# Adult Care Home Corrective Action Report (CAR)

**I.** Facility Name: Spring Arbor of Apex
Address: 901 Spring Arbor Ct., Apex, N.C. 27502
**II.** Date(s) of Visit(s): 3/22/24, 4/01/24, 4/03/24

County: Wake
License Number: HAL-092-223
Purpose of Visit(s): HCPR Investigation
Exit/Report Date: 4/10/24

**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 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**<br>*For each citation/violation cited, document the following four components:*<br>• *Rule/Statute violated (rule/statute number cited)*<br>• *Rule/Statutory Reference (text of the rule/statute cited)*<br>• *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)*<br>• *Findings of non-compliance* | **III (b). Facility plans to correct/prevent:**<br>*(Each Corrective Action should be cross-referenced to the appropriate citation/violation)* | **III (c). Date plan to be completed** |
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| Rule/Statute Number: **10A NCAC 13F .0909 (4)** | ☐ POC Accepted _____ *DSS Initials* | |
| Rule/Statutory Reference: **Residents' Rights,** Every resident shall have the right (4) to be free of abuse, neglect, and exploitation, and (1) to be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. | | |
| Level of Non-Compliance: Type A1 Violation | | |
| Findings:<br><br>Based on observation, record reviews and interviews the facility failed to ensure that 3 of 5 residents (Resident #1, Resident #2, Resident #3) received personal care that was complete and free of physical, verbal, and mental abuse.<br><br>The Findings are:<br><br>1.) Review of Resident #1's FL-2 dated 8/16/23 revealed:<br>-Diagnosis included pneumonia.<br>-Resident #1 was non-ambulatory and oriented.<br>-Resident #1 required assistance with bathing and dressing. | | |

Review of Resident #1's FL-2 dated 7/18/23 revealed:
-Diagnoses included Parkinson's, contracture of hand, and Coronary Artery Disease (CAD).
-Resident #1 required total care and was incontinent.
-Resident #1 needed her legs elevated when not in her wheelchair.

Review of Resident #1's Resident Register dated 5/31/23 revealed:
-Resident #1 was alert, cognizant, and with intact memory.
-Resident #1 required physical assistance with all her Activities of Daily Living (ADLs): ambulating, transfers, toileting, bathing, dressing, grooming, and positioning.

Review of Resident #1's Care Plan dated 7/03/23 revealed:
-Resident #1 was oriented.
-Resident #1 was totally dependent on staff for care.

Review of Resident #1's Licensed Health Professional Support (LHPS) nurse review dated 7/17/23 revealed Resident #1 required assistance to propel her wheelchair and with transfers for safety.

Review of Resident #1's Initial 24-hour Health Care Personnel Registry Report (HCPR) dated 3/21/24 revealed:
-On 3/20/24, Personal Care Aide (PCA) Staff C reported to the on-duty Medication Aide (MA)/Supervisor-in-Charge (SIC), Personal Care Aide (PCA) Staff B roughly handled Resident #1 while changing the resident's incontinence brief.
-Staff B ignored Resident #1's expressed pain and disrespect her personal care caused Resident #1.
-Staff B was suspended during the Executive Director's (ED's) investigation of this incident.

Observation of Resident #1 on 3/22/24 at 2:00pm revealed:
-Resident #1 sat in her wheelchair with limited mobility and her right hand contracted inward.
-Resident #1 exhibited difficulty and delay verbalizing

and was cognizant.
-Resident #1 had no visible bruising on her head, face, or other visible injuries.

Interview with Resident #1 on 3/22/24 at 2:00pm revealed:
-Resident #1 called for Personal Care Aide (PCA) assistance to toilet.
-Staff C, was new and arrived at Resident #1's room with Staff B on the evening of 3/20/24.
-Staff B told Resident #1, "You're too heavy; pee in your incontinence brief; then I'll come back to change you"'.
-Resident #1 felt frustrated and ashamed to urinate on herself; she asked for assistance to use the toilet.
-When Staff B returned, Staff B roughly flipped Resident #1 on her side towards the wall, hitting Resident #1's head on the wall, which caused pain to her head and fear of Staff B.
-Staff B then roughly yanked her soiled incontinence brief from beneath her; then roughly pulled her backwards and into a new brief.
-Resident #1 denied bruising/injuries to her head or body.
-This was not the 1st time Staff B told her to urinate on herself, instead of Staff B assisting her to the toilet.

Review of Staff C's witness statement dated 3/20/24 at 11:49am revealed:
-Her personal care shadow-training with Staff B on 3/19/24 from 11:00pm-7:00am was 'heart-breaking" and discomforting to watch.
-Staff B ignored Resident #1's request for assistance to the toilet.
-Staff B told Resident #1 to urinate on herself in her incontinence brief.
-Staff B roughly handled, turned, and changed the resident's brief without cleaning her.

Telephone interview with Staff C on 4/01/24 at 3:05pm revealed:
-She shadow-trained with Staff B in March 2024.
-She witnessed Staff B ignore Resident #1's call for help to the toilet.
-Staff B ordered Resident #1 to urinate on herself; then Staff B would change Resident #1's incontinence brief.
-Staff B harshly questioned and rushed Resident #1,

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| "Are you finished [urinating], are you finished?!"'<br>-She and Staff B waited until Resident #1 finished urinating on herself and in her brief.<br>-Resident #1 stiffened, unable to speak, as Staff B quickly and roughly turned the resident, yanking her incontinence brief from underneath her, and roughly pulling on a clean brief without cleaning her.<br>-Staff C did not feel comfortable talking with Staff B about Staff B's personal care with the residents.<br>-She reported this incident to her supervisor, the night of 3/19/24 and to the Executive Director (ED) and Resident Care Director (RCD) on 3/20/24.<br><br>Review of the SIC's statement dated 3/20/24 at 11:11am revealed:<br>-Staff C reported to her on 3/19/24 during the shift 11:00pm-7:00am, Staff C did not feel comfortable working with Staff B.<br>-Staff C did not like the way Staff B treated the residents.<br>-Staff B refused to assist Resident #1 to the toilet, telling Resident #1 to urinate on herself in her incontinence brief.<br>-Staff B did not clean the urine off Resident #1 before roughly applying a clean brief on the resident.<br>-Staff B did not completely clean all the feces off Resident #1's legs and buttocks.<br>-The SIC reported this incident to the ED 3/20/24.<br><br>Telephone interview with Staff B on 4/02/24 at 2:20pm revealed she refused to describe her personal care of residents while she worked at the facility, since her employment ended 3/22/24.<br><br>Review of the RCD note dated 3/22/24 revealed:<br>-The RCD began working at the facility in March 2024.<br>-Resident #1 reported, she was not assisted to the toilet by Staff B (date not documented).<br>-Staff B told Resident #1, the resident was too heavy, so the resident should urinate on herself.<br>-Resident #1 reported, she was afraid of Staff B.<br>-Staff B's approach and demeanor were over-powering, which made the resident feel nervous. | | |

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| Interview with the RCD on 3/22/24 at 12:40pm revealed:<br>-Resident #1 was reluctant to share her staff care experiences with her.<br>-Resident #1 denied rough personal care by Staff B.<br>-She assessed Resident #1's skin on 3/21/24 and found the skin without injuries.<br><br>Interview with the Executive Director (ED) on 1/09/24 at 1:30pm revealed:<br>-Staff C reported neglect and physical and mental abuse concerns for Resident #1 on 3/19/24 to the on-duty Supervisor-in-Charge (SIC) 3/19/24.<br>-The SIC reported Staff C's reports to her.<br>-Resident #1 reported to her, no one likes to urinate on themselves.<br>-Based on facility and Human Services' investigative findings, their Regional Director advised her to dismiss Staff B from her position.<br>-She dismissed Staff B from facility employment on 3/22/24.<br>-Staff B's last day working was 3/20/24.<br><br>Interview with the ED on 3/22/24 at 2:00pm revealed based on her investigation, current findings, and consultation with her Regional Manager(s), the ED terminated Staff B's employment on 3/22/24.<br><br>2.) Review of Resident #2's FL-2 dated 3/12/24 revealed:<br>-Diagnoses included Alzheimer's Dementia, depression, hypertension, over-active bladder, hyperosmolarity, and hypernatremia. (Hyperosmolarity is a condition of excessive sodium in the blood that draws water out of the body's organs. Hypernatremia is a rise in sodium in the body caused by total body water loss.)<br>-Resident #2 was non-ambulatory and incontinent.<br>-Resident #2 required assistance with bathing and dressing.<br><br>Review of Resident #2's Resident Register dated 3/15/24 revealed:<br>-Resident #2 was cognizant with intact memory.<br>-Resident #2 required assistance with ambulation, transfers, toileting, bathing, and dressing. | | |

Review of Resident #2's Care Plan dated 3/26/24 revealed:
-Resident #2 required extensive physical assistance ambulating and toileting.
-Resident #2 required extensive 2-person assistance with transfers and re-positioning.
-Resident #2 required continual supervision and assistance with bathing.

Review of Resident #2's 24-hour Health Care Personnel Registry (HCPR) report dated 3/21/24 revealed:
-On 3/19/24, Personal Care Aide (PCA) Staff C reported to the on-duty Medication Aide (MA)/Supervisor-in-Charge (SIC), Personal Care Aide (PCA) Staff B roughly handled Resident #2 on 3/19/24 while changing the resident's incontinence brief.
-Despite Resident #2's expressed pain during Staff B's personal care, Staff B ignored Resident #2 and continued her personal care of Resident #2.
-Staff B was suspended during the Executive Director's (ED) investigation of this incident.

Review of Staff C's note to the ED and Resident Care Director (RCD) dated 3/20/24 at 11:49am revealed:
-Resident #2 had several bowel movements throughout the night, and Staff B refused to completely clean all the feces off Resident #2.
-Staff B ignored Resident #2 and would not attend to the resident's pain or emotions.
-Resident #2 and Staff C noticed, Staff B left feces on Resident #2's vaginal areas.
-Resident #2 told Staff B her vaginal area still felt unclean with feces.
-Staff B looked at the feces on Resident #2's vaginal areas, ignored Resident #2; then proceeded to rush personal care, roughly handling Resident #2 to put a clean incontinence brief on the resident.
-Staff B told Resident #2, "We just have to do it this way"', then roughly turned Resident #2 on her arm she previously injured, causing the resident pain and her to cry, "Ow! Ow! It hurts! It hurts!"'
-Resident #2 told the MA, "I wish I could just die!"'
-Subsequent personal care visits for Resident #2 were continued to be handled physically rough by Staff B.
-One incontinence episode change, Staff B loudly told Staff C within Resident #2's earshot, "This is the death

xhit!"'

Review of the SIC's note to the ED and RCD dated 3/20/24 at 11:49pm revealed:
-Staff C reported, Staff B left feces on Resident #2's buttocks and legs, despite Resident 2 showing Staff B feces was still on her.

Interview with the RCD on 3/22/24 at 12:40pm revealed:
-Resident #2 denied personal care concerns.
-A leg skin tear was found on 3/20/24 after reports of Staff B's rough care of Resident #2 on 3/19/24.

Review of Resident #2's Progress Note (date and staff not documented) at 10:30pm revealed:
-The Primary Care Physician (PCP) was notified Resident #2 had a skin tear on her left leg from unwitnessed cause.

Observation of Resident #2 on 3/22/24 at 1:15pm revealed:
-Resident #2 sat in her room recliner.
-She had no visible bruising to her head or upper body.
-Her left thigh was wrapped above the knee in gauze.

Interview with Resident #2 on 3/22/24 at 1:15pm revealed:
-Resident #2 had been admitted to the facility 4 days prior.
-She was sick 3/19/24 and had diarrhea.
-Resident #2 expressed life was not worth living being cared for by staff like Staff B.
-Staff B roughly handled and tossed her from the toilet to her wheelchair, cutting her left leg on the wheelchair leg rests.
-Staff B yelled at and spoke disrespectfully to her.
-Resident #2 expressed fear of retaliation by Staff B or other staff if she reported Staff B's care.

Telephone interview with Staff B on 4/02/24 at 2:20pm revealed she declined to describe her personal care of any residents that she worked with at the facility, since her employment ended 3/22/24.

Interview with the Executive Director (ED) on 1/09/24 at 1:30pm revealed:
-Staff C reported neglect and physical and mental abuse concerns for Resident #2 on 3/19/24 to the on-duty Supervisor-in-Charge (SIC) 3/19/24.
-The SIC reported Staff C's reports to her.
-Resident #1 reported to her, no one likes to urinate on themselves.
-Staff C and Resident #2 reported Staff B left feces on Resident #2, despite Resident #2 telling Staff B she felt unclean.
-Resident #2 denied Staff B provided improper personal care or mistreated or disrespected her in any way.
-Based on facility and Human Services' investigative findings, their Regional Director advised her to dismiss Staff B from her position.
-She dismissed Staff B from facility employment on 3/22/24.
-Staff B's last day working was 3/20/24.

Review of the ED's 5-Day HCPR report investigative findings dated 3/27/24 revealed:
-Resident #2 experienced emotional abuse with Staff B's personal care.
-Staff B was suspended 3/20/24 during the ED's investigation.
-Staff B was dismissed from her position upon substantiation of the investigation on 3/22/24.

3.) Review of Resident #3's FL-2 dated 3/21/23 revealed:
-Diagnoses included acute on chronic heart failure, atrial fibrillation, glaucoma, paranoid disorder, hyperthyroidism, and insomnia.
-Resident #3 was non-ambulatory and incontinent.

Review of Resident #3's Care Plan dated 5/18/23 revealed:
-Resident #3 required limited assistance with ambulation.
-Resident #3 was totally dependent for toileting, bathing, dressing, and grooming assistance.

Observation of Resident #3 on 3/22/24 at 12:55pm revealed:
-Resident #3 sat in a recliner in his room.
-Resident #3 had no visible injuries.

Interview with Resident #3 on 3/22/24 at 12:55pm revealed:
-Day shift Personal Care Aid (PCA) usually took good care of him and were usually respectful.
-One day in March 2024, a PCA yelled at him, "Don't ring that [call] bell!"'
-Second shift PCAs who prepare him for bed were kind.
-Third shift (night) staff became easily annoyed and angry with him twice in March 2024 (names and dates not recalled) for calling for personal care assistance.

Telephone interview with Staff C on 4/01/24 at 3:25pm revealed Staff B spoke with a harsh, impatient tone with Resident #3 on 3/19/24 and other days, ordering the resident to get dressed.

Telephone interview with Staff B on 4/02/24 at 2:20pm revealed she declined to describe her personal care of any residents that she worked with at the facility, since her employment ended 3/22/24.

Review of the Supervisor-in-Charge's (SIC) statement dated 3/20/24 at 11:13am revealed Staff C reported, Staff B rushed Resident #3 to get dressed and Staff B's tone was 'hateful' with the resident.

Telephone interview with Staff C on 4/01/24 at 3:05pm revealed:
-Multiple other residents in Assisted Living (AL) reported fear, rough physical treatment, verbal abuse, and neglect by Staff B with their personal care.
-Staff B refused to take the residents to the bathroom.
-Staff B continued to roughly handle residents after multiple residents complained of pain when Staff B dressed them the next morning.
-Staff B rushed Staff C's personal care of the residents, telling Staff C to be quick and not provide thorough personal care.

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| -Staff B told Staff C to leave the residents unattended while providing personal care.<br>-Several residents expressed fear and emotional distress during Staff B's care.<br><br>Interview with the Executive Director (ED) on 1/09/24 at 1:30pm revealed:<br>-She initially was unaware Resident #3, and other residents, were also neglected and mistreated by Staff B.<br>-Based on facility and Human Services' investigative findings, their Regional Director advised her to dismiss Staff B from her position.<br>-She dismissed Staff B from facility employment on 3/22/24.<br>-Staff B's last day working was 3/20/24. | | |
| The facility failed to ensure the care and protection of 3 of 5 residents (Resident #1, Resident #2, Resident #3) from abuse from Staff B. Resident #1 was forced to urinate on herself, was roughly handled hitting her head on the wall, and her feeling afraid. Resident #2 was left with feces on her body, despite telling Staff B, and then sustained a skin tear to her leg after being forcefully transferred to her wheelchair, which resulted in the resident feeling pain, depression, and afraid of Staff B. Resident #3 experienced verbal abuse and disrespect for calling for personal care assistance. This failure resulted in serious physical harm (Residents #1, #2, #3 and constitutes a Type A1 Violation. | | |
| The facility provided a Plan of Protection in *10A NCAC 13F .0909 (4), Residents' Rights* in accordance with G.S. 131D-34 on 3/22/24. | | |
| CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED: ***5/10/24.*** | | |

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| **IV. Delivered Via:** | Electronically | Date: 4/10/24 |
| **DSS Signature:** | *Roberta Schmidt-Beebe* | ***Return Signed to DSS By: 4/11/24*** |

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| **V. CAR Received by:** | Administrator/Designee (print name): Tonya Headen-Lee | |
| ***POC Due to DSS: 5/01/24*** | Signature: Tonya Headen-Lee | Date: 4/11/24 |
| | Title: Executive Director | |

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

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| **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: | | |