Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Northlake House
Address: 9108 Reames Road Charlotte, NC 28216
County: Mecklenburg
License Number: HAL-060-150

II. Date(s) of Visit(s): 03/01/24, 03/04/24, 04/3/24
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 4/19/24

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.	X POC Accepted JW *DSS Initials*	
Level of Non-Compliance: Type A2 VIOLATION	"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State"	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
Findings: Based on observations, record reviews, and interviews the facility failed to ensure residents in the Special Care Unit (SCU) were properly supervised resulting in 1 of 5 sampled residents (#1) who had a history of exit seeking and wandering behaviors eloping the facility without staff's knowledge. Review of facility's Missing Resident/Resident Elopement: Standard Operating Procedure, dated 07/24/19 revealed: -It was the policy of facility to provide for the safety of each resident and to take swift and appropriate action in the event of a missing resident or elopement incident at the facility. -In the event that a resident was suspected to be missing or to have eloped from the facility, the following procedures shall be followed.		

-Resident would be deemed missing and/or to have eloped when all the following conditions are met: -The resident was not present at the community. -The resident's whereabouts cannot be readily determined. -There was reason to be concerned for the resident's safety or wellbeing. Based on observations and record reviews Resident #1 on 03/01/24 revealed Resident #1 was not interviewable. Review of Resident #1's current FL-2 dated 03/24/23 revealed: -Diagnoses included dementia with behavioral disturbance, pulmonary hypertension, Stage 3 chronic kidney disease, peripheral vascular disease, asymptomatic carotid artery stenosis and Type 2 Diabetes. -Resident #1 was constantly disoriented. -Resident #1 had functional limitations for sight, hearing and speech. -Resident #1 was ambulatory and incontinent of bladder and continent bowel. -Resident #1 could communicate verbally. -Resident #1's level of care was Special Care Unit (SCU). Review of Resident #1's Resident Register revealed she was admitted to the facility on 08/30/23 to the SCU. Review of Resident #1's Care Plan dated 02/25/24 revealed: -Resident #1 had a significant change and exit seeking behavior. -Resident #1 was ambulatory. - She was verbal with weak speech. -Resident #1 had a history of wandering. -Resident #1 was currently receiving medications for mental illness and behaviors. -Resident #1 required limited assistance with eating, toileting, bathing, dressings and grooming/personal hygiene. -There was no intervention documented on the care plan to prevent Resident #1 from eloping again. Review of Resident #1's incident report dated 02/25/24 at 9:26pm revealed: -On 02/25/24 at 3:00pm, Resident #1 eloped from the facility, and was located outside not on facility property. -There was no documentation of when Resident #1 was returned to the facility. -The incident was not witnessed by facility staff. -The incident was reported by medication aide.	Facility Executive Director will inservice appropriate staff on the following policies and standard procedures 1. Elopement Standards of Procedures 2. Guidelines for Incident Reporting 3. Charting policy 4. Missing Resident Policy 5. Guidelines for Supervision of Residents who Exhibit Difficult Behaviors policy 6. Behavior Management Evaluation, Intervention and Documentation policy 7. Resident Assessment and Care Planning policy 8. Accidents/Falls/Disaster & Fire Safety policy 9. Identification and Supervision of confused/ wandering resident policy. 10.Health Care Referral and Follow Up policy Facility Area Clinical Director of Operations will provide training to the Executive Director and Resident Care Coordinator on the Rule area listed to be in violation: -10A NCAC 13F .0901(b) Personal Care and Supervision. Facility Executive Director will conduct an inservice with Resident Care Coordinator and SICS on the importance of reporting any significant changes to the resident that would qualify for an updated Care Plan. Facility Executive Director and Resident Care Coordinator will be responsible for ensuring all updated information is reflecting to the Resident Care Plan if a Reisdnet Care has significaltly changed and attention to supervision is required for exit seeking/elopement a banner will be added to the face sheet of the Residents electronic Health Record, staff will be inserviced to this now risk and need for supervision. If increased supervision is deemed appropriate by the facility and the Residents Care Provider the order for increased supervision will also be added to the electronic health record and inserviced to the staff for new orders requiring increase supervision upon immediate notification of incident and/or behavior related to exit seeking/elopement. Facility Executive Director and/or Resident Care Coordinator will audit current residents with exit seeking/elopement behaviors and ensure that their electronic health record has been updated to include a banner that identifies their risk of elopement. Facility Executive Director and/or Resident Care Coordinator will review current residents care plans who exibit exit seeking/elopement behaviors to ensure the behaviors have been documented and identified. As well review that interventions if found to be appropriate have been documented within their care plan. Facility Executive Director and/or Resident Care Coordinator will ensure that an updated list can be located at the nurses station to identify residents who exibit exit seeking/ elopement behaviors and as well any resident that is currently on increased supervision.	Report

-Resident #1 Physician and Responsible Party (RP) were notified on 02/25/24 at 3:26pm. -Resident #1 was evaluated and did not need medical attention. -There was documentation the Memory Care Coordinator (MCC) signed and dated the report on 02/25/24 at 9:54pm. Review of Resident #1's progress notes dated 02/25/24 revealed: -Documentation of a late entry dated 02/25/24 at 10:28pm by Medication Aide (MA). -On 02/25/24 at 3:21pm, Resident #1 eloped. -Resident #1's Physician and RP were notified. -Resident #1 was placed on safety intervention of close monitoring by staff. Telephone Interview with Resident #1's RP on 03/01/24 at 11:00am revealed: -She received a telephone call from the Memory Care Coordinator (MCC) on 02/25/24 to report the elopement and stated Resident #1 was found at the property next door to the facility. -She was told the Regional Director Operations (RDO) would review the security cameras and find out how Resident #1 got out of the facility. -Resident #1 did not have a coat on but it was cold outside. -She was concerned for the facility lack of supervision. - She was told by the facility staff they were not aware Resident #1 had eloped until someone driving by called the facility and reported Resident #1 was outside of the facility. -The facility did not know how long Resident #1 was outside, but they told her it was not long. -Resident #1 was very active and always walked around the facility. -She expected staff to monitor the safety and wellbeing of Resident #1. Telephone Interview with Resident#1's Primary Care Provider (PCP) on 04/09/24 at 12:40pm revealed: -He was aware of Resident#1's elopement on 02/25/24. -Resident #1 had wandering behaviors. -Resident #1 was active and always walking around the facility exit seeking by pushing on doors. -The facility had an unexplained issue with the doors that allowed for Resident #1 to push the door open and exit the facility. -Resident #1 was able to walk down a busy the street to another business which was dangerous with a diagnosis of dementia.	Facility Executive Director will also ensure that the Facility Maintenance Manger is conducting weekly audits on all exit doors to ensure proper function of the mag lock system. In the absence of the Facilty Maintenace Manager the responsibility for completion of exit door audits will the Executive Director or designated manager. Any reportings of failure will be immediately addressed to the Executive Director and Regional Maintenance Manger to assist with repairs. Doors will be managed by staff during time periods where the system is not working and an alternative plan will immediatley be put in place to ensure the safety of all residents. Facility Executive Director and/or Resident Care Coordinator upon admission will complete a pre assessment to determine any past history exit seeking/ Elopement behaviors. If upon admission exit seeking/elopement behaviors have been identified Facility will complete the care plan as necessary to include identification of exit seeking/elopement behaviors as well as conduct if appropriate increase supervision for the first 72 hours minimally.	Facility expected compliance: ! 5/30/24

-Resident #1 was returned to the facility with no injury. -The facility doors should always be locked to ensure the residents are safe. -His expectation of the facility was to provide adequate care, supervision and communicate with him when something happened. Review of the local weather report revealed the temperature outside on 02/25/24 at 3:00pm was 56 degrees Fahrenheit with no precipitation. Observation of the SCU on 3/01/24 at 3:10pm revealed: -The facility was located on a busy street with a local bus route. -The facility was surrounded by a wooded area. -On the right side of the facility, there was a field area with a large ditch filled with rocks. -There was a two-lane road directly in front of the facility with a posted approximately speed limit of 35mph (miles per hour). -The property was in a community with over 100 other homes and several apartment complexes. -There was a gas station on the road as well. -From 3:10pm until 3:35pm the roadway was frequented by 90 passenger vehicles, a city bus, motorcyclists and 18-wheeler trucks. -On the right side of the facility, there was a field area with a large ditch filled with rocks between the facility and a local building. -The building where Resident #1 was found was surrounded by a wooded area. -Resident #1 was located 0.2 miles away from the facility at the front door of the local business building which was close on 02/25/24 pulling on the door. Requested to review the facility security camera was denied on 03/01/24 at 3:00pm by the RDO. Telephone interview with a medication aide (MA) on 03/04/24 at 4:00pm revealed: -She had just arrived to work on 2nd shift at the facility on 02/25/24 when she was receiving report from a 1st shift MA when the facility's telephone started ringing. -She answered the telephone, and the person stated they believed a resident had gotten out of the facility and was on the street. -She went and informed the MCC of the caller who reported Resident #1 was outside the building.		

-She and the MCC went outside to see if Resident #1 was outside, and she was found at the building next door. -She was unsure how the resident got out the facility. -She denied any door being left opened at the facility. -The alarms did not sound on the back door or side door that day. -The expectation was the doors in the SCU were to always remain locked. -Staff was unsure how the resident eloped from the facility. -Staff was unsure how long the resident was outside of the facility. -Staff completed a head count for all the residents in the building. Interview with a MA on 03/01/24 at 11:33am revealed: -She worked on 02/25/24 as a MA on first shift (7:00am - 3:00pm). -She was at the nursing station completing report to pass the medication cart to the next MA. -She was told by the 2nd shift MA that a resident was outside, after receiving a telephone call from someone outside the facility. -The 2nd shift staff had just came into work when the call came in. -The MCC and 2nd shift MA went outside to look for Resident #1. -Resident#1 was found outside at the building located down the street from the facility by the MCC after 3:00pm because 2nd shift had just started when the MA informed her of the telephone call. -The facility was short staffed that day, and the MCC came in to work the floor. -Resident #1 was returned to the facility with no injuries. -Resident #1 was given a shower and had a body check with no injuries found. -Staff did a head count of all residents and checked the facility. -Resident #1 was able to exit the building from the door located next to the parking lot and sidewalk. -The door was checked by staff and found to have a screw loose allowing the resident to push the door open. Interview with the Director of Maintenance, (DOM) on 03/01/24 at 4:56pm revealed: -He was called to the facility on 02/25/24 to check the SCU doors by the MCC. -He checked the SCU door and found a screw needed to be reattached to secure the door. -He was unaware how the screw came off the door.		

-He constantly checked the alarms around the building and provided the report to the administrator. Interview with Memory Care Coordinator (MCC) on 03/01/24 at 10:56am revealed: -She was working on 02/25/24. -She had to work due to a call out by one of the staff members. -The 2nd shift MA informed her of a telephone call which stated Resident #1 was outside the facility walking up the street it was around 3:00pm. -She went outside to check for Resident #1. -Resident #1 was located at the front door of a local business down the street from the facility, pulling on the front door. -She returned Resident #1 to the facility and completed a body assessment. -Resident #1 had no injuries. -She completed a check of the building and found Resident #1 was able to exit the facility by pushing the door open because the maglock was loose at the top of the door. -She had just seen Resident #1 walking around the facility around 2:00pm sometime. -She did not remember the exact time she last saw Resident #1. -She called the DOM to come in and secure the facility's door on 02/25/24. -She placed a staff member at the door until the door was secured. -Resident #1 had a history of exit seeking behaviors at the facility. -Resident #1 was placed on placed on increase supervision for the next 72 hours. Interview with the Regional Director Operations (RDO) on 03/01/24 at 2:00pm revealed: -The facility had an elopement on 02/25/24 and one resident was able to exit the building from the side door in the front hallway. -She had reviewed the security cameras showing Resident #1 exited the facility at 2:42pm. -The staff received a telephone call from someone outside the facility, reporting Resident #1 was on the sidewalk on the street. -She did not have the contact information for the person who call the facility to inform them of Resident #1 being outside the facility. -The security camera showed staff going out the door at 3:10pm to check for Resident #1. -She did not have the time Resident #1 was returned to the facility by staff.		

-She did not believe the facility was short staffed when the elopement happened. -Resident #1 should have been checked on frequently. -Resident #1 was placed on increased supervision. --- The facility failed to provide supervision for Resident #1 who resided in the Special Care Unit and had a history of exit seeking behaviors and wandering, which resulted in Resident #1 eloping from the facility for an unknown amount of time after walking out of the facility through an unsecured door and found down the street approximately 0.2 miles from the facility on a busy street. The facility's failure placed Resident #1 at a substantial risk of serious 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 03/04/2024. --- CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 05/30/24.		

Facility Name: Northlake House

IV. Delivered Via:	Hand	Date: 4-30-2024
DSS Signature:	Tonya R. Wright	Return to DSS By: 5-15-24

V. CAR Received by:	Administrator/Designee (print name): Yolanda Sewell	
	Signature: Yolanda Sewell	Date: 4-30-24
	Title: BOM	

VI. Plan of Correction Submitted by:	Administrator (print name): Tiffany Kaminski	
	Signature: Tiffany Kaminski	Date: 5/15/2024

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

☐ *POC Not Accepted*	By:	Date:
Comments:		
☒ *POC Accepted*	By: Tonya Wright	Date: 5/23/2024
Comments:		

VIII. Agency's Follow-Up	By: Tonya R. Wright		Date: 7-23-2024
	Facility in Compliance: ☒ Yes ☐ No		Date Sent to ACLS: 7-23-2024
Comments: The facility is in compliance. The CAR abated.			

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