Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Pines on Carmel Senior Living
Address: 5820 Carmel Rd. Charlotte, NC 28226
County: Mecklenburg
License Number: HAL-060-168

II. Date(s) of Visit(s): 03/08/24, 03/15/24, 3/27/24, 04/16/24
Purpose of Visit(s): Complaint Investigations
Exit/Report Date: 05/06/24

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 provide supervision to 2 of 7 sampled residents (#1 and #2) who eloped from the Special Care Unit (SCU) without staff knowledge. Review of the facility's Wandering and Elopement Prevention Plan Program, effective 03/14/22 and revised on 07/12/22 revealed: - The purpose of the policy was to provide a system for identification of residents at risk for unsafe wandering and elopement, provide a program of supervision and interventions to minimize risk of resident elopements and elopement attempts, and provide team member education in effective wandering and elopement management through in-services and elopement drills.		

- Residents with cognitive deficits that resided in memory care or assisted living were to be evaluated for elopement risk by a member of the clinical team to identify their individual level of risk for wandering/elopement. - The Elopement Risk Evaluation was completed: A.) Before move-in to help determine whether the community was capable of safely and adequately meeting the needs of the resident; B.) Every 6 months; C.) After a significant change in condition; D.) After an elopement or an elopement attempt; and E.) After returning from a hospital, skilled nursing, or rehabilitation stay. - Residents who were identified as an elopement/wandering risk based on their elopement risk evaluation score would have an individualized service plan/care plan that included interventions to minimize the potential for elopement. - The individualized service plan/care plan would be created and shared with the resident (if appropriate), resident's responsible party, and community team members. - Community team members were supposed to be notified of residents "at risk" by utilizing an Elopement Binder. - The Elopement Binder was supposed to be placed in an area easily accessible by all community staff. - The Health Service Director (HSD) or designee was responsible for the upkeep of the Elopement Binder. - A plan to reduce the potential of elopement was supposed to be developed with input from the resident's legal representative and documented on the Individualized Service Plan/Care Plan such as the following but are not limited to: A. New residents were to be closely monitored and, if possible, have apartments away from exit doors and closer to the staff area; B. Institute whereabout checks so staff could account for all residents at risk for elopements on each shift at regular intervals. C. Instruct staff to maintain a visual line of sight of exit doors, particularly during shift change, mealtimes and emergencies, as these were times when residents may be able to exit the community unnoticed while staff attention was diverted. D. Utilize the life story to help redirect and set up diversion activities such as scheduled regular walks, monitor/increase involvement in activities, engage residents in purposeful activities daily such as bed making, laundry, cleaning, taking care of something they find important, etc. - Codes to emergency exits were only be utilized for emergencies and not as a means for entrance and exit by staff or visitors. - Alarms were supposed to be utilized to alert staff when residents enter or exit into the courtyard. - Courtyard doors were supposed to be secured and locked at dusk and unlocked in the morning.		

- Staff were supposed to be trained to promptly respond to door alarms.
- Elopement drills were to be conducted monthly on each shift so that each shift has a drill once per quarter, including one drill on each shift, including one weekend shift.
- An Elopement Drill Evaluation was supposed to be completed at the conclusion of each drill and documented in the documentation system by the Maintenance Director, including documentation of team member attendance.

1. Review of Resident #1's current FL-2 dated 12/19/23 revealed:
- Diagnoses included vascular dementia, end stage renal disease, gastro-esophageal reflux disease, gout, anemia, hypertension, and prostate cancer.
- Resident #1 was ambulatory, constantly disoriented, and continent of bowel and bladder.
- Resident #1's required level of care was SCU.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 12/28/22.

Review of Resident #1's Care Plan dated 08/30/23 revealed:
- Resident #1 was able to ambulate independently.
- There was no documentation regarding his need for assistance with transfers included.
- There was no documentation regarding Resident #1's elopement risk evaluation score or interventions that should have been implemented for him.
- Safety instructions were documented as "safety checks per policy".
- Special instructions were documented as "follow as written. Notify Supervisor of changes in care needs".
- There were no interventions documented to prevent elopements.

Review of Resident #1's SCU profile dated 08/14/23 revealed:
- Resident #1's behavior patterns included wandering, agitation/aggression, and disruptive behavior.
- Resident #1 was independent with transfers and ambulation.
- There were no interventions or comments documented on the form.
- Resident #1 was not oriented to place or time of day.

Review of Resident #1's SCU profile dated 01/01/24 revealed:
- Resident #1's behavior patterns included wandering, agitation/aggression, and disruptive behavior.
- Resident #1 was independent with transfers and ambulation.

- There were no interventions or comments documented on the form. - Resident #1 was not oriented to place or time of day. Review of the facility's Elopement Binder on 04/16/24 at 9:45am revealed: - Resident #1's face sheet was included in the binder, with his photograph and demographic information included. - The binder included contact information for all management staff. - The binder included clean copies of the facility's Missing Resident Search Checklist and a map of the vicinity of the facility, split into four quadrants. Review of Resident #1's Elopement Risk Evaluation form dated 08/14/23 revealed: - Resident #1 scored an equal number of high points regarding 3 questions: 1) "Is the wandering behavior a pattern, goal-directed (i.e. specific destination in mind, going home, seeking someone they can't find, hovering by staff and the door, going to work)?" 2) "Has the resident attempted to elope from this community?" and 3) "Is the resident upset they are in the community and want to go home or feeling confined, tricked, or imprisoned?" - Resident #1 was considered "high risk" for elopement. - There were no interventions documented to prevent elopements. Review of Resident #1's incident report dated 03/06/24 revealed: - Resident #1 eloped from the facility through a window on 03/05/24 at approximately 11:15pm. - The police called the community to ask if Resident #1 was a resident. - The police returned Resident #1 to the community on 03/06/24 at approximately 7:20am. - The resident had no visible injuries and no complaint of pain. - The Administrator interviewed 3rd shift staff and learned that Resident #1 eloped through a window. - All windows in the facility were checked to ensure the windows were working properly until a vendor came to assess the windows and provide a quote for window alarms. Review of Resident #1's progress note dated 03/05/24 at 9:35am revealed: - He was very agitated and aggressive and stated he did not "want to have to do what he is capable of doing".		

- There was no other documentation of interventions put in place to address his behavior.

Review of Resident #1's progress note dated 03/06/24 at 9:12am revealed his Responsible Party (RP) was notified that he eloped the night before and was returned to the facility safely, and that frequent checks would be conducted on Resident #1.

Telephone interview with Resident #1's RP on 04/17/24 at 1:20pm and 04/19/24 at 2:15pm revealed:
- She became aware Resident #1 had left the facility on 03/05/24 and was found in the community, when a staff member contacted her by phone on 03/06/24 at around 8:45am.
- The facility did not provide any specific information regarding where Resident #1 had been found.
- She spoke with police the day after Resident #1 was found and learned that a citizen called for assistance on 03/06/24 because they had observed Resident #1 sitting on their porch the morning of 03/06/24, approximately 8 miles from the facility.
- Police did not share the exact address of where Resident #1 was found.
- Police told her when they arrived at the citizen's house between 7:00am and 7:30am and asked Resident #1 why he was at the house he stated, "he lived there".
- Resident #1 pulled some papers out of his pocket, one which contained the name of the facility in which Resident #1 resided.
- The police called the facility and staff informed them that Resident #1 resided at the facility.
- The police told her they asked where Resident #1 was, and the facility staff member stated he was still in his room asleep.
- The police informed the staff member that Resident #1 was with him, and that they would bring him back to the facility.
- She spoke with the Administrator the next day, on 03/07/24, and the Administrator kept stating that Resident #1 had been agitated and kept exit seeking the night of 03/05/24, before the elopement occurred.
- She was surprised the Administrator's only response to the situation was that Resident #1 had been "exit seeking" and "agitated" the night before, because she thought these were behaviors the facility staff had been trained to address.
- It rained all night during the hours that Resident #1 was absent from the facility.
- Resident #1 always liked to walk and would have been able to walk 8 miles.

- Resident #1 had always had some exit seeking tendencies, especially when the season's changed. - The facility called her on a few occasions in the past, when Resident #1 was adamant about leaving, and she would talk to him to help settle him. - She did not receive any phone calls from the facility on 03/05/24 to make her aware that Resident #1 was exit seeking or agitated. - Resident #1 had never been aggressive with staff regarding leaving the facility, to her knowledge, but would just tell them he had to leave and would go to doors and try to open them. Review of historical weather data for 03/05/24 at 11:52pm - 03/06/24 at 7:30am revealed: - The temperature ranged from 57 - 60 degrees Fahrenheit. - The precipitation ranged from "light rain" to "rain". - The wind ranged from 5mph to 9mph. Observation on 05/02/24 at 11:00am of the most direct route between the facility and road on which Resident #1 was found by police on 03/06/24 revealed: - The distance from the facility to and the road on which he was found was 8.6 miles. - Most of the route consisted of a 4-lane road, with sidewalks, although some sections had no sidewalks. - Some areas had a median with foliage and there were many mature trees along the route. - Most of the route had streetlights at corners where roads met, but in many areas, there were no streetlights in between the street corners. - Resident #1 would have had to cross the road several times in order to have traveled the most direct route between the two locations. - There were several major intersections Resident #1 would have traveled through along the route. Attempted telephone interview with local law enforcement on 3/26/24 at 4:39pm and on 04/16/24 at 3:55pm was unsuccessful. Telephone interview with local law enforcement records division staff member on 03/27/24 at 8:14am revealed no police report was filed related to Resident #1's elopement. Interview with a Personal Care Aide (PCA) on 03/27/24 at 2:45pm revealed:		

- She worked on first shift from (7:00am - 3:00pm) on 03/05/24 and recalled Resident #1 did not seem to be agitated or exit seeking during her shift.
- She worked the next day on 03/06/24 and was at the facility when he was returned by police.
- Resident #1 was holding a plastic bag above his head because it was raining when he got out of the police car to come into the facility.
- Resident #1 was wet from the rain but did not appear to be "soaked".
- She sometimes worked from 7:00am - 7:00pm and observed in the evenings Resident #1 often became more agitated and exit seeking.
- Resident #1 would often talk about leaving the facility to find family members.
- Resident #1 became combative sometimes at night, saying he needed to leave, and one night had hit the door with a chair in an attempt to leave the facility.
- When Resident #1 began exit seeking, staff would attempt to redirect him by offering him a snack and talking about his prior career in sales.
- She did not recall any specific interventions she had been directed to use when Resident #1 began exit seeking.
- She was not working on second shift the night Resident #1 eloped.
- Prior to Resident #1 moving into the room in which he resided in at the time of the elopement, his room had been used as the COVID window visitation room and the window had been modified so that it would open up all the way, rather than just a few inches, like the other windows in the SCU.
- She thought the window must have still been able to open all the way in order for Resident #1 to have eloped through it.

Telephone interview with another PCA on 04/19/24 at 1:24pm revealed:
- She usually worked 1st shift in the facility but sometimes stayed over to work second shift.
- On 03/05/24, she worked from 7:00am to 11:00pm.
- Resident #1 rarely exhibited any exit seeking or aggressive behaviors on 1st shift, and this was the case on 03/05/24.
- Resident #1 was aggressive the evening of 03/05/24 and was exit seeking, insisting that he needed to leave because he was "waiting on a train" and kept opening other resident's doors after they had already gone to bed.
- When staff tried to redirect him, he swung his cane at a staff member on one occasion.
- Staff redirected him several times and he eventually settled down in his room and went to bed.

- Resident #1 was known to have exit seeking behaviors on second and third shift.
- When 3rd shift came in at 11:00pm on 03/05/24, she recalled discussing Resident #1's behaviors.
- She conducted rounds at the end of the shift and recalled Resident #1 was laying in bed around 11:00pm.
- Staff had not been directed to use any specific interventions to address his exit seeking and aggressive behaviors.

Telephone Interview with a third shift PCA on 4/18/24 at 5:15pm revealed:
- She worked 3rd shift at the facility and worked on 03/05/24, the night Resident #1 eloped.
- Resident #1 was often up when she arrived at the facility to work 3rd shift and would sometimes be in the living room watching television, or he would be walking around the facility asking to leave.
- Staff had not been directed to utilize any specific interventions for Resident #1, but she had found telling him that it was too dark to leave the facility, and that maybe he could go in the morning sometimes helped.
- Resident #1 would often tell staff someone was coming to pick him up, so they would ask him to wait in the living room and watch television until they arrived, which sometimes worked to calm him down.
- There were usually three staff members who worked 3rd shift.
- The three staff members, two PCAs and a MA, had assigned locations throughout 3rd shift; one would sit by the front door, another by the back door, and another in the center of the facility in the dining area.
- Each PCA was assigned a hallway on which the resident's rooms were located.
- Checks of residents were conducted at shift change (11:00pm), and at 12:00am, 2:00am and 4:00am.
- On 03/05/24, she did not recall second shift reporting any issues with Resident #1 at shift change, and he was already in bed for the night when she arrived at the facility.
- She was stationed by the front door all night, which was also right at Resident #1's bedroom door.
- Resident #1 was not assigned to her on 03/05/24, so she did not conduct checks on him throughout the night at 2:00am and 4:00pm.
- It was heavily raining all night and she did not recall hearing any noise from Resident #1's room.
- Resident #1 never opened his door, as he sometimes did on other nights.

Telephone interview with PCA on 04/19/24 at 1:11pm revealed:
- She worked third shift (11:00pm - 7:00am).
- She was not very familiar with Resident #1 but recalled he would sometimes be awake during 3rd shift and would occasionally attempt to push on the exit doors in the facility.
- When Resident #1 began exit seeking, staff would attempt to redirect him by changing the conversation to something besides leaving the facility, and she would remind Resident #1 with was the middle of the night, which usually reduced his exit seeking behaviors.
- During 3rd shift, staff were responsible for conducting 2 hour checks on residents.
- Her assignment on 03/05/24 did not include Resident #1, so she did not look in his room during 3rd shift.
- She was stationed by the back exit door in the living room area.
- Another staff member was stationed by the front door all night, which was right beside Resident #1's room.
- Some residents were usually awake and dressed before 3rd shift left, but many residents were still asleep at that time.
- Resident #1 would often sleep through breakfast, so it was not unusual for him to not be in the dining room when they left at the end of 3rd shift.
- She did not see Resident #1 the entire shift.
- She saw all residents assigned to her before she left that morning, but Resident #1 was not assigned to her.

Interview with a Medication Aide (MA) on 03/27/24 at 3:15pm revealed:
- She worked second shift (3:00pm - 11:00pm).
- She worked on 03/05/24 and left the facility at 11:00pm.
- Resident #1 was exit seeking the entire second shift on 03/05/24, which was not out of the ordinary for him.
- Sometimes during second shift, Resident #1 would become fixated on leaving through either the front door or back door of the facility.
- Approximately every "week and a half," Resident #1 would have a "bad day" when he returned to the facility from dialysis and would be hyper focused on leaving the facility the rest of the day and night.
- When Resident #1 became fixated on leaving the facility, staff would attempt to redirect him.
- When she left the facility at 11:00pm on 03/05/24, Resident #1 was laying in his bed with his eyes opened, which was not unusual for him.
- Staff had not be directed to use any specific interventions for Resident #1 when he began exit seeking.

Telephone interview with another 3rd shift MA on 04/18/24 at 5:48pm revealed: - She worked 3rd shift in the facility (11:00pm - 7:00am). - Resident #1 had always been exit seeking, but this behavior really increased after his family members told him he was going to be moving out of the facility, which caused him to start packing his belongings often. - Resident #1 was very focused on "needing to go to work." - Sometimes Resident #1 would still be up at the beginning of 3rd shift. - If he was still awake and exit seeking at the beginning of 3rd shift, staff would offer him something to eat and drink and talk to him awhile about his former work, and then he would eventually be ready to go to bed. - On 3rd shift, there were 3 staff members who worked the shift, and 2 were always stationed by the two exit doors to ensure no one left the facility. - Staff never thought Resident #1 would attempt to go out a window, especially in the rain. - She believed Resident #1 must have "worked on" the window in his room awhile to get it to open, as the mechanisms that allowed the window to only open a few inches had been broken. - On 03/05/24, staff members on 3rd shift were stationed at their assigned locations throughout the shift. - At shift change at 11:00pm, she conducted rounds on all the residents, and recalled observing Resident #1 in bed, but still awake. - Resident #1 appeared content and she had no reason to believe he was going to attempt to elope, especially since it rained all night. - Rounds were usually conducted by the PCAs at shift change (11:00pm), and at 2:00am, and 4:00am. - She did not know why the PCA who was assigned to Resident #1's side of the facility did not identify he was not in his room during rounds during the night. - There was no report from 2nd shift on 03/05/24 regarding any issues or behaviors with Resident #1. - Resident #1's exit seeking behaviors would usually start during 2nd shift and continue into 3rd shift. - On at least one occasion, he had attempted to get out of the facility by using a chair to hit a door. - When he had extreme behaviors, such as this, 2nd shift would attempt to calm him down and call his family members to assist in calming him down. - Prior to the elopement, staff had not been directed to use any specific intervention for Resident #1.		

- Staff had not been directed to use any specific interventions to address his exit seeking behaviors or agitation.
- Staff used tactics that they had found sometimes worked to decrease his behaviors and exit seeking, such as talking with him about his work or offering him a snack.

Interview with the Health Service Director (HSW) on 03/27/24 at 10:15am revealed:
- She was unaware that Resident #1 had any exit seeking behaviors.
- The former Special Care Coordinator (SCC) had not informed her of any issues related to Resident #1.
- If she had been aware Resident #1 had exit seeking behaviors, she would have ensured interventions were put in place to address the behaviors.

Interview with the Administrator on 03/27/24 at 10:00am and 04/16/24 at 10:30am revealed:
- Resident #1 eloped through his bedroom window on 03/05/24 at 11:15pm.
- She was able to identify what time Resident #1 left the facility from video footage that captured him walking away at 11:15pm, toward the main entrance of the facility.
- Staff were not responsible for watching a livestream of the security footage in real time.
- The video footage had since been recorded over since the incident occurred.
- Staff should have checked in on residents during the night and she was not aware this was not occurring.
- Resident #1 was able to get up and come out of his room on his own if he needed assistance with anything, and which may have been why staff did not check in on him during the night.
- She usually visited the SCU in the morning, after lunch, and occasionally in the evening or during 3rd shift.
- She had never observed Resident #1 exhibiting exit seeking or agitated behaviors and no one had brought any concerns regarding Resident #1 to her attention.
- The former SCC had not shared with her or the HSD that Resident #1 had been exhibiting exit seeking behaviors or agitation at any time.
- It was not until after the elopement occurred that she heard directly from staff that Resident #1 would frequently exit seek during 2nd and 3rd shift.
- Staff stated the former SCC was aware of the behavior and it was "normal" for Resident #1 to exit seek often.
- If she and the HSD had been aware there were exit seeking residents in the SCU, they would have immediately ensured there was an appropriate safety plan in place to address the

specific behaviors and that all staff were aware of interventions to use to address the individual resident's behaviors.

Telephone interview with Resident #1's Primary Care Providers (PCP) Office on 05/02/24 at 10:16am revealed:
- The PCP was unable to provide an interview.
- The PCP's nurse spoke with him and the PCP stated that his expectation was that Resident #1 would have been sent out the emergency department (ED) upon return to the facility by police, because he had been out of the facility for so long and it was unknown where he had been during that time.
- No further questions could be answered by the PCP.

2.) Review of Resident #2's current FL-2 dated 05/09/24 revealed:
- Diagnoses included dementia, non-traumatic intraventricular hemorrhage, hypertension, and benign prostatic hyperplasia.
- Resident #2 was ambulatory and intermittently disoriented.
- Resident #2 required level of care was SCU.

Review of Resident #2's unsigned Care Plan dated 01/29/24 revealed Resident #2 was independent with ambulation and transfers.

Review of Resident #2's SCU profile dated 01/01/24 revealed:
- There was a checklist with several behaviors listed including wandering, sundowning, or agitation/aggression, which documented he did not exhibit any of the listed behaviors.
- Resident #2 was independent with ambulation.
- Resident #2 was oriented only to person.

Review of the facility's Elopement Binder on 04/16/24 at 9:45am revealed:
- Resident #2's face sheet was included in the binder, with his photograph and demographic information included.
- The binder included contact information for all management staff.
- The binder included clean copies of the facility's Missing Resident Search Checklist and a map of the vicinity of the facility, split into four quadrants.

Review of Resident #2's Elopement Risk Evaluation checklist dated 02/20/24 revealed he was considered "low risk" for an elopement, with a total score of 4 points.

Review of Resident #2's incident report dated 03/24/24 revealed:

- On 03/24/24 at approximately 4:00pm, the gate to the SCU courtyard was found open by a MA. - The MA immediately directed staff to conduct a head count. - As the head count was started, a caregiver from the assisted living facility on the same property as the SCU facility came into the building with Resident #2, stating that she found him at the front door of the SCU, trying to get back inside. - The resident was returned at approximately 4:05pm. Review of Resident #2's progress note dated 03/24/24 revealed: - Resident #2 eloped from the SCU through a courtyard gate. - When the MA noticed the open gate, she immediately called for a head count of residents. - A PCA from the AL building located on the same property brought Resident #2 back to the facility and stated she found him trying to get in the front door of the building. - Resident #2 had no injuries. Observation of the exit route on 03/27/24 at 3:30pm revealed: - The courtyard was accessible through a secured door that required a code entered by staff to open, located in the common area of the facility. - The gate was secured by a magnetic lock. - There was a switch located on an adjacent wall, which disengaged the lock if it the switch was turned off. - A sensor was located on the courtyard gate. - A red alarm device was located on courtyard gate. Interview with a PCA on 03/27/24 at 2:45pm revealed: - Resident #2 was generally "pleasantly confused" and was never exit seeking inside the facility. - Resident #2 was very bonded with another resident in the facility, and if they were together, Resident #2 was content. - If the resident to whom he was bonded had to leave the facility for any reason, Resident #2 could become anxious and would look for the other resident and would go to the door and look out looking for her, but never actively attempted to leave the facility. - On 03/24/24, she recalled Resident #2 was not feeling well at about 1:50pm. - She left the facility at 3:00pm and was not there at the time of Resident #2 walked through the gate in the SCU courtyard that in the afternoon of 03/24/24. - She learned the next day that Resident #2 had walked out the open SCU gate.		

- The gate in the SCU courtyard was supposed to remain locked all the time but there was a switch on the wall next to the gate that disabled the magnetic lock on the gate. - She was aware that some staff sometimes disabled the lock on the gate so that they could go outside the courtyard during their breaks to smoke, but she was not aware the gate was unlocked on 03/24/24. Interview with a Medication Aide (MA) on 03/27/24 at 3:15pm revealed: - She was working at the time of Resident #2's elopement on 03/24/24. - Resident #2 went into the SCU courtyard with a PCA, but the PCA stepped back into the facility for a moment to assist another resident who needed assistance, leaving Resident #2 alone. - It was after the PCA stepped back inside that Resident #2 wandered through the gate in the SCU courtyard. - Resident #2 had never exhibited exit seeking behaviors. Interview with the Administrator on 03/27/24 at 10:00am revealed: - Resident #2 exited the SCU courtyard gate on 03/24/24 and was located within a few minutes by staff from the sister community, an ALF located on the same property as the SCU. - A staff member was originally sitting in the courtyard supervising Resident #2 but stepped right inside the door into the living room to assist another resident for a moment, when Resident #2 walked through the gate. - Staff were not aware the gate was unlocked at the time of the elopement. - The courtyard gate should have never been unlocked. - The gate was controlled by a "kill switch" located on the wall of the facility beside the gate. - After the incident occurred, she learned that some SCU staff used the gate when taking trash out. - She immediately notified staff that they were not allowed to use the gate in the SCU courtyard to dispose of trash. Interview with Administrator on 04/16/24 at 10:30am revealed: - The SCC was responsible for completing assessments for all residents in the SCU including Elopement Risk Evaluations every 6 months, Special Care Unit Profiles quarterly and Care Plans for residents in the SCU every 6 months. - She was not aware the SCC was not completing and updating all documentation as required. - When a resident scored in the "high" range on the Elopement Risk Evaluation, a Care Plan meeting should be held to discuss		

the specific interventions that would be used to address the behaviors, and the Care Plan should be updated to reflect the most recent evaluations score and interventions that should be used. --- The facility failed to provide supervision for 2 residents in the SCU, including Resident #1 who had a history of exit seeking and agitation behaviors, resulting in him eloping through his bedroom window and being absent from the facility for over 7 hours overnight with temperatures around 60 degrees and constant rain, before staff were made aware he was not present by police; and Resident #2 who wandered through an unsecured gate This failure resulted in substantial risk for physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/23/22. CORRECTION DATE FOR THIS A2 VIOLATION SHALL NOT EXCEED JUNE 05, 2024. ---		

Facility Name: The Pines on Carmel Senior Living

IV. Delivered Via:	Certified mail & hand delivered	Date: 5/10/24
DSS Signature:	Denise Boudeman / Nida M. Sanders	Return to DSS By: 6/3/24

V. CAR Received by:	Administrator/Designee (print name): Samantha Glass	
	Signature: Samantha Glass	Date: 5/10/24
	Title: Administrator	

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.*			