Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Landings of Smithfield
Address: 200 Kellie Drive, Smithfield
County: Johnston
License Number: 0051-65

II. Date(s) of Visit(s): 4-23-24, 4-24-24, 5-1-24, 5-8-24, 5-29-24,
Purpose of Visit(s): Complaint investigation

Instructions to the Provider ***(please read carefully)***:
Exit/Report Date: 7/08/24

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 13 F .0901 Personal Care and Supervision	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. Type A1 violation	Responses to sited deficiencies does not constitute an admission or agreement by the facility of the truth of alleged or conclusions set forth in this statement of Deficiencies of Corrective Action Report; the plan is solely as a matter of Compliance with state law. Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	08/07/2024
Findings: Based on observations, record reviews and interviews, the facility failed to provide supervision to 1 of 5 residents sampled who resided on the assisted living unit, who exhibited wandering behaviors resulting in the resident eloping from the facility without staff knowledge. The findings are: Review of the missing resident policy dated 09/21 revealed: -Each entry/ exit door was equipped with a mag lock system and keypad. -Codes were managed by the staff and management.		

-Codes were changed periodically for the security of the residents. -A resident was considered missing when he/she failed to be located and whereabouts were not known. -If a resident was deemed missing the staff notified the supervisor and all other staff immediately. -Staff would perform a hasty search of the building and the immediate areas outside the building. -If the resident was not found facility staff notified local law enforcement, residents family/responsible person, County Department of Social Services, Management on call, and Division Vice President of Operations and Divisional Director of Clinical Services. -Once everyone was notified staff will begin to expand their search to the extended outside areas until the resident was located. Review of Resident #1's current FL-2 dated 09/14/23 revealed: -Diagnoses included hypertension, hyperlipidemia, and hypothyroidism. -Resident #1 was intermittently disoriented and was ambulatory. -Resident #1 required assistance with bathing and dressing. -Resident #1's recommended level of care was documented as "other, assisted living facility (ALF)". Review of the Resident #1's care plan dated 09/24/23 revealed: -The resident was receiving either mental health, developmental delayed or substance abuse services. -The resident used a rolling walker for ambulation assistance. -The resident was sometimes disoriented. -The resident was sometime forgetful. Review of Physicians progress notes for Resident #1 dated 04/01/24: -Resident # 1 was a poor historian due to cognitive/ psychiatric impairment. -Resident #1's cognitive decline was associated with her cardiovascular disease. -Resident #1's cognitive state was characterized by derailment of thought and repetition in her phrases. Review of incident report for Resident #1 dated 04/21/24 revealed:	All Mag Lock screamer boxes were examined to ensure that they were on and the breakaway times were in place. All exit doors were examined to ensure that the chime alert was in place and turned on to alert when door was opened. Maintenance Tech and ED will do physical check of all exit doors no less than 3x a week to assure all breakaway ties and exit chimes are in place and in good working order. Inservice was provided to management and staff at the All Staff meeting for Elopement, Missing Resident, Personal Care and Supervision. Resident #1 was assessed and moved to the Special Care locked unit Residents that are assessed as a wandering risk for possible elopement will be admitted to the Special Care locked unit.	08/07/2024 08/07/2024 08/07/2024 04/30/2024 and 07/31/2024 04/25/2024 08/07/2024

-Resident # 1 was noted to be missing during breakfast on 04/21/24. -The resident was transported to the local emergency department at 3:00pm on 04/21/24. -The resident was prescribed a new medication for a urinary tract infection. -The facility increased supervision to every 15 minutes. Review of the emergency services incident report dated 04/2/24 revealed: -Emergency services was called at 2:36pm to a wilderness area behind a neighborhood to assist with a female who had been reported missing. -The primary impression was hypothermia a condition that occurs when core body temperature drops below 95 degrees Fahrenheit). -Patient presented sitting in a fire department all-terrain vehicle with fire department personnel. -Resident #1 was alert, oriented to self and event but not to place or time. -Resident #1's family reported this was the resident's baseline. -The resident had been missing since 3:30am that morning. -Police had been dispatched to do a welfare check on a resident being seen on a business camera at 4:10am. -Resident #1's facility reported the resident was missing around 11:30am. -Resident #1 was found with wet and soiled clothes and her skin was cold to the touch. -Resident #1 had several lacerations and abrasions on her lower extremities with minor swelling and controlled bleeding. -Resident #1 denied any pain. -Resident #1's temperature was taken and the resident was noted to be hypothermic. -Resident # 1 was transported to the emergency room. Review of the hospital discharge summary dated 04/21/24 revealed: -The patient was at her baseline and answered questions appropriately. -The patient had abrasions to her ankle, a skin tear to shin and two skin tears to her right shin and right ankle. -The patient also had a diagnosis of hypothermia. -The resident was discharged back to the facility at 4:38pm.		

Review of the weather for a 5 mile radius of the facility on 4/21/24 revealed: -The temperature at 3:00am was 65 degrees. -The temperature dropped to 62 degrees at 6:00 am, 53 degrees at 9:00am, 50 degrees at 12:00pm and 51 degrees at 3:00pm. -Precipitation started to fall at approximately 8:00am. -Precipitation increased throughout the afternoon. -Precipitation at 12:00pm was .05 of an inch of rain, and 0.4 of an inch of rain at 3:00pm. Observations of the door alarms on 04/21/24 at 1:15pm revealed: -The override switch box was zippy tied closed. -Pulling on the cover of the override box initiated an alarm. -A PCA came to see what the source of the alarm was and cut off alarm. Interview with Resident #1's family on 05/08/24 at 3:30pm revealed: -A PCA called the family at 10:18am and inquired if they had taken Resident #1 out and not signed her out. -Resident #1's family member said she had not, but she would call her other family members. -Resident #1's other family member stated no one had taken Resident #1 out of the facility. -The PCA told the residents family that Resident #1 was last seen at the 2:00am bed check. -The PCA advised Resident #1's family member that they were calling the police. Interview with kitchen staff on 4/21/24 at 4:30pm revealed: -She arrived at 6:45am and started cooking breakfast. -When the residents arrived to eat, staff noticed Resident #1 was not present. -Kitchen staff asked the PCA to go check Resident #1's room. -The PCA returned and noted that Resident #1 was not there. Interview with a PCA on 04/21/24 at 5:05pm revealed: -She clocked in at 11:05pm on 04/20/24. -Second shift signing off reported all residents were okay. -She checked on all residents that needed assistance at; 1:30am, 3:30am and 6:00am. -She was not aware of anyone out of the building at her arrival.		

-She did not know that Resident #1 was not supposed to be out of the building. -She never saw Resident #1 on her rounds. Interview with a second PCA on 04/21/24 at 4:45pm. -She walked through halls around 7:30am. -She assisted another resident getting up and ready for breakfast. -She went to Resident #1's room to see if she was going to breakfast but she was not in there. -She continued with her rounds. -When she arrived at the dining room and realized Resident #1 was not there, she began questioning other staff and then contacted the Resident Care Coordinator (RCC). Interview with a third PCA on 04/21/24 at 4:50pm revealed: -She was informed by kitchen staff that Resident #1 was not there. -She talked with the third shift medication aide and they both started searching for Resident #1. -Resident #1 was not located so they called the RCC. Interview with a MA on 4/21/24 at 4:20pm revealed she was helping with the morning medication pass and she realized resident #1 was not in her room or walking around like she normally did. Interview with the RCC on 04/21/24 on 4:55pm revealed that she was working on the evening of 04/20/24 and she saw Resident #1 last at 10:00pm when she was getting ready for bed. Interview with the Regional Manager (RM) on 04/23/24 at 2:45pm revealed: -She was the Administrator on record on 04/21/24. -She was notified about a missing resident on 04/21/24 at 11:00AM. -She arrived at the facility at 11:45am and began searching for the resident. -A PCA told her that Resident #1 was in bed at the 1:30am bed check. -The PCA explained to her that she had called the family to verify that Resident #1 was not with them. -The police were alerted at 11:35am. Interview with the Regional Vice President (RVP) Operations on 04/23/24 at 3:00pm revealed:		

-The facility had an assisted living side and a memory care unit. -All outside doors to the facility remained locked at all times. -All visitors had to be given access to the facility by a staff person. -Resident #1 was a resident on the assisted living side of the facility. -Kitchen staff noticed the resident was not at breakfast on 04/21/24 and asked about her location. -The PCA on duty checked the resident's room and called the resident's family to make sure she had not gone out with them. -Staff called her at 11:00am to notify her that Resident #1 was not in the facility. -Staff explained that they searched the building. -She instructed staff to search the grounds and notify emergency officials if the resident was not found. -She arrived at the facility around 12:00pm and joined in the search. -Resident #1 was located at approximately 3:00pm in a wooded area behind the facility. -Resident #1 was sent to the emergency room to be examined. -Resident #1 returned to the facility later that evening. -She interviewed staff regarding the elopement and was told the resident opened the override switch box and de-activated the door alarms. -The override switch box should have been prevented resident access but it was not. -The door alarms worked but Resident #1 pushed the button to override the door alarms. Attempted telephone interview with Resident #1's physician on 06/21/24 at 2:10pm was unsuccessful.		
The facility failed to provide supervision to Resident #1 who was intermittently disoriented and sometimes forgetful. Resident #1 deactivated the door alarm and exited the facility without staff knowledge sometime after 10pm on 04/20/24 and was not discovered missing until the dietary staff noticed she did not attend breakfast on 04/21/24. Resident #1 was found in a wilderness area approximately 17 hours after last being seen getting ready for bed. She was transported to the hospital and diagnosed with hypothermia and treated for abrasions to her ankle and skin tears to her shins. This failure resulted in neglect and constitutes a Type A1 Violation.		

The facility provided a plan of protection in accordance with G.S 131-D on 04/22/24. The correction date for this Type A1 violation shall not exceed 08/07/24.		
Rule/Statute Number:	☐ POC Accepted *DSS Initials*	
Rule/Statutory Reference: Type A2 violation		
Rule/Statute Number:		

Facility Name:

Rule/Statute Number:		—

IV. Delivered Via:	Hand	Date: 7-16-24
DSS Signature:	Devra J Hewett	Return to DSS By: 07-24

V. CAR Received by:	Administrator/Designee (print name): Shanel Ely	
	Signature: Shanel Ely	Date: 7/18/24
	Title: Program 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:		

Facility Name:

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