Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Woodlawn Haven Assisted Living
Address: 301 Craig Street Mount Holly, NC 28120
County: Gaston
License Number: HAL-036-040

II. Date(s) of Visit(s): 07/18/24, 07/25/24, 08/12/24, 08/21/24, 09/04/24, 09/09/24, & 09/16/24
Purpose of Visit(s): Complaint Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: 09/16/24

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 13F .0901 (c) Personal Care and Supervision	☑ POC Accepted MH *DSS Initials*	10/16/24
Rule/Statutory Reference: 10A NCAC 13F .0901 (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	Staff retrained and Policy Instated that staff number must be present	10/1/24
Level of Non-Compliance: Type A1 Violation		
Findings: This Rule is not met as evidenced by: Based on record reviews, interviews, and observation the facility failed to ensure staff were available to monitor the resident's change in medical condition to ensure care was rendered for 1 of 5 sampled residents (Resident #1). Review of Resident #1's current FL-2 dated 03/08/24 revealed: Diagnoses included: Unspecified dementia, cognitive communication deficiency, type 2 Diabetes Mellitus with		

hypoglycemia, type 2 Diabetes Mellitus with neuropathy, and essential hypertension.

Review of Resident #1's care plan dated 03/29/24 revealed:
-She was sometimes disoriented, and forget-needs reminders
-She required limited assistance required with toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring.
-She required the use of a wheelchair.

Review of Resident #1's record revealed there was no incident report completed on 07/17/24.

Review of Resident #1's facility nurse's notes dated 07/17/24 revealed:
-At 6:30am Resident #1 was throwing up and very weak.
-Medication Aide Supervisor (MA Supervisor) sent resident to the emergency room (ER) to be checked out.
-MA Supervisor called Resident #1's responsible person (RP) to let him know.
-There were no vital signs documented in the nurses' notes.

Review of Resident #1's Emergency Medical Services (EMS) report dated 07/17/24 revealed:
-Primary clinical impression was hypovolemia/shock (dangerous condition where the heart can't get the body blood and oxygen it needs to function).
-Secondary impression was hypotension (low blood pressure)
-Protocols used were hypotension/shock-non-traumatic and hypoglycemia/diabetic emergency (low blood sugar)
-Signs and symptoms were cardiogenic shock (a medical emergency resulting from inadequate blood flow to the body's organs due to the dysfunction of the heart), altered mental status, bradycardia (slow heartbeat), hypoglycemia, hypotension, and pallor (paleness, loss of color from normal skin tone).
-The resident's blood glucose was 36 at 6:44am
-The resident's blood glucose was 67 at 7:10am.
-Treatment by the paramedics consisted of intravenous (IV) medications to increase the heart rate and increase the blood pressure and blood glucose levels.
-Resident #1 was cold to the touch and pale with thready (difficult to feel) radial pulse.
-Oxygen saturation found patient to be hypoxemic (not enough oxygen in the blood).
-No positive response to IV fluids.
-No information regarding Resident #1's medical status was provided by facility staff.

With any resident who needs to be sent to ER until EMT take over situation and leave w/ Resident

All staff retrained on emergency Blood sugars/ vitals. Trained on Emergency situations and How to handle.

10/16/24

-Facility staff seemed to show no interest in the critical resident EMS was called out to evaluate.

Review of Resident #1's hospital medical records dated 07/17/24 revealed:
-Resident #1 had advanced dementia and presented with encephalopathy (inadequate brain function).
-Resident #1 had multiple vitals and electrolyte abnormalities.
-Resident #1 was bradycardic (low heart rate) with a heart rate as low as 36, blood pressure 60/38, saturating as low as 81% on room air.
-Resident #1 was hypothermic (low body temperature) with a temperature of 91.8.
-Resident #1 was admitted for inpatient hospice, comfort care measures.
-Resident #1 expired on 07/17/24 at 1619 (4:19pm).

Review of facility's policy and procedure for sudden illness date (unknown) revealed:
-When a resident becomes ill do the following.
-If Resident Care Director (RCD) or home health nurse is in the facility, they should be informed, and physician notified. If they are not in the facility inform supervisor.
-Get complete vitals.
-If resident requires immediate medical attention, and RCD or home health nurse are not in the facility, call 911 for ambulance transport to medical facility (ER).
-Notify physician, family, and Administrator.
-Make copies of chart to give to paramedics (face sheet, FL-2, physician orders, Medicaid, and Medicare Card).

Interview with a local paramedic on 08/09/24 at 3:15pm revealed:
-Upon arrival to the facility the local fire department was at the facility.
-When EMS staff walked in the facility, a staff member pointed to the hall where the room of Resident #1 was located.
-A lot of the staff were behind the front desk and none of the staff members walked with EMS staff to Resident #1's room.
-The fire department staff and EMS staff had to guess and figure out for themselves what was going on with Resident #1.
-Resident #1 was unresponsive (not able to communicate anything).
-Facility staff never came into Resident #1's room.
-Facility staff should have been in the room with the resident to inform first responders what was happening with the resident.
-Fire department staff checked Resident #1's blood sugar; it was read as 36.

Yearly trainig to be done with all staff regarding emergy situations | sending to ER | vitals | Done by our RN | Trainingnurse

10/16/24

-Resident #1's blood pressure was 56/30.
-Paramedic started an IV line with saline trying to increase blood pressure and administered glucose.
-Blood sugar increased to 76.
-The glucose was stopped, and another medication was administered to increase blood pressure.
-Resident #1's skin was pale and cold.
-Resident #1's fingers were too cold to get an oxygen reading.
-Resident #1 was in shock.

Interview with a MA Supervisor on 8/7/24 at 11:59am revealed:
-On 07/17/24 around 6:30am, a personal care aide (PCA) asked her to assist her and another PCA with a resident who was weak and on the floor.
-She went to the room of Resident #1 and assisted the PCA's with moving Resident #1 from the floor to the bed.
-Resident #1 was weak.
-She left the room to call EMS and copy needed paperwork for EMS upon their arrival.
-She left the PCA's in Resident #1's room.
-She did not know the PCA's had left Resident #1's room until she walked EMS to the room.
-Resident #1 was alone in the room.
-Resident #1 was moaning when EMS arrived in the room.
-Resident #1 was not to be left alone when EMS had been called for the resident.
-Anytime EMS is called to evaluate a resident that resident is not to be left alone.
-On 07/17/24, she checked Resident #1's vital signs.
-She did not check Resident #1's blood sugar because she was not a diabetic.
-Resident #1 never had symptoms of low blood sugar.

Interview with another MA Supervisor on 8/8/24 at 11:05am revealed:
-On 07/16/24 between 5:30am-6:00am, Resident #1 woke up while staff conducted room checks.
-Resident #1 stated she was thirsty and wanted a soda.
-There was no soda in the refrigerator.
- Resident #1 was given ice water to drink.
-Prior to giving Resident #1 ice water, her temperature was checked.
-Resident #1's temperature was 97.0.
-Resident #1's bed clothes were wet with sweat.
-Staff changed her bed clothes.
-Resident #1 had no vomiting but did have a bowel movement.
-Resident #1 got back into bed.

-Staff checked on Resident #1 several times and she was asleep.
-She did not think about checking Resident #1's blood sugar during this time.
-She never had to check Resident #1's blood sugar.
-She was prescribed Metformin for diabetes.
-She was not prescribed to have blood sugar monitored.
-There were no vitals taken.

Interview with Assistant Resident Care Director (ARCD) on 08/21/24 at 7:55am revealed:
-When EMS was needed at the facility for a resident, a MA, MA Supervisor, or possibly a PCA called 911.
-A staff member usually a MA was expected stayed in the room with the resident to monitor for any changes.
-Vital signs were expected to be taken in most cases.
-When EMS arrived at the facility the MA or MA Supervisor was expected to inform EMS of the situation that happened with the resident.
-If a resident was diabetic or shows signs and symptoms of hyperglycemia or hypoglycemia, the blood sugar would be checked.

Interview with a PCA on 7/18/24 at 2:20pm revealed:
-Around 6:30am on 07/17/24 she and another PCA were in Resident #1's room dressing Resident #1 for the day.
-Resident #1 complained of stomach pain.
-Resident #1 was slumped over.
-She and the other PCA lifted Resident #1 up, but she became dead weight.
-She and the other PCA lowered Resident #1 to the floor and placed a pillow under her head.
-The other PCA ran and got the MA Supervisor.
- Resident #1 was talking during this time
-All three of them lifted resident #1 from the floor and placed her on the bed.
-The MA Supervisor left the room to call EMS.
-She and the other PCA had to continue getting other residents ready for the day, so she and the other PCA left Resident #1 in the room alone.
-When she and the other PCA left the room Resident #1 was no longer talking and was moaning with her mouth open and eyes closed.
-The MA Supervisor was not informed they left the room.
- According to her MA training, it was the responsibility of the MA to check vital signs and stay with the resident until EMS arrived.

Interview with another PCA on 07/25/24 at 8:45am revealed: -A PCA was getting Resident #1 dressed for breakfast. -Resident #1 went limp and the other PCA called this PCA for assistance. -Resident #1 then collapsed and she and the other PCA lowered Resident #1 to the floor. -She ran and got the MA Supervisor. -All three staff members herself, the PCA, and MS Supervisor placed Resident #1 on the bed. -The MA Supervisor went to call EMS. -Resident #1 was talking then started moaning. -Resident #1 started vomiting and having a bowel movement. -She and the other PCA cleaned Resident #1 up. -She and the other PCA left Resident #1 in the room alone because they had to get the other residents up and ready for breakfast. Interview with RCD on 08/21/24 at 8:25am revealed: -When a resident did not appear to be their normal self, she conducted an assessment. -She talked to the resident to find out if the resident could answer any questions. -She would check vital signs including blood sugar. -The blood sugar was checked even if the resident was not a diabetic. -She followed the physicians advice. -If EMS was called a staff member usually a MA or MA Supervisor, would stay in the room and continued assessing the resident for medical changes. -If the resident is able the resident was brought to the front desk until EMS arrived. -The resident would not be left alone. Observation of the facility video camera on 08/12/24 revealed: -The fire department arrived at the facility on 07/17/24 at 6:38am. -No facility staff members walked firemen to Resident #1's room. -MA Supervisor was at the front desk at the medication cart. -MA Supervisor was administering medications to residents as the residents walked by to go to breakfast. -EMS arrived at 6:44am and the MA Supervisor points down the hall toward Resident #1's room. -No staff members walked EMS to Resident #1's room. -There were several staff members standing at the front desk. -The ARCD at 6:54am handed paperwork to a fireman as he left the facility.		

Interview with Co-Administrator on 07/25/24 at 9:05am revealed:
-A MA Supervisor informed her on 07/17/24 at 5:30am, Resident #1 was up talking to staff members.
-Resident #1 wanted staff to get her dressed.
-Resident #1 had a bowel movement and staff cleaned her up.

Interview with another Co-Administrator on 08/21/24 at 10:20am revealed:
-The situation with Resident #1 it was an emergency.
-She would have called EMS, and not got vital signs.
-She would have expected a PCA or MA Supervisor to stay with the resident until EMS arrived or walk with EMS to the resident's room upon EMS arrival.

Interview with Administrator on 09/10/24 at 4:44pm revealed:
-If staff members were trained to be in the room with the resident, the staff should have been in the room.
-He did not know why staff members left the resident alone.
-The MA Supervisor was in charge at the time of the incident.

The facility failed to ensure staff were continuously present to provide medical intervention when Resident #1 exhibited a significant decline in responsiveness. This failure resulted in Resident #1 being unattended and unable to explain her medical condition to EMS. As a result of the in the delay with her need for emergent care. Resident #1 was hospitalized and placed on hospice care, and she expired the same day. This failure resulted in serious physical harm and neglect and constitutes a Type A1 violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/18/24.

THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED (30 DAYS FROM 09/16/24).

IV. Delivered Via:	Hand delivered	Date: 09/16/24
DSS Signature:	Mary Hailey	Return to DSS By: 10/2/24

Facility Name: Woodlawn Haven

V. CAR Received by:	Administrator/Designee (print name): Beverly Wooten	
	Signature: Beverly Wooten	Date: 9/16/24
	Title: administrator	

VI. Plan of Correction Submitted by:	Administrator (print name): Beverly Wooten	
	Signature: Beverly Wooten	Date: 10/2/24

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		
☑ *POC Accepted*	By: Mary Hailey	Date: 10/04/2024
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.*		