Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Valley Pines Adult Care Home
Address: 2521 Muriel Drive, Fayetteville, NC 28306
County: Cumberland
License Number: HAL-026-052

II. Date(s) of Visit(s): 01/24/25,02/13/25,03/06/25, 03/21/25
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 03/21/25

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 Type A2 violation**, this agency may prepare an Administrative Penalty Proposal for the violation(s). Please submit any additional information within **5 days** to be considered prior to the preparation of the penalty proposal. If on follow-up survey the violations are not corrected, a civil penalty of up to $1000.00 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: 10A NCAC 13F . 0901 (b) Rule/Statutory Reference: Personal Care and Supervision Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. Level of Non-Compliance: Type A2 Violation Findings: The Rule area is not met as evidence by: Based on observations, interviews and record reviews, the facility failed to ensure staff provided supervision for 1 of 3 sampled (Resident #2) eloped from the facility. The findings are: Review of Resident # 2's current FL2 dated 02/06/24 revealed: -The resident's level of care was domiciliary (rest home). -Diagnoses included dementia, memory loss, essential hypertension, and benign prostatic hyperplasia low urine with outflow obstruction. -Cognition was constantly disoriented. Review of an Accident and Incident Report for Resident #2 revealed: -The date of the incident was 01/10/25 at 4:15pm. -Resident #2 left the facility. -Staff picked up the resident on a local street.	☐ POC Accepted _____ *DSS Initials*	

-The resident's family was notified.

Observations on 03/11/25 from 11:26am-11:29am along the route from the facility to where Resident #2 was found on 01/10/25 revealed:
-The facility was .04 miles from the location where Resident #2 was found.
-The facility was .03 miles from a busy four-lane highway with a speed limit of 45 miles per hour.

Interview with the Supervior on 01/24/25 at 4:43pm revealed:
-Resident #2 eloped on 01/10/25 and was last seen by staff at 4:15pm on that day.
-They realized Resident #2 was missing around 4:15pm, when they called for dinner.
-Staff found Resident #2 about 4:25pm not far from the facility.
-Staff had the resident to sit up front to keep an eye on him.
-The staff increased their rounds to lay eyes on the resident every one to two hours but the checks were not documented.

Review of an Accident and Incident Report for Resident #2 revealed:
-The date of the incident was 01/17/25.
-Resident #2 walked away from the facility.
-Staff did a call for dinner and noticed the resident was missing.
-Staff looked for Resident #2 at 5:00pm.
-Staff came back and called 911 at 5:19pm.
-Staff was unable to reach Resident #2's family and left a voice message.
-The Sheriff was dispatched to the facility and took the report and received description/details of the resident.

Review of an email received from the facility on 01/18/25 at 12:35am revealed:
-The police found Resident #2 on a local street at 11:55pm, which was 6.6 miles from the facility.
-Resident# 2's family was notified.

Observations on 03/11/25 from 11:09am-11:29am along the route from the facility to where Resident# 2 was found on 01/17/25 revealed:
-The facility was 0.3 miles from busy four-lane highway with a speed limit of 45 miles per hour.
-There was a moderate flow of traffic.
-There was a major intersection along the route that must be crossed.
-There were railroad tracks along the route.
-The street where Resident #2 was found was a two-lane road with a speed limit of 35 miles per hour.

-The facility was 6.6 miles from the street where Resident #2 was found depending on the route taken.

Review of the weather forecast for 01/17/25 revealed temperatures ranged from 54 degrees at 4:53pm to 37 degrees at 11:53pm.

Interview with Resident #2 on 01/24/25 at 4:01pm revealed:
-Facility doors were locked at night.
-Within the past two weeks, he left during the day to see his family twice.
-He walked downtown.
-He did not tell anyone.
-He was going to leave and come right back.
-He would normally tell them he was leaving.
-He came back in less than an hour.
-He was not harmed, taken advantge of, or attacked by animals or persons.
-He did not sign out.

Telephone interview with Resident #2's responsible party on 02/13/25 at 4:07pm revealed:
-They were unsure of Resident #2's admission date and stated somewhere around 2021.
-Resident #2 had gotten out of the facility twice but dates were unknown.
-The last elopement was bad because Resident #2 was not properly dressed and just walked off.
-Resident #2 had on blue jeans, an undershirt, a zip-up hoodie, and sneakers.
-They were always notified of any incident, even if it was about the resident not wanting personal care.
-Law Enforcement was notified about the second elopement and after three or four hours, the police put out a Silver Alert and it was scary.
-Resident #2's dementia has progressed.
-They visited the resident twice a year (Thanksgiving and July/August)
-During visits, staff constantly walked around to watch residents.
-The facility shared the following interventions: they watched him more, they had looked for a lockdown facility, but the place was not taking applications.
-They talked to staff about putting trackers on the resident.
-They asked staff to place trackers in the resident's shoes and the one sweatshirt jacket the resident loved to wear, even if it meant wearing the same clothes daily.

Telephone interview with housekeeping on 03/05/25 at 2:03pm

revealed:
- After Resident #2's first elopement, she was told to let medical staff know the times she saw Resident #2 since she was in and out of the rooms cleaning.
-After Resident #2's second elopement, she was told to do the same thing as before and to report the last time she saw the resident.
-The facility had audible alarms on the doors.
-The residents had certain doors they could use when they were going out or coming in.
-She was to alert someone, if the alarm went off because she could not touch the resident because she was housekeeping staff.
- She did not document the last time she saw the resident but provided the times verbally and would write down the time, if needed.

Telephone interview with a medication aide (MA) on 03/05/2025 at 11:37am revealed:
-Resident #2 was the only resident that eloped.
-She was told to do more frequent rounds, at least every hour, after each elopement.
-She worked third shift; and all doors were locked, and alarms were put on at 11:00pm.
-If the alarm went off, they went to whichever door it was to ensure nobody had gone outside or was at the door.
-Once they found out what was going on, they turned the alarms off and turned it back on.
-She documented elopements or any incident, a report was done, they contacted whoever needed to be contacted (emergency contact/contact person) and sent the report to Adult Home Specialist.

Attempted interviews with a personal care aide (PCA) were unsuccessful on 02/05/25 at 10:18am, 02/05/25 at 12:19pm, and 03/05/25 at 1:57pm..

Interview with the Supervior on 01/24/25 at 4:43pm revealed:
-Resident #2 eloped on 01/17/25.
-The facility did not have a surveillance camera.
-They conducted rounds every two to three hours.
-Staff last saw Resident #2 around 4:00pm.
-They realized the resident was missing around 4:45pm, when they called for dinner.
-Staff went looking for the resident and could not find the resident.
-Law Enforcement was called about 5:15pm.
-Resident #2 was found close to midnight.
-Resident #2 was returned to the facility by Law Enforcement.

-After Resident #2's second elopement, the facility bought AirTags to place in the soles of Resident #2's shoes.
-They sent a message to Resident #2's PCP regarding possible placement for a memory care unit.
-Resident #2's next appointment with his PCP was 01/28/25 at the facility.

Second interview with the Supervisor on 02/13/25 at 3:14pm revealed:
-After Resident #2's second elopement on 01/17/25, all staff were told to check on the resident every hour or more but this was not documented.
-On 02/24/25 air tags were put in place as an intervention to keep Resident #2 safe.
-She reached out to a local facility and was told they were not accepting admissions and there was a waiting list.

Telephone interview with the Supervisor on 03/05/25 at 2:49pm revealed:
-Resident #2 sat in the same spot all the time up front.
-If she was physically doing something, she came and checked on the resident every hour and sometimes it may be up to two hours and other staff was checking on the resident as well.
-After Resident #2's first elopement, they were told to increase checks to every hour, which was done but it was not documented.
- After the second elopement, they were told to try to do their due diligence to keep up with the resident until they could find placement.
-If Resident #2 went outside, one of the staff members must be with the resident and stay with him.
-In the daytime they did not use all the alarms, but all doors had chimes on them to notify when the doors were opened since residents could freely go in and out of the facility.
-At night all the alarms would be turned on.
-The two door alarms on each far end of the building were on all the time and the other two doors, where the residents could go in and out constantly during the day, would chime when opened.
-If the alarm went off, Staff got up right away and would check to make sure residents were safe and who went outside.
-She charted her notes about Resident #2's elopements and who was contacted but did not chart the interventions of increased checks and the usage of air tags.

Telephone interview with the Administrator on 03/05/25 at 4:49pm revealed:
-After Resident #2's first elopement, staff did more frequent checks.

-He saw the resident all the time because Resident #2 sat near where he sat, so he was able to see the resident all day.
-After the second elopement, AirTags were placed in Resident #2's shoe sole, which worked well.
-The AirTags relied on Bluetooth connection.
-The AirTags were not connected to each Staff's telephone.
-Until the facility could secure Resident #2 in a MCU, he had looked at other monitoring possibilities for the resident's safety such as a tracking device that would alert him when the resident went beyond 200-feet from the building.
-Staff documented incidents, contacted the family, and sent reports to AHS.
-Resident #2 has not eloped since January 2025.
-He had not reached out to the Department of Social Services for placement assistance.
-On 03/06/25, AHS provided a resource link for MCUs in the state of North Carolina to help with placement of Resident #2, which he would use right away.
-As of 03/06/25, a discharge had not been initiated because the resident had not been accepted by MCU facility.
-Staff had contacted two other MCU facilities in the area for placement of Resident #2 but had not heard back from either.

Review of the primary care provider (PCP) notes dated 01/28/25 for Resident #2 revealed:
-The resident had a history of dementia.
-The resident was seen today for a visit due to advancement in Alzheimer's disease.
-The resident had Alzheimer's disease listed as an active medical problem.
-The resident had an admit history of memory impairment.
-The resident was positive for memory loss, disorientation, confusion, wandering behavior, restlnessness, and delusions.
-The resident was oriented to person but disoriented to date, month, and year.
-The resident had short-term memory recall.
-The resident's cognitive status was forgetful, Dementia.
-The resident was ambulatory
-The resident's cognitive awareness and safety awareness were significantly impaired, as evidenced by recent episodes of elopement and difficulty recalling basic information.
-The resident was taking Namenda for Alzheimer's disease.
-The PCP continued the current medication regimen.
-The assessment and plan of the PCP's notes dated 01/28/25 recommended that Resident #2 be placed in a memory care unit of an assisted living facility for 24-hour supervision due to wandering behaviors and inability to manage medications; and to prevent further episodes of wandering.

Telephone interview with Resident #2's PCP on 02/04/25 at 3:36pm revealed:
-Resident #2 became her patient in Spring 2022 for primary care.
-Resident #2 had an elopement on 01/10/25 and was found less than one mile from the facility.
-Resident #2 was picked up by a staff member.
-On 01/17/25, Resident #2 left the facility and was gone for over seven hours and was found 6.6 miles from the facility.
-She was notified the day of the incidents that Resident #2 was missing and notified of the time he was returned.
-Last time staff saw Resident #2 on 01/17/25 was 4:00pm.
-She was unsure of the time Law Enforcement was contacted.
-Resident #2 was found by Law Enforcement about midnight.
-Emergency Medical Services cleared Resident #2 to return to the facility.
-She saw Resident #2 on 01/28/25 in the facility for an acute visit due to elopement.
-She wrote an order for Memory Care Unit (MCU).
-The process for placement would take time.
-Interventions after each elopment were to increase his safety by doing patient rounds hourly/hourly checks and keeping the resident in their eyesight.
-The Staff kept the resident within their eyesight and increased their rounds..
-The facility had inserted AirTags under the sole of his shoes for tracking, which was a safety precaution.
-If Resident #2 was sent to the hospital, he would not be kept there but would be sent back to an Assisted Living because he did not require a skilled level care.
-If Resident #2 was trying to leave the facility daily, then the hospital would keep him until placement due to safety issues.
-She and the Supervisor had reached out to a local facility, but they were not accepting any patients and had a waiting list.
-She encouraged the facility to expand their search to other counties for MCU placement.
-Staff notified the family of the need for MCU.
-She was unsure if family was aware of AirTags in the resident's shoes.
-Resident #2 was currently stable and had not eloped or tried to elope as of today, 02/04/25.
-Staff typically notified them with concerns and after an incident happened.

On 03/20/25, AHS received the census from Resident #2's current location, which verified Resident #2 was admitted in a Special Care Unit facility on 03/13/2025.

The facility failed to provide adequate supervision for Resident #2 who had a history of dementia resulting in the resident eloping from the facility on 01/10/25 and 01/17/25. The resident was missing for 10 minutes and found .04 miles from the facility on 01/10/25. The resident was missing for seven hours and found 6.6 miles from the facility on 01/17/25. The facility's failure resulted in substantial risk of death or serious physical harm which constitutes a Type A2 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/06/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 20, 2025.		

IV. Delivered Via:	in-person	Date: 3/21/25
DSS Signature:	Sandra A	Return to DSS By: 4/11/25

V. CAR Received by:	Administrator/Designee (print name): Artonga Copeland	
	Signature:	Date: 3/21/25
	Title: RCC	

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.*		