Adult Care Home Corrective Action Report (CAR)

I. Facility Name: TerraBella Fuquay-Varina
Address: 6516 Johnson Pond Road, Fuquay-Varina, NC 27526
County: Wake
License Number: HAL-092-219

II. Date(s) of Visit(s): 07/23/25; 08/05/25; 08/27/25; 09/18/25
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 09/18/25

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(b)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: Personal Care and Supervision Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.		
Level of Non-Compliance: Type A1 Violation		
Findings: Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs and facility policy and procedure for 1 of 5 sampled residents (#4) who had a diagnosis of Alzheimer's Disease and eloped from the facility without staff knowledge.		

The findings are: Review of the facility's policy on Community Rounds dated 10/09/24 revealed: -"Resident whereabouts will be monitored to minimize the potential for elopement from the Memory Care Community while allowing for resident independence and dignity." -Memory Care staff will ensure resident safety with awareness of where (the location) their assigned residents are throughout the day. -A systemic approach for resident monitoring will be provided with routine staff rounds. -Community rounds will be made per staff assignments. -Shift overlap time or "change of shift" time will include an additional accounting of all residents. -The Memory Care Director or designee will assign appropriate staff for rounds. -All residents will be physically visited to account for their whereabouts. -Any unsafe conditions will be corrected immediately and reported to the supervisor. -Any unusual situations will be brought to the supervisor's attention. -Any resident wandering aimlessly will be redirected toward the ongoing activity program or monitored closely if the resident prefers to wander or walk about. -Any resident appearing not engaged and isolated will be encouraged and redirected to participate in the ongoing activity program. -Any resident unaccounted for will be reported to the supervisor immediately. -If a resident is missing or unaccounted for, the Missing Person Elopement policy and procedures will be enacted immediately. Review of the facility's Missing Person Elopement policy dated 04/01/25 revealed: -"Memory Care Community staff will urgently and systematically respond with emergency procedures when any resident is suspected to be or identified as missing." -The Memory Care Director or designee will develop and maintain a current list of all dementia residents identified as wandering risks. -Staff will be routinely alerted as to individual residents who have been identified to be at risk via Service Plan. -Routine rounds will be made by staff to account for resident whereabouts. -Emergency supplies will include search lights, first aid kits, walkie talkies and radios to accommodate outside searches.		

-Elopement drills should be conducted in the Memory Care Community monthly by shift and may be documented on the Elopement Drill Record or electronically. Review of the facility's Elopement Drill Records on 08/29/25 at 12:33pm revealed elopement drills were completed on: *04/07/25 (1st shift) *05/03/25 (1st shift) *06/21/25 (3rd shift) *07/31/25 (2nd shift) Observation of the facility's Memory Care Unit (MCU) on 07/23/25 at 1:00pm revealed: -The unit had two exits leading to the outside, both equipped with egress systems that were locked when pushed. -There was a third exit that led to a fenced, outside courtyard; the courtyard had one exit leading to the parking lot; the exit door of the fence was securely locked. -There was an exit door that led to the Assisted Living (AL) hallway. This door was secured with a keypad that required a code to exit. -When the exit door to the AL hallway was opened, it took approximately ten seconds for the door to securely close. Review of Resident #4's current FL2 dated 04/04/25 revealed: -Diagnoses included: Alzheimer's Disease and Bladder Atony. -The recommended level of care was the Memory Care unit. -He was intermittently disoriented and identified as a wanderer. -He received Hospice services. Review of Resident #4's Resident Register revealed: -The resident's date of admission was 07/07/23. -He was admitted from his own residence. -Memory was described as a significant loss and must be directed. Review of Resident #4's Care Plan dated 04/06/25 revealed: -The resident required regular prompting due to confusion and disorientation. -He did not wander. -He liked to walk the halls in memory care from his room to the common area to sit. -He did not exhibit behavioral issues. -The resident was able to communicate needs to staff. -He required physical assistance to manage colostomy, catheter, and bedside commode. -The resident was independent in mobility.		

Review of Resident #4's Physician's Orders dated 03/05/2025 revealed: -Diagnoses included Alzheimer's Disease and Bladder Atony. -Instructions were to empty catheter every 3 hours and re-plug. Review of Resident #4's most recent Licensed Health Professional Support (LHPS) evaluation dated 07/11/25 revealed: -The date of the last evaluation was 04/15/25. -The Primary Diagnosis was Alzheimer's. -Personal care tasks included: Positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter, and PRN suppositories. -The catheter was an Indwelling Foley Leg Bag. Review of Resident #4's Accident/ Incident report dated 07/22/25 revealed: -The date of the Accident/ Incident was 07/21/25. -Resident #4 was not accounted for in the community. -A jogger nearby contacted the community to inquire about a man in the street (time not documented). -The staff conducted a head count and noticed the resident was missing. -Staff immediately began to search the community and property for the resident. -The Executive Director (ED) was notified (time not documented). -The police were contacted to report a missing resident (time not documented). -The resident's family members were contacted at 11:37pm on 07/21/25. -The hospice doctor was notified at 3:53am on 07/22/25. -Upon return to the facility, the resident did not appear to be harmed; a skin audit was completed. -He was noted to have two scratches on the left side of his head. Review of the Local Police Department (LPD) Incident/ Investigation Report revealed: -Prior to being reported missing, Resident #4 was last seen by police walking westbound on a residential street around 9:50pm. -Police approached him and he appeared to be "fine" and walked "normally for someone his age." -When asked where he was going, he stated he was going home.		

-Police asked several additional questions which he ignored; he did not violate any state laws or ordinances and was allowed to continue walking. -The incident was reported to police on 07/21/25 at 11:23pm (reporter unknown); Resident #4 was reported as last seen at the facility on 07/21/25 at 9:30pm. -He walked away from the facility on foot. -Based on the description of the missing person, police returned to the area where the resident was last seen and began a search. -Resident #4 was entered into the missing person database. -At approximately 2:45am, police began scanning the neighborhood on foot using the Forward-Looking Infrared (FLIR) optic. -The FLIR optic is technology that uses thermal cameras to create images based on the heat emitted by objects, allowing for real-time, two-dimensional viewing even in darkness or through smoke. -Police walked to the dead end of the street and began scanning the backyard of the house located there. -A heat signal on the FLIR optic was viewed across the pond area. -Police walked toward the signal to clarify what they saw. It was a dock. -Police proceeded beyond the dock towards the pond and found Resident #4 around some bushes, lying in the grass. -Police approached him and asked if he was okay to which he responded, "I am fine." -Family and staff at the facility were notified he was found. -He was evaluated by Emergency Medical Services (EMS) and transported back to the facility. Review of Resident #4's EMS Patient Care Record dated 07/22/25 revealed: -The call was received on 07/22/25 at 03:32am at the request of Law Enforcement and EMS arrived on scene at 3:46am. -The assessment was completed on 07/22/25 at 4:24am. -The chief complaint was noted as "eloped from nursing home." -Secondary complaint was noted as "injury to head." -The resident was found in custody of LPD. -The resident was conscious, breathing, alert and oriented with warm, dry skin and a strong radial pulse. -LPD reported the resident eloped from a Memory Care Unit approximately six hours prior and was found near a pond. -The resident's Power of Attorney (POA) was contacted and refused transport over the phone indicating that transport by ambulance to Emergency Department (ED) was unnecessary		

and wanted the resident transported back to the facility to be assessed by hospice. Interview with a neighborhood driver on 08/06/25 at 12:06pm revealed: -He was driving at approximately 9:30pm on 07/21/25 when he noticed a man walking in the right-hand lane of the street headed toward a 4-way stop sign. -The driver first noticed Resident #4 after he was "well past" the facility and within 100ft of the four-way stop sign. -There was no sidewalk. -The resident caught his attention because "you do not normally see that; especially not that late at night." -There was a jogger on the opposite side of the street waving his flashlight toward Resident #4 so cars passing by "could see him and not run over him." -The driver stopped and talked with the jogger and discovered they shared the same concerns about the resident; The jogger had already called the police. -Several police talked with the resident. -The police did not notice anything out of the ordinary and allowed the resident to continue to walk down the road. -The resident was wearing dark clothes: black/ dark grey jacket; he did not notice if he had on shoes. -The resident appeared his age and walked "normal for an older guy his age." -He did not appear to be harmed. -The driver called the facility after speaking with the jogger and police to ensure all residents were accounted for. -He gave facility staff a description of the resident and facility staff stated they would make rounds and would call back if needed. -The driver made the first call to the facility at 10:03pm. -The facility returned the call to the driver at 11:33pm and confirmed a resident was missing and based on the driver's description it was a resident of the facility. -The driver never talked with the resident. Review of Apple Map search completed on 08/05/25 at 1:47pm revealed: -The distance from the facility where Resident #4 resided and where he was found was 1.3 miles. -To drive the route took 5 minutes and to walk took 26 minutes. -The terrain was described as having a "moderate hill." Review of ChatGPT for area weather information for 07/21/25 through 07/22/25 revealed :		

-The high and low temperatures for 07/21/25 were 89°Farenheight (F) and 72°F; 07/22/25 were 93°F and 71°F -Hourly temperatures for 07/21/25 starting at 9:30pm through 07/22/25 ending at 4:30am ranged from approximately 74°F to 71°F. -Area observations showed thunderstorms/ light rain on 07/21/25 and light rain on 07/22/25; times were not provided. -The sun set at 8:26pm on 07/21/25 and rose on 07/22/25 at 6:14am. Observation of the route from the facility to the address in which Resident #4 was found revealed: -He walked east across the parking lot on to the nearby street -Traveling south on the road where the facility was located there were no streetlights and no sidewalks -He walked approximately .2 miles to a four-way stop sign intersection and then went west down a private residential neighborhood street. -The street did not have lights or a sidewalk. -The speed limit was 35 miles per hour. -The street was approximately .9 miles in distance with the last 700 feet (ft) of the road roughly paved and uneven and the last 250ft was all gravel and unpaved. -The home where the resident was found had a dock attached to the home and was adjacent to a pond. -The dock did not have any railing. -The distance from the dock to the pond was approximately 100ft. Telephone interview with a staff member on 08/13/25 at 12:00pm revealed: -She mainly worked on Assisted Living (AL) halls but was "very aware" of Resident #4. -On 07/21/25, a man called the facility, and a jogger came to the facility and described someone who he thought could be a resident. -A headcount on AL was completed and the medication aide (MA) on the MCU said she also completed a headcount. -About 10-15minutes later, the MA came to staff and said Resident #4 was missing. -Staff immediately began looking in every room, closet and bathroom. -Staff notified the ED and Memory Care Coordinator (MCC). -Resident #4 was known to "linger" around the door "wiggling and pushing trying to get out." Telephone interview with another staff on 08/13/25 at 12:12pm revealed:		

-On 07/21/25, she worked on AL halls, when a man called the facility to see if any residents were missing. -A man also came to the facility to see if any residents were missing. -A headcount on AL was immediately started and the Memory Care Unit (MCU) was asked to also do a headcount. -The MA called to AL and said all residents were accounted for. -"About 9:00pm or 10:00pm," the MA came to AL and said Resident #4 was missing. -The ED was called and AL and MCU staff began looking for the resident throughout the building and outside surrounding the building. -She was familiar with Resident #4, "he was always at that door saying he's going home." -Headcounts were completed every hour and room checks every two hours. Telephone interview with a third staff on 08/14/25 at 9:05am revealed: -Rounds were completed every two hours in the MCU. -Resident #4 was known to stand by the door and push on it to exit. -Staff were instructed to redirect Resident #4 from the door but he would still go back and stand by the door. -At 7:45pm on 07/21/25, rounds were completed, and all residents, including resident #4, were accounted for. -At 8:15pm she went on break; Resident #4 was standing at the door, leading to AL, pushing on it to get out. -She went around to the "other" door and left out of the MCU. -The "other" door was connected to the AL dining room and did not lead to an outside exit. -She returned from break at 8:45pm and Resident #4 was still at the door leading to AL pushing to get out; this was the last time she saw Resident #4. -Upon her return from break, she and another staff went to assist another resident leaving the MA at the front desk by the door. -She was unsure how Resident #4 eloped from the facility. -There were two PCAs and one MA working 2nd shift on MCU the night of 07/21/25. -Whenever the MCU door opened, which exited to the AL hallway, it activated the alarm and would not stop until the door closed. -A man called the MA around 9:00pm asking if a resident was missing and she said, "no as if she had counted the residents." -Rounds were completed again at 9:45pm and Resident #4 was not seen.		

-On 07/22/25, she stayed at work until 4:30am and saw Resident #4 upon his return to the community. -Resident #4 was smiling when he returned to the community but appeared as if he had been sleeping. -Resident #4 had two scratches on his head, and his catheter was full and needed to be emptied. **Attempted telephone interview on 08/12/25 with another MA and PCA that worked on the MCU, 2nd shift on 07/21/25 was unsuccessful. Confidential Interview with a fourth staff on 07/23/25 at 1:25pm revealed: -She often worked on the MCU since March 2025 and was very familiar with Resident #4. -She always worked 1st shift and stated Resident #4 "tries to get out the doors all the time." -She completed head counts twice every day, but it was not a requirement prior to the elopement. Telephone interview with a Hospice Triage Nurse on 08/12/25 at 5:10pm revealed: -Resident #4 had a Suprapubic Catheter. -The catheter was inserted through a small incision in the abdomen into the bladder to drain urine. -The tubing of the catheter was strapped with Velcro to the resident's leg to keep it in place. -Care must be taken when repositioning to ensure the tube was not dislodged. -Walking a long distance could cause a problem because the tube must remain inserted and able to drain. -The order was to empty the catheter bag when full; every four weeks the bag must be changed to prevent infection -The bag was checked each routine visit. -The bag would have to be full and overflowing for urine to backflow and cause a problem. -There were not issues noted with Resident #4's catheter when assessed on 07/22/25. Telephone interview with Hospice Nurse on 08/12/25 at 5:21pm revealed: -Resident #4 was examined before lunch on 07/22/25. -He had two abrasions on the left, temporal area of his head. -The abrasions were "more like carpet burns" and there was no bleeding and no open skin. -Vital signs were "fine," and the resident was not in pain. -There was an order to empty the catheter bag twice per shift; bag was to be changed as needed.		

-The suprapubic catheter bag held 500ml of urine; documentation of urine output was not required. -Resident #4 "eats and drinks well. His bag could be full in approximately 5 hours." -If the bag became full and was not emptied, urine from the bladder could not drain and would back up and increase the risk of infection. - A full and heavy bag could pull the catheter out. -The catheter area of Resident #4 was checked on 07/22/25 and "it was fine." There was no redness, the catheter was in place and urine was in the bag still properly draining. -Resident #4 was noted as alert and wasn't lethargic or tired. "If they didn't say anything, I would not have known anything happened." -She had worked with Resident #4 since entering hospice almost a year ago. -She has seen Resident #4 pressing on all doors trying to get out and, "they know he does that." -"He's pretty easily redirected." -She was told by staff Resident #4 had been telling them all day he was going to get out. -She spoke with the Resident #4's POA who stated the facility tried contacting her, but she was asleep. -He was placed in a facility from his home because he would wander away. Interview with the Memory Care Director (MCD) on 08/27/25 at 1:31pm revealed: -She first received a message about the elopement in the facility group chat at 11:34pm which read, "On the way" then received a call from the Executive Director (ED) at 12:50am on 07/22/25. -She arrived at the facility at 1:20am and the ED was taking reports from the 2nd shift staff. -The MCD, ED, Resident Care Director (RCD) and other staff immediately joined in the search in neighborhoods surrounding the facility. -At approximately 4:00am, a call was received stating Resident #4 was found and staff returned to the facility. -Resident #4's POA refused transport to the hospital and EMS returned the resident to the facility. -At 4:26am, the MA on duty took vitals and did a body assessment on Resident #4. -The MCD observed Resident #4 had a "scrape" on the left side of his head. -She did not observe the catheter. -Resident #4 acted like nothing was wrong and "he seemed to be fine."		

-Resident #4 was "always exit-seeking, standing at the door pushing trying to get it open;" "We verbally redirect him." -Staff should keep an eye on those residents that were exit-seekers; Resident #4 "is the main one you have to redirect because he really tries to get out." -Headcounts were done at shift change, after lunch and after dinner. -Rounds were done every two hours and were completed more often during the day because residents were active. -In-service trainings were done every 30 days and staff were reminded of when rounds and headcounts needed to be done. -In-service trainings were completed by the Health and Wellness Director (HWD) and the RCD. -Exit-Seekers were identified when assessed and the information was entered into the Care Plan and the Individual Service Plan (ISP) notebook. -The Care Plan and the ISP notebook were updated based on observation of behaviors. -The HWD was responsible for updating Care Plans. Interview with HWD on 08/27/25 at 2:20pm revealed: -Resident #4 was present for dinner at approximately 4:30-5:00pm. -A headcount was done at approximately 9:00pm - 9:30pm. -MCU staff were trained to lay eyes on residents every hour. -Rounds were completed every two hours. -During rounds, staff were checking to see if residents needed anything and they were not in someone else's room. -MCU staff had directions from the ED to notify via text when Resident #4's catheter had been checked and emptied. -Resident #4 was known to stand at the doors. -Staff would often take him on walks for redirection. -Resident behaviors were communicated in the Individual Service Plan (ISP) notebook and during Huddle meetings at shift change. -If there was a new behavior observed, staff would tell the MCD who should communicate to the HWD or staff would tell the HWD. -She was responsible for updating care plans. -Care plans were completed for MCU residents quarterly or when there was a change in behaviors. -She was not at the facility at the time of Resident #4's elopement. -There was a missed call at 10:49pm from the MA in the MCU; the ED called at 11:09pm. -She arrived at the facility around midnight and immediately went to the MCU and completed a room-to-room search. -AL staff simultaneously completed a room-to-room search.		

-Staff were instructed to open closets and doors; some staff searched outside. -She got in her car and began driving the surrounding neighborhoods. -There were no streetlights, and the car had to be directed to use the headlights to see in residential yards because it was so dark. -Staff continued to check-in and regroup to figure out which way to go. Interview with Resident #4's POA on 08/28/25 at 9:57am revealed: -She was asleep both times the facility called; the last call was received at 11:58pm on 07/21/25; she was unsure of the time for the first call. -She first learned about the elopement from a police officer that came to her home around 3:00am on 07/22/25. -The next call came from EMS around 2 hours later (approximately 4:45am - 4:50am) telling her the resident had been found, he had a few scratches on his head, looked like he fell but his vitals where "ok." -She told EMS, "If he is ok take him back to the facility;" "I am sure they are concerned." -She did not get any additional information until she called the facility at 8:00am on 07/22/25 and spoke with the MCD. -The MCD said the resident was fine and he did not have any injuries because of the elopement. -She did not know what happened or how it happened and thought it was "strange." -The ED called and explained everything and "ensured me measures have been put into place, so this does not happen again." -The resident had suffered from dementia since 2020. -"I was on duty 24 hours a day and would have a neighbor watch him while I would shower because you could not take your eyes off him." -"I told the facility he was aggressive and an elopement risk." -"I was told he would definitely be in memory care for approximately two weeks until an assessment could be completed but he has always been in memory care." -The resident was always trying to get out of the facility "from the beginning"; "he's always at the door, always trying to open the doors." Interview with the ED on 07/23/25 at 11:50am revealed: -Between 10:10pm and 10:56pm, staff were searching for Resident #4 without her knowledge.		

-She received a call at 10:56pm on 07/21/25 from a MA and was told Resident #4 was missing and all areas within the facility were checked; some staff had already started an outside search. -A MA stated she discovered the resident missing at approximately 10:03pm -10:10pm when a nearby jogger in the community called the facility. .-Headcounts in AL and the MCU were completed using a current census. -Headcounts were completed at the beginning and end of every shift. -Resident #4 was checked more frequently due to him having a catheter bag. -A text was sent to her at 10:03pm on 07/21/25 from a MA on the MCU stating Resident #4's catheter was checked. -She arrived at the facility at 11:40pm and split staff into groups to continue the search within the building for Resident #4; She and other administrative staff searched outside the facility and surrounding area. -She notified police that Resident #4 was missing at 11:33pm. -Resident #4's POA was called at 11:37pm; the resident's son was called at 1:53am after several unanswered calls to Resident #4's POA. -On 07/22/25 at 3:43am, local police informed her Resident #4 was found in the backyard of a private residence. -She returned to the facility at 3:49am and called Resident #4's POA to inform her the resident was found. **Attempted telephone interview on 08/13/25 at 11:57am to the local police department to clarify information was unsuccessful. The facility failed to ensure 1 of 5 sampled residents (#4), with a diagnosis of Alzheimer's Disease, was properly supervised according to the resident's assessed needs and he walked away from the facility without staff knowledge and was discovered by neighbors who alerted the facility. The resident had walked 1.3 miles from the facility and was found more than five hours later by law enforcement. He was located on a dock with no railing adjacent to a private residence overlooking a pond with an average depth of four feet. This failure of the facility resulted in serious neglect of the resident and constitutes a Type A1 violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 for this violation on 07/23/25.		

Facility Name:

THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED 10/18/25.		

IV. Delivered Via:	Hand Delivery	Date: 9/18/25
DSS Signature:	Vanya Reynolds	Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name): Melissa Holloman	
	Signature:	Date: 9/18/25
	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:		
☐ ***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.*			