Adult Care Home Corrective Action Report (CAR)

I. Facility Name: The Stratford
Address: 405 Smith Level Road Chapel Hill, NC 27516
County: Orange
License Number: HAL068025

II. Date(s) of Visit(s): 5/25/25, 5/27/25, 5/28/25, 5/29/25
Purpose of Visit(s): CI

Instructions to the Provider ***(please read carefully)*****:**
Exit/Report Date: 6/17/2025

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 .0902(b)	☐ POC Accepted _____ *DSS Initials*	7/17/2025
Rule/Statutory Reference: 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.		
Level of Non-Compliance: TYPE A1 VIOLATION		
Findings: The rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (Resident #1) related to delayed evaluation of an incident resulting in a fractured arm. The findings are: Review of Resident #1's current FL2 dated 2/20/25 revealed: -Diagnoses included Alzheimer's Dementia, Chronic Obstructive Pulmonary Disease, and Atrial Fibrillation.	Response to the citied deficiencies do not constitute an admission or agreement by the facility of the truth of the fact alleged or conclusions set forth in the Statement of Deficiencies or Corrective Actions Reportable; the Plan of Correction is prepared solely as a matter of compliance with state law.	

Review of Resident #1's Care Plan dated 2/19/25 revealed: -The resident was totally dependent on staff with bathing, dressing, and grooming. -The resident required extensive assistance from staff with toileting, ambulation, and transfers. -The resident was independent with eating. -The resident was ambulatory with a wheelchair. -The resident had limited strength in the left hand, arm, and leg. -The resident was sometimes disoriented, forgetful, and needed reminders. Review of Resident #1's Special Care Unit Resident Profile and Care Plan dated 2/13/25 revealed: -The resident required one person staff assistance with toileting needs and hygiene. -The resident used a wheelchair requiring one-person staff assistance for ambulation. -The resident required one person assistance with transfers. Interview with the local Emergency Medical Services Technician (EMT) on 5/29/25 at 11:48 am revealed: -He was dispatched to facility around 1:00 pm on 5/24/25. -A staff member called 911 on 5/24/25 after discovering Resident #1's left arm was bruised and Resident #1 was complaining of pain in the left arm. -He was told by the same staff member that she had been told on 5/24/25 that Resident #1's arm was injured by another staff member while the staff member assisted resident off of the toilet on 5/22/25. -Resident #1's left arm was badly bruised from her forearm to the upper arm. -He believed Resident #1's arm was broken. -Resident #1 was transported to the local hospital for evaluation and treatment. -Emergency Medical Services had not received any calls from the facility until 5/24/25 for Resident #1. Review of Resident #1's Incident Report dated 5/24/25 at 1:11 pm revealed: -Resident #1 was observed in the Special Care Unit (SCU) dining room with a discolored and swollen left shoulder with complaints of left shoulder pain. -Resident #1 exhibited symptoms of moaning with a soft groan. -Resident #1's Primary Care Provider (PCP) was notified of the incident on 5/24/25 at 1:15 pm.	An immediate skin assessment and fall risk assessment completed on resident #1 Executive Director (ED)/ Care Manager implemented 30 minutes safety checks for 10 days, then resident #1 was reassessed to determine care needs. Executive Director conducted an immediate in-service on Incident/Accident reporting, Clinical Nurse Consultant (CNC) conducted an immediate in-service on falls, residents rights, and incident/accident reporting. Synchrony Therapy conducted an immediate in-service on transferring residents. ED/Care Manager conduct and completed skin assessments on every resident in the community to ensure that there are no bruising or injuries.	5/25/25 6/4/25 5/25/25 5/30/25 5/30/25 6/25/25

-Resident #1 was sent to the local hospital emergency room (ER). -Resident #1 received a diagnosis in the ER of a displaced fracture of the surgical neck of the humerus bone. Review of After Visit Summary from the ER for Resident #1 dated 5/25/25 revealed: -Resident #1 was seen in the ER on 5/24/25 for elbow injury. -Resident #1 had diagnoses of left upper limb pain and a closed displaced fracture of the surgical neck of the left humerus bone. -Resident #1 had an order to follow up with orthopedics for further evaluation and treatment. Interview with the ER nurse on 5/25/25 at 12:36 pm revealed: -Resident #1 arrived at the ER on 5/24/25. -Resident #1 was diagnosed with a fractured left humerus bone. -Resident #1's left arm should be kept immobilized in a sling until the resident was evaluated by orthopedics. Attempted interview on 5/25/25 at 12:40 pm with the physician from the ER was unsuccessful. Observation of Resident #1 on 5/25/25 at 12:44 pm revealed: -Resident #1 was lying in the hospital bed in the ER. -Resident #1 had a sling on her left arm. Interview with Resident #1 on 5/25/25 at 12:45 pm revealed: -Resident #1 was having a lot of pain in her left shoulder. -A staff member knocked into her hard while helping her off of the toilet. -Resident #1 did not know the name of the staff member. -Resident #1 could not remember if she started to fall or not. The staff member could have been trying to catch her from falling. -Resident #1 could not remember when the injury occurred. Interview with Resident #1's PCP on 5/28/25 at 2:03 pm revealed: -He was not notified that Resident #1 had sustained an injury to her left arm on 5/22/25. -He received a hospital discharge summary from the facility with a diagnosis of displaced fracture of the surgical neck of the humerus bone on 5/27/25. Interview with a medication aide (Staff A) on 5/25/25 at 11:00 am revealed:	Orange County Regional Ombudsman conducted an in-service with staff on Residents Rights. Synchrony Rehab conducted an in-service with staff on transferring residents, doffing and donning with UE sling, hygiene and ADLS, body mechanics, wheel chair management transferring, positioning, gait belts, 2 person transferring. Clinical Nursing Consultant conducted and in-service on .0902 Health Care; follow up on routine and acute needs, who to report incident/ accidents, when to report incidents/accidents, How to report incidents/accidents, and what does delay of treatment mean. Executive Director/ Care Managers or designee will make rounds no less than twice a day. Executive Director/Care Managers will meet weekly to discuss falls, incidents, and any residents at risk.	6/30/25 6/30/25 6/30/25 5/25/25 5/25/25

-Staff A discovered Resident #1 had a bruise on her left arm on 5/24/25. -Resident #1 was complaining of pain in her arm. -Staff A called 911 for Resident #1 to be evaluated. -A personal care aide (Staff B) told Staff A that Resident #1 fell while another personal care aide (Staff C) was transferring the resident on 5/22/25. -Another personal care aide (Staff D) assisted Staff C in placing Resident #1 into the bed. -No staff reported the fall on 5/22/25 or 5/23/25 that Staff A was aware. Interview with Staff B on 5/25/25 at 11:10 am revealed: -Staff B was assisting another resident on 5/22/25 when she heard Resident #1 screaming from her room. -Staff C and personal care aide (Staff E) was in the room with Resident #1 when Staff B heard the resident screaming. -Staff C yelled for Staff D to go into Resident #1's room. -Staff D assisted in putting Resident #1 into bed. -Staff B believed Resident #1 had fallen while being transferred. -Staff B did not work on 5/23/25. -When Staff B came into work on 5/24/25, she was surprised to see Resident #1 was in her room. She thought Resident #1 would have been in the hospital. -Resident #1 was complaining of pain in her left arm on 5/25/25. -Staff B pulled up the sleeve of Resident #1's shirt and noticed a large bruise on her left arm. Staff B alerted Staff A who called 911. -Staff B did not tell the medication aide (Staff F) on duty on 5/22/25 or the Administrator about the incident. She thought Staff C or Staff D would have reported the incident to Staff F. -Staff B did not know if any other staff involved told Staff F or the Administrator about the incident. Interview with Staff E on 5/25/25 at 11:15 am revealed: -Staff E was training with Staff C on 5/22/25. -Staff E was told by the Administrator that she should not be providing personal care to residents until she was fully trained. -Staff C told Staff E to transfer Resident #1 onto the toilet. -Staff E thought Staff C was her superior, so she attempted to transfer Resident #1 to the toilet. -During the transfer, Resident #1 fell onto the floor. -Resident #1 began screaming and said she was hurting. -Staff D went into Resident #1's room and assisted Staff C in putting Resident #1 in the bed.		

-Staff E did not tell Staff F or the Administrator about the incident. -Staff E did not know if any other staff involved told Staff F or the Administrator about the incident. -Staff E worked on 5/23/25, but she was not assigned to Resident #1 on that day. -Staff E saw Resident #1 in the dining room on 5/23/25 and Resident #1 seemed fine. Interview with personal care aide (Staff G) on 5/27/25 at 10:34 am revealed: -Resident #1 was non-ambulatory. -Resident #1 required assistance with transfers. -Resident #1 was able to stand and pivot with assistance of one aide. -Staff G immediately reported incidents/accidents involving residents to the MA on duty and they reported to the Resident Care Coordinator (RCC) and Administrator. Interview with personal care aide (Staff H) on 5/27/25 at 10:37 am revealed: -Resident #1 needed assistance with transfers. -Staff H immediately reported incidents/accidents involving residents to the medication aide on duty. Interview with Staff F on 5/27/25 at 10:40 am revealed: -Staff F was the medication aide on duty in the SCU on 5/22/25 and 5/23/25. -Staff F did not observe Resident #1 having pain on 5/22/25 or 5/23/25. -Staff F was not made aware of Resident #1's fall on 5/22/25, she was made aware of the incident on 5/25/25. -If Staff F had been told about the fall, she would have immediately called 911 and had Resident #1 evaluated at the local hospital. Interview with Staff D on 5/27/25 at 11:00 am revealed: -Staff C and Staff E were assigned to Resident #1 on 5/22/25. -Staff C told Staff D she needed help with transferring Resident #1. -Staff D told Staff C to wait a few minutes and she would assist her with Resident #1. -Staff D was told by Staff B that Resident #1 was screaming and that Staff D needed to go into the room to help. -Staff D observed Resident #1 sitting on the edge of the bed and Staff C was holding her. -Resident #1 was crying and screaming so hard that she could not talk and it was difficult for her to breath.		

-Staff D changed Resident #1's pull up and put her in the bed. -After a while, Resident #1 stopped crying and told Staff D that a staff member pulled her arm hard. -When Staff D left Resident #1's room, Resident #1 had calmed down. -The MA (Staff F) assigned to the SCU was on lunch break at the time of the incident. -Staff D did not report the incident to Staff F when she returned after lunch break. -Staff D had hoped that Staff C would have reported the incident to Staff F. Attempted interview with Staff C on 5/27/25 at 2:41 pm was unsuccessful. Interview with the Administrator on 5/25/25 at 1:35 pm revealed: -She became aware of Resident #1's injury on 5/24/25. -She thought Resident #1 had fallen on 5/24/25, she was unaware of the incident on 5/22/25. Interview with the RCC on 5/27/25 at 10:47 am revealed: -She was made aware that Resident #1 had a bruise on her left arm and was complaining of pain by Staff A on 5/24/25. -She instructed Staff A to call 911 and have Resident #1 sent to the local hospital for evaluation. -She became aware on 5/25/25 that Resident #1 had fallen while being transferred on 5/22/25. -She called Staff F on 5/25/25. Staff F had not been told by any staff of Resident #1's fall on 5/22/25. -Staff C told her that she and Staff E were transferring Resident #1 to bed when Resident #1 began to fall. Staff C said she grabbed Resident #1's arm to keep her from falling and Resident #1 began hollering in pain. -Staff C told her multiple different stories of the incident. -Resident #1 was able to stand and pivot with one person assistance. Staff C would not have needed Staff E's assistance with the transfer. -It was the expectation that the PCAs make the MA aware of any accident or incident involving a resident immediately. -The MA would assess the resident and make either the RCC or Administrator aware. -If an injury occurred with a resident, the resident should immediately be sent out for evaluation at the local hospital. Interview with the Administrator on 5/29/25 at 11:30 am revealed:		

-It was the expectation that when an accident or incident occurred with a resident, the MA on duty would have been immediately notified. -The MA should have immediately notified the RCC and Administrator. -In the case of injury, 911 should have been immediately called. Review of the facility's Accident or Incident Policy revealed: -An accident or incident called for prompt action. -When an accident or incident occurred, staff should send or call for help. -Staff should evaluate the situation and call 911 if necessary. -Staff should check the resident for injury. -Staff should administer first aid if appropriate. -Staff should remain with the resident until EMS arrived. The facility failed to ensure referral and follow-up related to an incident where Resident #1 received a fractured arm. The resident was not immediately sent to the hospital for evaluation, but instead remained at the facility for 2 days resulting in delayed treatment of the injury and Resident #1 being in pain. This failure resulted in serious physical harm and neglect and constitutes a Type A1 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 5/25/25 for this violation.		

IV. Delivered Via:	in person	Date: 6/17/25
DSS Signature:	Angela Riley	Return to DSS By: 7/9/25

V. CAR Received by:	Administrator/Designee (print name): Danita Thompson	
	Signature: [signature]	Date: 6-17-25
	Title: ED	

VI. Plan of Correction Submitted by:	Administrator (print name): Danita Thompson	
	Signature: [signature]	Date: 7/9/25

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		

Facility Name:

☑ *POC Accepted*	By: Angela Riley	Date: 7/10/25
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.*