Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Laurels in Highland Creek
Address: 6101 Clarke Creek Parkway Charlotte, NC 28269
County: Mecklenburg
License Number: HAL-060-161

II. Date(s) of Visit(s): 12/20/24, 01/02/25, 01/06/25, 01/14/25, 01/17/25, 01/28/25
Purpose of Visit(s): Complaint Investigations and Death Investigations
Exit/Report Date: 2/13/25

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: 10A NCAC 13F .0901(a)/Personal Care and Supervision	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.		
Level of Non-Compliance: Type A1 Violation		
Findings: Based on observations, record reviews and interviews, the facility failed to provide care and services to 1 of 5 residents (Resident #2), a resident who required assistance with transfers with the aid of a slide board, according to her care plan. 1. Review of Resident #2's current FL-2 dated 12/10/24 revealed: - Diagnoses included cerebral infarction, dysphagia, cognitive communication deficit, heart failure, muscle weakness, atrial fibrillation, polyneuropathy, and hyperlipidemia.		

- Resident #2 was intermittently disoriented, semi-ambulatory, and incontinent of bladder and bowel.

Review of Resident #2's Care Plan signed by the physician on 09/02/24 revealed:
- Resident #2 required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transferring.
- Resident #2 required 1-person assistance with transferring with the use of a slide board.

Review of Resident #2's Licensed Health Professional Support review dated 08/07/24 revealed:
- Resident #2 used a wheelchair for ambulation and required assistance of 1 staff with transfers.
- Resident #2 was a high fall risk.
- The recommendations included to assist with all transfers, using the appropriate number of caregivers, and the "proper technique to minimize the potential for skin tears or related injury".

Review of Resident #2's incident report dated 01/04/24 at 1:22am revealed:
- Resident #2 reported experiencing pain in her left shoulder and rated the pain 6 out of 10 (10 being the worst).
- Resident #2's blood pressure was 155/60 and her pulse was 51.
- Resident #2's was sent to the Emergency Department (ED) for evaluation.

Review of Resident #2's progress note dated 01/02/25 revealed she complained that her left shoulder was in pain.

Review of Resident #2's progress note dated 01/03/25 from the 3:00pm – 11:00pm shift revealed she reported her left shoulder hurt, and the caregiver reported this to the medication aide (MA), and a note was sent to her physician.

Review of Resident #2's progress note dated 01/03/25 from the 11:00pm – 7:00am shift revealed:
- Resident #2 was "expressing out loud" when the staff member was providing incontinence care, that her left shoulder was in pain, and rated her pain a 6 out of 10 (10 being the worst).
- Resident #2 was sent to the hospital at 12:40am for evaluation.

Review of Resident #2's Emergency Medical Services (EMS) dated 01/04/25 revealed:

- EMS arrived at the facility on 01/04/25 at 12:35am. - Resident #2 reported that on 01/02/25 a male worker, who's name she did not recall, attempted to transfer her by grabbing under her arms and was unable to transfer her properly by himself. - During the transfer, she felt an injury occur in her shoulder. - Medic observed visible swelling in her left shoulder, she had weak grip strength and "virtually no mobility" in her left arm. - There was no obvious deformity observed in the arm. - She reported her pain was an 8/10. - She had baseline weakness in her legs due to a previous fracture. Review of Resident #2's Emergency Department discharge note dated 01/04/24 at 1:33am revealed: - Resident #2 complained of left shoulder pain and reported that while staff was transferring her on 01/02/25 at 1:30pm she heard a pop in her shoulder and had pain since that time. - She had limited range of motion and swelling to her upper left extremity. - An x-ray was completed and revealed a possible fracture of the humerus (the upper arm bone). - Resident #2's arm was placed in a sling and she was discharged back to her facility, with a referral to an orthopedic surgeon. Review of Resident #2's Orthopedic physician's notes dated 01/08/25 revealed: - Resident #2 was seen for evaluation related to a closed nondisplaced fracture of proximal end of left humorous. - Her left shoulder was tender, and motion was painful, with minimal swelling and edema. - He recommended conservative treatment with immobilization in a shoulder immobilizer. - There were instructions that staff should be careful with transfers and not manipulate the left shoulder. Review of facility's Care Plan book revealed there was no care plan in the book for Resident #2. Interview with Resident #2 on 01/06/25 at 10:50am revealed: - She had a slide board that was supposed to be used when staff transferred her. - She had the slide board "a long time" and most staff were familiar with using it. - On Thursday (01/02/25) a male Personal Care Aide (PCA) who did not usually provide care to her, came in to transfer her from her chair to her bed for incontinence care.		

- He bent over to pick her up and she said, "why don't we use the slide board" and he said he "did not need it." - The staff member picked her up and placed her in bed and provided incontinence care for her, without incident. - He then prepared to transfer her back to her wheelchair and did not give her an opportunity to sit up in the bed, as she had been accustomed to doing, before grabbing her under her arms and pulling her up to a sitting position in bed. - When he went to sit her in her chair, he either tripped, or the chair may not have been properly locked, but he "just about dropped me" and had to grab harder under her arms to keep her from falling to the ground, which is when she first felt pain in her left shoulder. - After he almost dropped her, she asked again if they could use the slide board, but the staff member insisted he did not need it. - He sat her back on the bed and adjusted the wheelchair and then transferred her to the wheelchair without the aid of the slide board. - Her shoulder was "sore all day" but it was not an agonizing pain, and she thought it was probably just a pulled muscle and that it would get better with time. - She received scheduled narcotic pain medications already related to a fracture of her knee that occurred a few months ago while she was working with physical therapy. - She told the Medication Aide (MA) that the staff member almost dropped her and that her shoulder was sore as a result. - Her arm continued to be sore throughout the next day (01/03/25) but was still not excruciating in nature. - On 01/04/25, her arm was hurting more when she laid down in bed for the night. - On 01/04/25, when the third shift MA came in at the start of her shift and observed that she was in worse pain, she told her she really needed to go to the ED for evaluation and she agreed to go for assessment. Telephone interview with Resident #2's Responsible Party (RP) on 01/15/25 at 3:25pm revealed: - She was at the facility at the time Resident #2 experienced pain during transfer on 01/02/25. - A male staff member, whom she did not recognize, came to Resident #2's room to provide incontinence care. - She stepped out of the room while the staff member transferred Resident #2 from her wheelchair to the bed and provided incontinence care. - After the staff member was finished and had left the room, she went into the room, and Resident #2 immediately said "that guy almost dropped me" and reported that she told him she		

wanted to use her slide board to transfer to the bed, but he insisted he could transfer her without it. - Resident #2 reported the staff member picked her up from the chair and transferred her to the bed without incident and provided incontinence care. - Resident #2 reported to her that the staff member "picked her up" to put her back in her chair and "sort of tripped" and had to readjust his grip on her because he almost dropped her and grabbed under her arm, which was when she first felt pain in her shoulder. - Resident #2 did not think her shoulder was seriously injured because of the failed transfer and thought the soreness would feel better after a day or two, but the pain increased. - The next day, when staff put her in bed, she complained of worsening pain, and she was sent out to the ED for evaluation. Interview with the PCA on 01/06/25 at 3:10pm revealed: - He usually worked at a sister facility located next door but sometimes picked up shifts at this facility on second shift. - He had been assigned to care for Resident #2 on many occasions and was familiar with her needs. - He was aware that Resident #2 had right side paralysis because of a stroke. - He had been trained on how to properly use a slide board, but he had never used a slide board alone. - Often when Resident #2 needed to be transferred, he and the MA would transfer her together, and they would use a slide board. - On 01/02/25, he went into Resident #2's room to assist her in transferring from her wheelchair to her bed. - He asked her if she could stand, to which she responded she "thought she could". - He assisted Resident #2 in standing up by holding under her arms and observed Resident #2 was weaker than usual and could not bear weight. - He was holding under her arm and due to her unexpected weakness, he had to quickly assist her back onto the chair to keep her from falling to the ground. - After allowing Resident #2 to rest for a few minutes, he again attempted to transfer her to bed by holding under her arms and was able to get her into bed that time. - Resident #2 never asked to use the slide board, and she never said she was in pain. - He was aware Resident #2 had a stroke in the past and that her left side was her "weak side" because of the stroke, so he always tried to be on that side of her during transfers to provide more support on her weak side.		

- He had provided transfer assistance to Resident #2 independently on several occasions without the slide board and had never had any issues. - He usually learned about the needs of residents through the shift-to-shift report from the MA when he worked. - There was also a book located in the clinic that has the care plans of each resident, for staff who were not familiar with the residents. - He did not recall if he had ever looked at the care plan book. - He was unaware that Resident #2's care plan noted she had a slide board that should be used for transfers. Interview with a first shift MA on 01/28/25 at 11:45am revealed: - The PCA worked in the facility on many occasions and was familiar with the needs of the residents. - She directed him that residents needed assistance with incontinence care and asked if he recalled how to use a slide board, and he stated he was comfortable using the slide board. - Later in the shift, she saw the staff member, and he said he had completed rounds providing incontinence care and there were no concerns. - She did not see Resident #2 again on 01/02/25 after getting her out of bed that morning and administering her medications. - The next morning, on 01/03/25, she went to Resident #2's room to administer her medications and she said that her shoulder was sore because "that guy almost dropped me yesterday". - Resident #2 was already receiving controlled pain medication, so she did not say her shoulder was hurting badly, and only reported it was "sore". - Resident #2 did not want to be sent out to the ED for evaluation. - She was unsure what needs were documented on Resident #2's care plan. - From her observations, Resident #2 usually required 1-person assistance with transfers, using a slide board. - When she transferred Resident #2, their normal process was that the resident would sit up in bed by using the halo bar to pull herself up, and then she would position the slide board under her hip and Resident #2 would pull herself over on to the board. - She never attempted to transfer Resident #2 without the slide board and did not feel it would be safe because her left arm, and entire left side was completely "limp" due to a prior stroke, which made it very difficult to get a good grip on her left side.		

- To her knowledge, all staff used a slide board to transfer Resident #2. - There was a care plan book in the clinic on each floor of the facility that contained the care plans for each resident, and staff were supposed to review the book to learn about the needs of the residents. - When new staff started, she directed them to refer to the care plan book. - She did not review the care plan book often because she had worked at the facility so long she felt she was familiar with the residents and their needs. - She preferred to learn the needs of the residents, she usually asked new residents when they moved into the facility what assistance they needed from staff, and she also observed residents to learn their needs. Interview with second shift MA on 01/06/25 at 12:05pm revealed: - On 01/02/25, Resident #2 reported she had pain in her shoulder but said she didn't think she needed any pain medication. - Resident #2 did not report to her what had happened to cause her shoulder to hurt, and it was not uncommon for her to have "aches and pains" so she did not think the pain was out of the ordinary for Resident #2. - Resident #2 required assistance with transfers, and she always used a slide board to assist her. - When using the slide board, she would slide the board under her hip and then the resident would grab the side of the board and pull herself over to the other side of the board. - She recalled when she was first trained as a PCA in the facility, other staff members had shown her how to use a slide board. - She always used the slide board when assisting Resident #2 with transfers and would "be afraid not to use it" because it "didn't seem safe" for Resident #2. - She was unsure what assistance Resident #1's Care Plan reflected she needed and did not recall ever seeing the resident's care plan. Telephone interview with a second shift MA on 01/22/25 at 3:50pm revealed: - On 01/03/25, she recalled Resident #2 complained of shoulder pain and said that she was planning to try to see a doctor the next day to have her shoulder evaluated. - Resident #2 did not want to be sent out for evaluation on second shift on 01/03/25 for evaluation.		

- Upon hire, she learned about the needs of individual residents through shadowing another staff. - There was a Care Plan book located on each floor of the facility in the clinic that staff could reference to learn the needs of residents, if they had questions. - She was unsure if she had ever looked at Resident #2's care plan, but she had provided care to Resident #2 a long time and was very aware of her needs. - Resident #2 required assistance with dressing, bathing, and transferring. - She sometimes used a slide board for transfers when assisting Resident #2, but often used a gait belt instead, which "worked well" for she and Resident #2. - When using the gait belt, Resident #2 would put her arms around her neck and then she would use the gait belt around her waist and stand on her weak side to help her transfer from the chair to the bed. - Staff had not been directed that they were required to use the slide board for all transfers with Resident #1. Telephone interview with a second shift PCA on 01/22/24 at 4:22pm revealed: - When she worked on 01/02/24 on second shift, Resident #2 was in bed and reported her shoulder was hurting. - She worked in the facility for several years and usually worked on second shift. - The facility had a care plan book upstairs and downstairs, that staff could refer to learn the needs of individual residents. - Resident #2 required assistance with a slide board to transfer to bed and to her wheelchair. - When using the slide board to transfer Resident #2, Resident #2 was able to aid in sliding herself over on the board. Telephone interview with 3rd shift MA on 01/23/25 at 8:40am: - At the beginning of her shift on 01/03/25, the 2nd shift MA reported to her that Resident #2 was experiencing some pain in her shoulder but did not want to be sent out. - She went to her room immediately to check on her and Resident #2 said her shoulder was feeling better and she didn't think she needed to go to the ED to be assessed. - A little later in the shift, about 11:30pm, she went back into Resident #2's room to check on her and to provide incontinence care, as was their usual routine. - Resident #2 usually assisted her with incontinence care by rolling over in bed but on 01/03/25, she was unable to roll at all due to pain in her shoulder.		

- Since she seemed to be experiencing a good deal of pain, she strongly recommended Resident #2 go to the hospital for evaluation, and she agreed to go. - Because her shoulder was hurting so much, she did not try to pull up her sleeve to assess the area. -EMS came and transported her to the ED. - Resident #2 required assistance with incontinence care, dressing and transfers. - She had never assisted Resident #2 with transfers because she was always already in bed by the beginning of 3rd shift and was still in bed at the end of 3rd shift. - She had been trained on using slide boards and was comfortable with using them. - She learned about the needs of residents through shift-to-shift report, usually, and by reviewing the Care Plan books as necessary. - She was unsure if she seen Resident #2's care plan. Interview with Physical Therapist on 01/14/25 at 11:30am revealed: - She was not currently working with Resident #2 but had previously worked with her on building strength prior to fracturing her knee several months ago. - Resident #2 required assistance with all transfers. - Resident #2 had a slide board that could be used for assistance with transfers. - To use a slide board, staff would slide the board under a resident's bottom when the resident was in the sitting position and then the resident would hold on to the edge of the board and "scoot" themselves over onto the board and onto another surface. - Prior to Resident #2's knee injury, she was working with her to try build strength so that she could squat pivot. - At the time she stopped working with her several months ago, Resident #2 was sometimes able to successfully squat and pivot to transfer, and sometimes also used a slide board. - She had worked with several staff on utilizing slide boards with residents, when a staff member happened to be in a resident's room during a transfer of a resident who used a slide board. - For residents who have had a stroke resulting in paralysis, they were at a greater risk of fractures because the joints were weak and there was no muscle tone around the joint to help hold it in place.		

Interview with Resident Care Director (RCD) on 01/06/25 at 10:50am revealed: - Resident #2 was sent out recently because she was having pain in her shoulder. - He reviewed Resident #2's hospital documentation, which noted a fracture in the left shoulder. - It was his understanding that a PCA was attempting to transfer Resident #2 without the use of a slide board and the resident's legs became weak and she "went to her knees" and he had to grab her by the arm to keep her from falling to the ground. - Resident #2's left side was paralyzed from a stroke. - He was aware that Resident #2's Care Plan documented a slide board should be used for transfers. - The staff member had provided care to Resident #2 on several occasions and should have been aware a slide board was supposed to be used for transfers. - He had a meeting scheduled with the staff member today to find out what happened while he was providing care to Resident #2. Interview with RCD on 01/28/25 at 12:45pm revealed: - Care Plans were supposed to be completed for residents upon return from the hospital if a significant change to their condition was identified, upon admission to the facility, upon readmission from a skilled facility for rehabilitation, and annually for all residents. - The RCD or the ARCD was responsible for completing the care plans. - To begin the process of completing a care plan, a level of care assessment was conducted, which determined what information was included on each resident's care plan. - There was a care plan book on each floor of the facility for staff to use as a guide to know what assistance each resident required. - The ARCD was responsible for maintaining the care plan books. - The facility was currently without an ARCD, and he was unsure when or if the former ARCD had last updated the care plan books. - He understood from staff that the former ARCD mainly communicated changes to resident's care plans and care needs verbally to MAs and PCAs. - He was aware that Resident #2 required a slide board for transfers. - He interviewed the staff member who did not use a slide board when transferring Resident #2, that resulted in an injury,		

and the staff member stated he "thought he could move her" without the slide board. - Staff were responsible for reviewing the care plan book and for providing care according to resident's care plans. - The PCAs did not document each instance of personal care assistance provided to residents. Interview with Regional Operations Specialist on 01/17/25 at 10:10am revealed: - She was aware that Resident #2's care plan documented a slide board should be used for transfers but thought the staff who failed to use the slide board was likely unaware a slide board should be used because he did not typically work in the facility. - Care Plans were supposed to be maintained up to date in the Care Plan book located in the clinic on each floor of the facility for staff review. - The current care plans were also located within their electronic record system, but the PCAs did not have access to this system and should have been referring to the care plan books. - Any time there was a change to a resident's care plan, this should be communicated by the DRC and ADRC to the MAs and PCAs so they were all aware. - The ADRC was responsible for updating the care plans in the books when there were any changes to residents' care plans, and this should be flagged in the shift-to-shift report. - PCAs reviewed the shift-to-shift report to learn of any changes to residents needs at the beginning of each shift. - PCAs did not document each instance of personal care assistance provided to residents. Interview with Resident #2's Physician on 01/14/25 at 9:45am revealed: - Resident #2 had been his patient for about a year and had recently "been through a lot" with the loss of a close family member and she fractured her knee several months ago and had not fully recovered from that injury. - He received communication from the facility that Resident #2 complained of shoulder pain and was sent out to the ED for evaluation and diagnosed with a fracture in her shoulder. - He was aware that Resident #2's most recent care plan he signed included the use of a slide board for transfers, but he was unsure of how long the slide board had been available for the resident's use. - Slide boards were used to make transfers easier for weak residents, as they reduce the risk of injury.		

- Slide boards can safely be used by 1 staff member if the resident was able to hold on to the board and provide some assistance in moving to the board. - Resident #2 was paralyzed on her left side due to a previous stroke, which increased her risk of fractures on her paralyzed side. - It was his understanding that Resident #2 did not initially express being in pain due to the shoulder injury, so she was not initially sent out to the ED. - It was possible there was no visible injury or swelling in the first 24 hours after the fracture occurred. - Improperly transferring Resident #2 without the use of a slide board likely resulted in the fracture of her shoulder, and not using the slide board was detrimental to her health. - His expectation was that the facility would follow all residents' care plans to ensure they are receiving proper care, and if a care plan documents a slide board or other specific devices were required for transfers, then all staff should do so. --- The facility failed to provide care to residents in accordance with their care plans, including Resident #2, who obtained a closed nondisplaced fracture of proximal end of left humorous, as a result of a PCA who did not use a slide board to assist with transfer. This failure of the facility to provide care in accordance with residents' care plans resulted in serious injury of residents and constitutes a Type A1 Violation. --- CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED March 15, 2025. The facility provided a plan of protection in accordance with G.S. 131-34 on 01/17/24.		

IV. Delivered Via:	Certified mail/hand delivered Vida Sanders Tonya Wright	Date: 2/13/25
DSS Signature:		Return to DSS By: 3/6/25

V. CAR Received by:	Administrator/Designee (print name): Christine Ogden
	Signature: Christine M Ogden Date: 2/13/25
	Title: New Administrator effective 1/15/25

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.*		