Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060148	A. BUILDING: B. WING	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTONWOOD COTSWOLD	5215 RANDOLPH ROAD CHARLOTTE, NC 28211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an initial survey on 12/07/16, 12/08/16 and 12/09/16.	D 000	Waltonwood Cotswold will assure referral and follow-up to meet the routine and acute health care needs of our residents. We will reassure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment. This is and will be monitored by the Resident Care Manager, Regional Compliance Nurse and Executive Director. Our community will follow the policies in place to contact the attending physician to clarify all admission and readmission orders. A full chart audit of every resident was conducted during the month of January, 2017 to guarantee all resident care plans are signed and dated. This is monitored by the Resident Care Manager using a Compliance Tracker. The Compliance Tracker is supervised by the Regional Compliance Nurse and Executive Director. On December 9, 2016 a Resident Care Department meeting was held to educate and coach front line staff regarding the expectations of documentation, clarification of orders and physician follow-up. This plan of correction is in reference to the following deficiencies: D 263, D273 and D912.	
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure the resident's physician certified the care by signing and dating within 15 days of assessment completion for 1 of 5 sampled residents (#5). The findings are: Review of Resident #5's current FL2 dated 9/01/16 revealed: -Diagnoses included hypertension, prior cerebral vascular accident (CVA), chronic renal insufficiency, "possible Parkinsonism", and gastro-esophageal reflux disease. -An order for a mechanical soft diet with thickened liquids. -An order for "physical therapy, occupational	D 263		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Leah Nash TITLE Executive Director (X6) DATE January 16, 2017

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D 263	Continued From page 1 therapy and speech therapy to evaluate and treat for possible Parkinson's". Review of the Resident Register revealed an admission date of 9/15/16. Review of Resident #5's record revealed: -No care plan in Resident #5's record. -A physician's order dated 11/10/16 for "Hospice for diagnosis lymphoma". Interview on 12/07/16 at 3:30 pm with the Resident Care Director (RCD) revealed Resident #5's care plan was "in the (RCD's) office waiting for his physician to sign it". Review of Resident #5's prepared care plan revealed: -The care plan assessment was completed 10/15/16. -The resident needed limited assistance in eating, toileting, bathing, dressing and grooming, and needed no assistance in ambulation or tranfers. -There was a signature by the nurse completing the care plan. -There was no date for the signature of the nurse completing the care plan. -There was no signature by the attending physician. Further interview on 12/07/16 at 3:30 pm with the RCD revealed: -She was aware care plans were to be signed within 15 days of the resident's assessment. -She was responsible for making sure the resident care plans were signed by the physician. -She was not aware that Resident #5's physician had not returned a signed copy of the care plan dated 10/15/16 was faxed to the physician's office.	D 263	Waltonwood Cotswold will document every physician visit on the day of visit. All residents will be given the Physician Visit form for any physician visit outside and inside the community. It will be placed under the Physician Progress notes in each chart. Upon admission and readmission medications will be clarified to make sure orders are accurate. This will be monitored by the Resident Care Manager and Executive Director. The Medication Administration Record (MAR) will be monitored daily by the Resident Care Manger and Wellness Coordinators who will pull daily compliance reports from our EMAR system to assure all medications are administered correctly and any changes will be documented accurately in the MAR. This will be reviewed with the Regional Compliance Nurse and Executive Director on a monthly basis. Medication administration instructions will be followed for every residents. Proper follow up of medication and vital record parameters will be followed up with a physician notification. This will be monitored daily by the Resident Care Manager and supervised by the Executive Director. This plan of correction is in reference to the following deficiencies: D 263, D273 and D912.	

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D 263	Continued From page 2 -She was not aware if Resident #5's care plan had been faxed to his physician more than once in an attempt to get it signed. -She had not called the physician's office to request the care plan be signed. -There was no system in place to verify care plans were signed and returned timely. -She would request the physician's signature today. Telephone interview on 12/08/16 at 2:45 pm with Resident #5's physician's office representative revealed: -There was no care plan in the office files for Resident #5. -"There was lots of communications (from the facility for Resident #5) for other things, but nothing related to a care plan". -"If the facility tried to fax a care plan yesterday (12/07/16), our fax machine stays busy and it could take a while for the fax to be re-directed to the right person" for signature. Interviews on 12/07/16 at 9:50 am and 12/07/16 at 2:30 pm with Resident #5 revealed: -He was asked lots of questions and an assessment was done by a nurse when he moved into the facility. -He was not sure what all the forms were for, or who was to sign them. -His son took him to any physician appointments. -He fed himself, and was served thickened liquids, and a "chopped, soft" diet. -"I'm sure the staff would help me if I needed the assistance," but admitted he was "pretty independent". Interview on 12/07/16 at 3:40 pm with as Medication Aide revealed that Resident #5 was independent and needed very little assistance.	D 263	A Resident Care staff meeting was held on December 9, 2016 to review the community policies of physician follow up and MAR expectations with front line staff. The Resident Care Manager and Wellness Coordinator will monitor the MAR daily and make corrections as needed. This plan of correction is in reference to the following deficiencies: D 263, D273 and D912.	

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D 263	Continued From page 3 Interview on 12/08/15 at 12:15 pm with the Executive Director revealed: -She was not aware Resident #5's care plan dated 10/15/16 had not been signed by the physician. -The staff should "stalk the physician to death to get a care plan signed" which "would include faxed communications and telephone calls as necessary". -She expected staff to follow the policies of the facility, including care plans signed by the physician within 15 days. Further review of Resident #5's record on 12/09/16 at 10:00 am revealed there was no care plan signed by his physician in the record.	D 263		
D 273	10A NCAC 13F .0902(b) Health Care 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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up for 1 of 5 residents (Resident #1) by not notifying the resident's primary physician of elevated blood pressures as ordered and by not clarifying blood pressure orders and parameters upon readmission to the facility. The findings are:	D 273		

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D 273	Continued From page 4 Review of Resident #1's current FL2 dated 11/17/16 revealed diagnoses included hypertensive urgency and hypertension. Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 9/8/16. Review of Hospital Discharge Summary dated 11/17/16 revealed: -Physican's orders included metoprolol 25mg twice daily, clonidine 0.1mg three times daily, valsartan 320 mg once daily and chlorthalidone 25 mg daily (all medication used to treat high blood pressure). -Resident #1 was sent to hospital for low pulse and high blood pressures on 11/12/16 and 11/15/16. -Diagnoses listed on the discharge summary dated 11/17/16 included asymptomatic bradycardia, delirium, hypertension. -Resident #1's discharge summary and FL2 both dated 11/17/16 did not include blood pressure check orders. Review of Resident #1's record revealed: -A physician's order dated 9/30/16 to check her blood pressure twice a day and to notify the physician if the diastolic blood pressure was less than 60 or the systolic blood pressure was greater than 180. -There was no documentation that reflected the facility sought clarification of blood pressure checks and parameters at any time between 11/17/16 and 12/7/16. -There was an order dated 12/08/26 to discontinue blood pressure checks for Resident #1.	D 273		

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D 273	Continued From page 5 Review of Resident #1's October, November, and December of 2016 electronic Medication Administration Records (eMARs) revealed: -Resident #1's systolic blood pressure was above 180 sixteen times from 10/1/16 through 10/31/16. The range of these blood pressures was from 180/80 to 260/120. -Resident #1's diastolic blood pressure was less than 60 one time from 10/1/16 through 10/31/16. This blood pressure reading was 123/59. -Resident #1's systolic blood pressure was above 180 five times from 11/1/16 through 11/15/16. The range of these blood pressures was from 180/90 to 199/112. -Resident #1 had no diastolic blood pressure readings less than 60 from 11/1/16 through 11/15/16. -Resident #1 had systolic blood pressure readings above 180 seven times from 11/18/16 through 12/8/16. The range of these readings was from 180/60 to 222/82. -Resident #1 had diastolic blood pressure readings less than 60 three times from 11/18/16 through 12/8/16. The range of these blood pressures was from 94/53 to 111/54. Review of Resident #1's record revealed: -Documentation the facility contacted Resident #1's physician one time (on 10/17/16) about the resident's blood pressure. -There was no other documentation reflecting the facility notified Resident #1's physician of her blood pressures at any other time between 10/1/16 and 11/14/16. -A nurse's notes dated 11/15/16 documented "Resident was sent out to the emergency room because B/P was 220/112 and an oxygen level of 84". Interview with the Memory Care Coordinator	D 273		

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D 273	Continued From page 6 (MCC) on 12/8/16 at 10:30 AM revealed: -She was unaware that the Medication Aides had not reported and documented notifying the primary physician when Resident #1's blood pressure readings were in a reportable range. -Communication with residents' physicians occurred via telephone call or fax and was to be documented on a communication form which was to be kept in the resident's record. -If Resident #1 did not have any completed communication forms in the record, the Medication Aides had not contacted the physician. -She was unaware of any reason why Resident #1's blood pressures had not been reported to her primary physician as ordered. -She did not have a system in place to monitor whether or not Medication Aides had followed up with the physician about the blood pressures being in a reportable range to the physician. -Resident #1 had to be sent to the hospital twice for problems related to blood pressure since admission. -She was unaware Resident #1's FL2 did not include orders and parameters for blood pressure checks. -She had not clarified blood pressure checks and parameters with Resident #1's primary doctor when Resident #1 returned from the hospital on 11/17/16. -The facility's nurses, the Wellness Director and she were all responsible for ensuring that the Medication Aides followed-up on health care issues when needed. -She was responsible for checking behind the MAs to ensure medications and treatment orders were transcribed correctly on to the eMARs. Interview with three Medication Aides (MAs) on 12/8/16 at various times revealed:	D 273		

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D 273	Continued From page 7 -Resident #1's blood pressures were normally high. -When Resident #1 had high blood pressures, the MA would inform the MCC or one of the facility nurses. -MAs stated that when the concerns were reported to MCC or the facility nurses, they thought the MCC or the facility nurses would notify the primary physician. -None of the three MAs reported notifying the primary physician about Resident #1 high blood pressures via fax or telephone. -Any communication via fax or telephone call with resident's physicians was to be documented in the resident's record. -MAs stated they could document in the residents records. -MAs reported that since living in the facility, Resident #1 had been admitted to the hospital twice for high blood pressures. Interview with the Wellness Director (WD) on 12/8/16 at 2:56 PM revealed: -Resident #1 was admitted to facility with uncontrolled blood pressure problems. -Resident #1's family had reported to the facility that the resident had problems her entire life controlling her blood pressures. -Resident #1 had been seen by the facility's physician four times since admission on 9/28/16; 10/13/16; 11/4/16; and 11/17/16. -The facility staff had contacted Resident #1's physician on 11/15/16 regarding Resident #1's blood pressure being elevated. The physician informed her that he was unable to see Resident #1 and to send her to the hospital. -Resident #1 was discharged from the hospital on 11/17/16 with no written orders to check Resident #1's blood pressure. -No one from the facility documented clarifying	D 273		

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the order for Resident #1 to continue blood pressure checks twice a day; however, the MAs continued to check Resident #1's blood pressures twice per day.
-The facility had a care plan conference earlier this week with Resident #1's family, and the family decided to switch to the Hospice physician.
-Resident #1's blood pressures had not been reported to Hospice nor had the facility asked Hospice for clarification on completing blood pressure checks for Resident #1.
-She reported that currently, the facility did not have a system in place where staff documented that the discharge summary or current FL2 was reviewed when the resident returned from the hospital.
-She had not clarified blood pressure check orders for Resident #1 after the resident returned to the facility from the hospital on 11/17/16.

Interview with the Administrator on 12/8/16 at 3:30 PM revealed:
-The WD and the MCC were responsible for checking behind the MAs to ensure that all orders were clarified and that follow-up with the residents' physicians occurred when needed.
-The WD and MCC were able to pull a report from the eMAR on items the system flags that need to be followed up on.
-The WD and the MCC were responsible for ensuring follow up was documented and filed in the resident's chart.
-The Administrator was not sure how the eMAR system was monitored by staff to report a resident's blood pressures that were outside target range.
-The Wellness Director and the Memory Care Coordinator were responsible for checking behind the Medication Aides and to ensure that all orders are clarified.

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Review of a typed statement from Resident #1's primary physician received on 12/8/16 revealed:
-Resident #1 was seen by him on 11/17/16.
-He was aware of Resident #1's blood pressure.
-Resident #1 was now on Hospice.
-He had reviewed and approved Resident #1's hospital orders on 11/17/16.

Attempted interviews with Resident #1's primary physician on 12/08/16 and 12/09/16 were unsuccessful.

Telephone interview with the Hospice Registered Nurse (RN) on 12/8/16 at 4:05 PM revealed:
-Resident #1 began Hospice services on 11/18/16.
-Resident #1's vitals were taken at each visit.
-Hospice had seen Resident #1 five times since 11/18/16.
-Resident #1 had blood pressure ranges from 103/66 to 183/90.
-Hospice had not received any telephone calls from the facility reporting concerns about Resident #1's blood pressures.
-There were no orders given by Hospice to check Resident #1's blood pressures.
-She would expect the facility to notify Hospice with any abnormal blood pressure readings.
-The facility requested an order today to discontinue monitoring Resident #1's blood pressure twice per day.

Interview with Resident #1's responsible party revealed:
-Resident #1 had problems with her blood pressures her entire life.
-The Responsible party did not have any concerns about the care Resident #1 received.
-Resident #1 had 2 hospital admissions related to

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D 273	Continued From page 10 elevated blood pressures and low pulses since living in the facility. Based on record review, observation and interviews, it was determined that Resident #1 was not interviewable. The facility failed to report elevated blood pressures which were outside the physician ordered parameters for 1 of 5 residents (Resident #1). Resident #1 had diagnoses which included hypertensive urgency and hypertension which required 4 separate blood pressure medications as well as twice daily blood pressure monitoring. The failure of the facility to follow-up with Resident #1's physician could have resulted in a possible stroke, heart attack or death. This failure did result in a possible delay in the change of plan of care related to antihypertensive medications and ultimately did result in two hospitalizations. This failure was detrimental to the health of the resident and constitutes a Type B Violation. The Facility submitted a plan of protection on 12/8/16 as follows: -Contact attending physician to clarify all admission and readmission orders. -Conduct a full chart audit to confirm all orders have been clarified. -The facility will immediately provide education and training for our resident care staff regarding documentation and clarification of physician orders. -This will be monitored by the Resident Care Manager and the Executive Director. -The facility will document every physician visit on the day of the visit. -All residents will be given the Physician Visit Form for any physician visit outside and inside the	D 273		

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D 273	Continued From page 11 community. -The form will be placed under the physician progress notes in each chart. -Upon admission and readmission medications will be clarified to make sure orders are accurate. -This plan will be monitored by the Resident Care Manager and the Executive Director. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 28, 2017	D 273	Waltonwood Cotswold corrected this tag immediately by educating Culinary Director and staff regarding 10A NCAC 13F .0904 which states that all residents will always be served with a non-disposable place setting consisting of a knife, fork, spoon, plate and beverage container. This includes room service deliveries. Waltonwood policies were reviewed and edited to adhere to the regulation. The Culinary Service Director made the change on December 8th to use only real china and silverware when serving residents room service. The Culinary Service Director along with the Dining Room Supervisors will monitor this on an ongoing basis and implement training for all current and onboarding staff. This plan of correction is in reference D 287.	
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure that residents who received meals in their rooms were served on non-disposable service ware. The findings are: Observation during the 12/08/16 breakfast service at 8:50 am revealed: -A staff member leaving the dining room, and	D 287		

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D 287	Continued From page 12 carrying a tray with a Styrofoam to go box, a small Styrofoam plate with a fruit plate of 2 strawberries, 1 blackberry, 2 orange slices and 5 grapes and covered with plastic wrap, and a disposable cup with a plastic lid with a tea bag on top. No silverware was on the tray. -This staff member delivered the tray to a resident's room, set the tray on a table, and obtained a non-disposable knife, fork and spoon from the resident's kitchenette. -The resident's Styrofoam to go box contained an omelet with peppers, and an English muffin. Interview on 12/08/16 at 8:50 am with the staff member who delivered the meal to Resident #7's room revealed: -She was a Personal Care Aide (PCA) on first shift. -The kitchen prepared room trays for residents who did not want to go to the dining room. -The food delivered to the room was always served in disposable containers. -She was not aware the reason why non-disposable containers were not used. -She had never asked anyone about the use of the Styrofoam containers. Interview on 12/08/16 at 8:55 am with Resident #7 revealed: -She occasionally liked to eat in her room when she did not want to awaken early. -When she requested her meals delivered to her room, they were always served in Styrofoam containers or plates, but she used a non-disposable knife, fork and spoon from her kitchenette. -She was not aware the reason why non-disposable containers were not used. -It did not bother her to be served disposable containers. "I'm sure that is easier for the staff."	D 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060148	A. BUILDING: B. WING	12/09/2016

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D 287	Continued From page 13 Interview on 12/08/16 at 9:15 am with a dining room aide revealed: -The residents who ate in their rooms were served their food on disposable, Styrofoam containers, plates and cups. -She did not know why the residents who ate in their room were served on Styrofoam. -There were tray lids for the non-disposable plates that could be used for those residents. -She had never asked anyone about the use of the Styrofoam containers. Interview on 12/08/16 at 9:15 am with the Sous Chef and the lead kitchen server revealed: -For residents who were served meals in their rooms, "we always use disposable containers. If we send plates out, we do not always get them back." -There were enough non-disposable plates, glasses and silverware in the facility that could be used for residents who were served meals in their rooms. Interview on 12/08/6 at 9:25 am with the Chef revealed: -Residents were to be served non-disposable plates and table service even if the resident ate in their room. -The PCA picked up a resident's meal in the kitchen, delivered it to the resident's room, then returned later to collect the dirty dishes to be returned to the kitchen for cleaning. -Residents were not to be served disposable containers. Second interview at 12/08/16 at 11:00 am with the Chef revealed that staff "have been instructed to serve china to residents' rooms".	D 287		

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D 287	Continued From page 14 Interview on 12/08/16 at 12:15 pm with the Administrator revealed: -She had not been aware the residents who ate in their rooms were served on Styrofoam to-go containers. -There had not been any residents or families ever complain to her about the residents being served on Styrofoam. -The residents were to be served their meals on china, even those who ate in their rooms.	D 287		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding referral and follow up to the primary care physician. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 1 of 5 sampled residents (Resident #1) by not notifying the resident's primary care physician of elevated blood pressures as ordered. [Refer to Tag 273, 10A NCAC 13F .0902(b) (Type	D912		

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D912	Continued From page 15 B Violation).]	D912		