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 _____ *DSS Initials*	___
Level of Non-Compliance: Type A1 Violation		
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.		

-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.		

Waltonwood Cotswold

IV. Delivered Via:	Certified mail & on site visit	Date: 01/19/24
DSS Signature:	A. Hartmaster	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:	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.*		