Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Summit Place of South Park
Address: 2101 Runnymede Lane, Charlotte, NC 28209
County: Mecklenburg
License Number: HAL-060-116

II. Date(s) of Visit(s): 11/08/23; 12/04/23; and 12/14/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 01/03/24

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 .0901(b) Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	☐ POC Accepted _____ *DSS Initials*	
Level of Non-Compliance: Type A2 Violation Findings: Based on observations, interviews and record reviews, the facility failed to immediately implement its policy and procedures for an attempted elopement for 1 of 5 sampled residents (Resident #5) resulting in an elopement from the Special Care Unit (SCU). Observation of the SCU on 11/07/23 at 4:20pm revealed: -There was a common area upon entering the SCU. -Directly across the room from the entry door, there were two French doors leading to a secured patio area. -An alarm was positioned above each of two unlocked doors. -When either of the two doors were opened, neither alarm sounded. Observation of the SCU patio on 11/08/23 at 11:17am revealed:		Please develop a plan of correction with a specific date of completion submitted within fifteen (15) working days from the date of receipt of the Corrective Action

-There were resin benches on the patio with a seat height of 17-1/2 inches and back height of 31-1/2 inches. -The height of the brick security wall was 58-1/4 inches. -The total height of the brick security wall and metal-slated fencing atop the brick was 95 inches. -The height of a covered electrical box, affixed to the brick security wall beside the security gate was 48 inches. -The height of the metal-slated security gate was 88 inches. Review of the facility's Wandering and Elopement policy dated 08/01/22 revealed: - The Elopement Risk Assessment was to be completed upon admission for residents who had a history of wandering. - The facility needed to develop and/or update the resident's individualized service plan (ISP) as soon as practical and review with clinical team members if the resident was determined to be at risk for Elopement. The ISP would include interventions to minimize the potential for resident Elopement. Review of the facility's Guidelines of Wandering/Elopement Risk Evaluation Tool dated 04/01/21 revealed that a Wandering/Elopement Risk Evaluation was to be completed prior to admission/move-in or within eight hours of move-in/admission. Review of Resident #5's hospital Discharge Summary dated 11/02/23 revealed: -She had been in the emergency room from 10/11/23 until 11/02/23 with severe dementia with behavioral disturbance and severe agitation. -She was not oriented to person; place, or time. -She was verbally and physically abusive; dangerous to self and others; and wandered. -She required supervision with all activities of daily living. -She was discharged from in-patient care to a memory care facility on 11/02/23. Review of Resident #5's FL2 dated 11/02/23 revealed: -Resident #5's diagnosis was neurocognitive disorder. -She was constantly disoriented. -She was ambulatory and wandered. Review of Resident #5's SCU pre-admission assessment and profile dated 11/02/23 revealed: -Resident #5's diagnoses were neurocognitive disorder, hypertension, major depressive disorder, hyperlipidemia, and hypothyroidism.		Report

-Resident #5 had a history or current issue with psychiatric/mental diagnosis. -She was a serious danger to herself and others. -She was physically abusive and combative. -Resident #5 habitually wandered. Review of Resident #5's facility progress notes dated 11/04/23 revealed: -Resident #5 was very agitated during breakfast and was trying to get out of the emergency door. -Resident #5 refused lunch and stated she "needs to go and will eat when she gets home." -Staff tried prompting and cueing, and Resident #5 still refused to eat. Review of Resident #5's facility Resident Notes dated 11/05/23 revealed: -Before lunch, Resident #5 had to be redirected multiple times for trying to climb over the fence in the patio area. -She was very agitated. -Staff walked with Resident #5 one-on-one to try to calm her down. -There was no documentation of any additional interventions for Resident #5. Review of the Resident #5's accident/incident report dated 11/07/23 revealed: -On 11/06/23 at 2:30pm, Resident #5 eloped from the facility by hopping over the gate. -Resident was located by police and returned to the facility at approximately 3:25pm. -The elopement was unwitnessed, and Resident #5 was uninjured. Review of Resident #5's record revealed there was no documentation of an Elopement Risk Evaluation completed prior to 11/06/23, when Resident #5 eloped from the SCU. Review of Resident #5's emergency room (ER) discharge summary dated 11/06/23 revealed: -Resident #5 was seen for medical clearance after climbing a 8-10 foot fence and going for a 2-mile walk. -Resident #5 had several superficial skin tears on the right lower anterior leg. -Resident #5 was discharged back to the facility's Special Care Unit on 11/06/23.		

Review of Resident #5's police department incident report dated 11/06/23 revealed: -A missing person report was filed by the facility's Assistant Resident Care Director (ARCD) on 11/06/23 at 12:30pm. -The resident walked away from the residential care facility around 12:30pm and could not be located. Review of a follow up email dated 11/13/23 from the investigating detective revealed: -The exact route Resident #5 walked away from the facility was unknown. -She was located on 11/06/23 at 3:00pm. Observation on 12/04/23 of the route taken by Resident #5 revealed: -From the facility to where Resident #5 was located was 1.9 miles. -There were 5 intersections, 1 T-junction, and 5 sideroads to cross. -Of the 5 intersections, one intersection had 5 lanes; one had 4 lanes; one had 3 lanes, and two had 2 lanes each. -The 5 sideroads each had 2 lanes. -The T-junction had 5 lanes, one lane being a right turn on red lane. -Sidewalks lined each road. Observation of traffic patterns on 11/08/23 in front of the facility from 1:00pm until 1:30pm revealed: -There were five lanes of traffic. -The posted speed limit was 35 miles per hour. -There were 918 vehicles observed that passed within 30 minutes, including 3 city buses; 2 work trucks pulling large trailers with equipment; 1 tree cutting vehicle; and 1 commercial delivery truck. Observation of traffic patterns on 12/04/23 from 1:00pm until 1:30pm where Resident #5 was located revealed: -There were five lanes of traffic. -The posted speed limit was 35 miles per hour. -There were 1300 vehicles observed that passed within 30 minutes, including 1 wide load semi-truck hauling excavation equipment; 5 school buses; 1 large moving van; 2 straight trucks; 3 dump trucks; 3 tree cutting vehicles; 1 power truck; 1 garbage truck; and 14 pickup trucks pulling large trailers with equipment. Review of local weather history on 11/06/23 revealed:		

-The temperature on 11/06/23 at 12:30pm, when Resident #5 was reported missing, was 74 degrees. -The temperature on 11/06/23 at 1:00pm was 75 degrees. -The temperature on 11/06/23 at 1:30pm was 76 degrees. -The temperature on 11/06/23 at 2:00pm was 76 degrees. -The temperature on 11/06/23 at 2:30pm was 76 degrees. -The temperature on 11/06/23 at 3:00pm, when Resident #5 was located by police, was 76 degrees. Telephone interview with Resident #5's responsible person revealed: -When he arrived for a planned visit with Resident #5 on 11/06/23 at 4:00pm, he learned she had eloped; and police had brought her back to the facility. -The Assistant Director of Resident Care (ADRC) and Memory Care Director (MCD) was on the patio listening to Resident #5 telling them how she left the facility over the gate. -Resident #5 had some scratches on her right leg. -He was never notified of Resident #5's attempts to leave the facility or the elopement on 11/06/23. -The ADRC told him that Resident #5 had tried to leave the facility for three days. -The only other communication he had from the facility was on 11/02/23, the night Resident #5 moved into the facility, from the "sales guy" who said she was okay. -He was instructed to take Resident #5 to the hospital to be checked after she returned to the facility on 11/06/23. -Resident #5 was examined at the emergency room and released without any treatment. -When he returned to the facility with Resident #5, he was told he could not leave until a 24-hour sitter arrived. -Resident #5 had a psychiatric evaluation on 11/07/23. -For three days after Resident #5's psychiatric evaluation, he requested to review the results with the provider, which never occurred. -The ARDC told him on 11/08/23 that Resident #5's medications were working, and she seemed fine. -An hour later, on 11/08/23, he received a call that Resident #5 was being aggressive and was sent out to behavioral health. Confidential telephone interview with a staff revealed: -The first day she worked with Resident #5 was on 11/04/23. -Resident #5 was quiet and sitting and had some moments when she paced and tried to get out of exit doors. -On 11/05/23, the receptionist was alerted by someone in Assisted Living that Resident #5 was on the patio and tried to climb over the fence. -A staff from the SCU redirected Resident #5.		

-The Manager on Duty, who was the Business Office Manager (BOM) showed her a message from with the Executive Director (ED) with instructions to call the ADRC with instructions to call the family to provide Resident #5 with a sitter. -She called the ADRC with instructions, from the ED, to call the family to provide Resident #5 with a sitter. -Resident #5 did not have a sitter on 11/05/23 or 11/06/23, the date she eloped from the facility. -When she arrived for work on 11/06/23, she thought the facility was conducting an elopement drill. -Staff conducted a head count of residents, as they were unaware which resident was missing. -Resident #5 was returned to the facility by a police officer at 3:30pm. Confidential telephone interview with a second staff revealed: -She worked with Resident #5 on 11/05/23. -She was redirecting a resident and did not see Resident #5 go onto the patio. -The concierge altered her that Resident #5 was on the patio attempting to climb over the wall. -She observed Resident #5 had pushed a chair against the wall to assist her. -She was able to talk Resident #5 into coming down from the wall. -The incident was reported to the Medication Aide (MA) on the unit and the Manager on Duty. -She understood that the facility policy for elopement attempts was to notify the MA, the Manager on Duty, and oncoming shift of an elopement attempt. -She understood the facility's SCU supervision policy was for one staff to provide personal care to residents, while the second staff supervised the other residents. Interview with a first shift Medication Aide (MA) 11/08/23 at 12:38pm revealed: -She worked with Resident #5 on 11/03/23 in the SCU. -Resident #5 appeared to be "fine" and "normal" during the day; she was engaging with other residents. -Between 3:30pm-4:00pm on 11/03/23, Resident #5 became agitated; grabbed her clothes into her arms; was hitting at staff; and stated that she was "ready to go." -She was off work at 4:00pm on 11/03/23 and left. -On 11/06/23 during lunchtime, Resident #5 did not want to eat lunch. -Resident #5 left the dining room; came back to the dining room; ate very little; and sat in the dining area.		

-Resident #5 displayed no exit seeking behaviors during lunchtime. -She had read in Resident #5's record that she was exit seeking over the weekend. Interview with a first shift Personal Care Aide (PCA) on 11/08/23 at 12:45pm revealed: -She worked with Resident #5 on 11/03/23, who was running and trying to hit staff. -Resident #5 would sit on the floor and did not want to eat breakfast or lunch. -She did not recall Resident #5 going onto the patio on 11/03/23. -On 11/06/23, Resident #5 pushed her lunch plate away from her. -She took Resident #5 to the bathroom; but rather than use the bathroom, Resident #5 sat on the floor outside of her bedroom. -She did not see Resident #5 go onto the patio. -She had not seen Resident #5 since she sat on the floor at her bedroom earlier. -Staff did not notice Resident #5 was missing until about 2:50pm – 3:00pm. -Staff were not allowed to leave from first shift until Resident #5 was found. -She was unsure of the time that local police returned Resident #5 to the facility. Interview the Memory Care Director (MCD) on 11/07/23 at 4:25pm and 11/16/23 at 11:35am revealed: -Resident #5 was admitted to the SCU around 5:00pm on 11/02/23 when she was leaving work. -She was off work on 11/03/23, 11/04/23, and 11/05/23. -On 11/06/23, Resident #5 was in the dining room at lunchtime and did not want to eat. -When Resident #5 returned from the hospital after eloping, she showed her how she got out of the enclosed patio. -Resident #5 pulled a bench to the exit gate; climbed to the top of the brick wall by stepping onto the electrical box mounted beside the gate; slid through between the first metal post and the brick wall; and used the gate slats to climb down on the other side. -A 24-hour sitter was contracted by Resident #5's responsible person to provide continuous supervision for Resident #5. Telephone interview with the MCD on 12/06/23 at 10:23am revealed:		

-When she returned to work on 11/06/23, she did not hear about any elopement attempts by Resident #5 over the weekend. -She was told that someone told Resident #5 during the weekend that her husband recently passed away, and she was having behaviors. -She did not observe Resident #5 display any adverse behaviors on the morning of 11/06/23. -She assisted two other staff with serving lunch to residents on 11/06/23. -Resident #5 came to the dining room for lunch, but she left. -She brought Resident #5 back to the dining room, and she left again. -She noticed that Resident #5 was not in the SCU when she prepared for afternoon activities for residents. -She was unaware that Resident #5's assessment and FL2 indicated she had elopement risk behaviors. -She only received the comprehensive "life story" for Resident #5 for activity planning. -The policy and procedure for residents who displayed exit seeking was to redirect residents and to call the family to implement a one-on-one sitter. Interview with the BOM on 12/04/23 revealed: -As Manager on Duty on 11/05/23, she was informed by a staff that Resident #5 made an attempt to elope on 11/04/23 by climbing the wall on the patio in the SCU. -She called the ED to report Resident #5 attempted to leave by climbing over the patio wall in the SCU. -The ED's texted directive was for staff to make the ADRC aware of the attempted elopement; and if behaviors continued, send Resident #5 to Geropsychology. -She was unaware if any additional supervision measures were put in place. Interview with the ADRC on 11/07/23 at 3:45pm revealed: -Resident #5 moved into the SCU on 11/02/23. -She was agitated on 11/03/23 and 11/04/23. -Resident #5 tried to elope three times over the weekend; she was touching the patio gate. -He was unaware of any interventions put in place for Resident #5's attempted elopement. -On 11/06/23, Resident #5 was not in the SCU when he made rounds at 2:30pm. -Staff recalled seeing her at lunchtime and at about 1:00pm. -When he saw the bench at the exit gate to the secured patio, he called police to report Resident #5 missing.		

-Resident #5 was found by police sitting on a homeowner's front porch and returned to the facility at about 3:25pm on 11/06/23. -Resident #5's responsible person was present and was asked to take her to the emergency room to be checked for injuries. Telephone interviews with the ADRC on 12/06/23 at 9:58am and 12/08/23 at 2:21pm revealed: -Resident #5 was wearing jeans; a tee-shirt; a cardigan, and sneakers when she eloped. -He was first made aware that Resident #5 was exit seeking when he returned to work on 11/06/23 after being off on the weekend. -Staff reported that Resident #5 was trying to leave the facility and looking at the patio gate. -No one told him that Resident #5 had tried to scale the patio wall over the weekend nor called him to report it. -She was not trying to leave the hospital when he assessed her for placement on 10/23/23. -Hospital staff did not report that Resident #5 demonstrated elopement risk behaviors during the initial assessment. -He received Resident #5's FL2; discharge summary; and psychiatric case notes on 11/02/23 when she moved into the facility. -When Resident #5 was admitted into the SCU, she was introduced to staff and her service plan was provided for staff. -The MA was expected to review the admission documents and assemble the Resident #5's record. -If a resident attempted to elope from the facility, staff were expected to monitor the resident; call the manager on duty and the resident's family; and have one-on-one supervision put in place. Attempted interviews with psychiatric provider on 12/07/23 at 2:57pm and 12/08/23 at 1:21pm was unsuccessful. Telephone interview with the ED on 12/06/23 at 3:30pm revealed: -She did not recall when she was first made aware that Resident #5 attempted to elope from the facility. -She was not present at the facility when Resident #5 eloped. -She reported Resident #5's elopement on 11/06/23 to county Department of Social Services on 11/07/23. -There was no specific policy for supervision of SCU residents; it should be within the Elopement Policy. -The ADRC or the BOM were responsible for implementing the Elopement Policy and Procedures after an elopement.		

The facility failed to provide supervision for Resident #5, whose admission records indicated a neurocognitive disorder and demonstrated history of wandering and elopement risk. Resident #5 was admitted to the SCU on the evening of 11/02/23. She attempted to exit the through the emergency door on 11/04/23. She attempted to climb a wall inside a secured patio enclosure on 11/05/23. The facility did not implement the Wandering and Elopement policy or develop an individualized service plan policy to include interventions to minimize the potential for the resident's elopement. Resident #5 subsequently eloped from the SCU on 11/06/23. She was found by the local police 1.9 miles from the facility. This failure resulted in risk for serious physical harm and neglect which constitutes a Type A2 Violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED FEBRARY 3, 2024.

The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 11/07/23.

IV. Delivered Via:	Hand delivered	Date: 1/5/24
DSS Signature:	Karen Phillips	Return to DSS By: 1/29/24

V. CAR Received by:	Administrator/Designee (print name): Camilla Sherrill	
	Signature: Camilla Sherrill	Date: 1.5.24
	Title: ED	

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:			

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