Adult Care Home Corrective Action Report (CAR)

1550 Charles Road Shelby NC 28150I. Facility Name: TerraBella Shelby

Address: 1550 Charles Road Shelby, NC 28150

II. Date(s) of Visit(s): 11/12/24,11/14/2024, 11/18/2024,1/09/2024

County: Cleveland

License Number: HAL-023-048

Purpose of Visit(s): Complaint Investigation_____

Exit/Report Date: 01/10/2025

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)**, it indicates 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 surveys 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 (b)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: 10A NCAC 13F .0901 (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 A2 VIOLATION		
Findings: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 1 resident who had a history of wandering behaviors resulting in the resident eloping from the Special Care Unit (SCU) without staff knowledge (Resident #1). Review of Resident #1's current FL2 dated 10/07/24 revealed: -Diagnoses included Alzheimer's disease, and memory loss. -She was ambulatory. -She was constantly disorientated.		

-There was documentation she had a history of wandering behaviors.
-Her level of care was SCU.

Review of Resident #1's Resident Register dated 10/30/24 revealed:
-She was admitted to the facility on 11/04/24.
-She required redirection due to significant memory loss.

Review of Resident #1's admission records revealed there were no interventions put in place to address wandering behaviors.

Review of Resident #1's Incident/Accident report dated 11/09/24 revealed:
-At 9:30am she was found on the school campus across from the facility.
-The type of occurrence was elopement.
-The location was documented as "outside".
-Her vital signs and blood pressure were documented as normal, and no injuries were noted.
-Resident #1's family member was notified at 12:30pm.
-The facility's contracted Nurse Practitioner (NP) was notified on 11/11/24 at 4:35pm.

Observation of the location of the facility on 11/12/24 at 11:05am revealed:
-The facility was located on two lane busy road.
-On the right side of the road there was an embankment that was approximately 3 feet deep.
-On the left side of the road there was a great deal of storm debris that blocked a clear path along the side of road and would require someone walking down the road to walk over or around to continue on their path.
-The school where Resident #1 was found by staff on 11/09/24 was approximately 0.30 miles from the facility.

Telephone interview with Resident #1's family member on 11/13/24 revealed:
-The Administrator told him on 11/09/24 when he visited Resident #1 that the resident had eloped from the facility and was found down the road by two people.
-Resident #1 appeared to be fine and at her baseline when he visited her on Saturday 11/09/24.
-Resident #1 had a history of wandering behaviors which is the reason she was admitted to the facility's SCU.
-Resident #1 was diagnosed with Alzheimer's disease years ago and she had declined over the past year.

Interview with a personal care aide (PCA) on 11/12/24 at 12:15pm revealed: -She worked on the SCU on 11/09/24. -She completed two-hour checks on Resident #1, but she did not document them anywhere. -She did not know Resident #1 eloped from the SCU. Interview with another PCA on 11/14/24 at 11:52am revealed: -She worked on the SCU. -The 1st shift medication aide (MA) supervisor went out to smoke, and she went to the drink machine. -When she went back to the Special care Unit she sat down like normal, and the MA supervisor returned from break. -Another staff member came into the SCU and told staff to check the residents, and she learned Resident #1 had eloped. -She went to Resident #1's room and the resident was not there. -She had taken Resident #1 back to her room after breakfast. -Checks on residents were completed every two hours but they were not documented. -She was told to keep an eye on Resident #1 because Resident #1 was found standing behind the food cart trying to leave the SCU during meal service. -Resident #1 was very agitated that morning about her family member not being at the facility. -She did not know how Resident #1 eloped from the SCU and was found down the road from the facility. Interview with a 1st shift MA on 11/12/24 at 12:45pm revealed: -She worked on the SCU on 11/09/24. -She and another staff went to pick up Resident #1 when a person came to the facility asking if the resident lived at the facility. -She did not know how the resident eloped from the SCU. Interview with the 1st shift MA supervisor on 11/12/24 at 3:17pm revealed: -She was the MA supervisor for the SCU. -She worked 6:00am to 6:00pm on 11/09/24. -She took a smoke break at 8:50am for 10 minutes on 11/09/2024. -She gave Resident #1 her medications between 8:00am and 12:00pm on 11/09/24. -The last time she observed Resident #1 prior to her elopement was at 8:30am in the dining room on the Special Care Unit.		

-The only staff she saw go in and out of SCU was the dietary staff coordinator to retrieve the food cart, and two other staff members who left to take their 15-minute breaks. -When she came back in from her break, another staff member came and told her to do a "head count"; the "head count" was completed and it was determined Resident #1 was missing. -Another staff came and inform her a member of the public came into the facility asking if Resident #1 was a resident at the facility. Interview with the Health and Wellness Director (HWD) on 11/14/24 at 12:16pm revealed: -Staff called her home on 11/09/24 and told her Resident #1 eloped from the SCU. -She came to the facility and assessed the resident and no injuries were found. -She estimated Resident #1 went missing sometime between 8:30am and 10:00am that morning. -According to Resident #1's Medication Administration Record (MAR) she received her 8:00am medications on 11/09/24. Interview with the SCU Coordinator on 11/12/24 at 1:00pm revealed: -She wasn't working on 11/09/24 she was on call and available by telephone. -She was the on-call facility supervisor on 11/09/24, when staff called her and said Resident #1 had eloped. -Resident #1 had wandering behaviors but not exit seeking behaviors. -She came to the facility that morning and met with staff and the Administrator. -A staff member asked Resident #1 what door she went out and the resident led the Administrator straight to the door right outside her room. -She and the Administrator checked all the SCU doors to ensure they were locked and operational. -She did not feel certain she knew how Resident #1 eloped from the SCU. Interview with the Administrator on 11/12/24 at 11:05am and 11/14/24 at 12:30pm revealed: -The facility did not have camera or video surveillance. -Staff reported to her that Resident #1 was discovered missing around 9:34am on 11/09/24. -She immediately came to the facility to begin interviewing staff, checking the doors, and the residents.		

-The SCU door report indicated that the SCU doors were opened 8 times on 11/09/24.
-There were no visitors to the unit, but staff had taken their breaks throughout the day and the dining cart was delivered.
-Staff reported Resident #1 was last seen in the facility around 8:30am on 11/09/24 in the dining room.
-She estimated the resident was gone from the facility for approximately one hour, and the resident was found at the school down the road from the facility by two citizens and brought back to the facility.
-Staff must not have noticed Resident #1 leave out the front door when staff went out to take a break.

Interview with the facility's contracted NP on 11/13/24 at 11:06am revealed:
-On 11/09/24 staff informed her that Resident #1 had eloped and ask if they could get a urine sample to rule out a urinary tract infection.
-Interventions should have been in place to ensure all the doors in the SCU remained secured so none of the residents could elope.
-Resident #1's room needed to be located closer to the front of the unit so staff could keep an eye on her.

The facility failed to provide supervision for Resident #1, who had a history of wandering behaviors and was newly admitted to the facility, resulting in Resident #1 eloping from the facility and was located almost a half a mile from the facility without the staff knowing where she was for more than one hour. This failure put the resident at substantial risk for serious physical harm and constitutes a Type A2 Violation.

The facility provided a plan of protection in accordance with G.S. 131-34D on January 9, 2025.

THE CORRECTION DATE FOR THE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 12, 2025

Facility Name:

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Rule/Statute Number: _____	☐ POC Accepted _____ -DSS Initials	___
Rule/Statutory Reference:		
Level of Non-Compliance:		
Findings:		

IV. Delivered Via:	Hand Deliver	Date: 01/10/2025
DSS Signature:	Courtney Morehead, Adult Home Specialist	Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name): Jacqueline Sibley-Newton	
	Signature: Jacqueline Sibley-Newton	Date: 1/10/25
	Title: Executive Director	

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:		

Facility Name:

☐ *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.*		