Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Addison of Indian Trail
Address: 5306 Secrest Short Cut Road, Monroe, NC
County: Union
License Number: HAL-090-035____

II. Date(s) of Visit(s): 10/2/24, 10/3/24, 10/9/24, 10/18/24, & 10/24/24
Purpose of Visit(s): Complaint Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: 11/08/24

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)* • *Rule/Statutory Reference (text of the rule/statute 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** 12/02/24
Rule/Statute Number: 10A NCAC 13F .0902(b) HEALTH CARE _____	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.		
Level of Non-Compliance: TYPE A1 VIOLATION		
Findings: The rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to provide 1 of 5 sampled residents (#1) medical assistance for a resident with a diagnosis of dementia who complained of abdominal and back pain on numerous occasions throughout the day, after being mishandled by a staff member and an unwitnessed fall. The findings are: Review of Resident #1's current FL-2 dated 09/18/24 revealed: -Diagnoses included dementia, hypertension, chronic fatigue unspecified, and anxiety disorder. -Resident #1's level of care was for a Special Care Unit (SCU).		

Review of Resident #1's current care plan dated 09/16/24 revealed: -Resident #1 had a moderate memory impairment and required directions and reminders from others as well as supervision and oversight for safety. -Resident #1's level of assistance was independent for escorts as Resident #1 did not require assistance with escorting. -Resident #1 was independent with mobility/ambulation. -For the fall potential category, Resident #1 was to be monitored for falls and falls were to be reported to appropriate team members. Review of the Incident Report for Resident #1 received to the County Department of Social Services (DSS) on 10/01/24 at 4:35pm revealed: -The date and time of incident was documented as 8:15pm on 09/30/24. -The responsible party was notified on 09/30/24 at 8:15pm -The medical provider was notified on 10/01/24 at 10:50am. -Resident #1 complained of pain/discomfort of the back. -The responsible party, Special Care Director and the Administrator was notified. -The responsible party requested for Resident #1 to be sent out to the emergency department. Review of an addendum to the Incident Report dated 10/01/24 provided to the Adult Home Specialist on 10/02/24 at 3:30pm revealed: -On 09/30/24 at 9:30am, a staff member came up behind Resident #1 and grabbed Resident #1 under the arms and took Resident #1 out of the dining room. -A medication aide (MA) observed Resident #1 sitting on her buttocks by the medication cart. -At 10:35am, the Special Care Director observed Resident #1 in the dining room with her head on the table, Resident #1 stated "her back hurts". Review of the Emergency Medical Services (EMS) Report for Resident #1 on 09/30/24 revealed: -The time of call for emergency services was made at 7:00pm. -The chief complaint was for back pain and the secondary complaint was for abdominal pain. -Upon EMS arrival, Resident #1 was conscious to her normal, and had a history of dementia. -Facility Staff stated that Resident #1 complained of back pain, side pain and abdominal pain.		

-EMS observed that Resident #1 was unable to stand without assistance. -Staff reported that Resident #1 was normally up walking around. -EMS notated that Resident #1 stated that her back and abdomen hurt and did grimace with palpation. Review of emergency room hospital medical records for Resident #1 revealed: -On 9/30/24 at 9:58pm, Resident #1 was seen in the emergency room by a physician. -Chief complaint was for flank pain and altered mental status. -Records stated Resident #1 was sent from facility where she was noted to be altered throughout the day today. -Facility reported that Resident #1 was typically oriented and able to walk but she had been unable to do either today. -Facility also reported Resident #1 complained of flank pain. -Resident #1 stated "she hurts all over". -Resident #1 appeared significantly confused with nonsensical speech. -Resident #1 appeared to be diffusely tender to palpation throughout her abdomen. -A CT abdomen pelvis of Resident #1 showed evidence of acute right eighth, and ninth rib fractures. -The responsible party for Resident #1 was contacted and stated that he was told by the facility that Resident #1 fell and was found on the ground in her room. -This was not told to the medic on their arrival and not told in the medic report. -Resident #1's responsible party also conveyed that Resident #1 had some confusion but was typically more oriented and able to hold a conversation. -Resident #1 appeared to be more confused than her normal baseline. -CT chest imaging was obtained and showed eighth, ninth and tenth rib fractures with small hemothorax (an accumulation of blood within the pleural cavity). -Trauma surgery was consulted and was willing to accept Resident #1 for surgery if responsible party agreed. -Responsible party decided on pain control as alternative to surgery. -Problems addressed was closed fracture of multiple ribs of right side, initial encounter: complicated acute illness or injury Fall. Interview with a first shift personal care aide (PCA) on 10/03/24 at 1:26pm revealed: -She was working in the special care unit on 09/30/24.		

-She cautioned another PCA that Resident #1 had became aggressive with her on the previous day (09/29/24) and had scratched her. -The PCA responded that Resident #1 was not going to be doing that to her. -The same PCA went over to Resident #1 and started knit-picking with Resident #1 in the dining room where breakfast was being served. -She recalled that Resident #1 was not doing anything when she was approached by the PCA, and she did not hear Resident #1 say anything. -She observed the PCA yank Resident #1 up from behind and pulled her out of the room. -The PCA elaborated that the PCA had put her arms under the arms of Resident #1 from behind. The PCA forced Resident #1 into the hallway. -She saw the PCA push Resident #1 once out of the dining room and stated, "I don't care if she falls". -The incident occurred at 8:30am while they were preparing for breakfast. -After the incident, Resident #1 said her back was hurting. -On 09/30/24 at 10:30am she and another PCA who witnessed the incident, reported the incident to the Administrator as Resident #1 was still in pain and could barely walk. -She told the Administrator what had occurred which included Resident #1 being pushed by the PCA. Interview with another first shift PCA on 10/18/24 at 11:25am revealed: -She was working in the dining in the special care unit on 09/30/24. -She and two other PCA's were setting the tables and setting up breakfast around 7:30am. -She observed Resident #1 walk into the dining room perfectly fine. -She recalled that a PCA went up to Resident #1 and said, "I am not doing this (expletive) today" followed by the statement "Get your (expletive) up". -The PCA was standing behind Resident #1 and picked Resident #1's whole body up as Resident #1's feet were off the floor. -The PCA took Resident #1 around the corner and immediately after a MA stated that Resident #1 had fallen. -She observed Resident #1 on the floor near the towel cabinet door and employee bathroom on the memory care unit. -The PCA who had lifted Resident #1 out of the dining room assisted with Resident #1 being brought to the dining room after the fall.		

-She and another PCA reported the incident to the Administrator after it occurred, approximately at 10:30am. -When she returned to the dining room area, Resident #1 was crying and could not move. Resident #1 stated that her back hurt. -Resident #1 cried for a while and then fell asleep. -Resident #1 would not eat any of her food. -When she saw Resident #1 later in her shift, she thought it was odd that Resident #1 was still sitting in the dining room and had not been sent out for medical attention. -It appeared that no one took the incident seriously. Interview with a first shift medication aide on 10/09/24 at 12:20pm revealed: -She was working the medication cart on 09/30/24. -At around 8:15am she heard Resident #1 saying "somebody was trying to kill her". -She also overheard a PCA make the statement "not today". -She observed a PCA to have Resident #1 lifted off the floor with her arms underneath the arms of Resident #1. -The PCA took Resident #1 near the toilet tissue cabinet and employee bathroom located in the special care unit. -When she turned around, she observed that Resident #1 may have fallen backwards as she was positioned on her right side on the edge of the wall. -After the incident, Resident #1 said she did not want to eat and that she was in pain. -The Special Care Director was made aware and stated she would inform the Administrator. -She recalled that around 1:45pm, Resident #1 still complained that her back hurt. Resident #1 continued to complain about the same spot on her right side. -At 2:00pm, the occupational therapist came and was able to assist Resident #1 to stand up. -The second shift staff called the ambulance. -She was not sure as to why the ambulance had not been called on first shift when Resident #1 was injured and complained of pain. Interview with another first shift MA on 10/03/24 at 1:06pm revealed: -She was working the medication cart in the special care unit on 09/30/24. -The PCA's were getting residents ready for breakfast. -Another MA told her to look because Resident #1 was on the floor. -She went and assessed Resident #1 around 8:15am-8:30am.		

-She recalled Resident #1 told the special care director after the incident that her back was hurting. -The special care director informed the Administrator who in turn called the responsible party for Resident #1. -Resident #1 did not have any prior back pain or injuries. -The occupational therapist came later that afternoon and visited with Resident #1. Review of Home Health Records for a visit completed by the occupational therapist with Resident #1 on 09/30/24 at 2:02pm revealed: -Resident #1 was seen on 09/30/24 for a routine visit. -Resident #1 started receiving occupational therapy services on 09/13/24. -For breathing: Resident #1 occasional labored breathing and a short period of hyperventilation. -For vocalization: Resident #1 had repeated trouble calling out, loud moaning or groaning and crying. -Resident #1 displayed facial grimacing. -Resident #1 was holding her left hand in fist as if in pain. -Resident #1 was difficult to console and comfort. -Resident #1 was holding right flank. -Resident #1 was complaining of pain in her right flank. -Resident #1 had no signs of bruising or injury. -Staff denied that Resident # 1 had a fall. -It was noted that Resident #1 had new pain from prior visits that Resident #1 was unable to describe. -She notified staff during the visit about the new onset of pain of right flank for Resident #1. -Staff reported that they had been unable to get Resident #1 to stand up from the table since lunch. -Staff reported that Resident #1 had become increasingly aggressive and had sat down on the floor that morning and it took staff an extended period of time to get client to stand up. -Notes indicated extensive education to staff and the special care director on the changes with Resident #1 since the last visit. They reported they were aware and had notified the community physician. -The outcome of the visit was Resident #1 observed with decline and function from the prior week and appeared to be in pain. Interview with the Occupational Therapist for Resident #1 on 10/28/24 at 4:45pm revealed: -She had a visit with Resident #1 on 09/30/24 in the afternoon. -She recalled the visit was after lunch and Resident #1 was sitting in the dining room when she started the visit. -Resident #1 was not able to stand up on her own.		

-She assisted Resident #1 with standing up and took her back to her room. -She observed that Resident #1 appeared to be in pain as she was holding her right side. -Resident #1 was holding her hand in a fist which is a sign of being in pain. -She informed the Medication Aide of the changes with Resident #1 on this date. -She also spoke with the special care director about her observations of Resident #1 on this date. -The special care director responded that she was aware of the situation and would be consulting with the administrator and the health and wellness director. -The special care director also stated that Resident #1's medical provider had already been notified. -She specifically asked staff if Resident #1 had a fall, and staff denied this to be the case. Telephone interview with the primary care provider (PCP) for Resident #1 on 10/28/24 at 2:10pm revealed: -He was not contacted on 09/30/24 in reference to any medical issues or pain Resident #1 experienced. -The facility sent an email communication on 10/01/24 at 12:25pm that Resident #1 had been transferred to the hospital on 09/30/24. -Resident #1 was new to the community and he had only met with her once on 09/11/24 to establish care. -A referral was made for physical and occupational therapy to reduce fall risk for Resident #1. -The facility had not made him aware of any new medical or behavioral concerns as to Resident #1. -He was not at the facility on 09/30/24, he returned on 10/02/24 for visits with residents, Resident #1 was still at the hospital. - If he had been consulted about Resident #1's condition on 09/30/24 of being in pain due to alleged abuse allegations and/or an unwitnessed fall he would have recommended for Resident #1 to be sent to the hospital. Telephone interview with a second shift PCA on 10/25/24 at 4:15pm revealed: -She worked on 09/30/24 and started her shift at 3:00pm. -First shift had conveyed during rounds that Resident #1 had not been feeling well. -She was told by first shift staff that Resident #1's stomach was bothering her. -She tried to get Resident #1 to come to dinner but Resident #1 refused to eat.		

-She observed Resident #1 to be hunched over in her chair and screeched over in pain when she leaned over. -Resident #1 told her that her back and stomach hurt. -When Resident #1 would sit up the pain was worse. -It was obvious to her that Resident #1 had more than a stomach bug. -She went to get the MA who also observed the pain that Resident #1 experienced. -She and the medication aide sent Resident #1 out to the hospital around 7:00pm. -The responsible party, Administrator and special care director were all notified. -She denied having any issues with Resident #1 and stated that Resident #1 was very compliant. -Resident #1 was normally talkative and would be up walking around. Telephone interview with a second shift MA on 10/21/24 at 10:18am revealed: -She began her shift at 3:00pm on 09/30/24. -She was told by the first shift medication aide that Resident #1 had been combative and was not feeling well. -The PCA was working with Resident #1 when second shift began. -The PCA brought Resident #1 food, but she would not eat her food. -She examined Resident #1 and when she touched her on her back, Resident #1 was screaming. Resident #1 stated "oh my god, it hurts". -She also touched Resident #1 on the lower stomach and Resident #1 told her it was hurting as well. -She contacted the responsible party for Resident #1, and he informed her that the administrator and the special care director had told him earlier that Resident #1 was fine. -She told the responsible party that Resident #1 was in excruciating pain and was being sent out to the hospital. -She also notified the administrator and the special care director. -She never had any issues with Resident #1 and indicated that Resident #1 was mainly compliant. Interview with the Special Care Director (SCD) on 10/03/24 at 1:57pm revealed: -On 09/30/24 upon her arrival at 8:30am, she had a huddle with staff who reported that Resident #1 had acted out and showed extreme behaviors. -She observed Resident #1 sitting in the dining room with her head down.		

-Around 10:30am and 11:00am the Administrator requested for her to check on Resident #1. -Resident #1 was in the same position with her head down and held her head up and said "she was hurting". -Resident #1 motioned to her back as to where she hurt, she lifted Resident #1's shirt up and noticed Resident #1 was sensitive to touch in that area. -She indicated that she informed the Administrator of her findings. -Resident #1 remained in the dining room as she could not move. -The Occupational Therapist visited with Resident #1 and informed her that she could not get Resident #1 to do anything. -She and the Administrator contacted the responsible party and informed him that Resident #1 complained of back pain. -The responsible party was not made aware of all the events/details that occurred as to Resident #1 on this date. -She did not seek medical attention for Resident #1, because Resident #1 always complained about "this or that". Telephone interview with Resident #1's responsible party on 10/21/24 at 11:23am revealed: -On 09/30/24 the Administrator and the special care director informed him that Resident #1 had fallen. -The facility did not mention an incident with staff had occurred, only that Resident #1 had fallen. -He agreed that Resident #1 could be monitored instead of sent to the hospital. -If he had been provided with all the information that occurred to Resident #1 and repeated complaints of pain on 09/30/24 he would have requested for Resident #1 be sent to the hospital instead of being monitored. -He was contacted later in the evening and was told that Resident #1 was sent to the hospital. -He was informed by the hospital that Resident #1 had three rib fractures and surgery was offered although he opted not to do so. -The facility informed him on 10/01/24 that something occurred in the dining with Resident #1 and a staff member. Interview with the Health and Wellness Director (HWD) on 10/24/24 at 1:48pm revealed: -She was not present on 09/30/24. -She returned on 10/01/24 and participated in investigative interviews with staff regarding Resident #1 and a staff member.		

-She became concerned about the nature of the statements from staff that indicated that a PCA had placed her arms under the arms of Resident #1 and mishandled her. -She contacted the hospital on 10/01/24 and was informed that Resident #1 had three rib fractures and would possibly be sent to the trauma center in another county. -She sent an email communication to the PCP on 10/01/24 that Resident #1 was at the hospital. -When a resident complained of pain they were sent to the hospital, or the PCP was contacted for directives. -She learned that contact had not been made with DSS. She and the Administrator contacted the adult home specialist on 10/01/24 at 5:15pm about Resident #1 being mishandled by a staff member. -Law Enforcement was also contacted on 10/01/24 and arrived at 6:20pm and took an abuse report as to Resident #1. Review of the 24-Hour Incident Report sent to the Health Care Personnel Registry dated 10/02/24 revealed: -The incident date and time was documented as 09/30/24 at 9:00am. -A team member forcibly removed Resident #1 from the dining room. -Resident #1 was observed on the floor and assessed. -Upon first assessment of Resident #1, there was no indication of injury. -Resident #1 later expressed pain. -The community contacted the responsible party and offered for Resident #1 to be sent out for emergency room evaluation, but the responsible party declined. -Resident #1 exhibited heightened discomfort in the evening and was sent out to the emergency room for evaluation. Interview with the Administrator on 10/02/24 at 4:30pm revealed: -On 09/30/24 at 10:30am two PCA's spoke with her about another PCA being too rough with Resident #1. -One PCA told her that Resident #1 was told to get up and leave the dining room. Afterwards the same PCA witnessed Resident #1 being pushed to the ground after she was taken out of the dining room. -Another PCA informed her that the PCA had put her arms underneath the arms of the arms of Resident #1 and removed her from the dining room. -Both PCAs conveyed that the incident occurred at 8:15am. -She spoke with a MA who reported she did not see anything, only Resident #1 sitting on the floor.		

-A quick physical assessment was completed of Resident #1 by a MA and no injuries were found. Resident #1 stated she was okay. -She did not seek medical attention for Resident #1 because Resident #1 did not have any visible injuries. -She interviewed the PCA who was alleged to have mishandled Resident #1. The PCA stated that she was trying to redirect Resident #1 who was disruptive. The PCA did not know why Resident #1 was on the floor. The PCA acknowledged she went behind Resident #1 to move her out of the dining room. -She learned from interviews with staff that the PCA had stated "I am not dealing with this (expletive) today" and then went behind Resident #1 to remove her from the dining room. -She spoke with the responsible party on 09/30/24 and did not make him aware that Resident #1 had been improperly handled by a staff member and the current investigation into the incident. -The responsible party was made aware that Resident #1 had a fall. -The facility inquired if the responsible party would like to wait for Resident #1 to be seen by the medical provider or to be sent to the hospital. The responsible party was okay with Resident #1 waiting to be seen by the medical provider the next time when the medical provider was on-site. -The responsible party was informed of an investigation regarding the incident with Resident #1 and an employee on 10/01/24. -Resident #1's medical provider was not contacted on 09/30/24 regarding the incident for guidance/recommendations. -She gave no explanation as to why Resident #1's primary care provider was not contacted. -On 09/30/24 at 7:00pm, the medication aide notified her that Resident #1 was being sent out as she refused a shower and groaned of pain. -She had not communicated with second shift staff about the incident or a fall by Resident #1. -She did not notify the hospital of the incident or a fall by Resident #1. -She received the update on the morning of 10/01/24 that Resident #1 had rib fractures. -She worked on the 24-hour incident report. -She and the Health and Wellness Director spoke with the adult home specialist with the local DSS on the evening of 10/01/24 at 5:15pm. -Law Enforcement was contacted on 10/01/24 by the Health and Wellness after contact with DSS.		

The facility failed to ensure Resident #1, who had a diagnosis of dementia and repeatedly complained of right flank pain was provided with medical assistance after being mishandled by an employee and a subsequent immediate unwitnessed fall. This failure resulted in the resident not receiving timely medical treatment and being admitted to the hospital for three rib fractures and a hemothorax and altered mental status. This failure resulted in serious neglect and serious physical harm which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/24/24 for this violation THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 8, 2024.		

IV. Delivered Via:	Hand Delivered	Date: 11/8/24
DSS Signature:	Rosalyn Holdor	Return to DSS By: 12/2/24

V. CAR Received by:	Administrator/Designee (print name): TARA BENSON	
	Signature: Tara Benson	Date: 11/8/24
	Title: Executive Director	

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:		

Facility Name:

☐ ***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.*		