Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Pines on Carmel Senior Living
Address: 5820 Carmel Road, Charlotte, NC 28226
County: Mecklenburg
License Number: HAL-060-168

II. Date(s) of Visit(s): 05/16/25; 05/19/25; and 06/17/25
Purpose of Visit(s): Monitoring
Exit/Report Date: 07/10/25

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 A2 Violation		
Findings: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for 1 of 7 sampled residents (Resident #1) who eloped from the Special Care Unit (SCU) without staff's knowledge. The findings are:		

Review of the facility's Wandering and Elopement Prevention Plan Program, effective 03/14/22 and revised on 07/12/22 revealed: -The purpose of the policy was to provide a system for identification of residents at risk for unsafe wandering and elopements, provide a program of supervision and intervention to minimize the risk of resident elopements and elopement attempts, and provide team member education in effective wandering and elopement management through in-services and elopement drills. -A plan to reduce the potential of elopement was supposed to be developed with input from the resident's legal representative and documented on the Individualized Service Plan/Care Plan such as the following but not limited to: A. New residents were supposed to be closely monitored and, if possible, have apartments away from the exit doors and closer to the staff area. B. Institute whereabout check so staff can account for all residents at risk for elopements on each shift at regular intervals. C. Instruct staff to maintain a visual line of sight of exit doors, particularly during shift change, mealtimes, and emergencies. -The facility's goal was for all team members to be aware of their responsibility to reduce and properly respond to missing resident events. Review of Resident #1's FL2 dated 01/25/25 revealed: -Diagnoses included dementia and atrial fibrillation. -Resident #1 was ambulatory, intermittently disoriented, and incontinent of bowel and bladder. -Resident #1 wandered. Review of Resident #1's Resident Register revealed that he was admitted to the facility on 01/29/25. Review of Resident #1's Pre-admission Assessment dated 01/30/25 revealed: -Resident #1 was able to ambulate independently with a walker. -He was able to transfer independently. -Resident #1's behaviors included wandering and resisting care. Review of Resident #1's Care Plan dated 02/27/2025 revealed: -Resident #1 was able to ambulate independently with a walker. -He was able to transfer independently. -Resident #1's elopement risk evaluation score was at a level of moderate risk, the likelihood of attempting to leave the		

facility without authorization or necessary supervision, but without a high immediate danger of harm if successful.
-Resident #1 required redirection greater than 12 times daily.
-Safety instructions were documented as "offer resident a snack or take him to the restroom."

Review of Resident #1's SCU profile dated 02/03/25 revealed:
-Resident #1's behavior patterns included wandering.
-Resident #1 was independent with ambulation and transfers.
-Resident #1 liked to walk the hallways.
-There were no interventions documented on the form.
-Resident #1 was not oriented to place and time.

Review of Resident #1's SCU profile dated 05/02/25 revealed:
-Resident #1's behavior patterns included wandering and sundowning.
-Resident #1 was independent with ambulation and transfers.
-Resident #1 liked to walk the hallways.
-There were no interventions documented on the form.
-Resident #1 was not oriented to place and time.

Review of Resident #1's Elopement Risk Evaluation form dated 05/05/25 revealed:
-Resident #1 scored with potential risk regarding 2 questions: 1) "Does the resident wander aimlessly or no-goal oriented (i.e., Confused, moves without purpose, may enter other's rooms and explore others' belongings)?" 2) "Is the wandering behavior a pattern, goal-directed (i.e., specific destination in mind, going home, seeking someone they can't find, hovering by staff and the door, going to work)?"
-Resident #1 was considered "moderate risk" for elopement.
-There were no interventions documented to prevent elopements.

Review of Resident #1's incident report dated 05/15/25 revealed:
-Resident #1 was witnessed in the parking lot of the community.
-Staff immediately went to the resident and redirected him back to the SCU.
-Resident #1's vitals were taken, and the family and physician were notified.
-Resident #1 was placed on one-on-one care for 24 hours.

Review of Resident #1's progress notes dated 05/15/25 revealed:
-Resident #1 was witnessed in the parking lot at 5:00pm by staff.

-He was brought back to the SCU. -It was found that Resident #1 pressed the emergency release button to the front door and exited the building. -His vitals were taken and family and physician were notified. -Resident #1 was placed on 72-hour monitoring. Observation of the facility on 05/16/25 at 3:36pm revealed: -The SCU and the Assisted Living (AL) were separate buildings. -The SCU building was located at the end of the parking lot past the AL building. -A covered, fire alarm pull station, keypad used to unlock the front door, and a covered, emergency exit button was located on an adjacent wall from the front door. -The fire alarm pull station was located to the left of a keypad. -The emergency exit button was located to the right of the exit keypad. -The emergency exit button had a loud screamer when the plastic cover was raised. -A second, unlocked entry/exit door into the SCU chimed when opened. -Resident #1's apartment was the first apartment to the left of the front door. -Resident #1 was wandering and attempted to open the courtyard doors. Observation on 06/17/25 at 9:38am of the most direct exit route between the facility and where Resident #1 was located by facility staff revealed: -The distance from the facility to the sidewalk on which he was found was 449 feet. -The posted speed limit was 35mph on a 5-lane road. -A sidewalk lined the 5-lane road. Telephone interview with Resident #1's Responsible Person (RP) on 06/13/25 at 3:16pm revealed: -Facility staffed called her at 6:30pm on 05/15/25 to report that Resident #1 had "exited the building." -Staff were all at the "outside area" of the facility with other residents and did not hear the door alarm. -Resident #1 got out of the facility by pushing the green emergency exit button. -Resident #1 did not make it out of the facility parking lot when staff redirected him back to the facility. -She provided a one-on-one sitter for 2 weeks from 7:00am until 3:00pm.		

Interview with a Medication Aide (MA) on 05/16/25 at 5:02pm revealed: -She worked in the AL at the facility. -Her coworker was cleaning dining room tables after dinner when she saw Resident #1 in the parking lot. -Her coworker called staff in the SCU and the Administrator. -She and her coworker went outside to check on the resident. -Resident #1 was "out of sight" when they arrived in the parking lot. -They located Resident #1 walking on the sidewalk along the main road away from the facility. -Resident #1 was on the sidewalk at the street sign at a neighborhood adjacent to the facility. -She asked Resident #1 his name and where was he going. -Resident #1 stated his name correctly and that he was going home. -The MA redirected him back to the SCU without incident. Interview with a Personal Care Aide (PCA) on 6/17/25 at 4:18pm revealed: -She was coming down the hallway at the dining room when she saw a man walking toward the end of the parking lot. -She was unaware he was a SCU resident. -She called the MA in the SCU and the Administrator. -She and a coworker went outside to check on the resident walking in the parking lot. -She asked him his name, to which he responded. -Resident #1 stated he was "going home." -He was easily redirected back to the SCU. -The MA from the SCU was outside to take Resident #1 back into the facility. Interview with another PCA on 05/16/25 at 4:02pm revealed: -On 5/15/25, she was cleaning residents' dinner plates in the dining room. -She later learned that Resident #1 was in the parking lot. -She did not hear a door alarm. -The MA went outside to look for Resident #1. Interview with a second PCA on 05/16/25 at 4:06pm revealed: -On 05/15/25, she was feeding a resident her dinner in her room. -She finished feeding the resident and went into the SCU kitchen. -She learned that Resident #1 was in the parking lot. -When she went to the front door of the facility, Resident #1 was being escorted back to the facility.		

-She did not hear the door alarm while she was feeding another resident. -She was aware that Resident #1 would check facility doors and exit seek. Attempted interviews with the MA, who was working in the SCU on 05/15/25, on 05/16/25 at 4:00pm; 05/19/25 at 9:53am; and 06/17/25 at 4:16pm were unsuccessful. Interview with the Special Care Unit Coordinator (SCUC) on 05/16/25 at 3:36pm revealed: -She punched out of work on 05/15/25 at 5:17pm and left the facility. -The Administrator called her at 5:58pm and asked her to return to the facility due to Resident #1 being in the parking lot. -A staff member from AL saw Resident #1 in the parking lot and reported it to the SCU staff. -The emergency exit button had a screamer that sounded when the plastic box was opened. -The screamer stopped when the plastic box was closed, and the door magnetic lock released. Interview with the SCUC on 06/17/25 at 10:02am revealed: -When Resident #1 eloped, staff did not hear the screamer from the emergency exit button. -Staff were expected to check the doors if any alarm sounded in the facility to see who was entering or exiting. -Staff were able to view the front door from the back of the facility through glass windows. -Resident #1 walked around the SCU frequently. -Staff were unable to monitor Resident #1 every moment. -Staff were expected to monitor and to redirect Resident #1 as needed. Telephone interview with Resident #1's Family Nurse Practitioner (FNP) on 06/16/25 at 11:45am revealed: -The facility staff informed her when Resident #1 eloped from the facility on 05/15/25. -Resident #1 exhibited exit-seeking behaviors when she visited him at the SCU. -Resident #1 was often at the front door of the SCU attempting to leave to "go home". -He was easily redirected by facility staff. Interview with the Administrator on 05/19/25 at 11:27am revealed:		

-Staff called her to report that Resident #1 was outside of the SCU on 05/15/25.
-Staff from the AL went to bring the resident back to the SCU.
-Staff did not report how Resident #1 was able to leave the SCU.

Interview with the Administrator on 06/17/25 at 10:55am revealed:
-When a PCA from the AL called her about Resident #1 eloping, she returned to the facility.
-After staff escorted Resident #1 back to the SCU, the MA reset the emergency exit button that engaged the magnetic lock on the SCU front door.
-She interviewed staff on the SCU about the elopement.
-Staff was expected to check the facility doors if an alarm sounded.
-She understood that staff working on the SCU did not hear the screamer from the emergency exit button.
-Staff needed to be reeducated about residents' exit seeking behaviors.

The facility failed to provide adequate supervision for 1 of 7 sampled residents (Resident #1) who eloped from the Special Care Unit (SCU) and had a history of wandering and exit seeking behaviors, resulting in the resident exiting the SCU before staff were made aware he was not present and being found by staff on a sidewalk adjacent to a city street. This failure resulted in substantial risk of harm and neglect which constitutes a Type A2 Violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 09 2025.

The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 05/19/25.

Facility Name: The Pines on Carmel Senior Living

IV. Delivered Via:	Hand- delivered	Date: 07/10/25
DSS Signature:	Karen Phillips	Return to DSS By: 07/31/25

V. CAR Received by:	Administrator/Designee (print name): Samantha Glass	
	Signature: Samantha Glass	Date: 7/10/25
	Title: Administrator	

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.*			