Adult Care Home Corrective Action Report (CAR)

.I. Facility Name: Morning Star AL #4
Address: 941 Goins Rd., Pembroke, NC 28372
County: Robeson
License Number: HAL-078-067

II. Dates of Visits: 12/30/24, 1/3/25, 1/13/25, 2/13/25, and 2/24/25
Purpose of Visits: Complaint Investigation
Exit/Report Date: 2/26/25

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 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: 10A NCAC 13F .0901(b) Personal Care and Supervision Rule/Statutory Reference: (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 **This rule is not met as evidenced by:** **Based on observations, interviews, and record reviews, the facility failed to ensure supervision was provided in accordance with resident needs for 1 of 3 sampled residents (Resident #1) resulting in Resident #1 on the special care unit (SCU) exiting through a window and being attacked by dogs approximately 0.8 miles away from the facility.** The findings are: Review of Resident #1's FL2 dated 5/29/24 revealed: -Diagnoses included dementia, chronic kidney disease, iron deficiency anemia, schizophrenia, venous insufficiency, peripheral vascular disease, essential hypertension, and lymphedema.	☐ POC Accepted _____ *DSS Initials*	

-The recommended level of care was domiciliary (rest home) and special care unit.
-She was constantly disoriented.
-She was ambulatory.
-She was incontinent of bladder and bowel.
-She was a wanderer.
-She was able to communicate her needs verbally.

Review of Resident #1's Resident Register revealed:
-She had an admission date of 6/5/14.
-She signed her admission paperwork and she did not have a guardian or Power of Attorney.

Review of Resident #1's incident report completed on 12/29/24 at 1:20pm by the medication aide (MA)/Supervisor revealed:
-It was documented at 12:35pm on 12/29/24, Resident #1 was not in the building, she climbed out the window and the sheriff was notified.
-Resident #1 was alone.
-Resident #1 was sent to the hospital where she was admitted.
-Resident #1 sustained a laceration type injury to the front and back of her left leg due to dog bites.
-Resident #1's family member was notified.

Review of Resident #1's primary care note dated 11/13/24 revealed:
-Resident #1 was seen by the certified family nurse practitioner (FNP) for routine care.
-Staff did not report any recent behavioral changes or concerns.
-The FNP was scheduled to return for follow-up in two to three months or sooner if indicated.

Review of Resident #1's mental health provider's note dated 1/2/25 revealed:
-On 12/30/24 staff reported that on 12/29/24 Resident #1 left the property by getting out of a window during the daytime.
-Resident #1 was attacked by dogs and sent to the emergency department.

Review of the 911 call log revealed:
-A 911 call was received at 11:47am on 12/29/24.
-The location of the call was the location where Resident #1 was found by someone traveling through the area, approximately 0.8 miles from the facility.
-The caller stated he was on the side of the road in a white truck.
-The caller stated that a female had been attacked by dogs.

-The female was conscious and breathing.
-The caller stated that the dogs were still on the scene.

Review of a second 911 call log revealed:
-A 911 call was received from the facility reporting a missing person on 12/29/24 at 12:42pm.
-Caller stated that Resident #1 escaped the building through a window.

Review of Resident #1's hospital history and physical dated 1/14/25 revealed:
-Resident #1 had a hospital admission on 12/29/24 at 12:48pm.
-Resident #1 was discharged from the hospital on 1/8/25 at 3:33pm to another local adult care home.
-She presented to the emergency department after an animal attack.
-She was found walking alongside of the road and was attacked by three German shepherd dogs, fell down on the sidewalk in a puddle of water.
-A loss of consciousness was reported per the medical record.
-All of her wounds were aggressively irrigated and the larger wounds were loosely sutured to allow for drainage.
-She was given intravenous (IV) antibiotics, tetanus, rabies immunoglobulin, and rabies vaccine.
-She was given 2 liters of crystalloid solution due to being mildly hypotensive and hypothermic due to exposure to the cold and rain.
-She was 75 years old with a history of Alzheimer's disease with late onset, chronic kidney disease, acute kidney injury superimposed on chronic kidney disease, and hypotension.
-She had multiple dog bites to right and left lower extremities and right hand.
-She had a right hand wound that measured 2x0, 5x0, 1cm.
-She had a right medial foot wound that measured 2x2x0, 1cm.
-She had a right lateral lower leg wound that measured 6x0, 5x0, 1cm, sutures in place.
-She had a right lower leg wound that measured 8x4x0.2cm, sutures in place.
-She had right posterior cluster of full thickness wounds.
-She had a left lateral lower leg wound that measured 7.5x4.5x0, 1cm.
-She had a left posterior lower leg lower wound that measured 6x2x0, 1cm, sutures in place.
-She had a left posterior lower leg upper wound that measured 0.5x4x0, 1cm.
-She had a left posterior thigh cluster of 4 wounds.
-She had a left knee wound that measured 2x2x0, 1cm.

-She had wound beds with non-granulation, no odor, light drainage, and the around the wound was intact.
-She was admitted to the hospital as inpatient for intravenous antibiotics and wound care.
-Drug screen was negative.

Observation on 2/13/25 of the route taken by Resident #1 when she walked away from the facility on 12/29/24 revealed:
-She left the facility and turned right out of the parking lot and walked 0.3 miles down a two-lane rural road where she then made a left turn.
-She walked 0.6 miles down a rural two-lane road and turned left onto a rural two-lane road.
-She walked 0.1 mile to the location of where she was attacked by three German shepherd dogs.
-There were ditches about 2 to 3 feet deep on both sides of the rural two-lane roads with standing water.
-She walked past wooded areas on both sides of the two-lane roads.

Observation of the route Resident #1 traveled global positioning system (GPS) revealed that it took twenty-four minutes to walk.

Observation on 12/30/24 of the facility entrance and exits at 1pm revealed:
-The facility had 4 entry and exit doors that were only accessible by swiping a badge.
-The facility had a chain link fence that encompassed the rear and sides of the facility.
-The chain link fence did not encompass the front of the facility and the window Resident #1 exited.
-There was a garden fence that was shorter than the chain link fence that encompassed the window that Resident #1 exited.

Telephone interview with concerned citizen on 1/7/25 revealed:
-He was driving down a two-lane road on 12/29/24 at around 11:30am when he thought he saw a little boy playing with his dogs but as he got closer to the individual, he saw that the dogs had pulled the clothes off of Resident #1.
-It had been raining that day.
-When he got to Resident #1 she did not have pants and there was blood all over the road.
-It looked like the dogs had been pulling her in circles up and down the road.
-Resident #1 was helpless and had he not intervened when he did, Resident #1 would have had more extensive and serious injuries.

-He observed that Resident #1's left leg calf muscle was gone and her hands and side had been bitten.
-He tried to help Resident #1 by putting her inside of his truck and as he helped her the dogs were biting at him.
-The dogs were still trying to bite Resident #1 even while she was inside of his truck.
-There were 3 big German Shepherds and he did not notice if they had collars on.
-Once he got Resident #1 inside of his truck he called 911 and the deputy arrived to his location about ten minutes later.

Telephone interview with the personal care aide (PCA) on 12/31/24 at 5:20pm revealed:
-She was working alone on 1st shift in the facility on Sunday, 12/29/24.
-Resident #1 began acting "weird" the day after Christmas when her family came to visit her.
-Resident #1's behaviors consisted of walking and pacing and one day (date unknown) after Christmas the resident asked her where would she get a ticket to go home.
-Resident #1 poured liquid soap on the floor near the front door on 12/29/24.
-She called Resident #1 to come and get her snack on 12/29/24 at 10am but she did not come.
-Resident #1 told her that she wanted to go home on 12/29/24 at around 11am and she told the resident that she could not allow her to go out of the facility.
-Resident #1 cursed at her while she was at the front door of the facility.
-Resident #1 asked her for a glass of water and she walked to the kitchen and got her a snack and water and it was a little after 11am.
-Resident #1 went to her room and that was where she thought she was when she called for her to come eat lunch.
-The last time she saw Resident #1 was around 11:15am or 11:20am on 12/29/24.
-The (MA)/Supervisor came into the building around 11:45am to give out medications and noticed a liquid substance on the floor.
-She realized it was soap from the visitor's bathroom.
-Resident #1 was the only resident who went in the visitor's bathroom so she assumed Resident #1 had put the soap on the floor.
-She reported to the MA/Supervisor at that time that Resident #1 had been pacing and cussing because she could not get out.
-The MA/Supervisor did not say anything.
-She went back to the kitchen and prepared the lunch meals at around 12pm.

-She then started bringing the residents in Geri-chairs into the dining room first, then she brought in the residents who were in wheelchairs, and the residents who could walk on their own were asked to come in last. -She noticed that Resident #1 was not in the dining room with the other residents and she hollered for her and went to her room but she was not there. -She went to other residents bedrooms to look for Resident #1 but she was not in any of the other rooms. -She looked in closets and under beds and at about 12:24pm, she called the MA/Supervisor. -The MA/Supervisor asked her to check the facility again and she did. -She was inclined to check a resident's room that she had closed the door of earlier because the resident went to an appointment. -Upon walking into the room she noticed that the window was up and she hollered. -She called the MA/Supervisor back at 12:34pm or 12:35pm and told her that Resident #1 went out the window. -The MA/Supervisor called 911. -She thought the MA/Supervisor contacted other staff in the sister facilities and asked them to look for Resident #1 as well because she could hear staff outside hollering and screaming for Resident #1. -The MA/Supervisor also began looking for Resident #1. -While other staff had gotten into their own vehicles to go and look for Resident #1, she remained in the facility and supervised the remaining residents. -She briefly stepped outside of the facility and hollered for Resident #1. -The police officer came to the facility about 1pm, though she was not exactly sure of the time and asked her to show him the window located on the front of the facility that Resident #1 eloped from. -She was expected to supervise the residents at least every thirty minutes to make sure they were alright. -It was hard for her to supervise the other residents when she had to perform incontinent care or bathe another resident and it was also hard to keep an eye on the residents while preparing their meals. -If a resident left the facility she was supposed to call the Supervisor and the Supervisor would call the Resident Care Coordinator (RCC). -She was expected to report to the MA/Supervisor any different behaviors as soon as they were seen. -Resident #1 had just poured the soap on the floor prior to the MA/Supervisor entering the facility and she told the MA/Supervisor that Resident #1 cursed at her and poured the		

soap on the floor.
-The MA/Supervisor normally document the resident behaviors, she had never documented anything about a resident's behaviors.

Follow-up interview with the PCA on 1/13/25 at 10:55am revealed:
-Resident #1 tried to get out the door on 12/24/24 when her family member came to visit and she grabbed her hand and made her turn around.
-Resident #1 went straight to her room, sat on her bed, and about thirty minutes later she came out pacing up and down the floor.
-She thought she reported Resident #1's behavior to the MA/Supervisor the day of the incident.
-This was the first time that she saw this behavior from Resident #1.
-She reported resident behaviors to the MA.

Follow-up telephone interview with the PCA on 1/31/25 at 3:44pm revealed:
-She did not think that she worked the day Resident #1's family came to visit her.
-Resident #1 packed up her clothes a couple of days after her sister visited which was on Christmas Day.
-She did not observe this but another PCA told her about it after the elopement.
-Resident #1 also started pacing the halls and talked to herself all day and she would only stop when she would ask for water or when it was time to eat.
-When she informed the MA/Supervisor of Resident #1's behaviors on 12/29/24 this was the first time behaviors were reported.
-She thought the MA/Supervisor would have given Resident #1 something to calm her down or call the doctor or send her out.
-She worked in this building on 12/27/24 and 12/29/24 from 6am-2pm and she worked in a sister facility on 12/26/24 and 12/28/24.
-Prior to Christmas she worked 12/24/24 and she did not remember seeing anything unusual with Resident #1's behaviors.
-The RCC was normally in this facility on weekdays but the day of the elopement she was not there.

Telephone interview with a second PCA on 2/6/25 at 2:32pm revealed:
-She started working at the facility a few weeks prior to Thanksgiving.

-She worked in the facility on 12/28/24 and she observed Resident #1 with clothes, lotion, and other items in her hand.
-She was walking down the hall, coming from her room.
-She asked Resident #1 where was she going and she said that she was going home.
-She asked Resident #1 how was she going home and she said that a lady was coming to get her.
-She walked with Resident #1 back to her room and they put the items back where they belonged.
-Resident #1 did not exhibit anymore exit seeking behaviors the remainder of her shift and she did not say anything else to her about going home.
-That was the only time that she saw Resident #1 exhibiting any behaviors.
-She told the RCC but she did not say anything.

Interview with the MA/Supervisor on 12/30/24 at 1:31pm revealed:
-She left the property on 12/29/24 at 12:30pm to transport another resident to an appointment when she got the call from the PCA between 12:34pm and 12:35pm.
-The PCA asked if she had seen Resident #1 walking down the road and she asked her what she meant.
-The PCA stated that Resident #1 had climbed out of a window and that she was not in the facility.
-She asked the PCA where was Resident #1 and she said that she did not know.
-She told the PCA that she was going to call the RCC and she did and the RCC told her to call the local police.
-As she was dropping the resident off to her appointment, she called the local sheriff's office and informed the dispatcher that an officer was needed at the facility's address due to a resident elopement.
-She gave the dispatcher a description of Resident #1 and what she thought she was wearing.
-She was informed that an officer would be out to the facility as soon as they could.
-She then turned onto a two lane road and began looking for Resident #1 but she did not see her.
-She returned to the facility and talked with other staff in sister facilities to ask if they had seen Resident #1 and they all stated no.
-She backed up out of the parking lot and proceeded in another direction in an attempt to locate Resident #1.
-She drove down a couple of roads but did not see Resident #1.
-She received a phone call from a police officer who stated that the officer who was supposed to come out to assist her with the missing person was currently out on a dog attack.

-She proceeded to return to the road the facility was on and she observed people outside at a home and she stopped and asked if they had seen Resident #1 but they had not.
-She returned to the facility and a police officer came and stated that Resident #1 had been found and that she had been a victim of a dog attack and that she was on the way to the hospital.
-The officer stated that Resident #1 was messed up pretty bad and he showed her and other staff pictures of Resident #1 from his cell phone.
-She called the RCC and 911, she was supposed to call the local department of social services (DSS) but her nerves "were tore up" so the RCC made the calls to DSS and Resident #1's family member.
-She was informed of any behaviors exhibited by Resident #1 on 12/28/24 or 12/29/24.
-When she entered the facility on 12/29/24 there was something on the floor and she almost fell.
-She asked the PCA what was all over the floor and she walked out of the dining room and stated that Resident #1 had put the substance on the floor.
-The PCA never reported to her that Resident #1 was having behaviors.
-The PCA who worked on 12/29/24 did not always report resident behaviors to her.
-Every once in a while Resident #1 would go to the hall door and turn the knob to see if she could get out of the facility and when the door would not open she would turn around.
-The PCA told her that the last time she saw Resident #1 was around 11:05am or 11:10am on 12/29/24.

Follow-up telephone interview with the MA/Supervisor on 2/18/25 at 2:45pm revealed:
-She went to this building on 12/29/24 between 7:30am and 8am to give out medications.
-She observed that Resident #1 was in her room.
-She could not remember if Resident #1 was in or out of the bed.
-Resident #1 came and got her medications and she took them.
-Resident #1 responded appropriately to questions and was acting at her normal baseline.
-She left the facility a little after 9am.
-The residents started eating breakfast prior to her leaving the building.
-She was not sure if Resident #1 had eaten before she entered the building.
-"To tell you the truth I cannot remember seeing Resident #1 prior to me leaving the building."

-She went back and reviewed the MAR for medications that she gave to another resident and observed that the time stamp was between 11:21am and 11:41am.
-Resident #1 did not take any medicine at the 11am medication pass her next medicine pass would have been at 2pm.
-She completed the full medication pass and she did not see Resident #1 at any other time that day.
-She left the building to transport another resident to an appointment at 12:30pm.

Interview with the Resident Care Coordinator (RCC) on 12/30/24 at 12:40pm revealed:
-She was not working on 12/29/24 the day that Resident #1 eloped from the facility.
-She received a call from the MA/Supervisor on 12/29/24 around 12:40pm reporting the elopement.
-When staff observe resident behaviors they were expected to report it to the MA/Supervisor and the MA/Supervisor was supposed to inform her.
-She and both MA's on staff knew to do this.
-It depended on what she was told from the Supervisor that determined if a resident was sent to the hospital or if mental health was contacted.
-It was expected that staff call the police when there was a resident elopement but if they were able to bring the resident back to the facility then they were to call and inform the local department of social services, RCC, family, mental health providers, and the PCP.

Follow-up interview with the RCC on 1/13/25 at 10:05am revealed:
-Resident #1's family member and his spouse came to visit her on 12/23/24.
-Resident #1 did not appear to have any exit seeking behaviors on 12/23/24.
-Resident #1 walked her family to the front door and she had to tell her that she had gone far enough and she backed up away from the door.
-There have been times when she would allow Resident #1 to go out onto the porch with her at the end of a family visit.
-Resident #1 always walked her family to the door when they were ending their visit and she would always come back inside the building.
-The PCA did not inform her of any behaviors that Resident #1 was having and she did not document any.
-The expectation was that the staff inform her when they saw behavioral changes of the residents.

-The PCA made her aware Resident #1 talked about a bus ticket but it was after she eloped on 12/29/24.

Telephone interview with Resident #1's primary care provider (PCP) on 1/13/25 at 11:04am revealed:
-She visited the facility every other Wednesday.
-She had not had concerns about the care of Resident #1 prior to 12/29/24.
-She thought no one could get in or out of the facility without staff assistance.
-There were no behaviors reported to her about Resident #1.
-From a medical standpoint when any resident was sent to the hospital, she would follow-up with them at her next visit.
-If the resident needed something right away she would make sure they got what they needed but if they are in the emergency department (ER) they were getting what they need.
-The facility notified her of the incident that happened on 12/29/24 but it was after the fact and Resident #1 was in hospital and she was getting care.
-She would not expect the staff to stop what they were doing to call her but when they met the needs of the resident then they definitely need to call.
-She did not feel that Resident #1 would have been safe to leave the facility by herself at all.

Telephone interview with Resident #1's mental health provider on 1/13/25 at 11:16am revealed:
-She received a call from the facility on 12/30/24, about an incident that happened with Resident #1 on 12/29/24.
-She was told that during the daytime on 12/29/24, Resident #1 left the facility via a window and that she was sent to the hospital secondary to injuries she sustained from being attacked by dogs.
-The facility staff were not able to tell her how long Resident #1 had been gone from the facility.

-She did not recall staff reporting any behavioral problems for Resident #1 except that she remained forgetful and confused.
-Resident #1 did not have any mood problems, her baseline was that of a normal dementia patient, no trouble with sleep, depression, or anxiety, and staff did not report any exit seeking behaviors at her last visit on 12/10/24.
-Resident #1 was compliant with medications.
-Resident #1 was not able to leave the facility on her own and return. There was no guarantee that she would be able to find her way back.
-If she had been informed of the behavioral changes and the resident verbalizing the desire to catch a bus and go home she

would have assessed Resident #1's medications and asked staff questions about her anxiety and agitation to see if she needed more medication to calm her down to assist her so that she was not exit seeking.
-On 1/2/25, she was informed by facility staff that Resident #1 would not be returning to this facility.

Interview with the Vice President (VP) on 1/3/25 at 3:40pm revealed:
-He received a call from the MA/Supervisor on 12/29/24 around 12:43pm informing him that Resident #1 had eloped.
-It took him about 20-22 minutes for him to get to the facility from his home.
-The facility did have window alarms but they were not all working when Resident #1 got out.

Follow-up telephone interview with the VP on 2/24/25 at 10:32am revealed:
-He knew that there was no way the PCA last saw Resident #1 on 12/29/24 at 12pm after speaking with the officer who reported Resident #1 was found around 11:30am.
-He became aware that the window alarms were not working on 12/29/24 the day of the elopement.
-He was not aware of Resident #1 having changes in behavior until the day she eloped after she was found on 12/29/24.
-He learned from staff after the elopement that Resident #1 had been adamant about going home earlier in the week.

Telephone interview with the Administrator on 2/24/25 at 9:28am revealed:
-She could not remember exactly what time she received the call on 12/29/24 about Resident #1.
-The VP called her because the RCC had called to inform the VP, it might have been around 12:30pm.
-The VP stated that Resident #1 went out the window and that the staff had called her for lunch and when they went to look for her she was gone.
-The VP contacted the maintenance staff to assist him with looking for Resident #1 and she went looking for her as well.
-By the time she got to the facility she was told that the police had already found Resident #1.
-The expectations regarding staff supervision of the residents was that they know where the residents were at all times, there was no set time to do rounds but staff should know where residents were at all times.
-The PCAs were expected to report changes in resident behavior, health, or mental status to the MA/Supervisors and they were to report the behaviors to the VP and RCC as soon as they were told.

-The VP, RCC, or Supervisor would contact the PCP and mental health provider.
-She was not aware of any changes in Resident #1's behavior at the time of this incident and none were reported to her.
-She was told about behaviors that Resident #1 had when she was asked to do the plan of protection.

The facility failed to provide adequate supervision of Resident #1 on a locked special care unit after she began to exhibit exit seeking behavior and verbalized the desire to catch a bus and go home. This failure resulted in the resident leaving the facility through a window and the resident walking 0.8 miles to a destination where she was brutally attacked by 3 German Shepard dogs. This failure resulted in serious physical harm and constitutes a Type A1 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on for this violation on 12/31/24.

CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 28, 2025.

IV. Delivered Via:	CERTIFIED MAIL **7016 3010 0000 2191 2472**	**Date:** 12MAR2025
DSS Signature:	Katrina M. Williams, AHS	**Return to DSS** 2APR2025

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.*