Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Harmony at Greensboro
Address: 3420 Whitehurst Rd Greensboro, NC
County: Guilford
License Number: HAL-041-086

II. Date(s) of Visit(s): 9/20/23, 9/29/23, 10/25/23
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 11/17/2023

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 .0902 (b) Rule/Statutory Reference: 10 NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. Level of Non-Compliance: Type A2 Violation Findings: This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure timely primary care physician (PCP) notification for 1 of 5 sampled residents (Resident #1) related to residents indwelling Foley Catheter that was found to be out. The findings are: Review of Resident #1's current FL2 dated for 07/25/23 revealed: -Resident #1's diagnoses included Dementia with behavior disturbance -Resident #1 had an Indwelling Catheter -Recommended level of care was domiciliary -Resident #1 was intermittently disoriented. -Resident #1 was semi-ambulatory. Review of Resident #1's Care Plan dated 08/01/23 revealed: -Resident #1 had a Foley Catheter of the bladder.	☑ POC Accepted _____ *DSS Initials* The following is a summary of the Plan of Correction (POC) for Harmony at Greensboro Assisted Livng. This plan of correction is in regards to the complaint investigation initiated by Guilford County DSS. This POC is not to be construed as an admission of or an agreement with the findings and conclusions in the statement of deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outline specific actions in response to identified issues. We have not provided a detailed response to each allegation, nor have we identified mitigating factors. 10A NCAC 13F .0902 HEALTHCARE (b) The facility shall assure referral and follow up to meet the routine and acute care needs of residents. Education has been provided to the caregivers on OCTOBER 25th, 2023 in regards to cath. education by Ren Care Consulting. The community in addition has increased oversite from a 3rd party nursing clinician to weekly visits	

-Resident #1 had daily incontinence of bowel.
-Resident#1 required extensive assistance with toileting, bathing, dressing and grooming.

Review of Resident #1's HH notes revealed:
-HH RN visit was completed on 08/28/23 from 9:35am-10:16am.
-On 8/28/23, HH made a visit for Resident #1's Foley Catheter; the catheter site was assessed, clear yellow urine was in the bag and insertion site was clean.
-On 8/30/23, HH RN made a visit to Resident #1 at the facility, Resident #1 was with a bowel incontinent episode, incontinent care was provided prior to Foley Catheter insertion. Once the Foley Catheter was placed, Hematuria and blood was noted. The PCP for Resident #1 was notified. Facility staff were educated on catheter bag placement to be below bladder and free of dependent loops.

Review of Resident #1's physician's notes from an appointment on 08/29/23 revealed:
-Resident #1 had an indwelling Foley catheter. This had been in place for several years due to Benign Prostatic Hyperplasia (BPH). Resident #1 accidentally slipped the catheter out during sleep last night on 08/28/23, and his family member had been unsuccessful in getting anyone to replace this at the assisted living facility where Resident #1 resided.

Review of Resident #1's record revealed:
-HH notes were not available for review in the facility on 9/20/23 and 9/29/23.
-There were no Progress notes beyond 08/01/23 available for review.

Review of an email correspondence between facility's ED and HH liaison revealed:
-Email sent by facility ED on 08/29/23 at 6:46pm stated: "Cath was taken out…I am following up…HH nurse was here yesterday-do we know if it is out intentionally? Need to know-Internist was upset today about it…Just following up…".
-HH liaison replied to the ED email stating, "I have reached out to the nurse regarding the catheter".

Review of Resident #1's hospital Emergency Room (ER) report dated 8/30/23 revealed:
-Upon admission to the ER on 8/30/23, Resident #1 presented febrile up to 103 degrees and hypotensive, tachycardia, tachypnea, lactic acidosis, source considered urinary; also found to be bacteremic after workup.
-Resident #1 was diagnosed with severe sepsis, with a Urinary Tract Infection (UTI) with Escherichia coli (E. coli) and an

over a minimum of 8 weeks to aid in compliance and education for caregivers.

Team Members also now participate in a daily communication stand up to assist in providing more timely amd accurate feedback between shifts. INITIATED 11/1/2023 and ongoing lead by the SIC.

antibiotic resistant bacterium that went into his blood stream as the source.
-Resident #1 discharged to residential hospice on 9/8/23 for comfort care.

Interview with Resident #1's family member on 09/29/23 at 12:16pm revealed:
-Resident #1's family member was also a resident of this facility.
-The family member visited Resident #1 for extended periods of time daily.
-She was with Resident #1 on the morning of 08/29/23 and observed Resident #1's did not have his catheter in place.
-Resident #1's catheter was in place when the family member last saw Resident #1 on the afternoon of 8/28/23.
-On the morning of 8/29/23, she immediately notified care staff; whose names she could not recall; that Resident #1's catheter was out and would need to be reinserted.
-She never received a response from any staff regarding a plan to have Resident #1's catheter reinserted.
-The family member was extremely frustrated with the facility's failure to have someone reinsert the catheter.
-She was aware of the urgent need to replace Resident #1's catheter, as the relative was very involved in Resident #1's care, specifically related to his catheter.
-Resident #1's family member attempted to contact the facility's Registered Nurse (RN); however, she was out of the facility during the time from 08/28/23-08/30/23. With the absence of the facility RN; the staff did not do anything or contact anyone for Resident #1's catheter to be immediately reinserted.
-Resident #1's catheter was out sometime around 08/28/23 before being reinserted on 8/30/23.

Interview with a third shift Medication Aide (MA) on 09/29/23 at 5:02pm revealed:
- On Tuesday 08/29/23 at 6:00am, she observed that Resident #1's catheter was out.
-She did not observe the catheter to be out prior to her 6:00 am rounds.
-She observed Resident #1's catheter bag to be hanging on the side of his bed. The MA assumed by the position of the bag, Resident #1 could have gotten his leg caught on the cord, and accidentally pulled the catheter out.
-She notified the first shift Supervisor about Resident #1's catheter coming out on the morning of 8/29/23 at the change of shift around 7:00am.

Interview with a first shift MA/Personal Care Aide (MA/PCA) on 09/29/23 at 5:12pm revealed:

-On 08/29/23, she was scheduled and present to work as the first shift PCA for the secured assisted living unit.
-When she arrived on 08/29/23 around 7:00am, a third shift MA told her about Resident #1's catheter being out; however, because she was not the Supervisor that day, she thought the MA was just sharing information.
-She was unable to recall the MA's name that reported this information to her.
-She did not report this information to anyone else.

Interview with a third shift MA on 09/29/23 at 5:02pm revealed:
-The MA reported when she returned for her third shift assignment on 08/29/23, she observed Resident #1's catheter had not been replaced.
-Resident #1 had not urinated during the time his catheter was out.
-Resident #1's record was incomplete, the company contracted to service his catheter was not documented, and therefore she was unaware of who to contact.
-The MA did not speak with anyone regarding Resident #1's catheter again, until the end of her shift on the morning of 08/30/23.
-At 8:00am on 08/30/23, the MA called the Executive Director (ED) to let her know Resident #1's catheter was out.
-The ED told the MA she was aware and had contacted the Home Health (HH) agency to come reinsert Resident #1's catheter.
-She contacted the ED because she was concerned about the length of time Resident #1's catheter had been out.
-On Wednesday night 08/30/23, during third shift, she learned that HH had made a facility visit to reinsert Resident #1's catheter, but he was later sent out to the emergency room (ER) due to the appearance of blood in the catheter bag.

Interview with the Resident #1's primary care provider (PCP) on 9/29/23 at 9:34am revealed:
-She was the facility's in-house medical provider.
-The PCP received a call from the facility ED after Resident #1 was sent out to the ER on 8/30/23.
-The PCP was told by the facility ED that at some point, Resident #1's catheter came out, and the HH agency had come to reinsert it.
-The ED told the PCP that after HH replaced Resident #1's catheter, the bag filled with blood and had little to no urine output; and therefore Resident #1 was sent out to the ER.
-The PCP told the ED that she was not concerned about blood in Resident #1's bag unless Resident #1 had not had urine to drain in 6-8 hours.

-The ED did not provide the PCP any indication that Resident #1 had failed to have any urine drainage during any period greater than 6 hours.
-It was highly unlikely that Resident #1 would have any urinary incontinent episodes during the timeframe the catheter was out, due to the fact he was prescribed a catheter because of his inability to void adequately.
-If Resident #1's catheter was left out and the bladder was not draining for more than 6-8 hours, this could cause further health problems including a urinary tract infection (UTI), hydronephrosis, acute kidney failure, as well as urosepsis, which was an infection that could lead to Resident #1s death.

Interview with the ED on 09/29/23 at 4:11pm revealed:
-On Monday 08/28/23, Resident #1 had a visit from HH for a catheter change.
-On Tuesday 08/29/23, Resident #1 had a doctor's appointment and the resident's family member was upset at the ED about Resident #1's catheter being out.
- On 08/30/23 around 7:00am, the ED received a phone call from the third shift MA notifying her that on the morning of 8/29/23 she reported to the first shift staff that Resident #1's catheter was out; and that she became aware of this during final rounds on the morning of 08/29/23 about 7:00am.
-She immediately contacted the HH agency liaison for catheter reinsertion.
-The HH agency RN came to the facility around 1:00pm on 08/30/23.
-Resident #1 had the ability to void without a catheter.
-Once the catheter was inserted there was blood and the HH RN asked the ED for a facility policy relative to reporting blood in urine.
-The ED told the HH RN to contact the facility PCP as she was the primary medical provider for Resident #1.
-At the beginning of second shift on 08/30/23, the ED requested that the second shift Supervisor let her know if Resident #1 had voided.
-The ED's specific instructions to the Supervisor regarding monitoring Resident #1's ability to void were to send Resident #1 out to the ER, if Resident #1 had not voided by end of second shift, which would have been at 11:00pm.
-The ED checked on Resident #1 between 6:00pm and 7:00pm on 08/30/23.
-The ED contacted the on-call PCP for Resident #1 on 8/30/23 that Resident #1's catheter bag showed signs of low urine output and blood in the bag.
-The on-call PCP told the ED to send Resident #1 out to the ER.
-The ED contacted Emergency Medical Services (EMS) and Resident #1 was transported to a local hospital.

-After Resident #1 was sent out by EMS on 08/30/23, he was later discharged to a Hospice facility and did not return to the facility and Resident #1 later passed away.

Interview with the facility Registered Nurse (RN) 09/20/23 at 11:52am revealed:
-The RN's primary responsibility as the Healthcare Director was to oversee clinical services in assisted living and secured assisted living.
-There were two residents in the facility with catheters.
-The protocol for MAs and PCAs relative to resident care for individuals with a catheter were to empty the Foley Catheter bag, provide Foley Catheter care, clean the insertion area, and change the bag and tubing.
-Staff were to complete Foley Catheter care at each shift and at bowel incontinence episodes.
-The Catheter bag was to be emptied at each shift or more often as needed.
-As the RN, she was responsible for setting up the HH orders and monitoring/observation of the urine status.
-The HH's responsibilities for residents with catheters consisted of changing the catheter every 30 days and staff education.
-In the event a resident's catheter came out, and she was not in the facility for it to be reported to her; the protocol was for staff to notify the Supervisor or MA in charge, the Supervisor or MA would notify the ED, and the ED would contact the PCP and the HH for reinsertion.

Interview with Resident #1s family member on 10/25/23 revealed:
-She was an RN and had been very involved in Resident #1's catheter care since he had been at the facility.
-She was aware that on 08/29/23, Resident #1 had a doctor's appointment, and at the time of his appointment, his catheter was not inserted.
-She was aware that Resident #1's PCP made a referral for the HH agency contracted with the facility, to reinsert the catheter.
-She recalled on the day of 08/30/23, the HH agency was present at the facility to reinsert Resident #1's catheter.
-She was notified by the facility's ED that the HH agency had been having a difficult time reinserting the catheter, and that they were only getting blood output, and wanted to send Resident #1 out for emergency medical treatment, to which she agreed.
-She was with Resident #1 in the ER and was told by the attending physician that the catheter had been inserted incorrectly, specifically, the catheter bulb was being blown up while it was still in Resident #1's urethra.

-She was also told by the attending physician that Resident #1 was septic, due to a very bad E coli infection, and he therefore remained in the hospital for two weeks receiving antibiotics.

The facility failed to ensure the PCP was notified timely for 1 of 5 sampled residents, related to a delay in reinsertion of Resident #1's Foley Catheter resulting in the resident being sent to the hospital and was diagnosed with sepsis. This failure placed the resident at risk for serious physical harm and neglect which constitutes a Type A2 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/29/23 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 12/18/2023.

IV. Delivered Via:	Hand Delivered	Date: 11/17/2023
DSS Signature:		Return to DSS By: 12/12/2023
V. CAR Received by:	Administrator/Designee (print name): Laura Rumley	
	Signature:	Date: 11/17/23
	Title: Executive Director	
VI. Plan of Correction Submitted by:	Administrator (print name): Laura Rumley (Resubmitted)	
	Signature:	Date: 12-22-23

Resubmitted typed on Report

VII. Agency's Review of Facility's Plan of Correction (POC)

☐ *POC Not Accepted* | By: | Date:

Comments:

☑ *POC Accepted* | By: | Date: 12/22/23

Comments:

VIII. Agency's Follow-Up	By:	Date: 1/24/24
	Facility in Compliance: ☑ Yes ☐ No	Date Sent to ACLS:

Comments:

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*