Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Brookdale South Park
Address: 5326 Park Road, Charlotte, NC 28209
County: Mecklenburg
License Number: HAL-060-085

II. Date(s) of Visit(s): 05/30/25 and 06/24/25
Purpose of Visit(s): Monitoring
Exit/Report Date: 07/24/25

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) Personal Care and Supervision	☐ POC Accepted _____ *DSS Initials*	____
Rule/Statutory Reference: (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 A1 Violation		
Findings: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for 1 of 5 sampled residents (Resident #1) who eloped from the Special Care Unit (SCU) without staff's knowledge. Review of the facility's Missing Resident Policy dated April 1997 and revised March 2025 revealed: -An elopement was defined as any incident where a resident left the secured memory care area of the community or the secured courtyard, unescorted, with or without injury.		

-If associates discovered a resident's whereabouts were unknown, associates were supposed to immediately begin to follow the procedures of the Missing Resident Policy. -Staff were supposed to conduct a thorough interior and exterior search of community and immediate grounds. -The supervisor on duty was supposed to call the police and contact the Executive Director (ED) or designee. -The ED or designee was supposed to contact the resident's family or responsible party. Review of Resident #1's FL2 dated 04/04/25 revealed: -Diagnoses included unspecified dementia of unspecified severity with agitation. -Resident #1 was ambulatory, constantly disoriented, and continent of bowel and bladder. Review of Resident #1's Resident Register revealed that she was admitted to the facility on 04/07/25. Review of Resident #1's Pre-admission Assessment dated 04/09/25 revealed: -She was able to ambulate independently. -She was able to transfer independently. -She required set-up and supervision with Activities of Daily Living (ADLs). -Her behaviors included difficulty with orientation to person, place, and time. -She demonstrated anxious, compulsive, disruptive or obsessive behavior requiring additional staff attention. -A goal was to manage her behaviors with staff assistance. -Interventions included using a positive approach with a calm and gentle voice to direct or redirect her. Review of Resident #1's Care Plan dated 05/08/25 revealed: -She was able to ambulate independently. -She was able to transfer independently. -She required set-up and supervision with Activities of Daily Living (ADLs). -Her behaviors included difficulty with orientation to person, place, and time. -She demonstrated anxious, compulsive, disruptive or obsessive behavior requiring additional staff attention. -A goal was to manage her behaviors with staff assistance. -Interventions included using validation and responding to her "emotions behind anxious behavior, (e.g. looking for mother may mean they need comfort, security, and a sense of belonging)."		

Review of Resident #1's SCU profile dated 04/09/25 revealed: -Her behavior patterns included anxious, disruptive, or obsessive behaviors that required additional attention. -She required set-up of supplies and safety devices as needed. -She demonstrated reluctance to accept medication assistance. -Interventions included to use a "positive physical approach (e.g. go slow, make eye contact, and get down low)". Review of Resident #1's SCU profile dated 05/08/25 revealed: -Her behavior patterns included anxious, disruptive, or obsessive behaviors that required additional attention. -She required set-up of supplies and safety devices as needed. -She demonstrated reluctance to accept medication assistance. -Interventions included to use a "positive physical approach (e.g. go slow, make eye contact, and get down low)". Review of Resident #1's incident report dated 05/28/25 revealed: -She was exit-seeking after she returned from the hospital, which was shortly before she eloped on 05/28/25. -She was found on the property, but outside the secured building. -She fell in the grass and had no apparent injuries. -There was documentation she may have exited the facility behind an employee who did not notice her presence. Review of Resident #1's progress notes dated 05/28/25 at 3:20pm revealed: -She returned to the facility via hospital transport following a hospitalization. -She was very agitated. -She did not want to return to the facility and wanted to go home. -She would not get up from the transport chair and attempted to hit the transport driver. -It took several attempts for her to get up from the transport chair. -She began walking around the facility. Review of Resident #1's progress notes dated 05/28/25 at 5:35pm revealed: -When Resident #1 returned from the hospital, she was upset that she was not taken to her home. -Between 4:00pm and 4:20pm, she was located outside the facility. -She was found on the premises near the main road in front of the facility. -She fell and was sitting on her buttocks with no injuries noted.		

-She was assisted to standing and ambulated independently. -Staff redirected her back into the facility. -Staff were unable to determine how she exited the facility. -It was believed she exited through a kitchen door that was used by staff. -Her Guardian of Person (GOP) was looking for her when she eloped. -Her Primary Care Physician (PCP) was notified. Observation of the SCU on 05/30/25 at 9:49am revealed: -There was an unalarmed service entry/exit door that had a key-code lock. -The door did not always completely close if it was not physically pulled shut. -The door led to the fire alarm control panel, electrical panel, furnace room, kitchen entry door, utility room door, and facility entry/exit door. -To the left, past the control panels and kitchen entry, was the facility entry/exit door. -The facility exit/entry door was not alarmed or locked from the inside. -The facility exit/entry door locked from the outside when pulled shut. -The facility exit/entry door was ajar to the outside of the facility. Observation on 06/17/25 at 9:38am of Resident #1's exit route between the facility exit and where Resident #1 was located by facility staff revealed: -The approximate distance from the facility and where Resident #1 was found was 449 feet. -There was a sidewalk in front of the facility extending from the exit door across the length of the facility. -From the sidewalk extending the front length of the facility, there was a grassy section that led to a grassy slope below the sidewalk that lined a 5-lane road. -The posted speed limit was 35mph on the 5-lane road. Review of a 911 report dated 05/28/25 revealed: -Law enforcement was dispatched on 05/28/25 at 5:26pm to the facility address. -The call was closed on 05/28/25 at 5:31pm. -Another law enforcement officer was driving by when he observed Resident #1 on the grass off the sidewalk struggling to get up. -She told the officer she was going home, but she was unsure where home was.		

-Staff from the facility arrived and explained who Resident #1 was. -Emergency Medical Services (EMS) and the fire department arrived because she fell in the grass. Review of Resident #1's EMS report dated 05/28/25 at 5:31pm revealed: -EMS was dispatched by law enforcement at 5:31pm to the parking lot of the facility for a female who fell. -Upon arrival, Resident #1 was in the care of facility staff. -Facility staff were actively trying to coax Resident #1 back into the facility with EMS assistance. -Facility staff did not intend for Resident #1 to be transported to the hospital. -EMS did not obtain any resident demographics. Telephone interview with Resident #1's Responsible Person (RP) on 06/13/25 at 2:03pm revealed: -She received a call from the facility on 05/28/25 at about 3:00pm when Resident #1 returned from a hospital stay in an agitated state. -When she arrived at the facility, Resident #1 was not in her room. -She and the Health and Wellness Director (HWD) looked for Resident #1. -When she was not located, the HWD initiated elopement procedures. -The concierge reported she received a telephone call from a passerby about a potential resident being outside. -She went outside with the HWD. -A law enforcement officer, who observed Resident #1 on the grassy slope near the sidewalk of the 5-lane road, had stopped to investigate. -Resident #1 had fallen and was sitting on the grassy slope. -Facility staff were able to redirect Resident #1 back into the facility. -EMS responded to the incident, but Resident #1 was not transported to the hospital. -She stayed at the facility for about an hour to complete a wellness check. Telephone interview with a Medication Aide (MA) on 06/25/25 at 11:32am revealed: -She became aware Resident #1 eloped when the elopement procedure was initiated on 05/28/25. -When she went outside to look for Resident #1, several other staff were also outside looking for her.		

-A law enforcement officer who was driving by stopped to check on Resident #1. -The officer got out of his truck to talk to Resident #1. -Resident #1 was on the grassy slope trying to scoot up the slope on her buttocks. -Resident #1's Responsible Person, the HWD, and another MA attempted to redirect her back into the facility. -Staff assisted her onto her feet and began walking on the sidewalk along the 5-lane road toward the facility. -Resident #1 was agitated and did not want to go back to the facility. -A MA was able to redirect her back to the facility. Interview with a second MA on 6/25/25 at 1:08pm revealed: -Resident #1 came back from the hospital at 3:20pm upset because she did not want to be there. -Resident #1 walked around the SCU and the secured patio from the time she arrived back from the hospital. -She heard that staff were looking for Resident #1 on the walkie-talkie at 5:50pm. -Staff were unable to find her. -The concierge reported that someone called to report a woman was seen on the slope at the sidewalk of the 5-lane road in front of the facility. -When she went outside, a law enforcement officer was talking to Resident #1. -Multiple staff went outside to get her. -She was able to redirect Resident #1 back into the facility. -EMS was onsite and tried to talk to her, but she was not transported. Interview with Resident #1's Nurse Practitioner (NP) on 06/24/25 at 9:41am revealed: -Facility staff informed her that Resident #1 eloped from the facility on 05/28/25. -Resident #1 wanted to leave the facility since she was admitted. -Resident #1 carried her purse and would say she was leaving. -She completed a body check and consulted with Resident #1. -Resident #1 was not injured from falling outside. -Resident #1 had multiple hospital admissions for chronic medical conditions since she was admitted to the facility and would become agitated and exit seeing after each return from the hospital. -Resident #1 was unable to adjust to her new home. Interview with the HWD on 05/30/25 at 10:46am revealed:		

-Resident #1 returned from a hospital stay on 05/28/25 at 3:20pm. -Resident #1 was very restless and wanted to walk. -Resident #1 was seen through the doorways walking restlessly back and forth in the secured courtyard. -Staff were trying to bring Resident #1 inside since her Responsible Person was expected to come for a post-hospitalization visit. -When the responsible person arrived, staff were unable to locate Resident #1. -Resident #1 was not in the courtyard, and all of the courtyard gates were secured. -Facility doors leading to the courtyard were left unlocked for residents to have access to the secured courtyard. -She initiated elopement procedures. -A facility staff member reported that a passerby called to report that a female was scooting on her buttocks on the hill beside the facility property. -Multiple facility staff and Resident #1's Responsible Person went outside to find Resident #1 on the slope scooting toward the sidewalk that lined the 5-lane road in front of the facility. -A law enforcement officer had also arrived. -Resident #1 was very agitated. -A MA was able redirect Resident #1 back into the facility where she continued to walk and check doors until she was tired. -EMS was onsite, but did not transport Resident #1. -Resident #1 was hospitalized several times for chronic medical complications and was always agitated and exit seeking when she returned from the hospital. -After Resident #1 settled down for the evening, she checked all egresses in the facility. -She noted that the unalarmed service entry/exit door with a new key-code lock did not latch unless it was physically pulled or pushed shut. Interview with the Administrator on 05/30/25 at 9:49am revealed: -He was briefly out of the facility when Resident #1 eloped. -Resident #1 was back in the facility when he returned. -Staff were looking for Resident #1 before she was found. -Resident #1 was found on a grassy hill on the property where she had fallen. -Resident #1 was on the edge of the facility property line, and she was not hurt. -Resident #1 had just returned from the hospital and said, "this is not my home."		

-He believed Resident #1 exited the facility by following a staff member through the service door. -A new keypad was recently installed on the service door through the control panel room. -The service door leads to the facility egress, which was not locked from the inside. --- The facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) who had a history of exit seeking behaviors, resulting in her eloping from the Special Care Unit without staff knowledge when a service door was left unalarmed and would not close completely unless the handle was physically pulled to. Staff were unaware Resident #1 eloped and was observed by a passerby to be sitting on a grassy slope near the 5-lane highway that ran parallel to the facility. This failure resulted in serious neglect which constitutes a Type A1 Violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 23 2025. --- The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 05/30/25.		

Facility Name: Brookdale South Park

IV. Delivered Via:	Hand delivered	Date: 07/24/25
DSS Signature:	Karen Phillips	Return to DSS By: 08/14/25

V. CAR Received by:	Administrator/Designee (print name): Cynthia Jackson	
	Signature: Cynthia Jackson	Date: 7-24-25
	Title: BOM	

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.*		