Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Our Promise Family Care Home
Address: 303 Yorktown Drive Chapel Hill, NC
County: Orange
License Number: FCL 068-037

II. Date(s) of Visit(s): 9.3.2024, 9.16.2024, 10.3.2024
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 10.14.2024

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 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: 10 A NCAC 13G .0902	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.		
Level of Non-Compliance: Type A 1 Violation		
Findings: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 1 of 3 residents (#2) who had a fall and complained of right shoulder pain and was not sent to the hospital for evaluation for approximately 48 hours. The findings are: Review of Resident #2's FL-2 dated 5.30.2024 revealed: -Diagnosis included sepsis and urinary tract infection. -The resident was disoriented intermittently. Review of Resident #2's Care Plan dated 7.13.2024 revealed: -She was totally dependent on the staff for toileting. -She was totally dependent on the staff for ambulation and locomotion.		

-She required extensive assistance with bathing. -She required extensive assistance with dressing. -She required extensive assistance with grooming and personal hygiene. -She was totally dependent on the staff for transferring. Review of Resident #2's Licensed Health Professional Support Review and Evaluation dated 8.26.2024 revealed: -Resident #2 was now bed bound. -Resident #2 had a recommendation for a Hoyer lift for transporting to the wheelchair as needed. Review of the facility's' policy on accidents and incidents revealed: -It was the expectation of the facility that staff supervise residents and keep them safe from all accidents and incidents possible. There may be times in our communities in which residents are involved in accidents and injuries that are unavoidable. In the event of an accident or incident the procedures listed below should be followed. -Falls definition – when a resident loses the ability to remain seated or standing resulting in making a motion onto the floor, this includes rolling out of bed, tipping over in chairs/wheelchairs, tripping, lunging, and all other behaviors in which result in a resident going to the floor. -In the event in which a resident had a fall, staff should immediately attend to the resident and check the resident for any pain, cuts, bruises, or other abnormalities the resident did not have prior to their fall. -In the event in which a resident falls and hit their head, the resident should undergo further medical evaluation as soon as possible. In the event in which a resident was in pain, had a laceration that cannot be covered by basic first aid, exhibiting behaviors or gait not displayed before the fall, the resident should undergo further medical evaluation as soon as possible. Staff should notify the administrator immediately once the resident was safe of the fall, following a fall, the residents' guardian or power of attorney should be notified within 24 hours of the fall, the supervisor of the facility should place a note in the resident's chart as soon as possible. -The resident's physician should be notified with-in 24 hours of any fall resulting in an injury or further medical attention. -The staff member contacting the physician is expected to take note of all further recommendations and follow physicians' instructions. In the event in which a fall resulted in a resident requiring further medical attention other than first aid, hospitalization, or emergency evaluation, the facility should notify the department of DSS immediately but no later		

than 48 hours from discovery of the incident using the incident report form. Review of Resident #2's incident reports dated 8.31.2024 revealed: -Resident #2 had a fall in her room. -The Medication Aide (MA) entered the home and heard the resident calling out. -The resident was on the floor. -The M A took the resident's vitals and documented the resident complained of left shoulder pain. -Emergency medical services (EMS) were not contacted. -The physician was not contacted. Observation of Resident #2 on 9.3.2024 at 11:01 a.m. revealed: -She was in the hospital bed with a small bruise on her head, and bruises on and around her left shoulder. -Her left shoulder was in a sling. Interview with Resident #2 on 9.3.2024 at 11:01 a.m. revealed: -She was sitting in a wheelchair and dropped a paper on the floor. -She bent over to pick up the paper and the wheelchair dumped her out. -She bumped her head severely and the wheelchair fell on top of her. -No one came to check on her, she called for help multiple times. -She believed she was on the floor for 30 to 40 minutes. -The floor was very cold and she was in pain. -Her head was hurting an employee found her and ran for help. -When the employee came back they did not do anything. -She reported getting herself back into the bed. -Her family came and saw the bruises then called for medical assistance. -If her family had not come she would still be laying in pain. -She told staff she was in pain prior to her family arriving at the home. Interview with the MA on 9.3.2024 at 1:00 p.m. revealed: -On 8.31.2024, Resident #2 asked to go to her room because she was irritated and yelling for her husband. -She reached for something on the floor while in the wheelchair and fell. -He was not sure what time Resident #2 fell.		

-There were two staff at the home when the accident occurred and he was one of the staff. -Staff lifted her off the floor, put her in bed, and checked her vitals. -Resident #2 indicated her shoulder was in pain and asked for her family member. -Resident #2 asked staff not to move her so much, when he was doing a routine adult brief change. -An incident report was given to the Supervisor around 7:30 or 7:45 p.m. -After the fall, Resident #2 was checked on during the whole night. -Resident #2 sleep through the night. -Resident #2 was changed at 3 a.m. and did not complain of pain. -Resident #2 reported no more pain and there was no bruising observed by the M A at first. -When a resident fell the procedure was to notify the supervisor so the supervisor can notify the responsible person. Interview with the facility Supervisor on 9.3.2024 at 1:30 p.m. revealed: -She was unsure of the fall policies and procedures for the facility. -This was a new position for her and this was the first time someone fell while she was in this position. -She informed the Administrator that Resident #2 fell on 9.1.2024. Interview with the Medical Power of Attorney (MPOA) on 9.4.2024 at 1:00 p.m. revealed: -She visited Resident #2 on 9.1.2024 at 11:30 a.m. -Upon arrival Resident #2 was observed to have bruises all over her shoulder, around her neck, and on her head. -She spoke with the MAs to find out what happened. -She told the MAs to call for medical services. -Mobile health services were called to the home at the family's request on 9.1.2024 at 11:59 a.m. -Mobile health services arrived on 9.1.2024 at 12:30 p.m. -Mobile health services notified mobile x-ray services for a more thorough examination. -Mobile x-ray arrived on 9.1.2024 at 5:22 p.m. and took x-ray images. -Results of the x-rays were sent to mobile health service on 9.2.2024 at 8:13 a.m. -The health services provider attempted to reach the facility on 9.2.2024 at 9:59 a.m. and 10:50 a.m., both times messages were left.		

-Health services contacted the family with the results and indicated Resident #2 needed to go to the hospital. -She contacted EMS and Resident #2 was transported to the hospital emergency department on 9.2.2024. Interview with the Vice President of Operations on 9.4.2024 at 9:35 a.m. revealed: -The family was notified of Resident #2's fall when they were at the facility the next morning. -He was informed of the fall when the family arrived at the facility. -The family should have been notified when Resident #2 was found. -He did not believe Resident #2 informed staff she was in pain. -He did not believe she knew she was in pain because of her dementia. -Resident #2 informed staff she did not hit her head. -If staff were aware Resident #2 hit her head they would have immediately sent her to the E D. -The facility intervened with this fall by taking Resident #2's vitals and administering Tylenol to her. -There was no way Resident #2 asked for medical assistance and staff denied it. Interview with MA on 9.27.2024 at 10:16 a.m. revealed: -She entered the home after cleaning the outside of the home and heard Resident #2 calling for her family member. -When she neared the room, Resident #2 heard her and called for help. -When she entered the room, Resident #2 was on the floor on her left side. She ran and got another MA and they got her off the floor. -Resident #2 indicted her shoulder was in pain. -She told the other MA Resident #2's shoulder may have been broken because of the fall. -Resident #2 continued to complain that her shoulder hurt and MA gave her Tylenol. -EMS was not contacted, an accident report was completed and sent to the Supervisor. -The Supervisor indicated she would contact the Administrator. -She was not aware Resident #2's family was not notified of the fall. Review of Resident #2's ED and hospital record dated 9.2.2024 revealed: -She was in the hospital from 9.2.2024 to 9.14.2024.		

-A diagnosis of closed fracture of one rib of left side, closed displaced fracture of acromial end of left clavicle, atrial fibrillation, dementia, fall, and normal pressure hydrocephalus. Resident #2 presented to the E D with a fall from seated position and head strike. -The resident was diagnosed with a left clavicular fracture, non-displaced fracture of the posterior aspect of the left first rib, and left 3rd rib fracture. -Mild soft tissue swelling at the shoulder was noticed. -A very small superficial abrasion was noticed on her forehead. -Gross bruising was noted on the left upper shoulder as well as scattered throughout her body. -Resident #2's hemoglobin was persistently dropping throughout the night (9/9/2024 - 9/10/2024) from 9.8 on to 7.3 at midnight. Then from 5.8 at 4 a.m. and 4.6 at 5:30 a.m., concerning for an upper gastrointestinal bleed. -Resident #2 was pronounced deceased on 9.14.2024 at 12:01 a.m. -The events prior to death were severe anemia and the case of death was referred to the medical examiner. Review of Resident #2's Certificate of Death dated 9.19.2024 revealed the cause of death was blunt force injury to the torso. --- The facility failed to ensure referral and follow-up to meet the routine and acute health care needs of Resident #2 who fell and sustained injuries. The facility did not contact the medical power of attorney or the primary care provider at the time of the fall, and the resident was not sent to the hospital for evaluation until two days later. It was determined the resident had closed fractures of the rib and clavicle. The resident passed away approximately two weeks later from a blunt force injury of the torso. This failure resulted in serious pain, neglect, and injury, which constitutes a Type 1 Violation. --- A Plan of Protection was requested for the violation on 9.5.2024 in accordance with G.S. 131D-34. The facility's plan to ensure residents are protected from further risk or additional harm include:		

All staff will be re-educated on policies and procedures of falls and handling accidents. Staff will sign showing they have been re-educated.		

IV. Delivered Via:	By Hand	Date: 10.18.2024
DSS Signature:		Return to DSS By: 11.7.2024

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.*