# Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Spring Arbor Sandhills
Address: 8398 Fayetteville Rd Raeford NC 28376
County: Hoke
License Number: HAL_047-016

II. Date(s) of Visit(s): 03/17/25,04/09/25,05/13/25
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 05/21/25/05/22/25

**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**<br>*For each citation/violation cited, document the following four components:*<br>• *Rule/Statute violated (rule/statute number cited)*<br>• *Rule/Statutory Reference (text of the rule/statute cited)*<br>• *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)*<br>• *Findings of non-compliance* | **III (b). Facility plans to correct/prevent:**<br>*(Each Corrective Action should be cross-referenced to the appropriate citation/violation)* | **III (c). Date plan to be completed** |
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| Rule/Statute Number:<br><br>10A NCAC 13F.0901(b) | ☐ POC Accepted<br>_____ *DSS Initials* | — |
| Rule/Statutory Reference:<br>Personal Care and Supervision: Staff shall provide supervision of residents according to the resident's assessed needs, care plan and current symptoms. | It shall always be the policy for staff to provide supervision of residents according to the resident's assessed needs, care plan and current symptoms. | 4/2+4/3 |
| Level of Non-Compliance:<br><br>A2 | | |
| Findings:<br>Based on observations, interviews and record reviews the facility failed to provide supervision for 1 of 5 residents sampled (#4) in accordance with the resident's assessed needs and current symptoms that led to the resident's elopement from the facility without staff knowledge.<br><br>The Findings are:<br><br>Review of the facility's missing resident policy updated 02/22 revealed: | The Team immediately began to complete daily door checks at each and documents on the 24 hour log. All staff will immediate head counts at the sound. | 4/2+4/3 |

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| -Elopement/unsafe wandering risk assessments are completed upon move in, quarterly and with any significant change of condition/cognitive status to ensure the safety of all residents.<br>-When a team member recognized that a resident was missing they are responsible for taking immediate action to locate the resident and notify the Executive Director (ED), Resident Care Director (RCD) and the Cottage Care Director (CCD).<br><br>Review of Resident #4's current FL-2 dated 03/24/25 revealed:<br>-Diagnoses included Alzheimer's, dementia with behavioral disturbance, hypertension and B12 deficiency.<br>-Resident #4 wandered.<br>-Resident #4 resided on the special care unit (SCU) side of the facility.<br><br>Review of Resident #4's care plan dated 03/21/25 revealed:<br>-Resident #4 wandered.<br>-Resident #4 was sometimes disoriented.<br>-Resident #4 was independent with eating, ambulation/locomotion, and transferring.<br>-Resident #4 was totally dependent for toileting.<br>-Resident #4 required extensive assistance with bathing and grooming/personal hygiene.<br><br>Telephone interview with the individual who called 911 on the day of the elopement on 04/30/25 at 10:23am revealed:<br>-On 04/02/25 around 1:30pm she was traveling on the four-lane highway to the next town.<br>-There was a car stopped in the middle of the road and there was an elderly gentleman [Resident #4] in the middle of the road waving and smiling at the cars as they passed by.<br>-She initially observed Resident #4 in the road between the facility and the shopping center next door.<br>-The stopped car eventually went around the elderly gentleman [Resident #4] and so did she.<br>-She drove a few minutes up the road and then decided to turn around to make sure that the elderly gentleman [Resident #4] was ok.<br>-By the time she had turned her car around the elderly gentleman [ Resident #4] was walking in the grass on the side of the four-lane highway.<br>-Now Resident #4 had walked past the shopping center and walked on the other side of the local hospital that was about a mile from the facility.<br>-She then called 911.<br>-She followed behind Resident #4 in her car until local law enforcement (LE) arrived. | of an exit door alarm. All staff have been trained that if/when an exit door is disengaged, the staff member is required to stay on the door until that door is locked and they are re-engaged on 4/2 - 4/3 and ongoing.<br><br>Daily Door and alarm checks are required twice on their shift, by the CCD / Designee and documented on the door audit sheet.<br><br>Monthly and ongoing Elopement trainings for all staff, to include New Hire orientees will be completed and documented by the CCD/Designee.<br><br>All residents that have been diagnosed with intermitten or constant disorientation had had mini mental examinations at move in and at significant change. Sunflower audits will remain in place and New Care plans have been completed to include change of condition and ADL's updated with staff training on 4/2+4/3. | 4/2+4/3<br><br>4/2+4/3<br><br>4/2+4/3<br><br>4/2+4/3 |

-She observed Resident #4's pants were wet and it appeared that he had an incontinent episode.

Review of the local LE emergency communication logs dated 04/02/25 revealed:
-The local police department received a call on 04/02/25 at 1:37pm.
-The caller stated that an older gentleman was walking on the grass beside the four-lane highway.
-The older gentleman had obvious signs of mental decline as he tried to figure out where he lived.
-At 2:02pm LE went to the facility they assumed that Resident #4 lived.
-At 2:19pm a facility employee arrived at the scene.
-At 2:20pm it was made known that the elderly gentleman was a resident of the facility.
-The local police confirmed the facility employee with the facility executive director (ED) and allowed the employee to transport Resident #4 back to the facility.

Review of the facility accident/incident report dated 04/02/25 revealed:
-At 2:00pm Resident #4 was found on the four-lane highway near the local hospital.
-The elopement was reported by local law enforcement.

Observation of the area directly outside the exit door of the 300 hall on the cottage on 04/09/2025 at 11:18pm revealed:
-The door that led to the road behind the facility which led to the shopping center next door to the facility.
-The highway that Resident #4 was found on was a busy four lane highway.
-The speed limit on the highway was 55 miles per hours.

Interview with a personal care aide (PCA) on 04/09/25 at 11:26am revealed:
-On 04/02/25 someone saw an older man walking down the four-lane highway that ran in front of the facility and called 911 to report it.
-Another PCA who worked at the facility saw Resident #4, emergency medical services (EMS) and LE on the side of the four-lane highway.
-After Resident #4 was checked out on the side of the road the PCA was allowed to transport the resident back to the facility.
-There were outside vendors painting on the 300 hall of the cottage on that day and the door was left disengaged when they finished painting and left the facility for the day.

The Team will continue to complete daily door checks at the change of each shift and document on the 24 hour logs. 6/16/25

Staff will continue to complete, document and audit rounds and signatures for residents who require additional monitoring. 6/16/25

The ED/Designee will audit 24 hour logs weekly for 2 months to ensure that each shift is documenting door checks on the 24 hour log, and that the audits are documented for head counts at the sound of the exit door alarm. 6/16/25

All red fire switch covers have been replaced with continous alarm covers, so that once disengaged by anyone, the alarm will continue to sound until staff respond to silence the alarm and redirect the resident/s. 6/16/25 - ongoing

Maintenance/Designee will complete weekly checks on alarm covers to ensure that they operate correctly and batteries don't need to be replaced. 6/16/25

ED/Designee will complete monthly and prn checks 6/16/25

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| Interview with a second PCA on 04/09/25 at 11:06am revealed:<br>-She had gone to lunch around 1:30pm on 04/02/25 and when she came back she was informed by the CCD that they could not find Resident #4.<br>-LE came to the facility and asked was a resident missing from the facility.<br>-That is when a head count was done and it was realized that Resident #4 was not in the facility.<br>-Resident #4 was found down the road near the local hospital<br>-Resident #4 had tried to get out the facility all day; he had been "exit seeking".<br>-Around 1:00pm Resident #4 had tried to get out the door by his room on the 400 hall of the SCU.<br>-Resident #4 had lifted the switch, which disengaged the door, and when he opened the door it set the alarm off and he was stopped from leaving the facility.<br>-She had not been informed that the exit door on the 300 hall of the SCU had been disengaged.<br>-She was not told to do anything different when Resident #4 had exit seeking behaviors on that day.<br>-It was assumed Resident #4 eloped from the exit door on the 300 hall of the SCU.<br>-Resident #4 was found with urine on him to the point that his incontinence brief looked "really big."<br>-No one from the facility knew Resident #4 was gone.<br><br>Review of EMS notes for Resident #4 dated 04/02/25 revealed:<br>-EMS received a phone call at 1:37pm on 04/02/25.<br>-EMS was requested by LE in reference to a male subject walking on the side of the "road."<br>-A female employee that worked at the facility stated the male (Resident #4) was a resident of the facility.<br>-Resident #4 noted to have incontinence of urine to the front of his jeans.<br>-It was unknown how long Resident #4 had been out of the facility.<br><br>Review of a statement written by the PCA who transported Resident #4 back to the facility on 04/02/25 revealed:<br>-She was driving on the four-lane highway and noticed Resident #4 standing beside the road talking with LE.<br>-She pulled over and called the CCD to inform her what as going on.<br>-EMS was called and took Resident #4's vitals.<br>-She was allowed to transport Resident #4 back to the facility. | of alarm covers to ensure that all covers are kept in working order. 6/16/25<br>Any resident who is increasingly agitated and exit seeking will be immediately redirected and engaged in appropriate programming and sunflower program updated. 6/16/25<br>Care plans and ADL's will continue to be completed at change of condition and staff training ongoing.<br>The CCD/Designee will monitor and review all audits, daily, weekly and as needed to ensure that staff provide supervision of residents in accordance to their assessed needs, care plan and current symptoms. 6/16/25<br>The ED/Designee will monitor and review all audits weekly for 2 months to ensure residents are provided with supervision according to their assessed needs, care plan and current symptoms. 6/16/25 | |

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| Attempted phone interview on 05/20/25 at 3:00pm with the PCA who transported Resident #4 back to the facility on 04/02/25 was unsuccessful.<br><br>Interview with the CCD on 04/09/25 at 1:35pm revealed:<br>-There were outside vendors at the facility painting on 04/02/25 on the 300 hall of the SCU.<br>-She did not know what time the outside vendors had left the facility on 04/02/25<br>-The maintenance director for the facility had informed the PCAs on the cottage that the door on the 300 hall was disengaged; however he had not informed her.<br>-During the search for Resident #4 on the SCU she had checked all the exit door on the SCU and discovered that the that exit door on the 300 hall of the SCU was disengaged.<br>-She informed the ED that the exit door on 300 hall of the cottage was disengaged.<br>-It was the maintenance director's responsibility to ensure the doors on the SCU were locked or to let someone know the doors were disengaged if that is the case.<br>-After the elopement Resident #4 was placed on 30-minute checks for 72 hours.<br>-No one at the facility had any idea that Resident #4 was not in the facility until LE informed them.<br><br>Review of a statement written by a PCA on 04/02/25 reveled:<br>-Resident #4 ate lunch and was finished by 12:30pm.<br>-She was unaware the SCU door on the 300 hall was unlocked.<br>-The last time she saw Resident #4 he was walking around in the common area of the SCU.<br><br>Telephone interview with the former facility maintenance director on 05/08/25 at 11:31am revealed:<br>-On 04/02/25 there were outside vendors painting the ceiling on the 300 hall of the SCU.<br>-The door on the 300 hall of the cottage was disengaged and left open while the vendors painted so the paint smell would not be so strong in the facility.<br>-The outside vendors had been at the facility painting for the past three days,<br>-Resident #4 eloped from the facility on the last day [04/02/25] the outside vendors where at the facility.<br>-The outside vendors left the facility between 1:20-1:30pm.<br>-While the outside vendors were at the facility Resident #4 continued to try to get out of the door on the 300 hall and the outside vendors had to continuously redirect him away from the open door. | | |

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| -One of the PCAs who worked that day was informed by him that they needed to watch Resident #4 as he continued to go to the open door on the 300 hall.<br>-He was not sure which PCA had been notified.<br><br>Telephone interview with Resident #4's legal guardian on 04/09/25 at 4:49pm revealed:<br>-He was notified of the elopement on the same day around 4:00pm.<br>-He was told that Resident #4 had eloped and was brought back from to the facility.<br>-He was not aware that Resident #4 was found past the facility near the local hospital.<br>-He was notified by the facility staff that Resident #4 had attempted to elope from the facility earlier on the same day but was unsuccessful, however he was able to get out the facility on the second attempt.<br><br>Interview with the ED on 05/13/25 at 12:30pm revealed:<br>-Earlier in the day on 04/02/25, Resident #4 went to the door on the 400 hall and pulled the plastic piece over the switch that sets the alarm off to the cottage exit door.<br>-The last time Resident #4 had been seen wandering around the SCU side of the facility was between 12:30pm -1:00pm.<br>-She expected all staff to know where their residents were at all times.<br>-Resident #4 was found near the local hospital on the other side where something was being built.<br>-Around 2:00pm LE officer came to the facility and asked was there a resident missing from the facility.<br>-She was not aware that there was a resident missing from the facility, until a head count was completed and Resident #4 was not in the facility.<br>-The PCAs who worked on the day of the elopement stated they did not know the door on the 300 hall of the cottage was disengaged.<br>-Per conversation with the maintenance director the outside vendors left the facility around 1:20pm.<br>-The outside vendors had called the maintenance director and informed him they were leaving for the day.<br>-It was the maintenance director's responsibility to check the doors to ensure they were locked and if he could not do it he should have let someone know.<br>-When the CCD checked the door on the 300 hall of the cottage; the door was disengaged.<br>----------<br>The facility failed to provide 1 of 1 sampled resident (Resident #4) who had a history of dementia and exit seeking behavior, | | |

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| was sometimes disoriented and wandered by not supervising the resident after the resident had displayed exit seeking behaviors which resulted in the resident eloping from the facility and being found on a busy four lane highway by a passerby almost a mile from the facility without staff knowledge. Their failure resulted in substantial risk of physical harm, and constitutes a Type A2 violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131-D34 on 05/08/2025.<br><br>The correction date for the Type A2 violation shall not exceed 06/21/2025. | | |

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| **IV. Delivered Via:** | Electronic Delivery/Certified Mail | Date: 05/22/2025 |
| **DSS Signature:** | Antoinette McMillian SWS | Return to DSS By06/16/25 |

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| **V. CAR Received by:** | Administrator/Designee (print name): Myra J. Sinclair | |
| | Signature: Myra J. Sinclair | Date: 5/23/25 |
| | Title: | |

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| **VI. Plan of Correction Submitted by:** | Administrator (print name): Myra J. Sinclair | |
| | Signature: Myra J. Sinclair | Date: 6/17/25 |

**VII. Agency's Review of Facility's Plan of Correction (POC)**

☐ *POC Not Accepted* — By: Antoinette McMillian — Date: 6/18/25

Comments:

☑ *POC Accepted* — By: — Date: 6/18/25

Comments:

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| **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.*