Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Destiny Family Care Home #4 County: Wake
Address: 5818 Poole Road, Raleigh, NC 27610 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
Instructions to the Provider *(please read carefully)*: Exit/Report Date: 4/12/2024

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*	

-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'sWake 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 4^{th}, 5^{th}, 6^{th} 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.

-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

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.

-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		

-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): E.E. IHENACHO	
	Signature:	Date: 4/12/24
	Title: Administrator	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

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

☐ *POC Not Accepted*	By:	Date:

Comments:

☐ *POC Accepted*	By:	Date:

Comments:

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No		Date Sent to ACLS:

Comments: