Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Landings of Smithfield
Address: 200 Kellie Drive, Smithfield
County: Johnston
License Number: 0051-65

II. Date(s) of Visit(s): 4-23-24, 4-24-24, 5-1-24, 5-8-24, 5-29-24,
Purpose of Visit(s): Complaint investigation

Exit/Report Date: 7-8-24

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)* • *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 13 F .0901 Personal Care and Supervision	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.		
Type A2 violation		
Findings: Based on observations, record reviews and interviews, the facility failed to provide supervision to 1 of 5 residents sampled who resided on the assisted living unit, who exhibited wandering behaviors resulting in the resident eloping from the facility without staff knowledge. The findings are: Review of the missing resident policy dated 09/21 revealed: -Each entry/ exit door was equipped with a mag lock system and keypad. -Codes were managed by the staff and management.		

-Codes were changed periodically for the security of the residents. -A resident was considered missing when he/she failed to be located and whereabouts were not known. -If a resident was deemed missing the staff notified the supervisor and all other staff immediately. -Staff would perform a hasty search of the building and the immediate areas outside the building. -If the resident was not found facility staff notified local law enforcement, residents family/responsible person, County Department of Social Services, Management on call, and Division Vice President of Operations and Divisional Director of Clinical Services. -Once everyone was notified staff will begin to expand their search to the extended outside areas until the resident was located. Review of Resident #1's current FL-2 dated 09/14/23 revealed: -Diagnoses included hypertension, hyperlipidemia, and hypothyroidism. -Resident #1 was intermittently disoriented and was ambulatory. -Resident #1 required assistance with bathing and dressing. -Resident #1's recommended level of care was documented as "other, assisted living facility (ALF)". Review of the Resident #1's care plan dated 09/24/23 revealed: -The Resident was receiving either mental health, developmental delayed or substance abuse services. -The resident used a rolling walker for ambulation assistance. -The Resident was sometimes disoriented. -The resident was sometime forgetful. Review of Physicians progress notes for Resident #1 dated 04/01/24: -Resident # 1 was a poor historian due to cognitive/ psychiatric impairment. -Resident #1's cognitive decline was associated with her cardiovascular disease. -Resident #1's cognitive state was characterized by derailment of thought and repetition in her phrases. Review of incident report for Resident #1 dated 04/21/24 revealed:		

-Resident # 1 was noted to be missing during breakfast on 04/21/24. -The resident was transported to the local emergency department at 3:00pm on 04/21/24. -The resident was prescribed a new medication for a urinary tract infection. -The facility increased supervision to every 15 minutes. Review of the emergency services incident report dated 04/2/12024 revealed: -Emergency services was called at 2:36pm to a wilderness area behind a neighborhood to assist with a female who had been reported missing. -The primary impression was hypothermia a condition that occurs when core body temperature drops below 95 degrees Fahrenheit). -Patient presented sitting in a fire department all-terrain vehicle with fire department personnel. -Resident #1 was alert, oriented to self and event but not to place or time. -Resident #1's family reported this was the resident's baseline. -The resident had been missing since 3:30am that morning. -Police had been dispatched to do a welfare check on a resident being seen on a business camera at 4:10am. -Resident #1's facility reported the resident was missing around 11:30am. -Resident #1 was found with wet and soiled clothes and her skin was cold to the touch. -Resident #1 had several lacerations and abrasions on her lower extremities with minor swelling and controlled bleeding. -Resident #1 denied any pain. -Resident #1's temperature was taken and the resident was noted to be hypothermic. -Resident # 1 was transported to the emergency room. Review of the hospital discharge summary dated 04/21/24 revealed: -The patient was at her baseline and answered questions appropriately. -The patient had abrasions to her ankle, a skin tear to shin and two skin tears to her right shin and right ankle. -The patient also had a diagnosis of hypothermia. -The resident was discharged back to the facility at 4:38pm.		

Review of the weather for a 5 mile radius of the facility on 4/21/24 revealed: -The temperature at 3:00am was 65 degrees. -The temperature dropped to 62 degrees at 6:00 am, 53 degrees at 9:00am, 50 degrees at 12:00pm and 51 degrees at 3:00pm. -Precipitation started to fall at approximately 8:00am. -Precipitation increased throughout the afternoon. -Precipitation at 12:00pm was .05 of an inch of rain, and 0.4 of an inch of rain at 3:00pm. Observations of the door alarms on 04/21/24 at 1:15pm revealed: -The override switch box was zippy tied closed. -Pulling on the cover of the override box initiated an alarm. -A PCA came to see what the source of the alarm was and cut off alarm. Interview with Resident #1's family on 05/08/24 at 3:30pm revealed: -A PCA called the family at 10:18am and inquired if they had taken Resident #1 out and not signed her out. -Resident #1's family member said she had not, but she would call her other family members. -Resident #1's niece stated no one had taken Resident #1 out of the facility. -The PCA told the residents family that Resident #1 was last seen at the 2:00am bed check. -The PCA advised Resident #1's family member that they were calling the police. Interview with kitchen staff on 4/21/24 at 4:30pm revealed: -She arrived at 6:45am and started cooking breakfast. -When the residents arrived to eat, staff noticed Resident #1 was not present. -Kitchen staff asked the PCA to go check Resident #1's room. -The PCA returned and noted that resident #1 was not there. Interview with a PCA on 04/21/24 at 5:05pm revealed: -She clocked in at 11:05pm on 04/20/24. -Second shift signing off reported all residents were okay. -She checked on all residents that needed assistance at; 1:30am, 3:30am and 6:00am. -She was not aware of anyone out of the building at her arrival.		

-She did not know that Resident #1 was not supposed to be out of the building.
-She never saw Resident #1 on her rounds.

Interview with a second PCA on 04/21/24 at 4:45pm.
-She walked through halls around 7:30am.
-She assisted another resident getting up and ready for breakfast.
-She went to Resident #1's room to see if she was going to breakfast but she was not in there.
-She continued with her rounds.
-When she arrived at the dining room and realized Resident #1 was not there, she began questioning other staff and then contacted the Resident Care Coordinator (RCC).

Interview with a third PCA on 04/21/24 at 4:50pm revealed:
-She was informed by kitchen staff that Resident #1 was not there.
-She talked with the third shift medication aide and they both started searching for Resident #1.
-Resident #1 was not located so they called the RCC.

Interview with a MA on 4/21/24 at 4:20pm revealed she was helping with the morning medication pass and she realized resident #1 was not in her room or walking around like she normally did.

Interview with the RCC on 04/21/24 on 4:55pm revealed that she was working on the evening of 04/20/24 and she saw Resident #1 last at 10:00pm when she was getting ready for bed.

Interview with the Regional Manager (RM) on 04/23/24 at 2:45pm revealed:
-She was the administrator on record on 04/21/24.
-She was notified about a missing resident on 04/21/24 at 11:00AM.
-She arrived at the facility at 11:45am and began searching for the resident.
-A PCA told her that Resident #1 was in bed at the 1:30am bed check.
- The PCA explained to her that she had called the family to verify that Resident #1 was not with them.
-RM said the police were alerted at 11:35am.

Interview with the Regional Vice President (RVP) Operations on 04/23/24 at 3:00pm revealed:

-The facility has an assisted living side and a memory care unit.
-All outside doors to the facility remained locked at all times.
-All visitors had to be given access to the facility by a staff person.
-Resident was a resident #1 on the assisted living side of the facility.
-Kitchen staff noticed the resident was not at breakfast on 04/21/24 and asked about her location.
-The PCA on duty checked the resident's room and called the resident's family to make sure she had not gone out with them.
-Staff called her at 11:00am to notify her that Resident #1 was not in the facility.
-Staff explained that they searched the building.
-She instructed staff to search the grounds and notify emergency officials if the resident was not found.
-She arrived at the facility around 12:00pm and joined in the search.
-Resident #1 was located at approximately 3:00pm in a wooded area behind the facility.
-Resident #1 was sent to the emergency room to be examined.
-Resident #1 returned to the facility later that evening.
-She interviewed staff regarding the elopement and was told the resident opened the override switch box and de-activated the door alarms.
-The override switch box should have been prevented resident access but it was not.
-The door alarms worked but Resident #1 pushed the button to override the door alarms.

Telephone Interview with primary care physician on 06/21/24 at 2:10pm was unsuccessful.

Resident #1 who was cognitively impaired was able to de-activate the door alarms, exit the facility and elope and was not found for approximately 17 hours, from last sighting at 10:00pm on 04/20/24 until she was located at 3:00pm on 04/21/24, in temperatures as low as 50 degrees and precipitation. This failure resulted in risk for serious harm and constitutes a A2 violation.

The facility provided a plan of protection in accordance with G.S 131-D on 04/22/24.

The correction date for this Type A2 violation shall not exceed 08/09/24.		
Rule/Statute Number:	☐ POC Accepted DSS Initials	
Rule/Statutory Reference: Type A2 violation		
Rule/Statute Number:		
Rule/Statute Number:		

Facility Name:

IV. Delivered Via:	hand	Date: 7-8-24
DSS Signature:	Teresa J Heath	Return to DSS By: 7-29-24

V. CAR Received by:	Administrator/Designee (print name): Sharei Eley	
	Signature: S. Eley	Date: 7/8/24
	Title: Campus Director	

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.*