Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Gardens of Trent
Address: 2915 Brunswick Avenue, New Bern, NC 28560
County: Craven
License Number: HAL-025-035
II. Date(s) of Visit(s): 11/8/2022, 12/12/2022, 12/16/2022, 1/4/2023, 1/6/2023, 1/6/2023
Purpose of Visit(s): Complaint Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: 1/6/2023

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 Type A2 violation**, this agency may prepare an Administrative Penalty Proposal for the violation(s). Please submit any additional information within 5 days to be considered prior to the preparation of the penalty proposal. If on follow-up survey the violations are not corrected, a civil penalty of up to $1000.00 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
Rule/Statute Number: 10A NCAC 13F .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 A2 Violation Findings: This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#1), who had a diagnosis of dementia, was intermittently disoriented, was semi-ambulatory and eloped from the facility on 10/25/2022. The Findings are: Review of the Facility's Missing Resident Policy dated September 2021 revealed: -In the event of a suspected missing resident: A resident will be considered missing when he/she is not in the community and we cannot determine his/her whereabouts; and in addition, there is reason to be concerned for the resident's safety. -If the community discovers a resident is missing, we will:	☐ POC Accepted _____ *DSS Initials* Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law. Executive Director or designee will ensure all doors are in proper working order to include alarms and magnetic locks. A secondary alarm was installed on all doors 1-23-23.	1-23-23 and ongoing.

ED 2/7/23

notify the Supervisor and all other staff immediately and perform a hasty search of the building including the immediate areas outside the building. -If the resident is not found, we will immediately notify: Local Law enforcement, call 911 the resident's family member/responsible party; the county Department of Social Services; management on call, and the Divisional Vice President of Operations & Divisional Director of Clinical Services. Review of Resident #1's current FL-2 dated 08/03/22 revealed: - The recommended level of care was Special Care Unit (SCU). - Diagnoses included dementia, chronic infarct left cerebellar hemisphere, asymptomatic hypertension. -The resident was intermittently disoriented. -The resident was semi-ambulatory (no device listed). Review of Resident #1's Resident Register revealed Resident #1 was admitted on 02/07/22 and had a named Guardian. Review of Resident #1's Care Plan dated 02/10/22 revealed: -The resident was sometimes disoriented. -The resident was forgetful and needed reminders. -The resident required supervision/set up for ambulation/locomotion. -The resident required supervision/set up for transfers. -The resident required extensive assistance with bathing, -The resident required limited assistance with dressing and grooming/personal hygiene. Review of the Incident/Accident Report for Resident #1 which was dated 10/25/22 at 3:53pm revealed: -The incident type was an elopement off community grounds. - The location of the incident was outside, not on facility grounds. -The description of the incident was the resident was getting ready to eat. -The Primary Care Provider (PCP) was notified at 4:58pm on 10/25/22. -The Responsibly Party (RP) was notified at 4:59pm on 10/25/22. -Emergency Services were not notified. Review of Resident #1's Progress notes dated 10/25/22 at 5:13pm revealed: -The type of accident was noted as a fall not an elopement. -The date and time of the incident was 10/25/22 at 3:53pm.	Staff reeducated on the importance of reporting any time it is noted a door alarm or mag lock is not in functioning order, the importance of notifying responsible party/family member and the importance of following the missing persons policy. Executive Director or designee will notify law enforcement when a resident is unaccounted for.	1-23-23 2-17-23

-The RP was notified. Review of Resident #1's Progress notes dated 10/25/22-10/29/22 revealed no additional documentation related to Resident #1's elopement on 10/25/22. Interview with the Administrator on 01/06/23 at 3:04pm revealed: -The mag locks were not working, and doors were unlocked for 13-15 hours on 10/25/22. -She called for assistance from a Fire and Security company, but the company could not visit the facility until the following day. -Staff was monitoring doors on 10/25/22, sitting in general areas so they could view all doors. -Maintenance staff from another facility came and was looking for the breaker boxes. -Maintenance staff and the Administrator checked the breakers and one of the switches was tripped. -Police were not notified because staff believe they knew where Resident #1 was and were able to retrieve Resident #1. -She was not concerned about Resident #1 being at risk of harm because Resident #1 seemed to be very well versed in getting across streets because when Resident #1 was at another facility, he was out on the streets a lot. Interview with the Activity Director on 01/06/23 at 9:44am revealed: -Resident #1 often would push on doors and needed to be redirected. -The doors were not working on 10/25/22 and all the doors were unlocked. -Staff were supposed to watch all doors while the doors were unlocked. -The left side/green side of the facility where Resident #1 resides had 2 Personal Care Aides (PCA's) and 1 Medication Aide (MA) working 2nd shift on 10/25/22. -Training provided by administration stated a staff was to be at every door when locks malfunctioned, which they were not on every door or Resident #1 would not have gotten out. -Resident #1 could not be located at 3:53pm on 10/25/22 and she asked the other staff if they had seen Resident #1. -Staff checked every single room when staff realized Resident #1 was not in the building; the next step was to check outside. -She and 2 other staff left in the company van to look for Resident #1. - She and the other staff drove around and stopped at a gas station, got out and walked around looking for Resident #1 at local businesses.	Executive Director or designee will complete weekly checks of all doors for the next 30 days to ensure alarms and mag locks are working correctly. Executive Director or designee will immediately contact vendor to fix any alarm/mag lock not in working order. RCC identified residents who are at increased risk of of wandering/elopement and placed on increased supervision for safety.	2-17-23 2-17-23 and ongoing 1-23-23

-Resident #1 was located sitting by the entrance inside the restaurant. -She had concerns for Resident #1's safety due to his dementia and having to cross the street to get to the restaurant. Observation of the facility's surrounding area on 01/06/2023 at 9:15am revealed: -The facility's front entrance led to an open space of a paved parking lot. -There was a split parking lot, with 4 rows of parking spaces. -The distance from the facility to the paved road in front of the facility was 158 feet. -There was no sidewalk on the Facility side of the street. -There was a sidewalk across the street from the facility and a large ditch that measured 62 inches deep and 38 inches wide. Observation of the city highway that Resident #1 had to cross to get to the restaurant on 01/08/23 from 3:53-4:06 revealed: -The paved city highway that Resident #1 crossed has a posted speed limit sign of 45mph. -The distance from the facility to the restaurant where the resident was found was 704 yards. -From 3:53pm to 4:06pm approximately 330 vehicles drove past in both left and right directions on the city highway. Interview with the Lead Supervisor on 01/04/23 at 2:23pm revealed: -There was a new resident in the facility who was pushing on doors. -The staff were looking for the new resident who was on 15-minute checks when they realized they did not see Resident #1. -The Lead Supervisor and 2 other staff took the facility van to look for Resident #1. -A member of the community told staff Resident #1 was at a gas station. -When staff were at the gas station, one of the staff saw him in the window of the restaurant. -It was about 10 minutes from the time staff noticed Resident #1 was missing to the time Resident #1 was found. Second interview with the Lead Supervisor on 01/6/23 at 10:20am revealed: -Staff were looking for another resident who was on 15-minute checks when she did not see Resident #1. -The last time Resident #1 was seen by her was at 9:30am. She checked on residents 2 or 3 times throughout the day at that time.		

-Someone from the community came to the facility through a side door and stated they thought they saw a resident leave through the door. -Resident #1 was found sitting on a bar stool at the restaurant. -Resident #1 sat for 5 minutes, and someone gave him a meal. -This was not the first time the mag locks were not working. It did not happen a lot but had happened before. -If there was not enough staff to watch the doors, the office staff would sit at the doors, but it was mainly the PAC's and housekeepers. -She was concerned for Resident #1's safety as he did not have a steady gait and could be stubborn. He could have fallen when he was walking and could have been hit by a vehicle. - Didn't remember Resident #1 having a cane with him. Interview with a Community Member on 12/12/22 at 1:58pm revealed: -Resident #1 was walking past their business on their side of the street opposite of the restaurant. -A vehicle pulled into the parking lot of the business and a staff of the facility walked inside the business looking for someone. -She asked if everything was okay, and the staff stated a resident got out of the facility and they were trying to locate the resident. Interview with a Facility Staff on 01/04/23 at 3:44pm revealed: -The Lead Supervisor informed the staff that Resident #1 was missing and asked staff to drive the van to search for Resident #1. -She and 2 other staff got into the van. -She drove down the street and turned left onto major street. -They stopped at a gas station, parked the vehicle, and separated to look for Resident #1. -She checked 2 restaurants, a barbershop, and a medical supply business before another staff found the resident. -She got into the facility van and picked up Resident #1 at the restaurant. -Resident #1 had food and a drink from the restaurant. Interview with the Director of Resident Care (DRC) on 01/06/22 at 10:30am revealed: -Staff came and said Resident #1 was missing at 3:53pm on 10/25/23. -They started looking in bedrooms, bathrooms, and courtyards. -A member of the community informed her that they thought they saw Resident #1 at a store.		

-From the time they found out Resident #1 was missing to the time Resident #1 was found was 10-15 minutes.
-She was worried about Resident #1's safety as he had dementia.
-She was concerned about traffic but felt he could look both ways when crossing the street.
-Resident #1's main goal was to get to the specific restaurant.

Interview with the second shift MA on 01/04/23 at 3:25pm revealed:
-The afternoon on 10/25/22 was hectic, the residents were finishing BINGO, it was shift change, something was not working with the mag door locks, and Resident #1 got out of one of the doors.
-The doors were being fixed when Resident #1 got out of the facility.
-She stayed in building while 4 staff went out of the facility to look for Resident #1.
-About 15 minutes after he was found the doors were fixed.

Second Interview with the second shift MA on 01/06/23 at 3:40pm revealed:
-She believed Resident #1 got out of the side door on the green/left side of the of the SCU.
-She contacted Resident #1's RP.
-She contacted the PCP about checking on him the next day and notified the PCP about the incident.
-She believed he was at an increased risk of harm crossing busy streets.

Interview with the PCP on 01/06/23 at 8:43am revealed:
-Resident #1 found an issue with a door, got out and went to a restaurant; Resident #1 figured out how to get out the door.
-Someone bought him food from the restaurant before staff brought Resident #1 back to the facility.
-Resident #1 had cognitive issues.

Telephone Interview with Resident #1's RP on 01/06/23 at 1:20pm revealed:
-She was not aware that Resident #1 had left the facility on 10/25/22.
-She did not recall getting a phone call regarding Resident #1 eloping off the property.
-The only time she had been notified from the facility was when falls happened or Resident #1 had appointments.
-She was concerned how he managed to get out of a locked facility and why he was off the property alone.

The failure of the facility to provide supervision in accordance

with Resident #1's assessed needs and care plan resulted in Resident #1 eloping from the facility on 10/25/22. Resident #1 was found by staff approximately 704 yards away from the facility sitting at a restaurant where he had to cross a busy city highway. This failure placed the resident at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/23/23 for this violation. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 02/17/23		
Rule/Statute Number: 10A NCAC 13F .0305 Physical Environment Rule/Statutory Reference: (a) An adult care home shall provide living arrangements to meet the individual needs of the residents, the live-in staff and other live in persons. (h4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. Level of Non-Compliance: Type B Violation Findings: This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to hear and respond to an audible working sounding device for the mag lock switch cover after one of the locking switches was disabled resulting in potential detrimental risk of safety and the welfare of all residents as it was a Secure Memory Care Unit. The Findings are: Review of Resident #1's current FL-2 dated 08/03/22 revealed: - The recommended level of care was Special Care Unit (SCU). - Diagnoses was Dementia, Chronic Infarct Left Cerebellar Hemisphere, Asymptomatic Hypertension. -Resident #1 was intermittently disoriented.	Maintenance Director will check the door alarms and magnetic locks daily to ensure they are in proper working order and mag locks are engaged. Any door alarms or mag locks not in working order, the facility will begin fire watch.	1-23-23 and ongoing. 2-17-23 and ongoing

Review of Resident #1's Care Plan dated 02/10/2022 revealed that Resident #1 was forgetful, needed reminders and was sometimes disoriented. Review of Resident #2's current FL-2 dated 09/07/22 revealed: -The recommended level of care was Special Care Unit (SCU). -Diagnosis was Dementia, Acute Raspatory Failure with Hypoxia, Bilateral Pneumonia, Closed Head Injury S/P Fall, Cardiac Pacemaker in situ, Thrombocytopenia. -Resident #2 was constantly disoriented. Review of Resident #2's Care Plan dated 09/07/22 revealed that Resident #2 was forgetful, needed reminders, and was sometimes disoriented. Review of Resident #3's current FL-2 dated 01/05/22 revealed: -The recommended level of care was Special Care Unit (SCU). -Diagnosis was Schizo Effective Disorder, Dementia in Other Dis. w/ Behavioral Disturbances. Fibromyalgia, HTN, Anxiety, Osteopenia, Insomnia. -Resident #3 was intermittently disoriented. Review of Resident #4's current FL-2 dated 10/14/22 revealed: -The recommended level of care was Assisted Living with Memory Care. -Diagnosis was Alzheimer's Disease, Hypertension, Depression, Hypothyroidism, Kidney Disease, and Paroxysmal A Fib. -Resident #4 was intermittently disoriented. -Resident #4 was a wanderer. Review of Resident #4's Care Plan dated 11/21/22 revealed that Resident #4 had a social history of wandering, was forgetful, needed reminders and was sometimes disoriented. Review of Resident #5's current FL-2 dated 02/09/22 revealed: - The recommended level of care was Special Care Unit (SCU). - Diagnoses was Senile Dementia, Hypertension, Osteoporosis-Compression FX, Hyperthyroidism, Chronic Kidney Disease, Type 2 DM-Diet Only, Inflammatory Arthritis, Dyslipidemia.	ED/RCC reducated the staff on the importance of monitoring residents identified as requiring increased supervision, the importance of closely monotoring doors during fire watch and the importance of quickly reporting any compromised door exit alarms or mag locks.	1-23-23

-Resident #1 was intermittently disoriented.
-Resident #4 was a wanderer.

Review of Resident #5's Care Plan dated 03/02/2022 revealed that Resident #5 was forgetful, needed reminders, and was sometimes disoriented.

Observations of the facility on 11/08/22 at 4:26pm revealed:
-One of the doors at the back of the facility on the left side of the facility was unlocked.
-All other doors in the facility were locked.
-The mag lock was not engaged on the one door.
-The door was opened, and the alarm did not sound.
-The switch next to the door was flipped down.
-The cover for the switch was present.
-When the cover was removed, the alarm sounded.
-Staff were not aware the door was unlocked.
-Staff had a code that they used if they wanted to open the door, they did not use the switch.

Interview with the Activity Director on 01/06/23 at 9:44am revealed that Resident #1 often would push on doors and needed to be redirected.

Interview with the Director of Resident Care (DRC) on 12/16/22 at 4:20pm revealed:
-The switch states to lift cover in the case of emergencies.
-The residents have dementia and so if they see the words lift here, they will think to lift it.

Interview with the Administrator on 11/08/22 at 4:50pm revealed:
-It was unknown when the switch was flipped.
-Conducted protocol for possible missing residents including a head count on 11/08/22.
-All resident were accounted for on 11/08/22 by 4:40pm.

The facility failed to hear and respond to an audible working sounding device for the mag lock switch cover after one of the locking switches was disabled resulting in potential detrimental risk of safety and the welfare of all residents who are known to wander as it was a Secure Memory Care Unit.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/08/22 for this violation.

CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 02/17/2023

Facility Name: Riverstone

IV. Delivered Via: In Person **DSS Signature:**		Date: 1/27/23 Return to DSS By: 2/17/23
V. CAR Received by:	Administrator/Designee (print name): Kris Boe Signature: Title:	Date: 1/27/23
VI. Plan of Correction Submitted by:	Administrator (print name): Kris Boe Signature:	Date: 2/1/23

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

☐ *POC Not Accepted* — By: — Date:

Comments:

☒ *POC Accepted* — By: — Date: 2/18/23

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.*