Adult Care Home Corrective Action Report (CAR)

W2-2021. Facility Name: Destiny Family Care Home #4
Address: 5818 Poole Road, Raleigh, NC 27610
II. Date(s) of Visit(s): 03/16/24, 03/27/24, 04/30/24, 05/13/24, 05/14/24

County: Wake
License Number: FCL-092-290
Purpose of Visit(s): Complaint Investigation

Instructions to the Provider *(please read carefully)*:

Exit/Report Date: 05/14/24

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 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 *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 13G .0901** 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: **Unabated A1 Violation** Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 4 residents (#1) who was adjudicated incompetent, appointed a guardian, and had a history of wandering and risky behaviors, who eloped the facility on four occasions and remains missing. The findings are: Review of the facility's Missing Residents policy and procedures on 03/16/24 at 9:45am revealed: -When a resident was determined missing, the facility would immediately check the home, grounds, and immediate area. -Local law enforcement was notified immediately and informed of the resident's medical history. -The county's social services notified as soon as possible and no later than 24 hours. -The resident's responsible party, next of kin and primary physician was to be notified as soon as possible and no later than 24 hours.	☐ POC Accepted ________ *DSS Initials* In compliance with rule 10A NCAC 13G. 0901(b), staff will provide supervision of residents in accordance with each resident's assessed need, care plan and current symptoms. The administrator has received assessment and re-assessment training from a registered nurse consultant to assist him with recognition of the need for reassessment and implementation of new strategies when new behaviors and new needs of a resident arises. To identify interventions and supervision needs that is to be implemented in the care plan of that individual. **This training was completed on May 15, 2024.**	6/5/24

Review of Resident #1's current FL-2 dated 01/29/24 revealed:
-Diagnoses included renal insufficiency, lithium toxicity, altered mental status, acute metabolic encephalopathy, hypercalcemia, thyrotoxicosis, atypical chest pain, bradycardia.
-There was no information regarding inappropriate behaviors, orientation, or personal care assistance.
-The resident was ambulatory.
-The recommended level of care was "Domiciliary (Rest Home)"

Review of Resident #1's Resident Register revealed:
-She was admitted to the family care home on 02/01/24.
-The register's section describing "memory status if different from the FL-2" indicated "forgetful-needs reminders."

Review of Resident #1's care plan dated 03/12/24 revealed:
-The resident was identified as a wanderer.
-There was no documentation of a need for increased supervision or inappropriate behaviors.
-The resident required limited assistance with Activities of Daily Living (ADLs).
-She required extensive assistance with administration of medicines.

Review of Resident #1's Letters of Appointment of Guardian of the Person dated 10/05/16 revealed:
-The resident was declared an "Incompetent Person."
-The resident had an appointed legal guardian.

Review of "House Rules" contract dated on 02/01/24 revealed:
-The form was signed by the legal guardian and the Administrator
-House rule #4 informed "Residents must sign out when leaving the family care home and must provide the Supervisor-in-Charge (SIC) with a contact number and person."

Review of Resident #1's Progress Note dated 03/09/24 revealed:
-The Medication Aide/ SIC (MA) spoke with Resident #1's family member who stated the resident had a history of "wandering away."
-The resident had wandered away several times in the past.

Review of Accident/ Incident Report (I/A) for Resident #1

- The Administrator will ensure staff training during orientation, annually, and as needed for continuous education in the following areas:
- Care Plan
- Supervision
- Missing Resident (search procedures & reporting procedures)
- Assessment(using the resident register and DMA3050r assessment tool to identify any history of wandering and elopement)
- Wandering and Elopement
- Communication and Reporting
- Review of facility policy and procedures on the noted training
- Accident and Incident reporting (procedure, followup care, reporting/notification, management of physical aggression or assault, policy on abuse, neglect, and misappropriation of resident property.
- Communication and Reporting
- Documentation
- Resident's Rights

  The Administrator will ensure the above training is completed and understood.

- **Intervention:**
- An alarm system has been installed on exits doors that announces "front door open, back door open". The Administrator will be responsible to ensure that the system is functioning as intended. * The system will be checked each shift by staff to make sure it is working and each check shall be documented in a log book located in the home. The logbook shall have the name of the staff, time, date, and signature of staff who conducted the sounding device check of each of the doors.
- A maintenance record of services of the devices will be done at least every quarter by the Administrator.
- If the device malfunctions, it shall be documented and fixed as soon as possible.
- During this time, extra supervision will be provided to residents who were determined as stated in their plan of care as wanderer or risk of elopement.
- The resident identified as a wanderer or eloper will have an alarm installed on their bedroom door.
- A color coded identifier will be used to identify a resident who has been assessed as a wanderer. The color amber will be the color coded for this client that will be displayed on the resident's MAR.

  Supervision:

- Staff will frequently monitor the resident's whereabouts to assure he or she remains in the facility.
- Staff will document observations in the log book implemented for that purpose.
- This resident will be guided to sit in common areas such as the living room to be easily observed.

dated 03/14/24 revealed:
-The accident/incident occurred on 03/13/24 at 3:30pm.
-Resident #1 stated to staff she was going out but did not specify her whereabouts.
-The MA/SIC notified the Administrator when Resident #1 did not return for evening medications at 8pm.
-Resident #1's guardian was notified on 03/14/24 at 10:00am, 14 hours later.
-There was not a return date or time reported.

Review of the facility's sign in/out sheet revealed there were no entries for Resident #1 on 03/13/24.

Review of Progress Note for Resident #1 dated 03/14/24 revealed:
- The MA/SIC notified the police and the guardian the resident was missing.
-The time police were notified was not written.
-The legal guardian reinforced the resident was a wanderer who could disappear for "days sometimes."
-The police entered a missing person report.
-All attempts to contact the resident by phone failed because the phone was not operable.

Review of County's Sheriff's Office Incident/ Investigation Report dated 03/14/24 at 6:24pm revealed:
-The dispatched call was about a missing person adult.
-The SIC informed the officer Resident #1 signed herself out on 03/13/24 at approximately 3:00pm.
-There was a call initially made at 11:31am but there was nothing done because Resident #1 had gone missing before this date and usually returned when she was out of money.
-The director of the facility decided not to make a report and wait a few days to see if she returned.
-The officer informed the director since the resident was deemed incapable of taking care of herself, in the future, there was no choice but to enter a report.
-The resident's family member informed the officer of the history of substance use and illicit sexual activity.
-On 03/15/24 at 2:30am it was reported by the MA/SIC the resident had returned.

Review of Progress Note for Resident #1 dated 03/15/24 revealed:
-The resident returned to the facility by way of taxi at 2:15am.
-The MA/SIC contacted the Administrator and Sheriff and notified them of her return.
-The Sheriff arrived at the home at 3:10am and spoke with the resident.

- To help engage this resident from the propensity of wandering, additional activities will be provided and engagement in games and activities with other residents will be fostered.

- The sign in and sign out sheet will be in place and monitored frequently.

If it has been determined that the resident is missing, the search procedure policy will be strictly adhered to that will include the time allotted for search, notification of law enforcement, supervisor, next of kin, and notification of DSS and any additional tasked as delineated in the facility policy and procedures on missing residents.

Tracking System:
A system of tracking residents that have left the facility without permission, have failed to follow protocol of signing in and out of the log book, and the number of incidents involving police missing reports will be implemented using the following data:
- Incident report log (# of occurrences)
- Law enforcement response

The tracking system will determine if the resident is in need of a higher level of care and the decision will involve a team meeting of all appropriate persons (e.g., Administrator, Guardian, PCP, Psych, etc.)

Interview and observation of Resident #1's room on 03/16/24 at 9:30am revealed:
-The resident was lying in the bed.
-She went to visit friends when she left of 03/13/24.
-Her room, which was located at the back of the house, had two beds, a bathroom, and an exit door to the outside.
-There was a working, audible door alarm on the outside door located in the resident's room.

Interview with MA/SIC on 03/16/24 at 10:15a.m. revealed:
-The MA/SIC had been the live-in staff since 02/26/24.
-She could not verify that Resident #1 signed out.
-She "assumed" the resident had signed out since she was holding a pen.
-The resident was identified as missing on 03/13/24 after she did not return at medication time.
-Medication time was between 7:00pm and 8:00pm.
-Once the resident did not return, the MA/SIC checked the sign out book and realized the resident did not sign out.
-She contacted the Administrator at 8:00pm on 03/13/24.
-Police were contacted on 03/14/24 "around 12:00pm."
-She was unsure what time the guardian was contacted by the Administrator.
-The resident returned on 03/15/24 around 2:00a.m.
-She was unsure if there was a curfew in place for residents but thought residents were expected to return between 6:00p-7:00p the same day as signing out.

Interview with Administrator on 03/16/24 at 11:50a.m. revealed:
-Residents identified with wandering behaviors should enter the exact place they were going when they signed out.
-There should be a clear time of return.
-Staff were informed about a resident's wandering and should perform checks on the resident by calling the resident using the provided contact number.
-There was no set interval of how frequent the checks should occur.
-Residents were expected to return to the facility no later than 8:00pm.
-The expected time of return was not documented in policy.
-The Administrator was not aware of a policy on wandering.
-Staff were not instructed to check the sign out sheet after a resident signed out.
-Staff were only asked to have residents sign in and out.

Review of the County's Sheriff's Office Incident/ Investigation report dated 03/16/24 at 9:12pm revealed:

-The dispatched call was about a missing person adult.
-The resident signed herself out on 03/16/24 at 3:29pm.
-She stated she was going to a restaurant.
-The resident was observed by the MA/SIC walking next door to a junk yard and entered a vehicle.
-It was unclear if the resident left on foot or in the vehicle.
-The guardian and family member were informed.
-At 10:04pm on 03/16/24, a missing person was entered into the database.
-Due to a report being made within the last 48 hours, the report was taken by phone.
-Resident #1 returned on 03/17/24 at 8:33a.m.

Review of Accident/ Incident Report dated 03/25/24 revealed:
-The resident signed out on 03/24/24 at 12:02pm.
-She was going next door and would be back.
-She did not return for the nighttime medication pass at 9pm.
-The MA/SIC notified the Administrator and contacted the Sheriff.
-The Sheriff came to the facility, gathered information, and filed a missing person's report.
-The MA/SIC was advised to notify the Sheriff's office upon the resident's return so she could be removed from the missing person's database.
-The legal guardian was notified on 03/24/24 at 9:08pm.

Review of the facility's sign in/out sheet revealed:
-Resident #1 signed out on 03/24/24 at 12:02pm.
-She documented her destination as "out."
-She did not document the entry for "Responsible Party Name/Number."
-There was not a documented entry for "Comments."

Review of the County Sheriff's Office Incident/Investigation report dated 03/24/24 at 10:07pm revealed:
-The dispatched call about a missing person was made on 03/24/24 at 9:13pm.
-The resident signed herself out at approximately 12:00pm.
-She stated she was going next door.
-The resident was entered into the missing person's database.
-The resident was reported missing 3 times this month and 5 times this year.
-She returned to the facility on 03/25/24.
-She was removed from the missing person's database.

The Administrator sent the County Department of Social Services a text message on 03/25/24 at 6:58pm indicating Resident #1 returned to the facility at 5:45pm.

Interview with Resident #1 on 03/27/24 at 10:35a.m. revealed: -She left to see a family member. -She knew she needed to sign out. -She signed out with the word "out." -She had been "locked up 14 years and wanted some freedom." -She thought curfew was 10:00pm. -She caught the city bus when she left the facility and when she returned. -She was never told she could not leave the facility. Interview with Administrator on 03/27/24 at 10:45am. revealed: -Staff on site had the responsibility to check the sign out register for residents. -Ultimately, it was his responsibility to check the sign out register. -This was the first time a resident had not followed the rules. -He was unable to recite the policy/procedure for residents who wished to leave the facility. -There was an "unwritten" and "assumed" rule that residents are expected to return to the facility before medication time 8:00pm. Interview with Resident #1's Legal Guardian on 04/02/24 at 9:57a.m. revealed: -Resident #1 was at a group home and then a local hospital before her admittance to the facility -She was aware of the resident's history of wandering. -Resident #1 was arrested in another part of the state for behaviors. -No one from the facility consulted with her before admitting the resident from the local hospital. -Resident #1 was aware she was not supposed to leave the facility on her own. -She thought consent was needed from her to allow the resident to leave the facility. Interview with the MA/SIC on 04/30/24 at 10:20a.m. revealed: -Resident #1 was away with a family member. -Resident #1 left with a family member on 04/28/24 and was expected to return on 05/02/24. -There was not a sign out entry for Resident #1. -The family member was contacted by the MA/SIC 04/29/24 to check up on Resident #1. -The family member informed the MA/SIC the resident was asleep in the recliner.		

Interview with the Legal Guardian on 05/01/24 at 11:01a.m. revealed:
-She was not aware the resident had left the facility on 04/28/24 to be with a family member.
-She assumed "no news was good news" when she had not heard anything from the facility.
-She called the family member and confirmed Resident #1 had not been there.
-The family member stated she last spoke to Resident #1 on 04/26/24.
-The family member had not seen the resident and did not know her whereabouts.
-The guardian entered a police report to convey Resident #1 was missing.

Interview with Resident #1's family member on 05/01/24 at 12:19pm revealed:
-She last saw Resident #1 over two weeks ago.
-She last spoke to the resident on 04/28/24.
-She never reported to the MA/SIC the resident was with her.

Interview with the Legal Guardian on 05/07/24 at 9:39am revealed:
-Resident #1's whereabouts were still unknown.
-She had never been missing this long.
-The facility was "absolutely" informed about the resident's history of wandering and inappropriate behaviors prior to admittance.
-The resident and staff were told the resident should not be able to leave without permission due to her history.
-On 04/12/24, more appropriate accommodations were found for the resident.
-The family member wanted the resident to remain in the area because she was able to visit with her.
-The owner of the home assured the guardian the resident would be safe and there was no need to move her.

Interview with Administrator on 05/07/24 at 11:43am revealed:
-Resident #1's whereabouts were still unknown.
-After the last incident, the resident was informed she could not leave without permission from staff but still permitted to leave unsupervised.
-Staff was instructed to have residents sign in and out with a phone number and exact location.
-Other than staff requesting residents to sign in and out, no other interventions were implemented to prevent reoccurrence.
-The Administrator was aware of the resident's history of

wandering and inappropriate behaviors.
-A discharge was initiated by the Administrator in March 2024 due to the resident's behaviors.
-The guardian was aware of the discharge and agreed the resident needed a higher level of care.
-The guardian found placement for the resident in April 2024 but was told by the owner of the home there was not a need to move the resident since the police "scared" her into not leaving.
-The Primary Care Physician (PCP) was not informed until approximately May 1 – May 3.
-The Administrator verbally informed the PCP while at a medical appointment with another resident.

Follow up interview with the MA/SIC were attempted on 05/07/24 but unsuccessful.

Telephone interview with PCP was attempted on 05/28/24 at 12:19pm but unsuccessful.

The facility failed to provide supervision for Resident #1 who had a diagnosis of altered mental status and had a history of wandering and inappropriate behaviors. The resident wandered from the facility on four different occasions and, her whereabouts were unknown for 34 hours and 45 minutes during the first occasion. The facility failed to implement any interventions and the resident went missing for 17 hours during the second occasion, 29 hours, and 43 minutes on the third occasion and remains0 missing after wandering away on the fourth occasion.
This failure resulted in serious neglect and constitutes a Type A1 violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 03/26/24 and 05/02/24 for this violation.

Correction date for this Unabated A1 shall not exceed 06/13/2024.

IV. Delivered Via:	Hand delivery	Date: 5/14/24
DSS Signature:	[signature]	Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name): EZE IHENACHO	
	Signature: [signature]	Date: 5/14/24
	Title: ADMINISTRATOR	

VI. Plan of Correction Submitted by:	Administrator (print name): EZE. IHENACHO	
	Signature: [signature]	Date: 6/5/2024

ADMINISTRATOR

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		
☑ *POC Accepted*	By: Vanya Reynolds	Date: 6/12/2024
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.*			