Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Calyx Living of Fuquay-Varina
Address: 1121 E. Academy St., Fuquay-Varina, NC 27526
II. Date(s) of Visit(s): 2/13/25, 2/26/25, 3/03/25, 3/06/25

County: Wake
License Number: HAL-092-227
Purpose of Visit(s): Death Investigation
Exit/Report Date: 03/31/25

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 *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: Personal Care & Supervision, 10A NCAC 13F .0901 (b)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: Personal Care & Supervision, (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.		
Level of Non-Compliance: Type A1 Violation		
Findings: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 1 sampled resident (#1) who became entrapped and asphyxiated between his Halo Safety Ring and bed. Review of the facility's Resident Check Protocol dated 02/2025 revealed: -The purpose of the protocol was to ensure consistency and compliance for Personal Care Aide (PCA) and Medication		

Aide (MA) resident checks, during rounds and otherwise, in the Assisted Living (AL) and Special Care Unit (SCU). -Aides were to locate and check on their assigned residents to ensure their needs are being met. -Aides were to check the resident's toileting needs. -Aides were to perform visual observations to assure the resident had normal breathing and skin color, reporting any abnormalities to the Supervisor immediately. -Aides were to monitor the resident's environment for safety. -Resident checks were to be conducted approximately every 2-3 hours in AL and every 1-2 hours in SCU. -Night checks in AL could be less frequent as desired by residents who can operate a call pendant. -Night checks in AL and SCU were to include visual checks to ascertain if a resident was sleeping without waking the resident, acting as the PCA during the day, unless otherwise indicated in the resident's care plan. Review of the facility's In the Event of a Fall form dated 02/2020 revealed: -Ensure resident care; notify provider and responsible parties. -Following a resident fall, the Supervisor or RCD was to complete the Functional Assessment in the Accident Reporting section of the Resident Handbook. Review of the facility's Emergency Procedures in the Event of a Fall dated 02/2020 revealed staff were to document incident care actions in the Resident Care Progress Notes, including time of accident/injury, cause of concern, time and contact attempts to PCP and family member, and when the ED or RCD were notified. Review of Resident #1's current FL-2 dated 12/04/24 revealed: -Resident #1's recommended level of care was AL. -Diagnoses included Urinary Tract Infection (UTI), in-dwelling catheter, hematuria (blood in the urine), and a history of subdural hematoma (bleeding near the brain. -Resident #1 had urinary incontinence. -Resident #1 required limited assistance with ambulation, transfers, toileting, and eating. Review of Resident #1's Resident Register dated 06/27/24 revealed: -Resident #1 was admitted to AL on 06/27/24.		

-Resident #1 required assistance ambulating, toileting, bathing, and dressing. -Resident #1 had adequate memory. -Resident #1 required eyeglasses and a walker to ambulate. Review of Resident #1's Care Plan dated 10/25/24 revealed: -Resident #1 was oriented and ambulatory with a high walker and wheelchair. -Resident #1 had limited bilateral upper extremity strength. -Resident #1 had "daily" urinary incontinence and an indwelling catheter. -Resident #1 required extensive assistance with ambulation, transfers, toileting, bathing, dressing, and grooming. -Resident #1 had a history of falls. -Resident #1 had multiple falls at the facility. Review of Resident #1's Fall Risk Assessment dated 06/19/24 by the previous Resident Care Director (RCD) revealed: -Resident #1 had Parkinson's Disease and vision impairment. -Resident #1 was continent of bowel and bladder. -Resident #1 received PT. -Resident #1 ambulated with a rollator and had a bedrail. -Resident #1 had 1-2 falls 90 days prior. -Resident #1 sustained minor injuries (unspecified injuries and date). -Resident #1 was on medications that caused hypotension, confusion, or sedation. -Resident #1 was able to rise with his arms with more than 1 attempt. Review of Resident #1's PT orders dated 09/02/24 revealed Resident #1 required PT 3 times a week for transfers, ambulation, and balance, due to Parkinson's Disease and weakness. Interview with Resident #1's PT 02/13/25 at 11:25am revealed: -Resident #1 received PT 2 times a week, due to a fall and resulting total hip replacement prior to facility admission. -Resident #1 required a hospital bed and Halo bedrail to assist himself with mobility and transfers. -He evaluated Resident #1, measured and installed the Halo Safety Ring in November 2024 on Resident #1's hospital bed. -For safe transfers, Resident #1 required 1 staff for standby assistance.		

-He instructed Resident #1 to use his call pendant to call for transfer assistance or help, since the resident tried to rise and transfer without help and fell in September 2024. -He instructed staff, Resident #1 was not to move or transfer without staff assistance and posted this transfer order on the wall beside the resident's bed. -Resident #1 had deconditioning (weakness) following 4 catheter and UTI-related hospitalizations in November-December 2024. -Resident #1 exhibited improvement in strength, ambulation, and transfers in January 2025. a.) Review of facility documentation to Resident #1's Primary Care Provider (PCP) dated 09/05/24 revealed: -Resident #1 had an unwitnessed fall at 08:20am on 09/05/24. -Resident #1 sustained abrasions to his back. -This document was signed and dated by staff. -The document was not signed, dated, or responded to by the PCP. Review of Resident #1's Falls Risk Assessment by the previous Resident Care Director (RCD) dated 09/06/24 revealed: -Resident #1 had Parkinson's Disease and was continent. -Resident #1 had foot, ankle, or knee dysfunction or weakness. -Resident #1 ambulated with a high-walker and wheelchair. -Resident #1 had 1-2 falls 90 days prior. -Resident #1 sustained minor injuries (unspecified injuries and date). -Resident #1 was on medications that caused hypotension, confusion, or sedation. -Resident #1 was able to rise with his arms with assistance. -Resident #1 was anxious about falling. -Resident #1 had a prior fall requiring Emergency Room (ER) or skilled nursing rehabilitation. -Resident #1 required assistance with all transfers. -Resident #1 used his call pendant for assistance. Interview with a personal care aide (PCA) on 02/26/25 at 1:30pm revealed: -Residents' needs and supervision frequency were listed on the facility's application on staff's phones. -Residents were to be checked every 2 hours. -Resident pendant calls went to all staff's phones. -Resident #1 had a call pendant. -Resident #1 was to be checked every 30-60 minutes for toileting, transferring, or ambulation needs.		

-She checked residents with incontinence every 30 minutes. -She decided to check on Resident #1 every 20-30 minutes since he was non-ambulatory and incontinent. -Resident #1 could sit up in bed. -Resident #1 could not transfer out of bed without assistance. -She did not know if Resident #1 had any falls. Telephone interview with Resident #1's Power-of-Attorney (POA) on 02/14/25 at 1:15pm and on 02/19/25 at 2:30pm revealed: -Resident #1 had a history of multiple falls, due to Parkinson's Disease weakness. -Resident #1 showed strength improvement with Physical Therapy (PT) in June-July 2024. -Resident #1 fell on the facility's outdoor patio in late July 2024 and broke his left hip and suffered a concussion with disorientation and increased confusion. -Resident #1 underwent emergency total hip replacement surgery in late July 2024. -Following hip surgery, Resident #1had decreased strength and required increased care assistance and increased supervision. -In the fall of 2024, Resident #1 could not independently sit up in bed or transfer himself without staff assistance. -Resident #1's disorientation resolved with hospitalization in December 2024. -The Executive Director (ED) increased Resident #1's supervision in September 2024 to hourly checks after his falls. -The PT ordered and installed a Halo Safety Ring in November 2024 to Resident #1's bedframe at the mattress crease to aid Resident #1's mobility and transfers. -The PT posted, "Call, Don't Fall" on Resident #1's wall by his bed since Resident #1 tried to pull himself up without staff assistance with the Halo Safety Ring in January 2025. Interview with the Supervisor on 02/13/25 at 11:25am revealed: -She checked on residents every 2 hours. -Resident #1 could transfer to, and pedal-propel, his wheelchair independently. -She was unaware if Resident #1 had any falls. b.) Review of Resident #1's facility documentation to his PCP dated 09/12/24 revealed: -Resident #1 had an unwitnessed fall to the floor on 09/12/24 at 6:00pm from his wheelchair.		

-Resident #1 sustained skin tears to his right arm. -Emergency Medical Services (EMS) assisted Resident #1 off the floor to his wheelchair. Review of Resident #1's PT service note dated 09/16/24 revealed Resident #1 was not to move or transfer without assistance. Review of Resident #1's PT service note dated 09/25/24 revealed it fatigued Resident #1 to sit up in bed and transfer safely, to keep from sliding out of bed. c.) Review of Resident #1's Incident/Accident (I/A) Report dated 10/17/24 revealed: -Resident #1 had an unwitnessed fall in his room on 10/17/24 at 8:30pm. -Resident #1 sustained an injury to his left forehead/eyebrow. -Resident #1 was transported to an Emergency Room (ER) for evaluation and treatment. Review of Resident #1's ER Discharge Summary dated 10/17/24 revealed: -Resident #1's diagnoses included a fall, weakness, difficulty urinating, and a subdural hematoma. -Resident #1 had decreased mobility. -A neurosurgery consult was ordered for 2-3 weeks later. Review of Resident #1's Falls Risk Assessment by the previous Resident Care Director (RCD) dated 10/23/24 revealed: -Resident #1 was incontinent of bowel and bladder. -Resident #1 had foot, ankle, or knee dysfunction or weakness. -Resident #1 ambulated with a walker and wheelchair. -Resident #1 had 3 falls 90 days prior. -Resident #1 sustained a major injury (unspecified injuries and date) requiring hospital treatment and skilled nursing rehabilitation. -Resident #1 was on medications confusion or sedation. -Resident #1 was able to rise with his arms with more than 1 attempt. -Resident #1 received PT within the prior 6 months.		

Interview with Resident #1's PCP's nurse on 02/26/25 at 2:30pm revealed: -Resident #1 had limited ability to independently transfer, ambulate, and toilet but needed assistance to ensure his safety. -Resident #1 was capable of rolling in bed. -Resident #1 had multiple falls over the past year. -The PCP made no specific supervision or ADL orders. -The PCP made a referral to Home Health (HH) PT to treat the resident's weakness and to decrease his falls in September 2024. -HH provided PT to strengthen Resident #1 to avoid further falls from bed, wheelchair, or walker. -This PCP last saw Resident #1 on 10/22/24 for follow-up care for a head hematoma after a fall and ER care. d.) Review of Resident #1's hospital discharge summary dated 11/02/24 revealed Resident #1's diagnoses included a fall, weakness, and urine retention. Review of Resident #1's hospital discharge summary dated 11/29/24 - 12/02/24 revealed: -Resident #1 was at moderate risk of death, due to hematuria, UTI, trauma, and staph infection from catheterizations. -Resident #1 had cognitive impairments. -Resident #1 had muscle weakness with decreased strength and decreased mobility. -Resident #1 could roll in bed so the resident should be monitored. -Resident #1 required assistance to sit up in bed. -Resident #1 could transfer from bed to wheelchair or walker with minimal assistance. Review of Resident #1's Progress Note dated 01/06/25 revealed Resident #1's indwelling catheter was removed. Interview with a MA Supervisor on 03/03/25 at 6:45am revealed: -The Executive Director (ED) established residents' checks frequency, including Resident #1's checks. -She checked on residents every 2 hours at night. -There were 4 AL residents that she did not check on at night per their request and the ED's instructions.		

-She checked Resident #1 every 2 hours at night when his room was across from the Medication Aide (MA) station, when he had a catheter. -After Resident #1's falls September-December 2024, his checks were increased to every 1-1.5 hours until 01/06/25. -She checked Resident #1 every 1-1.5 hours nightly when he had a catheter. -When Resident #1's catheter was removed 01/06/25, Resident #1 did not want to be checked at night. -In January 2025, the ED told her to only check Resident #1 when Resident #1 rang for help. -She did not recall the PT's order that Resident #1 required assistance to move/transfer. e.) Review of Resident #1's death report dated 02/03/25 at 8:40am revealed: -The facility reported Resident #1's death on 02/03/25 at 8:40am to the Division of Health Service Regulation. -Staff discovered Resident #1 dead on 02/01/25 at approximately 6:30am. -Resident #1 was found partially in and partially out of his bed. -Resident #1's chest was wedged between his bed and Halo Safety Ring. -Resident #1 was not restrained within 7 days of his death. -The Medication Aide (MA) called 911 on 02/01/25 (at an undocumented time). -Emergency Management Services (EMS) and Law Enforcement (LE) responded to the facility's call. -A LE Detective investigated the facility scene of Resident #1's death. -The LE Detective reported, Resident #1's cause of death appeared to be asphyxiation from becoming wedged between his bed and Halo Safety Ring. -The body was transferred to the state Medical Examiner's (ME) Office for further evaluation. Review of Resident #1's Incident/Accident (I/A) Report dated 02/01/25 revealed: -The 3rd shift MA discovered Resident #1 on 02/01/25 at 6:27am lying partially on and off his bed with his upper body on his bed and under the Halo Safety Ring. -The MA called 911 (6:30am), the ED (6:30am), the Power-of-Attorney (10:30am), and the PCP (10:00am) on 02/01/25. -County Human Services was notified 02/01/25. -The body was released to the county ME's Office 02/01/25.		

Attempted review of Resident #1's Progress Notes dated 01/31/25 and 02/01/25 was unsuccessful.

Review of Resident #1's EMS report dated 02/01/25 revealed:
-EMS responded to a 6:34am cardiac event call on 02/01/25 at 6:40am.
-Resident #1's body was found between the side of the bed and a Halo Safety Ring.
-Resident #1's back was toward the bed with his chest against the Halo Safety Ring and his chin resting on top of the Halo Safety Ring.
-Resident #1's lower legs rested on the floor and his arms laid at his side.
-Resident #1 felt cold; his skin appeared bluish-purple; and rigor mortis was evident in his jaw.
-EMS services were transferred to LE on the scene.

Telephone interview with a responding EMS Paramedic on 02/24/25 at 8:24am revealed:
-Facility staff contacted LE and EMS on 02/01/25 at 6:40am for help.
-Staff appeared visibly distressed.
-Resident #1 appeared entrapped behind the Halo Safety Ring and his mattress.
-Resident #1's neck and jaw rested on top of the Halo Safety Ring with his feet and legs on the floor with his back to the mattress.
-The cause of death appeared to be asphyxiation.
-Rigor mortis had set in to his jaw, hands and fingers, indicating Resident #1 had been dead a long period of time.
-A strong body odor could be smelled.
-The mattress was elevated at its maximum 90-degree angle (straight up).
-The Supervisor reported, she last checked on Resident #1 on 02/01/25 at 1:30am.
-The ED arrived sometime after 6:40am.
-The body was transferred over to LE.
-The LE Detective investigated the scene.
-The body was then transferred to the ME's Office for evaluation.

Telephone interview with LE Captain of Criminal Investigations Division on 02/17/25 at 2:50pm revealed:
-LE received a call from the facility on 02/01/25 at 6:30am.

-The Medication Aide (MA) Supervisor discovered Resident #1 deceased on 02/01/25 at 6:30am. -EMS pronounced Resident #1's death 02/01/25 as 6:34am, their arrival and assessment time. -Resident #1 was wedged with his weight pushed against the Halo Safety Rail, which kept him on the bed and restricted his airway/throat. -Resident #1's call pendant was around his neck. -Resident #1's call pendant and hospital bed remote control were wedged between his chest and Halo Safety Ring. -An impression of the remote control was imprinted in Resident #1's chest. -LE review of facility cameras showed staff did not check Resident #1 from 8:22pm on 01/31/25 until 6:30am on 02/01/25. -On 02/01/25, the MA Supervisor reported the last staff to see him alive was the Supervisor who administered his medications on 01/31/25 at approximately 8:22pm. Telephone interview with a MA Supervisor on 02/14/25 at 2:45pm revealed: -She worked 11:00pm-7:00am on 01/31/25 to 02/01/25. -Resident #1 was able to transfer and toilet independently. -She usually checked AL residents every 2 hours. -Resident #1 did not have scheduled checks. -Her supervisor, the Executive Director (ED) initiated all resident checks and their frequency. -The ED instructed her not to check Resident #1 at night. -The ED instructed staff to assist Resident #1 only when he activated his call pendant for help. -She did not know why increased checks on Resident #1 were not initiated after his September 2024 falls. -In the past, she checked Resident #1 when she checked on another resident nearby who snacked in his room late nights. -She began administering medications on 02/01/25 at 6:00am. -She did not check Resident #1 on from 11:00pm on 01/31/25 to 6:00am on 02/01/25 because the resident usually used his call pendant for help. -The 2nd shift MA Supervisor said, she last saw Resident #1 when she administered medication to him on 01/31/25 at 8:22pm. -She did not remember seeing a pendant call for Resident #1 01/31/25 to 02/01/25. -When she arrived at Resident #1's room with his medications 02/01/25 at 6:30am, she discovered Resident #1 was deceased. -Resident #1 was not breathing; his chest was pinned between his Halo Safety Ring and bed with his legs hanging off the bed.		

-She panicked; then called a Special Care Unit (SCU) Personal care aide (PCA) who helped her make calls to EMS and LE. -EMS and LE arrived and took over the incident. Interview with a 2nd Medication Aide (MA) Supervisor on 02/13/25 at 11:25am revealed: -She checked on residents every 2 hours. -Resident #1 could transfer to his walker and wheelchair without assistance. -Resident #1 could pedal-ambulate his wheelchair independently. -Staff assisted the resident with ambulation and transfers when needed or when Resident #1 pendant-called for help. -She was unaware if Resident #1 had any falls. -She did not work on 01/31/25 or 02/01/25. Telephone interview with a PCA on 02/19/25 at 4:10pm revealed he called for LE/EMS since the AL MA Supervisor was too distressed. Telephone interview with a LE Detective on 02/14/25 at 5:30pm revealed: -LE requested his investigation since Resident #1's death initially appeared suspicious. -He observed the bed remote wedged between Resident #1's chest and bedframe with his call pendant around his neck. -Resident #1 died due to asphyxiation being entrapped between the bedframe and Halo Safety Ring. -Nightstand drawer and personal effects were pulled out on the floor, evidence Resident #1 tried to reach for his cell phone atop his nightstand. -Resident #1 was last seen alive at 8:22pm on 01/31/25 when he was administered his medication, according to their facility camera footage review. -Rigor mortis and skin coldness had already set in by 6:30am on 02/01/25. Telephone interview with a Forensic Pathologist Supervisor on 02/03/25 at 2:35pm revealed: -Resident #1's death was determined to be due to entrapment and positional asphyxiation. -With traumas events, death could occur instantly or over several hours, depending on skin, other medical conditions, and environmental factors (room temperature, etc.).		

-Resident #1's death, based on his conditions, was instant to taking several hours since minimal rigor mortis was found. -In North Carolina, time of death was determined when the body was discovered, which was 6:30am. -Resident #1's body sustained abrasions to his top, lower chest and the top layer of skin was gone from his back. -The body had red bruising to his right inner arm, left outer arm, and a 1/2" x 1/2" x 7.6" bruising to his left knee. Interview with the Resident Care Coordinator (RCC) on 03/06/25 at 11:00am revealed: -Resident #1 was able to rise and transfer from bed to his ambulation devices independently. -Staff were expected to intercept Resident #1 to assure his safe movements. -Resident #1 routinely called staff for help with his pendant. -Resident #1 required toileting, dressing, TV remote assistance, and help rising from the floor sometimes after his falls. -The facility's policy was to check all residents, on all shifts, every 2 hours. -Resident #1 had no problem with being checked nights. -Residents with incontinence were to be checked every 1-2 hours or as often as possible. -Resident #1 was on 30-minute checks when he had a catheter and after his falls in September 2024. -Resident #1 was on 1–2-hour checks without a catheter. -Resident #1 also had a call pendant he used. -After Resident #1's catheter removal in January 2025, Resident #1 was on 2-hour checks. -She did not work the evening of 01/31/25 or 02/01/25. Interview with the Resident Care Director (RCD) on 02/26/25 at 2:30pm revealed: -She was just hired 01/13/25 and was in training 01/31/25 to 02/01/25. -Residents were to be checked every 2 hours on all shifts. -Residents were to be checked even if they requested no checks. Interview with the facility's Regional Nurse on 02/26/25 at 2:50pm revealed: -Residents' supervision frequency depended on their Care Plans but usually every 2-3 hours.		

-Residents with safety needs were checked every 30-60 minutes. -Residents with safety checks 30 minutes and less received a sitter. -Resident #1 did not require more than 2--3-hour checks. -Resident #1 had leg weakness but could sit up independently. -She was unsure if Resident #1 required transfer assistance. -Resident #1 would try to transfer himself between bed and his ambulation devices. -She expected staff to provide incontinence checks before and after each round. -She did not know if Resident #1's supervision was increased from 2-3 hours in 2024-2025. -The ED determined residents' supervision frequency. -She was not aware if Resident #1's supervision was increased, due to his weakness and after his falls. -She was not aware if Resident #1's POA requested increased supervision for him. -She did not work 01/31/25 or 02/01/25. Interview with the Executive Director (ED) on 02/26/25 at 3:15 pm revealed: -Residents were to be checked every 1-2 hours and per residents' choice. -Some residents, like Resident #1, did not like night checks. -Night staff knew which residents did not want night checks. -There were 2 residents who refused night checks. -Care Plans were written by the Regional Nurse or RCD in 2024-2025. -Resident check plans were not documented or in Care Plans. -Resident checks depended on their Care Plan. -Resident #1's initial Care Plan was not received back from the PCP (for signature). -There were no residents on 1-hour checks in 2024-2025. -Resident #1 was on 2-hour checks in 2024-2025. -Resident #1 was capable of transferring himself from bed to walker or wheelchair. -She instructed staff not to check residents at night who did not want nightly checks. -Resident #1 used a call pendant for assistance. -She verbally instructed night staff not to check on Resident #1 at night since Resident #1 did not like staff in his room or to be checked at night. -She did not document for staff how often residents should be checked. -Resident #1's PT instructed Resident #1 to pendant-call for 1 staff to assist him with transfers for safety.		

-She was unsure if Resident #1's checks increased after his falls and hospitalizations in 2024/2025. -Resident #1's 2-hour checks did not increase in 2024/2025. -She was unsure if increased checks were requested by the POA in 2024/2025; she would have to check. -She did not know the last time Resident #1 was checked on the evening of 01/31/25 to 02/01/25. -Resident #1's Progress Notes should have the time of his last check on 01/31/25 to 02/01/25. -The 2nd shift Medication Aide (MA) Supervisor administered medications to Resident #1 the evening of 01/31/25 (time unknown). -The 02/01/25 MA Supervisor found Resident #1 deceased at 6:30am on 02/01/25 when administering medications. -The LE investigations found the Halo Safety Ring had entrapment warnings. -Hospital bed and Halo Safety Ring safety protocols and training were conducted by the facility after Resident #1's death. -She arranged for every resident's Halo Safety Ring installation to be re-evaluated for safety after 02/01/25. Attempted telephone interviews with Resident #1's Home Health providers on 02/26/25 at 2:45pm and 03/06/25 at 4:00pm were unsuccessful. Attempted telephone interviews with Resident #1's neurologist on 02/26/25 at 2:50pm and on 03/10/25 at 3:00pm were unsuccessful. Attempted telephone interviews with the 01/31/25 evening Medication Aide (MA) Supervisor on 02/17/25 at 3:17pm and on 03/10/25 at 12:35pm were unsuccessful. The facility failed to provide supervision for a resident (#1), who had diagnoses of Parkinson's Disease and muscle weakness and had incontinence and disorientation. Prior to admission, Resident #1 had a history of falls and had 4 subsequent falls at the facility. The Physical Therapist ordered a Halo Safety Ring and staff assistance with the resident's transfers and ambulation. For his safety and incontinence needs, Resident #1 was placed on 1-2-hour checks. Resident #1 sustained fractured ribs, extremity bruising, and subsequent asphyxiation after not being checked on for 10 hours during the evening of 01/31/25 to 02/01/25 when he became		

entrapped between his bed and Halo Safety Ring. The staff were unaware of the resident's fatal injury until the next morning at 6:30am, during a medication pass. This failure resulted in death and constitutes a Type A1 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 2/26/25. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED: 04/30/25.		

IV. Delivered Via:	Hand-delivered	Date: 03/31/25
DSS Signature:	Roberta Schmidt-Beebe Roberta Schmidt-Beebe	Return to DSS By: 03/31/25

V. CAR Received by:	Administrator/Designee (print name): Renee Esposito, LPN	
	Signature: ReneeEsposito, LPN	Date: 3/31/25
	Title: LPN, Resident Care Director	

VI. Plan of Correction Submitted by:	Administrator (print name):	
POC Due: 04/21/25	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.*