Adult Care Home Corrective Action Report (CAR)

I. Facility Name: _Woodridge Assisted Living Facility____ County: _Union____
Address: 2515 Fowler Secrest Road, Monroe, NC 28110 License Number: HAL-090-036
II. Date(s) of Visit(s): 7/11/24, 7/12/24, 7/19/24, 7/23/24, 7/31/24, 8/5/24, & 8/9/24 Purpose of Visit(s): Complaint Investigation

Instructions to the Provider *(please read carefully)*: Exit/Report Date: 9/6/2024

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** 09/27/24
Rule/Statute Number: 10A NCAC 13F .0901(a) PROVIDE PERSONAL CARE TO RESIDENTS	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.		
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 ambulation assistance with a wheelchair for a resident (Resident #1) with limited upper body strength and a diagnosis of dementia who was outside for an unknown period of time, in the sun and heat and experienced heat exhaustion.		

The findings are: Review of Resident #1's current FL-2 dated 02/16/24 revealed: -Diagnoses included hypertension, coronary artery disease, transient ischemic attack, vascular dementia, constipation hematochezia, osteoarthritis, depression, congestive heart failure, incontinence of bowel and bladder, hypercholesterolemia, edema, chronic kidney disease stage 3, benign prostatic hyperplasia, elevated prostate-specific antigen, B12 deficiency, interstitial lung disease, and vitamin d deficiency. Review of Resident #1's current care plan dated 02/16/24 revealed: -Resident #1 was sometimes disoriented and forgetful and needed reminders. -Devices needed for ambulation for Resident #1 included a walker and a wheelchair. -Resident #1 had limited strength with upper extremities. -Resident #1 required limited assistance with eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring. Review of the Incident Report dated 07/09/24 for Resident #1 revealed: -The type of incident was listed as medical-possible heat stroke. -The location of the incident was listed as outside on facility grounds. -The description of what was observed was noted to be Resident #1 was sitting in his chair outside with head down with slobber coming out of his mouth. -Resident #1 was sent to the hospital on 07/29/24 at 6:30pm. -The recorded status of the emergency room visit was for heat exhaustion and an acute urinary tract infection. Review of the Time and Date Weather temperatures for 07/09/24 for the area of the facility revealed: -The recorded temperature on 07/09/24 was 93 degrees. -The humidity was recorded at 51% for the hours between 3pm-4pm, 51% for the hours between 4pm-5pm and 52% for the hours between 5pm-6pm. Observations of the area on 07/11/24 with a MA at 5:00pm on the outside patio of the facility where Resident #1 was sitting on 07/09/24 revealed: -The patio has an open area and a screened in portion area.		

-Resident #1 was sitting on the portion of patio that was not screened in according to MA.
-Resident #1 was sitting partially under the umbrella but not completely under the umbrella.
-The front of Resident #1s body was exposed to direct sunlight.

Review of hospital medical records for Resident #1 dated 07/09/24 revealed:
-The chief complaint for the visit was for heat exposure.
-Emergency Medical Services (EMS) reported the resident was found sitting outside of his facility in his wheelchair and was altered.
-Bystanders stated that he was there since 10:00am.
-The resident was not speaking but would respond by shaking his head.)
-Visit diagnoses were heat exhaustion and acute urinary tract infection.
-The resident was known to have a history of dementia.
-Resident #1 was observed to have a sunburn.
-Skin observations for Resident #1 were sunburn on the face and arms bilaterally.

Review of the Medication Administration Record (MAR) for Resident #1 for June 2024 and July 2024 revealed:
-There was an entry for outside patio time to be supervised every shift by staff.
-Special instructions listed on the order was that supervision was needed to avoid behavior.
-The order date started 09/27/23 and was currently opened.
-Staff documented on the MAR that checks had been completed.

Interview with a first shift medication aide (MA) on 07/23/24 at 1:45pm revealed:
-She worked from 7:00am-3:00pm on 07/09/24.
-She gave Resident #1 his morning medications at 8:00am and his mid-day medications at 2:00pm.
-Resident #1 looked normal during her shift and she had no concerns with Resident #1.
-Resident #1 ate breakfast and lunch that day.
-Prior to her leaving the facility, Resident #1 was already sitting outside.
-She notified the second shift MA between 3:15pm and 3:30pm that Resident #1 was sitting outside.
-She recalled that 07/09/24 was an extremely hot day.
-Resident #1 was compliant with staff's efforts to assist, including ambulation in a wheelchair.

Interview with a second shift MA on 07/11/24 at 4:40pm revealed: -She learned from another staff member that Resident #1 was alleged to have been outside all day on 07/09/24. -She worked second shift on 07/09/24 and arrived at 3:00pm. -When she started her shift, she was not told anything about Resident #1. -One-hour checks on residents were done during her shift. -She observed Resident #1 sitting outside near an umbrella when she arrived. -She noticed that Resident #1 was not himself as he usually had a different upbeat demeanor. -She denied Resident #1 had any physical indications of sunburn when she saw him. -She told Resident#1 to come in for ten minutes around 3:15pm. -She observed Resident #1 made the effort to come into the facility by moving his wheelchair a little bit, but he did not go into the facility. -She told Resident #1 she was going to give him five more minutes to be outside. -Around 3:30pm or 4:00pm she went back out to give Resident #1 medication. -Resident #1 took three sips of water but did not want to come into the facility. -She was shocked when Resident #1 did not come in per her request as she did not have any issues with Resident #1 as he was compliant. -A family member for Resident #1 could have been contacted as they would have assisted as they had done in the past in different situations. -She did not contact a family member on this date because she intended to give Resident #1 five more minutes to be outside, and check back on him, however she had gotten busy with another resident. -Two other staff members helped her to wheel him inside around 5:50pm. -Resident #1 was not responding at that time, only to his name. -Resident #1 had slobber coming out of his mouth and nose. -Resident #1 was also observed to be breathing heavily. -Resident #1 had sweat on his face and the back of his neck and she thought he was overheating. -She and other staff put cold rags on Resident #1. -The Resident Care Coordinator (RCC) was contacted, and staff were instructed to send Resident #1 to the hospital. Interview with the Activities Director on 07/19/24 at 12:39pm revealed:		

-She recalled that Resident #1 went to lunch on 07/09/24. -She saw Resident #1 sitting outside on the back patio around 3:00pm when shifts were changing. -It was very hot on that day. -She observed Resident #1 around 6:00pm still sitting outside with his head dropped like he was napping. -She told Resident #1 to come inside for dinner and Resident #1 lifted his head and said he was coming. -At 6:00pm, she told the second shift MA to get Resident #1 to come inside because he had been outside since 3:00pm. Interview with a personal care aide (PCA) on 07/12/24 at 3:30pm revealed: -She worked second shift on 07/09/24 and had arrived at the facility at 2:54pm. -Resident #1 was already outside on the patio when she arrived, however she was not sure how long he had been out there. -Resident #1 was not sitting in the screened in shaded portion of the patio. -The first shift staff did not communicate any issues regarding Resident #1 on this date. -Around 5:00pm or 5:30pm, she went outside and told him to come inside to which he responded "okay". -She went back outside and found Resident #1 "kind of out of it". -She observed that Resident #1 had his head down, his nose was dripping, he could not lift his legs, he had signs of weakness and heavy breathing. -Resident #1 did not have much response and she proceeded to get the MA. -She and the MA were able to get Resident #1 back into the facility and gave him room temperature water and a cold wet rag around 5:45pm. -Dinner was being served at this time, however Resident #1 did not have dinner due to his condition. -The RCC was contacted, and Resident #1 was sent to the hospital. -She had never had any issues with Resident #1 being compliant and with her efforts to assist him. -Resident #1's family was involved and could be contacted if assistance was needed. Interview with the RCC on 07/12/24 at 3:34pm revealed: -She saw Resident #1 at breakfast on 07/09/24 which was served between 8:30am and 9:00am. -She saw Resident #1 at lunch around 12:30pm and he remained in the sitting area after lunch.		

-She also saw Resident #1 around 2:00pm or 2:30pm rolling in his wheelchair to his room. -She left around 5:30pm on 07/09/24. -She denied that she had seen Resident #1 sitting outside. -Staff were supposed to check on residents every two hours. -Staff did not report any concerns about Resident #1 to her. Interview with a second personal care aide (PCA) on 07/23/24 at 3:08pm revealed: -She worked second shift on 07/09/24. -Resident #1 was sitting outside when she arrived at 2:55pm. -Resident #1 was sitting at the table where the umbrella was located. -The MA asked Resident #1 to come inside between 3:15pm and 3:30pm. -She recalled that Resident #1 was asked to come inside more than one time as it was very hot outside. -She asked Resident #1 to come in around 3:45pm and his response was "he would be okay". -An hour later another resident tried to get Resident #1 inside of the facility. -They could not get Resident #1 inside of the facility because Resident #1 was putting his legs down. -She attempted to push Resident #1 inside, but he continued to put his foot down, which prevented her from doing so. -The wheelchair legs were on; however, she could not push him as he continued to put his foot down, she did not seek assistance from another staff member. -Around 5:45pm to 6:00pm, Resident #1 looked flushed, and his skin was reddish, and he was sweaty, his head was dropped at this time, and he was drooling. -She reported that Resident #1 was not moving and that his responses were slow. -A cool rag was placed on Resident #1's head and EMS was contacted. Interview with the Interim Administrator on 07/11/24 at 2:00pm revealed: -Resident #1 was in and out of the facility on the day of the incident. (07/09/24) -Resident #1 was not outside from 10:00am-6:00pm as reported. -She arrived at 11:00am on that day and passed Resident #1 a couple of times in the hall. -She went on the porch two times during that day and one time Resident #1 was there and the other time he was not. -She was aware of the high temperatures, and she tried to get the residents to come inside.		

-She put a sign up on 07/03/24 that stated it was hot outside for residents to please not stay outside as the reported temperature on that day was 110 degrees. -She took the sign down on 07/11/24 as the sign had been damaged. -Resident #1 could read the sign but it was not clear if Resident #1 could fully comprehend the consequences of not following the recommendation on the sign due to his cognitive status. -No concerns were reported about Resident #1, and he had no issues with staff, no behavioral issues and did not refuse assistance. -The facility could have done more to prevent the incident. -Resident #1's family could have been contacted for assistance with getting the resident to come inside. Interview with the local Emergency Medical Services (EMS) Supervisor on 08/14/24 at 3:30pm revealed: -He responded to the call for Resident #1 on 07/09/24. -Resident #1 was severely altered and unresponsive. -On the EMS scale, Resident #1 was determined to be not alert as staff had to produce pain to get a response. -Upon his arrival, Resident #1 appeared to be very sick. -Resident #1 had secretions coming from his mouth. -Resident #1 was completely soaked in sweat. -Resident #1 was also observed to be covered in urine on the lower part of his body. -The temperature on 07/09/24 was over 100 degrees and it was incredibly hot. -Staff at the facility reported to him that Resident #1 had been outside on the patio for two to three hours. -A family member who was visiting with another resident, informed him that they had noticed that Resident #1 had been outside since 10:30am up until EMS's arrival after 6:00pm and minimal effort had been made by staff to bring Resident #1 inside. Interview with the Physician Assistant with the local hospital on 07/16/24 at 6:00pm revealed: -Upon arrival to the hospital, Resident #1 had a temperature of 104 degrees. -Resident #1's temperature resolved after being given Tylenol and fluids. -Resident #1's face and body parts not covered by clothing were sunburned. -The temperatures for that day were in the 100s. -He learned from EMS that Resident #1 was allegedly outside from 10:15am to 6:00pm as stated by another party. However,		

the facility staff reported to EMS that Resident #1 was only outside for a couple of hours. -Based on his observations, Resident #1 was outside for an inappropriate amount of time considering the temperatures for that day. -Based on Resident #1's condition, the resident had to be outside for at least one hour in the high temperatures in order for the heat exhaustion to occur. -Upon assessment, Resident #1 did not have the capacity to process getting out of the sun on his own due to his very limited cognitive status. -He spoke with to a family member of Resident #1 due to Resident #1's cognitive status. -Resident #1's family member disclosed that they had observed a cognitive decline for Resident #1 for the last three months. -Resident #1 did not have the mental state or capacity to make decisions when seen in the emergency room on 07/09/24. -Resident #1 was found to have a urinary tract infection, however it was not impressive; specifically, a significant amount of bacteria was not found for the infection. -To avoid heat exhaustion, more water should have been provided and direct sunlight should have been avoided for Resident #1. Telephone interview with the primary care provider (PCP) for Resident #1 on 07/26/24 at 12:15pm revealed: -She was made aware that Resident #1 was transported to the hospital for heat exhaustion. -Staff should have brought Resident #1 inside based on the high temperatures that week. -Resident #1 had dementia. -Staff were not checking on Resident #1 frequently enough in order for the incident to occur. -Staff could have wheeled Resident #1 inside of the facility to prevent the incident. -Resident #1 had a feisty personality, was pleasant and joked around but was not non-compliant with staff. -Staff could have also contacted a family member for Resident #1 for assistance if they had any difficulty or concerns with Resident #1. Telephone interview with a family member for Resident #1 on 07/16/24 at 11:37am revealed: -She was contacted by a MA around 6:00pm on 07/09/24 and informed that Resident #1 had a heat stroke and an ambulance was called.		

-She talked with the emergency room doctor and was notified that EMS was told that minimal effort had been made by staff to get Resident #1 inside from the heat throughout the day. -She spoke with Resident #1 while he was at the hospital, and he was severely confused. -She spoke with the Interim Administrator who conveyed that she saw Resident #1 for lunch and that Resident #1 was in and out of the facility all day. -The Interim Administrator explained to her that it was a resident's rights to sit outside all day. -The family member expressed that Resident #1's safety should come first. -She was given different variations of what occurred with Resident #1. -She was told by the Interim Administrator that Resident #1 was brought inside of the facility every fifteen minutes and was being given water. -She was also told that staff were having difficulties getting Resident #1 back inside of the facility. -She was never contacted by the facility on this day regarding any issues with Resident #1 as she would have come to the facility to provide any assistance as she has done in the past. -Normally the facility would contact her with any issues with Resident #1. Telephone interview with another family member for Resident #1 on 07/11/24 at 3:30pm revealed: -She spoke with the Interim Administrator regarding the heat exhaustion incident that occurred with Resident #1 on 07/09/24. -The Interim Administrator reported that staff had been outside three times on the day of the incident and tried to bring Resident #1 inside. -The Interim Administrator indicated that staff became concerned between the hours of 3:00pm-6:00pm and were checking on Resident #1 every fifteen minutes and gave Resident #1 fluids. -The Interim Administrator explained that the Heat Index was 105 on 07/09/24. -She was informed by the Interim Administrator that resident rights was the reason why the staff could not bring Resident #1 inside. -She communicated concerns as to why the safety and well-being of Resident #1 was not considered over residents' rights. -The facility had contacted the family member or another family member as to Resident #1 in the past with any issues. -No family members of Resident #1 were contacted by the facility for assistance.		

-When issues arose with Resident #1 in the past, family members would come to the facility, if necessary. The facility failed to ensure Resident #1, who had limited upper body strength and a diagnosis of dementia, was provided assistance with ambulation in a wheelchair to return inside and subsequently left outside for an unknown period of time in the sun and temperatures in the 90's. This failure resulted in the resident experiencing a change in his level of consciousness, being transported to the hospital where he had a temperature of 104 degrees Fahrenheit, sunburn to his face and arms and a diagnosis of heat exhaustion. 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 07/12/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 6, 2024.		

IV. Delivered Via:	Hand Delivery	Date: 9-6-24
DSS Signature:	Donalyn Holder	Return to DSS By: 9-27-24

V. CAR Received by:	Administrator/Designee (print name): Jennifer Hill	
	Signature:	Date: 9-6-24
	Title: ED	

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.*		