Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Open Arms Retirement Center
Address: 612 Health Drive Raeford NC 28376
County: Hoke
License Number: HAL-047-014

II. Date(s) of Visit(s): 08/27/24,08/29/24,09/25/24,10/17/24
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 10/18/24/11/08/2024

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)* • *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**
Rule/Statute Number: 10A NCAC 13F.0902(b)	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents		
Level of Non-Compliance: Type A1 Violation		
Findings: Based on observations, interviews and record reviews, the facility failed to ensure health care referral appointments were made for 1 of 5 sampled resident (Resident #5) which resulted in the resident open wounds getting worse and having exposed orthopedic screws and hardware, being in pain and infection. The findings are: Review of Resident #5's Fl-2 dated 05/30/24 revealed: -Diagnoses include: gait instability, hypertension, chronic kidney disease stage 3, deep vein thrombosis, chronic obstructive pulmonary disease, history of polysubstance abuse, left tibula- fibula fracture and injury in a motor vehicle accident. -Resident #5 ambulated with a wheelchair.		

-Resident #5 was oriented.

Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 06/21/24.

Review of Resident #5's primary care provider (PCP) visit notes dated 07/05/24 revealed:
-Resident #5 was seen on this day to be established with the practice.
-The facility staff requested a referral for Resident #5 to be seen by physical therapy (PT) due to gait instability, ankle injury and generalized weakness.
-Resident #5 had surgery in February 2024 on the left ankle with a non-healing wound.
-Resident #5 requested pain medication due to ankle and back pain.
-There was wrote an order for Percocet for 14 days until seen by pain management.
-The resident was noted to have an open lesion to the left lateral malleolus, approximately 1cm round.
-An order was written for Resident #5 to be seen at the pain clinic for evaluation and treatment
-An order was written for Resident #5 to be seen by home health skilled nursing for wound care for on the left ankle.

Review of Resident #5's PCP visit note dated 07/17/24 revealed:
-Resident #5 was seen for a follow up appointment.
-Home health was ordered at the last visit with Resident #5 on 07/05/24.
-Resident #5 stated that home health "had not been to see him yet".
-Resident #5 had 2 open areas to the left lateral malleolus, approximately 1cm round with drainage
-Resident #5 was noted to have 2+ edema with tight shiny skin, his foot was warm however his toes were cool.
-The PCP again ordered Resident #5 to be seen at the first available pain clinic appointment.

Review of a successful fax sent to the local home health agency on 08/09/24 revealed:
-The cover sheet stated physical therapy (PT) referral for Resident #5
-There was nothing indicating that Resident #5 needed to be seen by home health skilled nursing for wound care.
-The cover sheet was signed by the facility Resident Care Coordinator (RCC).

Review of Resident #5's PCP visit notes dated 08/14/24 revealed:
-Home health nursing orders were provided on the initial visit with Resident #5 on 07/05/24 however it "did not start".
-The PCP provided additional home health nursing orders for wound care to the left ankle/foot wounds at this visit.
-Resident #5 was positive for joint and back pain.
-Resident #5 requested pain medication.
-Resident #5 was currently prescribed acetaminophen (used to treat mild to moderate pain) 500mg as needed however the resident requested something stronger.
-Resident #5 was prescribed to Tramadol HCL 50mg (used to treat moderate and severe pain) twice a day for 30 days.
-Resident #5 was waiting to have the appointments scheduled.
-The PCP would reiterate with the facility scheduler the importance of these appointments.
-It was noted that on 07/05/24 a referral was made for Resident #5 to be seen at the first available appointment at the pain clinic.
-Resident #5 had 2 open areas to the left lateral malleolus approximately 1cm round with scant drainage with 2+ edema with tight shiny skin, foot warm toes cool.

Review of the of the facility's report health services to resident's form dated 08/29/24 revealed:
-The form stated "home health nurse to come out to evaluate and treat wound on Resident #5's left ankle/foot".
-It was written by the facility RCC on 08/29/24 and signed by Resident #5's PCP on 09/04/24.

Review of a fax cover sheet dated 08/29/24 revealed the report of the facility's health services to resident's form dated 08/29/2024 was successfully faxed to a local home health agency.

Review of the home health wound care skilled nurse communication note dated 08/30/24 revealed:
-A skilled nursing evaluation related to wound care was completed on Resident #5 today.
-The home health nurse made Resident #5's PCP aware that the resident was being sent to the local emergency department (ED) due to having exposed hardware on the left lateral ankle and concern for infection.
-Resident #5 complained of pain and there was noted swelling to the left lateral ankle and the resident's skin was slightly warm.
-She recommended Resident #5 be seen by the wound care clinic once the resident returned to the facility.

Review of home health wound care skilled nurse visit notes dated 09/03/24 revealed: -Resident #5 was in constant pain. -Resident #5 stated" his ankle hurts, can't you do something". Resident #5's pain was described as an aching, burning, sharp, shooting, throbbing pain and was an 8 out of 10 on the pain scale. -Referral for wound care center consult was put in Resident #5's PCP communication book by the home health wound care nurse. -Resident #5 had exposed hardware on his left ankle. Review of Resident #5's PCP visit notes dated 09/04/24 revealed: -Resident #5 was seen for an ED follow up. -Resident #5 was positive for back and joint pain. -Resident #5 had two open areas to the left lateral malleolus 1cm round with scant drainage with 2+ edema with tight shiny skin, foot warm toes cool. Review of home health wound care skilled nurse visit note dated 09/11/24 revealed: -Resident #5's wound to the left lateral ankle with exposed hardware measured 1.5 x1.5x 0.1 cm with 3 screws and plate visible. -Resident #5 was in constant pain. Review of home health wound care skilled nurse visit note dated 09/20/24 revealed: -Resident #5 was in constant pain. -The facility staff was trained on how to perform wound care for Resident #5 when home health wound care was not available or if the bandages were loosened or soiled. -Resident #5's wound was present on admission. -The comment section on the note for Resident #5 stated "exposed hardware of 4 screws and plates with pressure sore superior to ankle". -The wound on Resident #5's left lateral ankle measured: length 4.5cm, width 1.5cm, depth 0.2cm, surface area 6.75cm. Review of home health wound care skilled nurse visit note dated 09/25/24 revealed: -At this visit Resident #5 skin edges were beefy red and the left foot was slightly warm to touch and slightly swollen. -The facility RCC was able to view the wound and exposed hardware on Resident #5's left lateral leg.		

-Resident #5's prior pressure ulcer was now opened and revealed more hardware and another screw; there were 5 screws exposed.
-The wound on Resident #5's left lateral ankle measured: length 4cm, width 1.4cm, depth 0.1cm, surface area 5.6cm.

Review of Resident #5's home health wound care nurse visit discharge summary dated 09/30/24:
-Resident #5 was taken to the orthopedist doctor on 09/26/24 by the facility transporter for follow up of left ankle.
-He was sent to the local hospital directly from the orthopedic appointment to have the ankle hardware removed.

Review of Resident #5's orthopedic clinic visit notes dated 09/26/24 revealed:
-Resident #5 was admitted directly to the hospital from the orthopedic clinic after exposed orthopedic hardware was discovered on exam.
-Resident #5 stated about "2 months ago he was fine until he bumped his ankle on his walker when he was getting out the shower".
-Resident #5 had increased pain and drainage from the left lateral ankle wound.

Review of Resident #5's hospital infectious disease consultation dated 09/26/24 revealed:
-The reason for the consult was the evaluation and treatment of osteomyelitis (which is a bone infection).
-Resident #5 had the orthopedic hardware removed at the hospital on 09/27/24

Interview with the facility appointment scheduler and transporter on 09/25/24 at 10:30am and 11:15am revealed:
-The RCC was responsible for giving her the orders for residents if there was an order or referral made after a visit with the PCP.
-The RCC usually put the orders for Resident #5 on her desk.
-The month of July she was in and out the office a lot and may not have had the time to make the appointments for Resident #5.
-If the matter was urgent she would try to get the appointments scheduled sooner.

Interview with Resident #5 on 09/25/24 at 1:00pm revealed:
-He was always in pain.
-He was not sure when he had first been seen by the home health wound care skilled nurse or at the pain clinic
-The facility scheduled all his appointments for him.

Telephone interview with the receptionist at the pain clinic on 10/10/24 at 1:30pm revealed: -Resident #5 was seen for the first time at the pain clinic on 09/19/24. -Someone from the facility called the pain clinic on 08/21/24 to schedule Resident #5 an appointment. Review of Resident #5's office visit notes with the pain clinic dated 09/19/24 revealed: -Resident #5 was a new patient. -Resident #5's chief complaint was back pain and pain in the left leg. -Resident #5 described the pain as "radiating down the left leg. -Resident #5 was prescribed Oxycodone-acetaminophen 5-325mg (used to treat severe pain). Interview with the home health wound care skilled nurse on 09/25/24 at 10:53am revealed: Nursing services for wound care for Resident #5 started on 08/30/24. -The agency had received the referral on 08/29/24 from the facility. -On the initial visit with Resident #5 on 08/30/24 she "did not know what to do for him" as he had screws exposed on the hardware that was placed in the left lateral ankle. -She sent Resident #5 to the local emergency department due to the exposed hardware. -She had written an order for Resident #5 to be seen at the wound care clinic for continued care. -Last week during her visit with Resident #5 on 09/25/24 there were 4 screws exposed now there were 5 screws exposed. Telephone interview with Resident #5's PCP on 09/25/24 at 12:15pm revealed: -She did not know why it took so long for Resident #5 to be seen by home health or at the pain clinic -She was made aware that the home health wound care had not started when the facility staff came to her and asked for a new referral as the original referral she had previously written had expired. -She was not sure when the new referral was requested. -She would have liked for Resident #5 to have been seen by home health skilled nursing and at the pain clinic sooner than he eventually was. -The concern she had for Resident #5 not being seen after the first referrals on 07/05/24 was that the resident had open, nonhealing wounds and was in pain.		

Interview with the facility administrator on 10/17/24 at 1:46pm revealed:
-There was not a body assessment done when Resident #5 was admitted to the facility to document the status of the wound to the left lateral ankle.
-She was not aware that Resident #5 had the open non-healing wound on his left ankle.
-She was not aware that he had not been seen by home health wound care skilled nurse in a timely manner.
-The facility did not keep nurses or progress notes when the facility staff communicated with the residents' PCP or other providers.
-The facility transporter/scheduler did not have a backup person to assist her with ensuring all appointments are scheduled in a timely manner.
-There were no checks and balances to ensure the appointments were made for the residents.
-Resident #5 was currently in a skilled nursing facility due to the resident having the hardware removed from his left ankle and was on intravenous antibiotics.

Attempted telephone interview with Resident #5's family member on 09/25/24 at 1:20pm was unsuccessful.

The facility failed to ensure the acute health needs were met for a resident (#1) by not making sure the resident was seen by a home health wound care nurse and at the pain clinic as ordered. This resulted in the open wound to resident's ankle to deteriorate and exposed the orthopedic screws and hardware, and not getting needed pain medication and having an infection. The exposed screws went from none to 5 in eight weeks. The non-compliance resulted in serious neglect and constitutes a Type A1 violation.

The facility provided a plan of protection in accordance with G.S. 131-D34 on 10/21/24

The correction date for this Type A1 violation shall not exceed 11/18/24.

Rule/Statue Number: 10A NCAC 13F.0903(c)

Rule Statutory Reference: Licensed Health Professional Support: The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in Paragraph (a) of this Rule is completed within the first 30 days

of admission or within 30 days of the date a resident develops the need for the task and at least quarterly thereafter. Level of Non-Compliance: Standard Deficiency Findings: Based on observations, interviews and record reviews, the facility failed to assure 2 of 5 residents (Resident #1 and #3) had Licensed Health Professional Support forms completed quarterly. a. Review of Resident #1's current Fl-2 dated 08/28/24 revealed: -Diagnoses included hypothyroidism, protein calorie malnutrition, bipolar disorder, Alzheimer's disease, Stage 3 kidney disease, edema, urinary incontinence and generalized muscle weakness. -Resident #1 was constantly disoriented. -Resident #1 did not ambulate. Review of Resident #1's Resident Register revealed she was admitted to the facility on 11/13/23. Review of Resident #1's Care Plan dated 08/29/24 revealed Resident #1 was totally dependent for eating, toileting, bathing, dressing, transferring, grooming/personal hygiene and ambulation/locomotion Review of Resident #1's Licensed Health Professional support (LHPS) form completed for Resident #1 dated 03/25/24 revealed: -Resident #1 required assistance with feeding techniques due to swallowing problem, transferring of semi-ambulatory or non-ambulatory residents and ambulating using assistive devices that required physical assistance. -There were no other completed LHPS review form after the one dated 03/25/24. b. Review of Resident #3's current Fl-2 dated 01/31/24 revealed: -Diagnoses included: unspecified generalized muscle weakness, abnormalities of gait and mobility, unspecified hemiplegia and hemiparesis hydrocephalies. -Resident #5 semi-ambulatory. Review of Resident #3's Resident Register revealed he was admitted to the facility on 01/03/2024.		

Review of Resident #3's facility record on 08/29/24 revealed there was a restraint order for bed rails to prevent falls and repositioning dated 01/17/24.

Review of Resident #3's LHPS form completed for Resident #3 was on 04/30/24 revealed:
-Resident #3 required assistance with transferring of semi-ambulatory or non-ambulatory residents and ambulating using assistive devices that required physical assistance and the care of residents who are physically restrained.
-There was no other completed LHPS review form after the one dated 04/30/24.

Interview with the facility Resident Care Coordinator (RCC) on 09/25/24 at 12:52pm revealed the facility contracted nurse was responsible for completing the LHPS reviews.

Interview with the facility administrator on 10/17/24 at 2:00pm revealed:
-The facility contracted nurse was responsible for the completing the LHPS reviews.
-The contracted nurse retired from working at the facility on 09/26/24.

Rule/Statue Number: 10A NCAC 13F.0311(a)

Rule Statutory Reference: The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.

Level of Non-Compliance: Standard Deficiency

Findings: Based on observations, interviews and record reviews, the facility failed to ensure that a call bell system was working properly to alert staff through the pager system for assisted living and special care unit residents who resided in the facility.

The findings are:

Interview with a resident on the assisted living side of the facility on 08/27/24 at 10:05am revealed:
-He did have a hand bell in reach no one never responded when he rang it.
-The personal care aides (PCA) on all shifts had not respond when he has rung the bell.

-The bell was to be used for emergencies.

Interview with another resident on the assisted living side of the facility on 08/27/24 at 10:07am revealed:
-She had a hand bell on her bedside table.
-She picked the hand bell up and rang it.
-She complained how low the sound of the handbell was.
-If the facility staff was in another room or down the hall they could not hear the hand bell.

Interview with another resident on assisted living side of the facility 08/27/24 at 10:40am revealed:
-He had a hand bell but did not know why as no one ever came after he rang and rang the hand bell.
-When a PCA did come down the hall the aide would say they did not hear the bell.

Observation of a resident's room on the assisted living side of the facility on 08/27/24 at 10:45am revealed there was a hand bell on the bedside table however it was still in the plastic.

Interview with another resident on the assisted living side of the facility 08/27/24 at 10:45am revealed:
-She did not have a hand bell.
-She looked around the room and saw a bell on the bed side table behind a lamp.
-Since the bell had a ringer she assumed it was to be rang when she had an emergency.

Observation of a resident's room on the special care unit (SCU) on 08/27/4 at 11:00am revealed:
-The aide in the resident's rooms pushed the room's call bell.
-There was no audible sound heard nor did the call bell light up.

Observation of another resident's room on the SCU on 08/27/24 at 11:08 revealed:
-The resident had the call light laid across her bed.
-There was no hand bell in the resident's room.
-She pushed the call light button.
-There was no audible sound heard nor did the call bell light up.

Interview with a resident on the SCU on 08/27/24 at 11:10am revealed:
-She had the call light on the bed so she could call for help if anyone tried to come into her room.
-She did not know the call bell system did not work.

-She did not have a bell.

Interview with a personal care aide (PCA) on the SCU side of the facility on 08/27/24 at 11:15am revealed she had no "idea" the call bell system did not work

Interview with a medication aide (MA) on 08/27/24 at 10:00am revealed:
-The call bell system still did not work.
-The call bell system had been out since about February of this year.
-The residents were using hand bells to signal the staff when they needed something.
-It was hard to hear the handbells on certain parts of the hall.

Telephone interview with a resident's family member on 08/30/24 at 12:15pm revealed:
-Their family member was admitted to the facility in December 2023; the call lights at the facility were working then.
-Around February 2024, the calls lights were working off and on and then they completely stopped working.
-She had gone to the facility Resident Care Coordinator (RCC) several times about getting the call bell system fixed at the facility.
-The RCC stated that someone was supposed to come fix the call bell system.
-She has been at the facility on several occasions when her family member rang the hand bell several times and no staff ever came.
-The hand bells were hard to hear if you were not in close proximity of it.

Interview with the facility administrator on 10/17/24 at 11:46pm revealed:
-She had sent a quote on 05/30/24 to the home office to the have the call bell system repaired.
-The call bell system had completely stopped working sometime in February 2024
-Someone from the home office was at the facility last week and had approved for the call bell system in the whole facility to be replaced.
-She was not sure when the call bell system would be fixed.

IV. Delivered Via:	Electronic Mail/Certified Mail	Date: 11/08/2024
DSS Signature:	Antoinette McMillian SWTL	Return to DSS By: 12/4/24

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

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.*