Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Terra Bella at Little Avenue
Address: 7745 Little Avenue, Charlotte, NC 28226
County: Mecklenburg
License Number: HAL-060-156

II. Date(s) of Visit(s): 04/01/25, 04/16/25, 04/25/25
Purpose of Visit(s): Follow-up Incident report
Exit/Report Date: 05/27/25

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 observation, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents with a history of wandering behaviors. (Resident #1) in the facility's Special Care Unit (SCU) resulting in one resident, eloping from the facility. Observation of the SCU on 04/16/25 revealed: -There was an emergency entry/exit door off to the left main entrance sitting area of the SCU; which led to a side parking area. -There was an emergency entry/exit door off the main corridor of the SCU, which led to the rear of the property.		

-There was an emergency entry/exit door off the main corridor of the SCU, which led to the rear of the property. -There was an exit door which led to a locked courtyard near the common area of the SCU. -There was an emergency entry/exit door to the left of the common area, which led to the outside near the garbage dumpsters. -There was an emergency entry/exit door to the right of the common area, which led to the outside near the kitchen driveway. -There were keypads, magnetic locks, sounding devices and screamers located on all doors with a sign above the door stating there was a 15 second egress. Review of the facility's Missing Person Elopement policy dated 10/09/24 revealed: -The Memory Care Community staff will urgently and systematically respond with emergency when any resident is suspected to be or identified as missing. -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's whereabouts. -Elopement drills should be conducted in the Memory Care Community once every six (6) months and documented on the Elopement Drill Record. -Staff will immediately respond to door alarms and/or other monitoring alert systems. -If NO resident is found near any monitored door (in or out) ALL residents in the secured area will be accounted for starting with residents on the wandering risk list immediately. -If a resident is found near the doorway staff will redirect the resident. Review of Resident #1's current FL2 dated 10/04/24 revealed: -Diagnoses included dementia, coronary artery disease, chronic renal disease, hypertension, gastroesophageal reflux disease, B12 deficiency, chronic kidney disease, and vitamin D deficiency. -The recommended level of care was SCU. Review of Resident #1's Resident Register revealed he was admitted to the facility on 08/31/23 from home. Review of Resident #1's Care Plan dated 02/24/25 revealed: -Resident #1 wandered intrusively but was easily redirected. -Resident #1 experienced intermittent confusion or short-term memory loss.		

-Resident #1 eloped in the past or attempted an elopement.
-Resident #1 was ambulatory, used a wheelchair for extended distances.
-Resident #1 had a history of falls.
-Resident #1 was cognitively impaired and impaired in safety awareness.

Review of Resident #1's Elopement and Wandering Assessment completed 11/11/24 revealed:
-Resident #1 was cognitively impaired with poor decision-making skills, (i.e. intermittent confusion, cognitive deficits or disoriented).
-He exhibited wandering behaviors.
-He wandered aimlessly (i.e. confused, moved without purpose, may enter others' rooms and explore others' belongings.)
-Resident #1 was determined not to be at risk for elopement on 11/11/24.

Review of Resident #1's incident / accident report dated 03/30/25 revealed:
-Resident #1 exhibited exit seeking behaviors.
-Resident #1 was found in parking lot on the side of the facility by a team member.
-Resident #1 was assisted back into the facility and staff completed an assessment with no injuries noted.
-Resident #1 was placed on hourly checks for 3 days.

Review of Resident #1's Elopement and Wandering Assessment dated 03/31/25 revealed:
-Resident #1 was at risk for elopement at this time as evidenced by (wandering & exit seeking).
-"New interventions were put in place, door codes were changed, staff trained on door alarm response, all alarms checked for function, staff trained on incident reporting; screamer' keys in lockbox, assessment completed 03/31/25."

Observation of the distance Resident #1 walked and where he was found to the left of the front parking lot was approximately 49 steps from the door where he exited.

Telephone interview with Resident #1's responsible party on 04/24/25 at 1:29pm revealed:
-Resident #1 was admitted to the assisted living (AL) and was later admitted to the SCU due to exit seeking behaviors.
-Staff notified her on 03/30/25 in reference to the exit seeking behaviors and they wanted to send him to the Emergency Room (ER).

-She did not recall if she was told he eloped from the SCU.
-She requested they call hospice before sending him to the ER, because sending him to the ER would "cancel" his services provided by hospice.
-Hospice made a visit to the facility on 03/30/25 and conducted an assessment that included changes to his medications to help manage his agitation and anxiety.
-Resident #1 could be determined and focused when something was on his mind.
-When he was looking for his deceased spouse, Resident #1 was difficult to re-direct.

Telephone interview with a personal care aide (PCA) on 04/29/25 at 2:24pm revealed:
-She worked at the facility since October 2024.
-She worked primarily on the SCU side.
-She was in the laundry room when Resident #1 eloped from the unit.
-She heard the alarms go off, but recognized it was on the side of the SCU.
-Another PCA came to her and requested the code to reset the alarm.
-She assumed the PCA checked the parking lot and verified all residents were accounted for once she reset the alarm.
-She did not realize Resident #1 eloped from the facility until the AL staff returned him to the SCU.
-She immediately contacted management, and they contacted the family.

Interview with a 1st shift medication aide (MA) on 04/01/25 at 11:38am revealed:
-She had been employed at facility since July 2024.
-She was the MA on duty when Resident #1 eloped from the SCU on 03/30/25.
-It was her responsibility to ensure all alarms were engaged and the doors were locked when she started her shift.
-If she heard the alarm go off, she was supposed to complete a visual check outside the door to ensure no residents were outside of the facility and re-engage the alarms.
-She did not report a head count was conducted after Resident #1 eloped from the SCU.
-She was passing medications when Resident #1 eloped from the SCU and was not in a position to respond to the alarm.
-Another team member reset the alarm, and Resident #1 was escorted back to the SCU by an AL team member.

Interview with Business Office Manager (BOM) on 04/28/25 at 12:07 revealed:

-She was the designated Manager-on-Duty when Resident #1 eloped 03/30/25. -She was upstairs in her office and did not hear the door alarms. -She was alerted by the AL MA who saw Resident #1 as she was returning from break. -The MA escorted him back to SCU, and the staff notified all management, the family and his primary care provider (PCP). -The ED changed the protocol after the first elopement. Interview with the Health and Wellness Director (H&WD) on 04/01/25 at 11:56am revealed: -Staff were aware Resident #1 was exhibiting exit seeking behaviors all morning. -The Supervisor was expected to verify all doors were locked and the alarms were engaged at the start of the shift. -All doors made the same type of sound when activated and staff carried smart phones which indicated which door alarm was going off. -An AL staff member noticed Resident #1 walking away from the building as she returned from break off campus. -Resident #1 exhibited exiting seeking behaviors earlier on the shift he said he wanted to see his spouse. -Resident #1 ambulated short distances and used a wheelchair for extended distances. Telephone interview with a nurse from hospice on 04/29/25 at 3:26pm revealed: -She was told Resident #1 walked from the building. -She was surprised he was able to stand and walk that distance from his room to the exit, down the steps and into the parking lot as he was very weak. -He often talked about finding his spouse and his dog, going from room to room on the unit in his wheelchair. -She only saw him ambulate once, and he would go into other residents' rooms. -He was declining; however, it was a slow decline for him. -He was discharged from hospice services on 08/21/24 and was readmitted on 02/12/25 due to numerous falls. Interview with Administrator on 04/01/25 at 12:59pm revealed: -The MA on duty called the H&WD at 8:32am, to report Resident #1 was constantly exit seeking and that redirection and medication were not effective. -At 11:15am, the exit door alarm near Resident #1's room sounded for 52 seconds.		

-The PCA walked to the other side of the building and asked another PCA for the door code, and then returned to shut off the alarm in the SCU. -Neither the PCA or the MA checked outside the door, nor conducted a headcount. -The MA from AL escorted Resident #1 back to the SCU at 11:34am. -The SCU MA administered an as needed medication due to Resident #1's increased agitation. -The responsible party and hospice staff were notified of the incident. -Emergency Medical Services (EMS) was called, but the family declined for Resident #1 to be sent out for an evaluation because he was receiving hospice care. -The hospice nurse arrived at facility around 3:15pm and a new medication ordered was scheduled every 4 hours for 3 days. -All onsite staff were re-trained regarding appropriate response to door alarms and following missing person policy. -Resident #1 was placed on hourly checks for 3 days. The facility failed to provide adequate supervision Resident #1 who resided in the Special Care Unit with a history of exit seeking and wandering behaviors, which resulted in the resident eloping from the facility without staff knowledge when staff failed to check outside of the facility for Resident #1 and complete a headcount. This failure resulted in substantial risk for serious physical harm and constitutes a Type A2 Violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 26, 2025. The Facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 04/01/25 and 04/16/25.		
Rule/Statute Number: 10A NCAC 13F .0407(a)(5) Other Staff Qualifications	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256		

Level of Non-Compliance: Citation		
Findings: Based on interviews and record reviews, the facility failed to ensure 5 of 5 staff (Staff A, B, C, D, and E) sampled had Health Care Personnel Registry checks completed with no substantiated findings prior to hire. 1.Review of Staff A's, medication aide's (MA), personnel record revealed: -Staff A was hired 04/08/25. -There was no documentation that Staff A's Health Care Personnel Registry (HCPR) was completed. Follow-up telephone interview with Staff A on 05/01/25 at 4:07pm revealed; she signed a consent form which authorized the facility to do background checks and to confirm their credentials prior to hire. 2.Review of Staff B's, PCA's personnel record revealed: -Staff B was hired 02/21/24. -There was no documentation that Staff B's HCPR was completed. Follow-up telephone interview with Staff B on 05/05/25 at 12:18pm revealed; when hired more than a year ago, she signed a consent form which authorized the facility to conduct a background check. 3.Review of Staff C's, PCA's personnel record revealed: -Staff C was hired 10/01/24. -There was no documentation that Staff C's HCPR was completed. Follow-up telephone interview with Staff C on 05/01/25 at 3:28 revealed; she signed a consent form which authorized the facility to do background checks and to confirm their credentials prior to hire. 4.Review of Staff D's, PCA's personnel record revealed: -Staff D was hired 03/11/25. -There was no documentation that Staff D's HCPR was completed. Follow-up telephone interview with Staff D on 05/05/25 at 3:19pm revealed:		

-She was hired early March 2025.
-She completed a consent form at hire to give facility permission to do a background check prior to starting work at the facility.

5.Review of Staff E's, Business Office Manager's (BOM), personnel record revealed:
-Staff E was hired 06/10/24.
-There was no documentation that Staff E's HCPR was completed.

Follow-up telephone interview with Staff E on 05/01/25 at 3:56 revealed:
-She signed a consent form which authorized the facility to do background checks and to confirm their credentials prior to hire.
-All new hires signed a consent form and provided their social security numbers.

Telephone interview with BOM on 04/28/25 at 2:07pm revealed:
-She was hired in June 2024.
-She assisted with orientation of new hires, and she set up the employee files.
-She had some training with BOM from another facility.
-There was no focus on HCPR checks doing her training with the other BOM.
-There were no audit checks for employee records from the regional or corporate offices.
-She assumed the HCPR checks were completed by nursing staff.
-The HCPR checks have been "hit or miss" as to who completed the task for new hires.

Telephone interview with the Executive Director (ED) on 04/29/25 at 11:28am revealed:
-There was miscommunication regarding which manager was responsible for completing the HCPR checks.
-The BOM thought nursing completed the HCPR checks, and nursing assumed that the BOM completed the HCPR checks for new hires.
-Going forward it would be the BOM or the designee's responsibility to do the HCPR checks.
-The BOM would add task to the New Hire checklist.

Facility Name: Terra Bella at Little Avenue

IV. Delivered Via:	in person	Date: 05/27/2025
DSS Signature:	Lora McDowell	Return to DSS By: 06/17/2025

V. CAR Received by:	Administrator/Designee (print name): Jennifer Gorczyca	
	Signature: EP	Date: 5/27/25
	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.*