POC

Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Waltonwood Cotswold
Address: 5215 Randolph Rd. Charlotte, NC 28211
County: Mecklenburg
License Number: HAL-060-148

II. Date(s) of Visit(s): 11/30/23, 12/18/23, 01/11/24
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 01/19/24

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)* • *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 .0902 HEALTH CARE (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	☑ POC Accepted (AT) *DSS Initials*	—
Level of Non-Compliance: Type A1 Violation	POC attached	
Findings: Based on observations, record review, and interviews, 1 of 7 sampled residents (Resident #1), the facility failed to ensure Resident #1 was referred to the emergency department for evaluation and treatment after a fall which resulted in a fracture while exhibiting severe pain and skeletal abnormalities. Review of the facility's Resident Care Calling 911 policy dated 11/14/17 revealed: -The facility policy was to contact 911 on behalf of a resident who may show signs of medical distress. -Staff were to call 911 for a fall or accident which involved severe pain, swelling, or abnormal body position. Review of Resident #1's current FL-2 dated 03/31/23 revealed: -Diagnoses included dementia and Stage III Chronic Kidney Disease.	Eu Davis 2/6/2024	

-He was ambulatory and intermittently disoriented.
-Resident #1's recommended level of care was Special Care Unit (SCU).
-Resident #1 was admitted to the SCU on 01/19/23.

Review of Resident #1's Care Plan dated 09/28/23 revealed:
-He required moderate assistance with dressing and bathing, and assistance with grooming.
-He required minimal assistance with ambulation and was independent with transfers.
-He had a potential for falls.

Review of Resident #1's incident report dated 11/25/23 revealed:
-Resident #1 had a fall at 10:15am, he did not complain of pain.
-Resident #1 later complained on left hip pain and a mobile x-ray was ordered.
-Resident #1 kicked an x-ray technician on 11/25/23 and another x-ray was attempted and completed on 11/26/23.
-X-ray results were received on 11/27/23 which indicated a moderately displaced femoral neck fracture.
-Resident #1 was sent the hospital on 11/27/23 due to inability to ambulate.

Review of Resident #1's November 2023 progress notes revealed:
-On 11/25/23 at 10:30am, Resident #1 was observed on the floor laying on his back in the bathroom.
-On 11/25/23 at 5:27pm, Resident #1 had a change in condition, an x-ray technician was unable to perform an examination due to the resident kicking staff and the technician.
-On 11/25/23 at 5:37pm, Resident #1's physician was notified that Resident #1 continued to be ambulatory with instructions to re-attempt an x-ray without requiring referral to the emergency department (ED).
-On 11/25/23 at 8:44pm, Resident #1 complained of pain during Activities of Daily Living (ADL) care.
-On 11/26/23 at 7:27am, Resident #1 complained of pain.
-On 11/26/23 at 9:36pm, Resident #1 complained on left leg pain and x-ray results determined Resident #1 was diagnosed with an acute left hip fracture.
-On 11/27/23 at 4:46am, Resident #1 was found on his knees with his upper body on his bed, Resident #1 was assisted by two staff onto the bed.
-On 11/27/23 at 10:22am, Resident #1 was sent to the ED due to a fall on 11/25/23.

Review of Resident #1's physician's verbal order dated 11/25/23 revealed Resident #1's physician requesting an x-ray of Resident #1's left hip signed by the facility's Resident Care Director (RCD) and countersigned on 11/28/23 by Resident #1's Nurse Practitioner.

Review of Resident #1's radiology interpretation findings dated 11/26/23 revealed Resident #1's radiologist documented left leg pain and a moderately displaced acute femoral neck fracture of the left hip electronically signed at 2:43pm and faxed to an unknown fax number on 11/26/23 at 2:44pm.

Review of Resident #1's Emergency Medical Technician (EMS) record dated 11/27/23 revealed:
-EMS service was requested for a non-emergent dispatch on 11/27/23 at 8:55am and arrived at the facility at 9:42am.
-Staff stated Resident #1 had a fall on 11/25/23 and had an x-ray performed.
-On 11/27/23 Resident #1's physician requested the resident be sent to the ED due to a left hip fracture.
-Resident #1's left leg was noted to be rotated outwards and slightly shorter than the right leg.

Review of Resident #1's Emergency Department record dated 11/27/23 revealed:
-Resident #1 sustained a fall on 11/25/23 and had been complaining of pain in his left leg.
-Resident #1 was uncooperative when an x-ray was attempted on 11/25/23.
-Resident #1 had an x-ray performed on 11/26/23 which identified a left femur fracture.
-Resident #1 was complaining of pain in his left hip.
-Resident #1's examination revealed left-sided hip tenderness, with left leg shortened and externally rotated.
-Resident #1 was admitted for orthopedic surgical intervention treatment.

Review of Resident #1's hospital record dated 11/28/23 revealed:
-Resident #1 was diagnosed with a left femoral neck fracture.
-On 11/28/23, Resident #1's fracture was treated with an open reduction and internal fixation (ORIF) (a type of surgery used to stabilize and heal a broken bone).

Review of Resident #1's audio and video surveillance recordings in his room between 11/26/23 and 11/27/23 revealed:

-On 11/26/23 at 11:34am, four staff were observed transferring Resident #1 from his bed to a rollator. The Resident Care Director (RCD) was present. Resident #1 verbalized pain and said loudly "Ahhh, it hurts when I walk, I'm not faking."
-On 11/26/23 at 4:28pm, three staff were observed transferring Resident #1 from his bed to wheelchair. The resident verbalized pain and said "Ow, oh God this hurts."
-On 11/26/23 at 8:12pm, two staff were observed transferring Resident #1 from his wheelchair to his bed. Resident verbalized pain and said, "Oh God, I know your not trying to hurt me."
-On 11/27/23 at 3:44am, two staff were observed notifying Resident #1 that he had a hip fracture and should not be out of bed. Staff assisted Resident #1 onto the bed face down and rolled him to his back. The resident verbalized pain during positioning.
-There were no additional audio or video surveillance recordings available for review.

Telephone interview with Resident #1's Responsible Party (RP) on 12/04/23 at 3:41pm revealed:
-Resident #1 required a rollator for ambulation.
-Resident #1 occasionally ambulated between his bed and his bathroom without using his rollator.
-On 11/25/23, the facility left a voicemail notification that Resident #1 had a fall without injury.
-On 11/27/23, the facility called and notified him that Resident #1 had an x-ray examination performed on 11/26/23 with a diagnosis of a left hip fracture, and Resident #1 was to be transferred to the hospital for evaluation and treatment.
-Resident #1's bedroom was monitored with electronic audio and video surveillance equipment.
-He had audio and video surveillance between 11/26/23 and 11/27/23 which indicated Resident #1 expressed severe pain during transfers and ambulation and staff were aware of Resident #1's x-ray findings.
-Resident #1's audio and video surveillance recording on 11/27/23 at 3:44 am identified staff informed Resident #1 that he had a fractured hip.

Telephone interview with an x-ray technician on 01/11/24 at 10:00am revealed:
-On 11/25/23, he was scheduled to perform bi-lateral leg x-rays for Resident #1 in the facility related to a fall.
-On 11/25/23, he attempted to perform x-rays with Resident #1 from Resident #1's bedside.
-On 11/25/23, Resident #1 was uncooperative while he positioned Resident #1's left leg.

-On 11/25/23, Resident #1 kicked towards him with his right leg, verbalized left leg pain, and did not want x-rays performed. -On 11/25/23, he notified the RCD of Resident #1's behavior and inability to perform the x-rays. -On 11/25/23, he was unable to examine Resident #1's legs for any musculoskeletal abnormalities. Telephone interview with Resident #1's Nurse Practitioner (NP) revealed: -She was Resident #1's contracted medical provider. -On 11/25/23, the RCD notified her that Resident #1 had a fall without abnormal gait or length of leg but had minor pain. -On 11/25/23, the RCD requested a mobile x-ray to determine if Resident #1 had sustained a hip fracture. -On 11/25/23, based on the RCD's assessment, she ordered a mobile x-ray and instructed the facility keep Resident #1 immobile and prevent Resident #1 from ambulation. -On 11/27/23, she was notified of Resident #1's x-ray findings dated 11/26/23. -If the facility had notified her of Resident #1 expression of severe pain, she would have recommended Resident #1 be sent to the ED immediately to evaluate and treat any injury. -If the facility had notified her of Resident #1's leg exhibiting shortness or abnormal rotation, she would have recommended Resident #1 be sent to the ED immediately to evaluate and treat any musculoskeletal abnormalities. Telephone interview with a first shift Medication Aide (MA) on 01/08/23 at 10:30am revealed: -Resident #1 ambulated with a rollator but often forgot to use the device. -On 11/25/23 between 10:00am and 10:30am, Resident #1's assigned Personal Care Aide (PCA) notified her that Resident #1 was on his floor in-between his bathroom and bedroom. -On 11/25/23 between 10:00am and 10:30am, she observed Resident #1 on his floor, Resident #1 requested help getting up. Resident #1 was able to ambulate with two-person assistance and did not complain of any pain. -On 11/25/23, she left a voicemail for Resident #1's RP to notify him of the fall without any injury. -On 11/25/23 at 12:00pm, the RCD assessed Resident #1 and he complained of left leg pain. -On 11/25/23, the RCD requested a mobile x-ray of Resident #1's left leg. -The RCD instructed staff to keep Resident #1 in bed.		

-On 11/25/23, the RCD was responsible to determine if 911 was notified for EMS assessment or transport to the emergency department.
-On 11/26/23, Resident #1 complained of unspecific pain and a re-attempt mobile x-ray was requested by the RCD.
-On 11/26/23, she and a PCA transferred Resident #1 between his bed and wheelchair for lunch.
-Resident #1 did not utilize a wheelchair prior to 11/26/23.
-On 11/26/23 between 1:30pm and 2:00pm, an x-ray technician completed an x-ray exam of Resident #1.
-When a resident fell, if the resident could ambulate, staff were permitted to assist the resident off the floor and notify the nurse on duty, responsible party, and physician.
-If a resident sustained a fall and complained of pain, staff were to immediately notify 911.

Interview with a second shift MA on 11/30/23 at 3:35pm revealed:
-She worked as the SCU second shift MA on 11/25/23 and 11/26/23.
-On 11/25/23, an x-ray technician arrived at the facility around 5:00pm but Resident #1 was uncooperative and kicked at the technician, and Resident #1's x-ray was unable to be obtained.
-On 11/25/23, Resident #1 complained of pain in his left leg and hip area and was agitated while the x-ray technician manipulated his leg but was not screaming in pain.
-On 11/25/23, staff transferred Resident #1 from his bed to a wheelchair to attend dinner because he was complaining of pain, but staff did not know exactly what his injury was.
-On 11/26/23, Resident #1 received a mobile x-ray during first shift.
-On 11/26/23, between 8:00pm and 9:00pm, an x-ray technician called the facility and notified her of Resident #1's 11/26/23 x-ray findings of a left hip fracture and notified her the x-ray findings had been faxed to the facility.
-On 11/26/23, she was unable to locate the x-ray results from the facility fax machine.
-On 11/26/23, she sent an electronic text message to the RCD and notified her of Resident #1's x-ray findings.
-On 11/26/23, she did not notify anyone else regarding Resident #1's x-ray findings.
-On 11/26/23, she awaited the RCD to instruct staff how to proceed with Resident #1's needs related to the x-ray findings, which did not occur.
-MAs were expected to notify the RCD or manager-on-duty (MOD) when a resident had a fall and wait for further instructions on what to do for the resident.

Telephone interview with a third shift MA on 01/09/24 at 12:10pm revealed: -She worked during third shift between 11/26/23 and 11/27/23. -She did not recall any incident or accident involving Resident #1 during her shift on 11/27/23 at 3:44am. -She did not recall documenting Resident #1's fall on 11/27/23 at 4:46am. -If a resident had a fall, MAs were responsible for notifying the residents' responsible party and 911 if the resident was in severe pain. Telephone interview with a first shift personal care aide (PCA) on 01/10/24 at 4:16pm revealed: -On 11/25/23, she was responsible to provide care for Resident #1. -On 11/25/23 at 10:15am, she observed Resident #1 on the floor in-between his bathroom and bedroom area. -On 11/25/23, she requested the first shift MA to assist Resident #1 while he was laying on the floor. -On 11/25/23, between 10:15am and 10:30am, the MA determined Resident #1did not sustain a head injury and requested to be lifted off the floor. -On 11/25/23 at 10:30am, Resident #1 complained of right knee pain and was able to ambulate using his rollator to his bed. -On 11/25/23, she did not recall any instructions from the MA or RCD related to Resident #1's ambulation. -On 11/26/23, she was responsible to provide care for Resident #1. -On 11/26/23, an x-ray technician was able to perform x-rays on Resident #1's legs. -On 11/26/23, Resident #1 complained of generalized pain and said "it hurts" when staff assisted him with ambulation from the bed to a wheelchair. Interview with a second shift PCA on 11/30/23 at 4:15pm revealed: -On 11/25/23, she was Resident #1's assigned PCA during second shift. -On 11/25/23, she assisted Resident #1 with incontinence care from his bedside, while rolling him side-to-side, he complained of generalized pain but was not in severe pain. -On 11/26/23, she was Resident #1's assigned PCA during second shift. -On 11/26/23, she and two additional PCA assisted Resident #1' from his bed to a wheelchair and brought him to dinner and the bathroom for toileting.		

-On 11/26/23, during Resident #1's ambulation, he complained of pain but did not appear in severe pain. -On 11/26/23, the second shift MA notified her of Resident #1's x-ray findings and was waiting for the RCD to provide instructions for what to do with Resident #1. Interview with the Special Care Coordinator (SCC) on 12/18/23 at 3:25pm revealed: -She was not working between 11/25/23 and 11/27/23 when Resident #1 had an incident resulting in hospitalization. -Resident #1 was known to have occasional falls, agitation, and aggressive behavior. -Prior to Resident #1's incident on 11/25/23, his responsible party was resistant to the facility referring Resident #1 for emergency department evaluation for other incidents and accidents. -On 11/27/23 during second shift, the MA which was notified of Resident #1's x-ray findings was expected to request the responsible party to send Resident #1 to the emergency department and verbally notify the nurse on duty. -On 11/27/23 at 3:45am, the third shift MA should have immediately notified 911 of Resident #1's fall and x-ray findings and refer Resident #1 to the emergency department -MAs were expected to determine if a resident sustained a head injury from an incident. -If a resident sustained a head injury, MAs were to immediately notify 911, residents responsible party and physician. -If a resident did not sustain a head injury, MAs were expected to determine if the resident could move to a sitting or standing position and notify the nurse on duty. Interview with the Resident Care Director (RCD) on 11/30/23 between 2:15pm and 3:30pm revealed: -She was a Registered Nurse (RN). -She was responsible for resident clinical assessments and oversight of MAs. -On 11/25/23, staff notified her of Resident #1's fall that morning. -On 11/25/23 sometime after 10:15am she performed a range-of-motion (ROM) with Resident #1 lower body. -On 11/25/23, Resident #1 complained of right knee and right leg pain but did not complain of left leg pain. -On 11/25/23, she manipulated Resident #1's left leg, but he would not permit her to move the leg laterally. -On 11/25/23, she noted Resident #1's left leg was slightly rotated outwards during the ROM assessment.		

-On 11/25/23, she requested a mobile x-ray from Resident #1's physician, "I was concerned he was hurt which an x-ray might determine." -On 11/25/23, Resident #1 complained of leg pain during ambulation, but she did not think his pain was severe. -On 11/25/23, Resident #1's physician did not recommend Resident #1 be referred to the emergency department. -On 11/25/23, she instructed staff to try and keep Resident #1 comfortable and in bed. -On 11/26/23, she performed another ROM of Resident #1's legs from a standing position and Resident #1 complained of inner left groin pain and left hip pain. -On 11/26/23, she instructed staff to utilize Resident #1's rollator to assist with ambulating Resident #1 during toileting. -On 11/26/23, the second shift MA left an electronic text message notification on her telephone at 10:16pm regarding Resident #1's 11/26/23 x-ray findings of a left hip fracture. -On 11/26/23, she would have preferred the second shift MA to call her with Resident #1's x-ray findings. -Between 11/25/23 and 11/26/23, she did not refer Resident #1 to the emergency department because in the past, Resident #1's responsible party was resistant to referrals to the emergency department for other incidents involving Resident #1. -Between 11/25/23 and 11/26/23, she would have referred any other resident to the emergency department that showed signs or symptoms similar to Resident #1's. -On 11/27/23 at 6:05am, she read her telephone text messages and notified the Administrator of Resident #1's x-ray findings. -On the morning of 11/27/23, she learned that during third shift on 11/26/23, staff observed Resident #1 kneeling on the side of his bed and assisted him back to bed. -On 11/27/23, 911 was notified and Resident #1 was referred to the emergency department for evaluation and treatment of his left hip fracture. -MAs were responsible to perform a basic observation and interview of a resident after a fall and determine if 911 was required and/or notify the facility's nursing department for further assessment. Interview with the Administrator on 11/30/23 between 2:00pm and 3:30pm revealed: -MAs were responsible for determining if a resident sustained a head injury from a fall and if so, call 911 immediately. -MAs were responsible for assisting a resident to a sitting or standing position, with additional staff, if necessary, if the resident was capable after a fall. -MAs were responsible for notifying the nurse on duty for any resident falls.		

-Resident #1 was ambulatory with the use of a rollator but he did not always utilize his rollator. -Between 11/25/23 and 11/26/23, the RCD determined Resident #1 was not in severe pain and did not require referral to the emergency department. -On 11/26/23 during second shift, he would have expected the second shift MA to verbally notify the RCD of Resident #1's x-ray findings and refer Resident #1 to the emergency department. -On 11/27/23, at approximately 6:00am, he was notified by the RCD of Resident #1's x-ray findings and recommended he be sent to the hospital. Based on record reviews and interviews the facility failed to ensure Resident #1 was referred to the emergency department for evaluation and treatment after a fall which resulting in a hip fracture while exhibiting severe pain and musculoskeletal abnormalities which delayed Resident #1 in receiving treatment from 11/25/23 at 10:15am until 11/27/23 at 10:15am (approximately 48-hours) that required Resident #1 to have hip surgery. The failure resulted in serious physical harm which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/30/23 for this violation. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED February 18, 2024.		

IV. Delivered Via:	Certified mail + on site visit	Date: 01/19/24
DSS Signature:	A. Hofmeister	Return to DSS By: 02/09/24

V. CAR Received by:	Administrator/Designee (print name): Eric Davis	
	Signature: Eric Davis	Date: 1/19/24
	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: A. Hofmeister	Date: 2/23/24
Comments:		

VIII. Agency's Follow-Up	By: A. Hofmeister	Date: 4/5/24
	Facility in Compliance: ☑ Yes ☐ No	Date Sent to ACLS:
Comments: Review training materials, interview residents, responsible parties, staff. Review resident records		

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

Appendix 1-B: Plan of Correction Form

Plan of Correction

Please complete all requested information and email completed Plan of Correction form to:

Plans.Of.Correction@dhhs.nc.gov

Provider Name:	**Waltonwood Cotswold, LLC**	**Phone:**	**704-496-9310**
Provider Contact Person for follow-up:	**Eric Davis, Executive Director** **Christian Cunningham, Resident Care Manager**	**Fax:**	**704-496-9402**
		Email:	**Eric.Davis@singhmail.com**
Address:	**5215 Randolph Road Charlotte, North Carolina 28211** **Provider #** HAL-060-148		

Finding	Corrective Action Steps	Responsible Party	Time Line
10A NCAC 13F .0902 Health Care	Community will evaluate all incidents with potential injury according to company policy, and react according to state regulations. In the event that a resident appears to be injured, community will take immediate action and ensure that they receive necessary medical care. After an incident, all details including description of pain, will be reported to residents primary care physician. If it is outside of normal business hours, the Med Tech will call the on-call nurse to report the incident and determine the course of treatment, if unsure. If the nurse on call is not available, the Med Tech is to notify the Executive Director.	Executive Director Resident Care Manager	Implementation Date: 1/19/2024 Projected Completion Date: 1/19/2024
10A NCAC 13F .0902 Health Care	Necessary medical care may consist of: -Mobile Imaging -On Site evaluation by NP, PA, or MD, if available -911 EMS with hospital transfer If mobile imaging is ordered and a resident refuses such imaging, resident will be transferred to the hospital for evaluation. If mobile imaging is successful, and while waiting for the results a residents' condition worsens, resident will be sent to the hospital. If mobile imaging is successful, upon receipt of the results,	Executive Director Resident Care Manager	Implementation Date: 1/19/2024 Projected Completion Date: 1/19/2024

Continued from page 1	Med Tech staff will confer with Nurse to determine if there is injury and resident will be sent out if such injury occurs. If report of a fracture is discovered via medical testing or otherwise, immediate medical attention will be sought. If a PA, NP, or MD evaluation is completed, community will follow the course of action as directed by the provider. If resident condition worsens, resident will be sent for evaluation at the hospital. If it is determined that 911 be called, EMS will transfer the resident per community policy to seek additional treatment	Continued from page 1	Continued from page 1
10A NCAC 13F .0902 Health Care	Staff training was conducted on 11/30/23 and 12/1/23 in regards to notification of resident changes and injuries. Staff is to notify provider of incident details and carry out any interventions as ordered. All injuries since this date have been in accordance with policy. Staff training has been successful. Staff have been instructed to send injured residents to the hospital, regardless of family desire to ensure that residents get the necessary medical interventions.	Executive Director Resident Care Manager	Implementation Date: 11/30/2023 Projected Completion Date: 12/1/2023
10A NCAC 13F .0902 Health Care	Ongoing training and education will take place with all team members as it relates to incidents and injuries upon hire and annually thereafter. Training currently ongoing in person for all resident care associates to be completed by 2/7/2024. Training will include a review of the Waltonwood policy and procedure as well as training specific to the state regulations in rule area .0902 (Health Care). Training will also be conducted to educate all Resident Care associates on identifying and recognizing pain. This training will educate team members on recognizing resident changes and what we can do to get them the necessary medical care. To maintain compliance, ED and RCM will review and sign all incident reports to ensure that policy and procedure for incidents with injuries is followed and residents receive all necessary medical care and follow up.	Executive Director Resident Care Manager	Implementation Date: 1/19/2024 Projected Completion Date: 2/7/2024