Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Wickshire Steele Creek
Address: 13600 S. Tryon St. Charlotte, NC 28278
County: Mecklenburg
License Number: HAL-060-166

II. Date(s) of Visit(s): 07/07/23, 07/14/23, 08/01/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 08/03/23

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)* • *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 PERSONAL CARE AND SUPERVISION (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.	☐ POC Accepted _____ *DSS Initials*	____
Level of Non-Compliance: Type A1 Violation		
Findings: Based on record reviews and interviews, the facility failed to call emergency medical services (EMS) for 1 of 5 sampled residents (Resident #1) when they discovered they were not able to unlock her door and enter her room resulting in the staff neglecting to provide her care needs for six hours. The findings are: Review of Resident #1's current FL-2 dated 06/20/23 revealed: -Diagnoses included dementia, hypertension, stage three chronic kidney disease. -The recommended level of care was Special Care Unit (SCU). -Resident #1 required total care assistance.		

-Resident #1 was non-ambulatory and required full assistance with transfers.
-Resident #1 was incontinent of bladder and bowel.

Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 06/27/23.

Review of Resident #1's Level of Care plan dated 06/28/23 revealed:
-Resident #1 had a potential for falls and required periodic observation from staff for safety needs.
-Resident #1 was oriented to person.
-Resident #1 required assistance with eating, bathing, grooming, dressing, toileting, transfers, and ambulation.
-Resident #1 was unable to exit the building without total assistance.
-The facility Health and Wellness Director (HWD) electronically signed on 06/30/23, and there was no signature by the primary care provider.

Review of Resident #1's Progress Notes revealed:
-An entry dated 07/02/23 at 7:09am documented by the Health and Wellness Director (HWD) Resident #1 was found in bed at 2:45am unresponsive, vitals taken, no pulse or breathing detected.
-911 was contacted at 2:58am and did not recommend Cardio-Pulmonary Resuscitation (CPR).
-EMT and Local Law Enforcement arrived at 3:10am.
-The Medical Examiner assessed resident and gave cause of death as natural causes.

Review of Resident #1's Incident Report dated 07/02/23 revealed:
-Resident #1 was found in bed at 2:45am unresponsive, vitals taken, no pulse or breathing detected.
-911 was contacted at 2:58am and did not recommend Cardio-Pulmonary Resuscitation (CPR).
-EMT and Local Law Enforcement arrived at 3:10am.
-The Medical Examiner assessed resident and gave cause of death as natural causes.

Review of the emergency medical technician (EMT) report dated 07/02/23 revealed:
-EMT received a emergency call at 3:17am on 07/02/23.
-EMT arrived at the facility on 07/02/23 at 3:30am.
-Facility staff reported Resident #1 had been locked inside her room for 4.5 hours with the bedroom key locked inside the room.

-Staff reported they had been waiting for a locksmith to open the door, who arrived on 07/02/23 at 3:00am.
-Staff found Resident #1 on 07/02/23 to be unresponsive and cold to the touch and did not initiate CPR.
-Resident #1 was found in bed, extremely cold and rigor (Rigor Mortis is a condition in which muscle stiffness occurs after death) noted throughout her entire body.

Review of the local Law Enforcement Incident Report dated 07/02/23 revealed:
-The date of incident was documented to have occurred between 9:00pm on 07/01/23 and 3:00am on 07/02/23.
-The incident was classified as a sudden/natural death.

Observation of local fire department on 08/01/23 between 4:20pm and 4:30pm revealed the station was located 1584 feet from facility.

Review of Resident #1's Certificate of Death dated 07/02/23 revealed:
-Resident #1's immediate cause of death was dementia.
-Resident #1's manner of death was natural.
-Resident #1's death was not referred to medical examiner.

Review of the facility emergency call bell policy dated 10/01/20 revealed:
-When a resident is unable to understand or use the call button system, this inability will be included in the resident's service plan.
-During each resident check, staff will approach the resident and verbally or visually confirm the resident is well and not in need of assistance.
-If the staff is unable to complete the wellness check, the staff will notify management or supervisor on duty.

Telephone interview with Resident #1's responsible party on 07/21/23 at 12:49pm revealed:
-Resident #1 was admitted to the facility on 06/27/23 due to decreased ambulation and increased Activities of Daily Living (ADL) needs.
Resident #1 required total assistance with all ADL's except for eating.
He was not aware of Resident #1 requiring end-of-life services, such as hospice or palliative care.
-Upon Resident #1's admission, he was informed that SCU staff performed frequent, daily well-being checks with residents for incontinence care, responding to signs of distress and assuring residents remained alive.

-He was planning to utilize the facility's contracted physician, but the process had not been completed prior to Resident #1's death on 07/02/23. -On 07/03/23, he met with the Executive Director (ED) and HDW, who stated Resident #1 had died peacefully in bed between 07/01/23 and 07/02/23 without incident. -He was not aware staff had locked Resident #1 in her room on 07/01/23 until facility care staff informed him of the incident. -On 07/01/23, he visited with Resident #1 and recalled opening her window blinds during the visit. -Staff informed him that wellbeing observations of Resident #1 were completed by looking in her window between 07/01/23 at 9:00pm until 07/02/23 at 1:00am when her door was locked, and they could not enter. -Staff stated they were responsible for conducting a minimum of every 2-hour physical, in-person, wellbeing checks for Resident #1. -He would have expected the facility to call 911 immediately upon identification that Resident #1 was locked in her bedroom and staff were unable to open the door. -Resident #1 did not have an order to withhold resuscitation (DNR). Telephone interview with Resident #1's Primary Care Physician (PCP) on 07/17/23 at 12:42 pm revealed: -She was Resident #1's PCP through 06/27/23 upon Resident #1's discharge to Resident #1's current facility. -Resident #1's diagnoses included dementia, chronic kidney failure, and hypertension. -In June 2023, she determined Resident #1 was not exhibiting signs or symptoms consistent with end-of-life decline. -The resident did not have an order from a physician to not resuscitate (DNR). -She did not know if Resident #1 had obtained a new PCP upon admission to Resident #1's current facility. -Resident #1 required assistance with all ADL's. -Resident #1 was non-ambulatory and incontinent of bladder and bowel. -Resident #1 was unlikely to have physical capacity to utilize the facility's call bell system. -Resident #1 was known to have frequent falls while attempting to transfer from her bed. -She expected staff to perform a wellness check for Resident #1 at least every two-hours to determine if Resident #1 required assistance with any ADL's and was alive. -She expected Resident #1's wellness checks by staff to be performed in-person with physical hands-on observations.		

-If Resident #1 exhibited signs of shortness of breath or other signs of distress, she expected staff to contact 911 immediately. -If Resident #1 was found unresponsive, she expected staff to initiate CPR and contact 911 for further instructions. -She expected staff to immediately contact 911 if they could not gain entry to Resident #1's locked bedroom door. -She was not aware Resident #1 expired sometime between second shift on 07/01/23 or third shift on 07/02/23. Telephone interview with the facility's contracted locksmith representative on 08/02/23 at 2:19pm revealed: -He received a telephone call from the HWD on 07/02/23 at 1:45am requesting a locksmith to conduct an onsite service. -Facility staff stated a sick resident was locked in her bedroom. -A locksmith was dispatched to the facility on 07/02/23 at 2:20am to unlock a residents bedroom door. -He had no additional information related to the locksmith service performed on 07/02/23. Telephone interview with a Personal Care Aide (PCA) on 07/14/23 at 1:35pm revealed: -He was hired on 06/23/23 to work as a PCA in the SCU. -PCA's were expected to perform a wellness check with each resident at least every two-hours. -Wellness checks required staff to ensure the residents were safe, incontinence care was provided when necessary, and residents were not exhibiting signs of distress, and were alive. -If a resident exhibited signs of distress, PCA's were to notify the Medication Aide (MA) immediately. -Resident #1 was newly admitted to the facility on 06/27/23. -Resident #1 required total assistance with ADL's. -Resident #1 was wheelchair and bed bound. -If Resident #1 required assistance, it was unlikely she was physically capable of using the facility's call bell pull cord system. -On 07/01/23, he attempted to perform a wellness check with Resident #1 at 9:00pm and determined she was in her bed with the door locked by looking through her exterior bedroom window outside of the building. -On 07/01/23 between 9:00pm and 07/02/23 at 1:00am, he performed exterior bedroom window observations of Resident #1 lying in bed, but he could not determine if she was in distress or alive. -On 07/01/23 between 9:00pm and 11:00pm window observations of Resident #1's bedroom, he observed the bedroom door key hanging on the back of Resident #1's wheelchair.		

-He knew Resident #1's door was locked from 9:00pm on 07/01/23 until 3:00am on 07/02/23. -The facility did not have any additional keys for staff to use to open Resident #1's bedroom door. -Resident #1's bedroom door handle locked automatically upon closure of the door and required a key to unlock. -On 07/01/23, during second shift, he notified the MA about Resident #1's bedroom being locked and the key missing. -He assumed the MA had notified facility management on 07/01/23 about the missing door key. -On 07/02/23 at 12:56am, he called the MCC for guidance on how to get into Resident #1's bedroom and she instructed him to wait for a locksmith to open Resident #1's door and not attempt to break into Resident #1's bedroom. -Between 07/01/23 and 07/02/23 while Resident #1 was locked in her room, staff did not notify 911. -On 07/02/23 at 2:44am, a locksmith unlocked Resident #1's bedroom door. -On 07/02/23, at 3:00am he performed a wellness check with Resident #1 and determined she was unresponsive, pulseless, cold to the touch with signs of extremities unable to be easily re-positioned. -On 07/02/23, he and the MA determined Resident #1 had expired and notified 911. -On 07/02/23, 911 instructed the MA not to initiate CPR. -On 07/02/23 at 4:45am, the HWD arrived at the facility to assist staff with Resident #1's unexpected death. Interview with a first shift MA on 07/07/23 at 2:00pm revealed: -She was responsible for administering resident's medication and assuring staff completed resident personal care. -The PCAs were responsible to complete a minimum of every two-hour, in-person physical well-being checks on each resident. -The PCAs were expected to reposition residents, provide incontinence care, and observe residents for signs of distress. -The PCAs were required to immediately report any concerns for a resident to the MA. -The MAs were responsible to immediately communicate safety and well-being concerns to the Manager-on-Duty, MCC or HWD, or call 911. -Resident #1 was admitted to the SCU on 06/27/23. -Between 06/27/23 and 07/02/23, she did not know Resident #1's ADL needs but did recall Resident #1 required transfer and ambulation assistance. -Resident #1's bedroom door automatically locked upon closure.		

-Resident #1's bedroom door lock required a master key to unlock. -Management had informed staff that Resident #1's door lock key was different from all other resident bedroom door lock keys on the unit and had its own master key. -Staff had access to one master key which unlocked Resident #1's bedroom door. -Staff were instructed by management to return Resident #1's door lock key to the nurse's station after every use. -She was not aware of any additional master keys available for staff to unlock Resident #1's bedroom door. -She did not work between 07/01/23 and 07/02/23. Telephone interview with a second shift MA on 07/10/23 at 9:17am revealed: -She was employed by a staffing agency as a MA. -She was responsible for ensuring medication administration activities were completed and respond to PCA's needs. -On 07/01/23, she was assigned to work in the facility's SCU from 7:00pm until 7:00am. -On 07/01/23 around 9:00pm she left a message for the HWD related to staff unable to locate the key to open Resident #1's door. -On 07/01/23 at 9:30pm she thought the HWD spoke with a second shift PCA by telephone regarding Resident #1's door lock. -On 07/01/23 between 9:00pm and 2:30am, she was focused on locating the key to open Resident #1's bedroom door and seeking guidance from members of the facility's management team. -On 07/01/23, she did not think of calling 911 to unlock Resident #1's door. -On 07/02/23 at 2:40am, after a locksmith unlocked Resident #1's bedroom door, a PCA found Resident #1 unresponsive and called her for assistance. -On 07/02/23 at 2:45am, she determined Resident #1 was laying laterally in her bed with no signs of injury, pulseless and cool to the touch. -On 07/02/23, after observation of Resident #1's condition, she contacted 911 for assistance and was instructed not to perform CPR. -The HWD arrived at the facility between 4:00am and 5:00am on 07/02/23. Telephone interview with another second shift MA on 07/10/23 at 10:05am revealed: -She worked as a MA and assisted with resident care.		

-On 07/01/23, she worked in the SCU between 3:00pm and 9:30pm. -Resident #1's bedroom door had a door handle which automatically locked upon closure of the door. -Resident #1's bedroom door unlocked with a master key, kept at the nursing station. -The facility only had one master key for staff to utilize for Resident #1's bedroom door. -On 07/01/23, she provided personal care to Resident #1 from bedside between 7:00pm and 7:30pm. -On 07/01/23, after completion of Resident #1's personal care in Resident #1's room, she returned Resident #1's master key to the nursing station and instructed staff to keep Resident #1's door open. -The PCAs were responsible for providing wellness and incontinence checks periodically during each shift, at a minimum of every two hours. -Resident wellness and incontinence checks included ensuring the resident was breathing and not in distress, cleanliness of the resident and bedroom, and provision of incontinences care. Telephone interview with Department of Health Service Regulation Construction Section Supervisor on 07/07/23 at 12:30pm revealed: -The facility's SCU bedroom doors were permitted to have a single action unlocking mechanism to exit. -If the facility utilized a keyed lock for resident bedrooms, staff should have access to the keys to always be able to unlock the door. -If staff were unable to locate keys to access a resident bedroom when a resident was in the room, staff should immediately notify 911. Interview with the Memory Care Coordinator (MCC) on 07/07/23 at 3:05pm revealed: -She was aware Resident #1's bedroom door lock had its own key, which utilized a different key from all other keyed door locks in the facility. -PCAs were expected to perform a minimum of every two-hour wellness check on each resident in the SCU. -Staff that performed wellness checks were expected to ensure residents were not exhibiting signs of pain or in distress, provide incontinence care if necessary, and assure general safety and thriving. -Staff that performed wellness checks were expected to physically evaluate if a resident required incontinence care or exhibited signs of distress. -Resident #1 was admitted on 06/27/23 to the SCU.		

-Resident #1 required total care assistance with ADL's. -On 07/02/23 at 12:59am, she was contacted by Resident #1's assigned PCA and was notified that he could not gain entry to Resident #1's bedroom as the door was closed, locked, and he could not locate the door lock key. -On 07/02/23, she did not instruct Resident #1's PCA or the MA to contact 911. -On 07/02/23, Resident #1's assigned PCA planned to kick down Resident #1's bedroom door, but she instructed him to wait until a locksmith could resolve the issue. -On 07/02/23, Resident #1's assigned PCA notified her that he had observed the resident on 07/01/23 between 9:00pm and 10:00pm by looking through Resident #1's exterior bedroom window and Resident #1 showed signs of movement from the bed because her door was locked, and he could not locate the key. -On 07/02/23 between 1:30am and 1:45am, she notified Resident #1's assigned PCA that a locksmith was enroute. -On 07/01/23 and 07/02/23, she did not communicate with the second shift MA because MAs reported to the HWD. Interview with the Health and Wellness Director (HWD) on 07/07/23 between 11:40am and 1:00pm revealed: -She was responsible for assuring health needs for residents were met. -PCAs were responsible for providing resident care which required a minimum of two-hour wellness checks throughout first and second shifts. -On third shift, she expected PCA's to complete wellness checks at least every four hours. -Wellness checks minimally required staff to observe if a resident required assistance with toileting. -Resident #1 was admitted to the facility's SCU on 06/27/23 from another facility. -She planned to have Resident #1 assessed by the facility's contracted physician on 07/05/23. -Resident #1 required assistance with most ADL's except for feeding assistance and was non-ambulatory. -She did not know if Resident #1 had a DNR on file. -Resident #1's bedroom door locked automatically and required its own separate key to unlock. -Staff were expected to utilize Resident #1's bedroom door key and return it to the SCU nurse's station after each use. -She was not aware if staff had access to any additional keys which would unlock Resident #1's bedroom door. -On 07/02/23 at 1:00am she was notified by the MCC related to Resident #1's bedroom door being locked and staff unable to locate the key to open the door.		

-On 07/02/23, she contacted a locksmith to open Resident #1's bedroom door. -On 07/02/23, she was notified by the SCU MA that Resident #1 was found unresponsive in bed at 3:00am. -On 07/02/23, she arrived at the facility sometime after 4:00am to participate in Resident #1's unexpected death. Additional interview with the HWD on 07/14/23 at 10:30am revealed: -On 07/01/23, she had communicated with the SCU MA between 7:00pm and 9:00pm related to the MA's access to the facility's electronic resident record system. -She was not notified prior to 07/02/23 at 1:00am by facility staff related to Resident #1's missing key to open her bedroom door. -On 07/02/23, upon identification of Resident #1 exhibiting signs of being unresponsive and pulseless, staff immediately contacted 911 and were instructed not to initiate CPR. Interview with the facility Administrator on 07/07/23 between 11:22am and 1:00pm revealed: -Resident #1 was admitted to the SCU on 06/27/23. -Resident #1's SCU bedroom had been an model room which utilized a different door lock mechanism from all other door locks in the facility. -She was aware the facility had two keys which opened Resident #1's bedroom door lock. -On 07/01/23, staff had access to one key to unlock Resident #1's bedroom door, which was kept at the SCU nurse's station, the additional key was not accessible to staff. -On 07/02/23, she was notified by the HWD around 1:00am, related to staff notification about Resident #1's bedroom door being locked without access to a key to unlock the door. -On 07/02/23, she instructed the HWD to contact a locksmith to open Resident #1's door. -On 07/02/23, after Resident #1's door lock incident, she began an internal investigation to determine the timeline of events. -On 07/01/23 at 9:00pm staff identified Resident #1 was in her bed, and staff were locked out of her bedroom. -On 07/01/23 between 9:00pm and 07/02/23 at approximately 2:00am, staff were unable to conduct an in-person, physical assessment of Resident #1 because she was locked in her room. -On 07/01/23 between 9:00pm and 07/02/23, staff had conducted exterior window visual checks of Resident #1 and determined she had remained in her bed during each check. -She expected the HWD and MCC to communicate with staff related to resident care needs and frequency of wellness and incontinence checks.		

The facility failed to ensure Resident #1 remained free from neglect when she was found deceased after staff waited to call EMS while she remained locked in her bedroom because they could not find a key to unlock her room for six hours. This failure constitutes a Type A1 Violation Correction date for this Type A1 Violation shall not exceed September 2, 2023. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/07/23.		

Wickshire Steele Creek

IV. Delivered Via:	Certified mail, email, + Hand Delivery	Date: 8/3/23
DSS Signature:	L. Hy mesta	Return to DSS By: 08/24/23

V. CAR Received by:	Administrator/Designee (print name): Kristain Walker	
	Signature: K. Walker	Date: 8/3/23
	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:		
☐ ***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.*		