# 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
Exit/Report Date: 6/17/2025

**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**<br>*For each citation/violation cited, document the following four components:*<br>• *Rule/Statute violated (rule/statute number cited)*<br>• *Rule/Statutory Reference (text of the rule/statute cited)*<br>• *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)*<br>• *Findings of non-compliance* | **III (b). Facility plans to correct/prevent:**<br>*(Each Corrective Action should be cross-referenced to the appropriate citation/violation)* | **III (c). Date plan to be completed** |
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| Rule/Statute Number:<br>10A NCAC 13F .0902(b) | ☐ POC Accepted<br>_____<br>*DSS Initials* | 7/17/2025 |
| Rule/Statutory Reference:<br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. | | |
| Level of Non-Compliance:<br>TYPE A1 VIOLATION | | |
| Findings:<br>The rule is not met as evidenced by:<br><br>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.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 2/20/25 revealed:<br>-Diagnoses included Alzheimer's Dementia, Chronic Obstructive Pulmonary Disease, and Atrial Fibrillation. | | |

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| Review of Resident #1's Care Plan dated 2/19/25 revealed:<br>-The resident was totally dependent on staff with bathing, dressing, and grooming.<br>-The resident required extensive assistance from staff with toileting, ambulation, and transfers.<br>-The resident was independent with eating.<br>-The resident was ambulatory with a wheelchair.<br>-The resident had limited strength in the left hand, arm, and leg.<br>-The resident was sometimes disoriented, forgetful, and needed reminders.<br><br>Review of Resident #1's Special Care Unit Resident Profile and Care Plan dated 2/13/25 revealed:<br>-The resident required one person staff assistance with toileting needs and hygiene.<br>-The resident used a wheelchair requiring one-person staff assistance for ambulation.<br>-The resident required one person assistance with transfers.<br><br>Interview with the local Emergency Medical Services Technician (EMT) on 5/29/25 at 11:48 am revealed:<br>-He was dispatched to facility around 1:00 pm on 5/24/25.<br>-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.<br>-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.<br>-Resident #1's left arm was badly bruised from her forearm to the upper arm.<br>-He believed Resident #1's arm was broken.<br>-Resident #1 was transported to the local hospital for evaluation and treatment.<br>-Emergency Medical Services had not received any calls from the facility until 5/24/25 for Resident #1.<br><br>Review of Resident #1's Incident Report dated 5/24/25 at 1:11 pm revealed:<br>-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.<br>-Resident #1 exhibited symptoms of moaning with a soft groan.<br>-Resident #1's Primary Care Provider (PCP) was notified of the incident on 5/24/25 at 1:15 pm. | | |

-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:

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

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

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

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| -It was the expectation that when an accident or incident occurred with a resident, the MA on duty would have been immediately notified.<br>-The MA should have immediately notified the RCC and Administrator.<br>-In the case of injury, 911 should have been immediately called.<br><br>Review of the facility's Accident or Incident Policy revealed:<br>-An accident or incident called for prompt action.<br>-When an accident or incident occurred, staff should send or call for help.<br>-Staff should evaluate the situation and call 911 if necessary.<br>-Staff should check the resident for injury.<br>-Staff should administer first aid if appropriate.<br>-Staff should remain with the resident until EMS arrived.<br><br>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.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 5/25/25 for this violation. | | |

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

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

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| **VI. Plan of Correction Submitted by:** | Administrator (print name): | |
| | Signature: | Date: |

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

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| ☐ ***POC Accepted*** | By: | Date: |
| Comments: | | |
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| **VIII. Agency's Follow-Up** | By: | Date: |
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| | Facility in Compliance: ☐ Yes ☐ No | Date Sent to ACLS: |
| Comments: | | |
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| **For follow-up to CAR, attach Monitoring Report showing facility in compliance.* | | |