care and Supervision. Assessment: • within 72 hours of admission the initial assessment will be completed by the Administrator on the resident register form DHSR AC 4207, • within 30 days the Administrator of the facility will conduct a thorough complete assessment using form DMA 3050R The Personal Care Physician Authorization and Care Plan form. • The Administrator will use an updated Fl2 and any hospital records that accompany the resident and/or any documents from prescribing practitioner and/or other licensed healthcare professionals including interview with resident and family to determine the level of risk for falls. • The reassessment will be at least annually thereafter. And, within 10 days of a significant change such as a fall or conditions as specified in rule 10A NCAC 13F.0801. •	5/30/24

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-The resident had limited range of motion with upper extremities. -The resident was "sometimes disoriented." -The resident was "forgetful – needed reminders." -The resident had limited vision "sees large objects." -The resident required extensive assistance with all Activities of Daily Living (ADLs). Review of Resident #3's Wake County Emergency Medical Services (EMS) report dated 12/10/23 revealed: -The chief complaint was injury to the chest due to a fall on 12/08/23, while out with Supervisor in Charge (SIC). -The resident hit the pavement and sustained a chest injury. -The SIC did not witness the fall or injury. Review of Resident #3's Emergency Department (ED) Discharge Summary dated 12/10/23 revealed: - The resident was admitted due to a fall and history of a seizure disorder. - She endorsed falling two days prior with pain with palpation, and deep breaths. - The resident stated her caregiver was trying to make her walk too fast and she lost her balance. -The resident reported she fell face first on the concrete. - Per radiology, the resident suffered acute left 4th, 5th, 6th rib fractures. Review of Resident #3's incident and accident reports revealed there were no reports submitted for the fall on 12/08/23. Review of Resident #3's Primary Care Provider (PCP) report dated 12/19/23 revealed: -The reason for the visit was a follow up from a hospital admittance due to a fall and broken ribs. -The resident was admitted to the hospital for one night between 12/10/23 to 12/11/23. -The resident stated she was walking, and someone was pulling her, and she tripped and fell. -The fall resulted in the resident having 3 broken ribs on her left side. Review of Resident #3's incident and accident report dated 12/25/23 revealed: -The resident was not using her walker while going outside and fell. -911 was called. -The resident was assessed, and paramedics got her off the floor.	**The facility has implemented the following: Intervention** • A call bell system in each resident's room that is connected to the staff room. • Each staff has a pager that is also attached to the call bell system in the event they are not in the staff office. • The facility has installed an alarm system on each exit door that announces "Front door open, Back door open" for quick awareness of persons entering and exiting the doors. • The facility has a sign in and out log for all residents and visitors entering and leaving the facility. • If a resident has been assessed as being a high risk for falls, the Administrator will request PT/OT orders from the client's PCP or Licensed health care professional, and a medication review from pharmacist, PCP, or Licensed health professional to ascertain possible causes of the fall. • Order request will include hospital type beds for clients who have been assessed as being a high risk for falls. • The facility will ensure that the bedrooms have night lights, bedrooms well lit, the hallways with night lights, and all areas such as hallways, exits, rooms and common areas are free of clutter and obstructions. • The bathroom showers have non-skid mats and grab bars installed in shower and toilet area.	5/30/24

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-No injuries were noted. Review of EMS records dated 12/25/23 revealed: -EMS was dispatched due to a fall. -Upon arrival, the resident was found lying supine on the ground. -The resident endorsed right flank pain. -The resident remained on the ground until arrival of EMS due to inability to get up without assistance. -The resident was lifted off the ground without complication and placed in a nearby chair. -No additional treatments were rendered. -The resident refused ambulance transport to the hospital. Review of Resident #3's incident and accident report dated 12/28/23 revealed: -The resident fell between the bed and wall. -She was not using her walker. -911 was called and the resident was assessed. -The resident stated she did not want to go to the hospital. -The paramedics told the resident if she falls again, she must go to the hospital. Resident #3 could not refuse transport anymore. Review of EMS records dated 12/28/23 revealed: -EMS was dispatched due to a fall. -The resident was found sitting upright, alert, and oriented, on the floor. -The resident complained of right leg pain. -EMS encouraged the resident to go to the hospital; she refused. Review of Resident #3's incident and accident report dated 01/10/24 revealed: -The resident fell on the floor. -She was able to get up on her own. -She was instructed to always use her walker. -She was assessed for injury and no injuries were discovered. -No additional action was taken by Medication Aide (MA)/SIC. Review of Resident #3's incident and accident report dated 01/15/24 revealed: -The resident was bending down and toppled over to the floor. -She was assessed for injury; no injuries were discovered. -No additional action was taken by MA/ SIC. Review of Resident #3's incident and accident report dated	**Supervision:** The facility has implemented a closer monitoring system of personal care and assistance for clients who have been assessed as high risk for falls. • The facility will increase staff assistance at specific high-risk times (mornings, evenings, high-traffic periods, like mealtimes) and have (scheduled) toileting every 2 hours with staff assistance. • These clients' MAR will be flagged using red color coding so all staff are aware that they have a high risk of falls. • Staff will accompany these type of clients during shower and bathing, • Staff will assist these type of clients when they get in and out of bed, • Staff will check clients every 2 hours through observation and document these observations in a log book implemented for that purpose. • These clients will be placed in areas where they are easily observed such as the living room and giving them individualized activities to also create easier and visual observation.	

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01/18/2024 revealed:
-The resident fell going to the bathroom without shoes.
-She slipped on the floor and fell backwards.
-She broke her left arm.
-She was in a lot of pain.
-EMS was called.

Review of Resident #3's EMS Runsheet dated 01/18/2024 revealed:
-The chief complaint was a fall with injury to the shoulder and upper arm.
-She was found lying on the floor inside the residence.
-She was alert, coherent, and cooperative and appeared to be in pain.
-She was transported to the hospital where she remained.

Review of ED discharge summary dated 01/18/24 revealed:
-The resident was admitted due to a fall.
-She suffered a fracture in the left humerus.
-The resident's arm was placed in a splint.

Review of ED summary dated 01/19/2024 revealed:
-The resident returned and was admitted to the hospital.
-She returned due to the splint on her arm shifting throughout the night.

Observation and interview of Resident #3 at a local hospital on 01/30/24 at 11:18a.m. revealed:
-Resident #3 had a sling covering her left shoulder and arm. She was lying in bed with a red band identifying her as a fall risk.
-She was confused and not a good historian.
-She stated she fell and broke her arm while downtown with her caretaker for an appointment.
-She wasn't sure if she had her walker with her.
-She was unaware if she had a seizure.
-She stated she was rushed by the caretaker stating, "I can't move but so fast."
-She could not recall injuring her ribs.

Telephone interview with Resident #3's PCP on 02/21/24 at 3:45p.m. revealed:
-The resident had been a patient since December 2022.
-The resident was usually not accompanied by anyone during her visits.
-A referral was made to a Neurologist in October 2023 due to the resident's "remarkable" history of seizures.
-She was unaware the resident had 14 falls from 12/2022 – 01/2024.

Incident Fall Tracking

5/30/24

The facility has implemented the following tracking system for incidents of falls:

- The Administrator will review incident reports monthly and determine if a higher level of care is required. And, if more intervention is required depending on what is working and what is not working
- A 24 hour shift report log will be implemented.
- Staff will document all incidents that occurred on that shift in the 24 hour shift report log.
- Staff will fill out an incident report of the incident that occurred providing all information of what happened, where, time, location, resident, if hospitalized, and any additional pertinent information surrounding the incident.
- Staff will also communicate verbally with the on-coming staff of the next shift any incident and falls that occurred during their shift.
- In case of multiple falls and falls with injury, a care plan meeting with a family/POA/RP will be held to discuss the falls and inform them of what has been implemented by the facility, what is working and not working, and if a higher level of care is required for the safety of the resident.

5/30/24

Staff Training:

The Administrator will ensure that the following training is done during orientation, annually, and frequent in-service training, including after an incident such as a fall:

- Assessment training for staff that conduct assessments
- Fall Prevention
- FL2/Care Plan
- Wandering/Elopement
- Ambulation Training(Gait, transfer)
- Symptoms of illnesses (e.g., UTI, high blood pressure, seizures, etc.)
- Devices and alarms
- Mental Health training
- CPR/FA
- Facility Policy and Procedure Review (e.g., incident reporting, elopement/wandering, Communication with PCP and other licensed healthcare professionals, abuse and neglect

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-She was unaware the resident was hospitalized due to a broken left arm.
-She saw the resident on 12/19/23 as a follow up visit from a hospital visit on 12/10/23 due to a fall.
-She learned of the resident's fall after receiving reports from the hospital.
-Additional referrals to neurology would have been completed if the provider was aware of the fall history.

Interview with SIC, on 03/6/24 at 11:47a.m. and 03/25/24 at 10:38a.m. revealed:
-The written policy/ procedure on resident falls was to contact Department of Social Services after each fall.
-The facility used a fall assessment form.
-In the event of a fall, staff were trained to call 911, document the incident/ accident and inform the Administrator.
-After each fall, Resident #3 received hourly checks to make sure she was using her walker.
-There were no other interventions implemented to prevent future falls.
-The SIC reported she informed the hospital of Resident #3's need for a higher level of care but she was always returned to the family care home.

Interview with the Administrator on 03/06/24 at 1:30pm revealed:
-He was out of the country from 11/25/23 – 02/29/24.
-The SIC was the point of contact/ person in charge during his absence.
-He was not aware of the fall history for Resident #3.
-He was not aware of the details of Resident #3's most recent fall.
-The facility did not have a written fall policy.
-Staff were trained to call 911 for falls to ensure residents were safe.
-Staff should notify the Administrator and document the incident or accident.
-The resident should be reassessed by their PCP.
-Residents were identified as a "fall risk" per documentation on the FL-2.
-If a resident suffered multiple falls, an assessment was completed to determine a change in functioning.
-The facility did not have a tracking system to track falls.
-If a change in functioning had occurred, the facility would reassess to determine if the resident's needs could be met.
-After each resident fall, staff should monitor the resident for 7 days to determine functioning status.
-The Administrator should be notified.
-Staff were trained on falls during orientation

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-The last training on falls was 2 years ago.

Attempted telephone interview with a MA on 01/31/24 at 3:01pm, 02/01/24 at 12:33pm, 02/03/24 at 3:58pm, 02/07/24 at 10:00am, 02/13/24 at 2:27pm were unsuccessful.

The facility provided a Plan of Protection (POP) in accordance with G.S. 131D-34 received on 03/6/24 for this violation.

The facility failed to provide supervision for one resident (#3) who had a diagnosis of generalized muscle weakness and a recent history of seizures and a recent history of multiple falls. The resident sustained six falls between December 2023 to January 2024 one of which resulted in three fractured ribs and another that resulted in a fracture to her left arm.

This failure resulted in serious physical harm and constitutes a Type A1 violation.

Correction date for this A1 violation shall not exceed 05/12/24.

IV. Delivered Via:	**Hand Delivery**	Date: 4/12/24
DSS Signature:	Vanya Reynolds	Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name): EZE IHENACHO	
	Signature:	Date: 4/12/24
	Title: Administrator	

VI. Plan of Correction Submitted by:	Administrator (print name): EZE IHENACHO	
	Signature:	Date: 5/31/2024

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

☐ ***POC Not Accepted*** By: Date:

Comments:

☑ ***POC Accepted*** By: Vanya Reynolds & Lillian Rayner Date: 5-31-2024

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.*

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