STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 conducted a complaint investigation with onsite visits on March 3-4, 2021, March 9, 2021, and March 11, 2021 and desk review survey on March 5, 2021, March 8, 2021, March 10, 2021, and March 12, 2021 with a telephone exit on March 12, 2021.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and telephone interviews, the facility failed to provide supervision in accordance with the resident's assessed needs for 2 of 4 sampled residents (#2, #3), including a resident who was found sleeping in his shower in a t-shirt and urine-soaked adult briefs (#2) and a resident with 11 unwitnessed falls resulting in right thumb and wrist contusions, right elbow and wrist bruises (#3). The findings are: 1. Review of the facility's Falls Management policy updated June 2019 revealed: -There were procedures for a fall without suspicion of a fracture or head injury and a fall with suspicion of a fracture or head injury. -The procedure for a fall without an injury was to observe the resident for visible signs of injury,	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 1	D 270		

staff were to check the resident's vital signs, consciousness, broken/bruised skin, pain, swelling, inability to move, bleeding, provided first aide, notified the physician, completed an incident report, and documented all actions in the resident record.
-The procedure for a fall with an injury was as follows: staff were to notify emergency management services (EMS) if the resident complained of pain, there was a suspicion of fractures, or head injury, staff were to request a refusal form if a resident or Power of Attorney (POA) refused medical transport, staff notified the physician, reported the incident to oncoming shift, completed an incident report, and documented all actions in the resident's record.

Review of Resident #3's current FL-2 dated 10/22/20 revealed:
-Diagnoses included mixed Lewy body and subcortical vascular dementia, gait instability, urinary retention with incomplete bladder emptying, and adjustment disorder with mixed anxiety and depression.
-Resident #3 need personal care assistance with bathing, feeding, dressing and required total care with activities of daily living (ADL).
-Resident #3 was semi-ambulatory and she had an indwelling catheter.

Review of Resident #3's Resident Register revealed she was discharged from the facility on 11/09/20.

Review of Resident #3's care plan with a reassessment date of 12/06/19 revealed:
-Resident #3 resided on the memory care unit.
-Resident #3 was assessed to exhibit wandering behaviors and was ambulatory with an assistive device (rollator).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 2	D 270		

-Resident #3 had significant memory loss and needed directions for tasks.
-Resident #3 needed extensive assistance from staff with toileting.
-Resident #3 needed extensive assistance from staff with ambulation/locomotion.
-Resident #3 needed supervision from staff with transfers.

a. Review of Resident #3's incident report dated 01/08/20 revealed:
-Resident #3 was found on the floor at the entryway of her bathroom on first shift.
-Resident #3 had swelling in her right thumb.
-Resident #3's Primary Care Provider (PCP) and POA were notified.
-Resident #3 was not transported to the hospital on 01/08/20.
-The incident report was reviewed by the Memory Care Wellness Director (MCWD who was equivalent to the position of Resident Care Coordinator), the former Executive Director (ED), and the former facility Registered Nurse (RN).

Review of Resident #3's handwritten progress notes dated 01/08/20 at 7:30am revealed:
-Resident #3 was found on floor in front of the entryway of her bathroom.
-Resident #3's right thumb was bruised, and the plan was to monitor the thumb "for the next couple of days".
-Staff spoke with PCP's nurse, and staff spoke with the POA's family member.

Review of Resident #3's handwritten progress note dated 01/09/20 revealed:
-Staff noted at 7:30am Resident #3's right thumb was bruised and "really swollen".
-Resident #3's POA was called and he was enroute to take Resident #3 to obtain an x-ray.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 3 -Resident #3 denied pain. Review of Resident #3's second handwritten progress note dated 01/09/20 revealed: -The medication aide (MA) spoke with the POA and Resident #3 did not have a fracture. -There was no time documented for this note. Review of Resident #3's third handwritten progress note dated 01/09/20 revealed: -The time of the notes was for 3:00pm to 11:00pm. -Resident #3's x-ray indicated she did not have a fracture per her POA. -Resident #3's right thumb was bruised and swollen. Review of Resident #3's January 2020 activities of daily living (ADL) record revealed: -Hourly safety checks were completed from 01/01/20 to 01/31/20. -On 01/09/20, Resident #3 was out of the facility. Review of Resident #3's urgent orthopedic physician after visit summary dated 01/09/20 revealed: -Resident #3 was brought to the office by her POA. -Resident #3 had right thumb and right wrist contusions without nail damage. -Resident #3 had right wrist pain at the level of 2 out of 10. -Resident #3's x-rays showed soft tissue swelling over the right thumb and wrist without fractures. -There were no interventions ordered for Resident #3 to prevent her from falling. Attempted telephone interview on 03/12/21 at 12:25pm with the former MA, who completed Resident #3's 01/08/20 incident report, was	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 4 unsuccessful. Refer to telephone interview with Resident #3's POA on 03/10/21 at 9:11am. Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am. Refer to telephone interview with a MA on 03/11/21 at 11:39am. Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm. Refer to telephone interview with a former MA on 03/10/21 at 12:30pm. Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am. Refer to interview with the facility's RN on 03/11/21 at 4:08. Refer to interview with the ED on 03/11/21 at 4:25pm. Refer to telephone interview with the ED 03/12/21 at 1:47pm. b. Review of Resident #3's incident report dated 01/27/20 revealed: -Resident #3 was found on the floor in her room and had a red bruise on her right elbow. -Resident #3 did not have any pain. -Resident #3's POA and PCP were notified on 01/27/20 at 9:51 am. Review of Resident #3's handwritten progress notes dated 01/27/20 revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 5	D 270		

-Resident #3 was found on the floor by a personal care aide (PCA) with a hand full of candy.
-Resident #3 did not have any injuries, but she had a red spot and small bruise on her right elbow.
-Resident #3's vital signs were documented as blood pressure (BP): 123/62, pulse: 87 beats per minute respirations: 16, and temperature: 98.4 degrees Fahrenheit (F).
-Resident #3's POA and PCP were notified.
-There were new orders from Resident #3's PCP.

Review of Resident #3's January 2020 ADL record revealed hourly safety checks were completed from 01/01/20 to 01/31/20.

Review of Resident #3's PCP office notification dated 01/30/20 revealed:
-There was a notification for Resident #3 to the PCP's call center.
-There were no new orders or interventions for Resident #3.

Review of an electronic mail from Resident #3's POA to the Executive Director (ED) dated 02/27/20 revealed:
-Resident #3 had a sitter from an agency.
-Resident #3's POA expressed concerns that the facility was not taking responsibility of the care of Resident #3 because she had a sitter.
-Resident #3's POA welcomed another care planning meeting to further discuss the plan of care for Resident #3.

Attempted telephone interview on 03/12/21 at 12:23pm with the former MA who completed Resident #3's 01/27/20 incident report was unsuccessful.

Refer to telephone interview with Resident #3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 270	Continued From page 6	D 270		

POA on 03/10/21 at 9:11am.

Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am.

Refer to telephone interview with a MA on 03/11/21 at 11:39am.

Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm.

Refer to telephone interview with a former MA on 03/10/21 at 12:30pm.

Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am.

Refer to interview with the facility's RN on 03/11/21 at 4:08.

Refer to interview with the ED on 03/11/21 at 4:25pm.

Refer to telephone interview with the ED 03/12/21 at 1:47pm.

c. Review of Resident #3's handwritten progress notes dated 04/21/20 revealed:
-The note was written on the 3:00pm to 11:00pm shift.
-Resident #3 was "yelling and screaming, very agitated, very anxious" and she was exit seeking.
-Staff attempted to redirect Resident #3 unsuccessfully.

Review of Resident #3's second handwritten progress note dated 04/21/20 revealed
-The time of the note was 5:32pm.
-Resident #3 was observed on the floor next to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 7	D 270		

her bed sitting on her buttocks.
-Resident #3 did not have pain or injuries.
-Resident #3's POA was notified.
-There were new orders from Resident #3's PCP.

Review of Resident #3's third handwritten progress note dated 04/21/20 revealed:
-The time of the note was third shift.
-Resident #3 complained of back pain at 6:30am and the MA noted she would give Resident #3's scheduled Tylenol at 7:00am.
-Resident #3 had a bruise on her right wrist but did not complain of wrist pain.
-There were new orders from Resident #3's PCP.

Based on record reviews, there was no incident report for Resident #3 dated 04/21/20.

Review of Resident #3's April 2020 ADL record revealed hourly safety checks were completed from 04/01/20 to 04/31/20.

Review of Resident #3's PCP office after visit summary revealed she was evaluated by the PCP on 04/23/20, but no new orders were given.

Attempted telephone interview on 03/12/21 at 12:23pm with the former MA, who completed Resident #3's 04/21/20 handwritten progress note, was unsuccessful.

Refer to telephone interview with Resident #3's POA on 03/10/21 at 9:11am.

Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am.

Refer to telephone interview with a MA on 03/11/21 at 11:39am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 8	D 270		

Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm.

Refer to telephone interview with a former MA on 03/10/21 at 12:30pm.

Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am.

Refer to interview with the facility's RN on 03/11/21 at 4:08.

Refer to interview with the ED on 03/11/21 at 4:25pm.

Refer to telephone interview with the ED 03/12/21 at 1:47pm.

d. Review of Resident #3's handwritten progress notes dated 05/05/20 revealed:
-Resident #3 observed sitting on the floor next to her closet.
-Resident #3 was not injured.
-Resident #3's POA was notified.
-There were no new interventions put into place for Resident #3, nor was the PCP notified.

Based on record reviews, there was no incident report for Resident #3 dated 05/05/20.

Review of Resident #3's May 2020 ADL record revealed there was documentation that hourly safety checks were completed from 05/01/20 to 05/20/20.

Review of Resident #3's Psychiatric provider visit dated 05/27/20 revealed:
-Staff reported resident fell on 05/05/20.
-There were no changes made to Resident #3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 9	D 270		

medications.
-There were no new orders or interventions to prevent Resident #3 from falling.

Review of Resident #3's PCP after visit summary dated 05/14/20 revealed:
-Resident #3 had a fall on 05/14/20.
-There was no documentation concerning a fall on 05/05/20 or interventions put into place after the falls.

Review of Resident #3's PCP after visit summary dated 05/19/20 revealed Resident #3 had medication changes for Seroquel, senekot, and magnesium hydroxide.

Attempted telephone interview on 03/12/21 at 12:23pm with the former MA, who completed Resident #3's 05/05/20 handwritten progress note, was unsuccessful.

Refer to telephone interview with Resident #3's POA on 03/10/21 at 9:11am.

Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am.

Refer to telephone interview with a MA on 03/11/21 at 11:39am.

Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm.

Refer to telephone interview with a former MA on 03/10/21 at 12:30pm.

Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 10	D 270		

Refer to interview with the facility's RN on 03/11/21 at 4:08.

Refer to interview with the ED on 03/11/21 at 4:25pm.

Refer to telephone interview with the ED 03/12/21 at 1:47pm.

e. Review of Resident #3's handwritten progress notes dated 05/20/20 revealed:
-Resident #3 was observed on her blanket on the floor without injuries or bruises.
-Resident #3 denied pain and was assisted off the floor to eat dinner.
-Resident #3's POA was notified and there was documentation the POA stated "why laying on the blanket on the floor considered a fall?"
-There were no interventions put into place after Resident #3 was found on the floor, nor was the PCP notified.

Based on record reviews, there was no incident report for Resident #3 dated 05/20/20.

Review of Resident #3's electronic charting notes dated 05/21/20 revealed the Memory Care Wellness Director (MCWD) noted the resident was placed on every 30 minutes checks until "sitters can return" to the facility.

Review of Resident #3's May 2020 ADL revealed thirty-minute safety checks were completed from 05/21/20 to 05/31/20.

Review of Resident #3's Psychiatric provider visit dated 05/27/20 revealed:
-Staff reported resident fell on 05/20/20.
-There were no changes made to Resident #3's medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 11 Attempted telephone interview on 03/12/21 at 12:23pm with the former MA, who completed Resident #3's 05/20/20 handwritten progress note, was unsuccessful. Refer to telephone interview with Resident #3's POA on 03/10/21 at 9:11am. Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am. Refer to telephone interview with a MA on 03/11/21 at 11:39am. Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm. Refer to telephone interview with a former MA on 03/10/21 at 12:30pm. Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am. Refer to interview with the facility's RN on 03/11/21 at 4:08. Refer to interview with the ED on 03/11/21 at 4:25pm. Refer to telephone interview with the ED 03/12/21 at 1:47pm. f. Review of Resident #3's handwritten progress notes dated 05/24/20 revealed: -The note did not have a time documented. -Resident #3 was found on the floor in the doorway of her closet without injuries. -Resident #3's PCP was notified, and staff spoke	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 12	D 270		

with a nurse.
-There were no interventions ordered by the PCP.

Based on record reviews and interviews on 03/11/21, there was no incident report for Resident #3 dated 05/24/20.

Review of Resident #3's May 2020 ADL revealed thirty-minute safety checks were completed from 05/21/20 to 05/31/20.

Review of Resident #3's Psychiatric provider visit dated 05/27/20 revealed:
-Staff reported Resident #3 was found on the floor in the doorway of her closet.
-There were no changes made to Resident #3's medications.

Review of Resident #3's PCP after visit summary revealed she was evaluated by the PCP on 05/24/20, but no new orders were given.

Telephone interview on 03/11/21 at 12:23pm with the MA, who completed Resident #3's 05/24/20 handwritten progress note, revealed:
-She worked in the memory care unit (MCU) as a MA/PCA on second shift.
-She remembered Resident #3 and she needed assistance with toileting, dressing, emptying her catheter drainage bag, and bathing.
-Resident #3 had a sitter and until the coronavirus pandemic restrictions were put into place.
-When a resident fell, the MAs had to complete an incident report and notify the POA and PCP.
-She did not recall any interventions put into place for Resident #3 after the fall.
-The management team had meetings with staff about resident falls, but she did not know of any changes for Resident #3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 13 Refer to telephone interview with Resident #3's POA on 03/10/21 at 9:11am. Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am. Refer to telephone interview with a MA on 03/11/21 at 11:39am. Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm. Refer to telephone interview with a former MA on 03/10/21 at 12:30pm. Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am. Refer to interview with the facility's RN on 03/11/21 at 4:08. Refer to interview with the ED on 03/11/21 at 4:25pm. Refer to telephone interview with the ED 03/12/21 at 1:47pm. g. Review of Resident #3's incident report dated 05/26/20 revealed: -Resident #3 was found on the floor in front of the couch in the living room area. -Resident 3 had no injuries. -Resident #3's POA and PCP were notified. -The MCWD reviewed the incident report and documented "still waiting on son to decide about sitters, resident on thirty-minute checks." Review of Resident #3's electronic charting notes dated 05/26/20 revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 270	Continued From page 14	D 270		

-Resident #3 was observed sitting on the floor in front of the couch.
-Resident #3 had no injuries.
-Resident #3's POA and the facility's contracted provider were notified.
-There were no interventions ordered for Resident #3.

Review of Resident #3's May 2020 ADL revealed thirty-minute safety checks were completed from 05/21/20 to 05/31/20.

Review of Resident #3's PCP after visit summary dated 05/26/20 revealed:
-Resident #3's PCP was notified of the fall.
-There were no interventions ordered for Resident #3 to prevent falls.

Telephone interview on 03/11/21 at 5:16pm with the MA, who completed Resident #3's 05/26/20 incident report, revealed:
-Resident #3 would walk backwards without her walker.
-She thought Resident #3 fell purposely.
-Resident #3 would try to sit on other residents.
-She did not know of anything put into place after the 05/26/20 fall that would prevent Resident #3 from falling.

Refer to telephone interview with Resident #3's POA on 03/10/21 at 9:11am.

Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am.

Refer to telephone interview with a MA on 03/11/21 at 11:39am.

Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 270	Continued From page 15 Refer to telephone interview with a former MA on 03/10/21 at 12:30pm. Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am. Refer to interview with the facility's RN on 03/11/21 at 4:08. Refer to interview with the ED on 03/11/21 at 4:25pm. Refer to telephone interview with the ED 03/12/21 at 1:47pm. h. Review of Resident #3's incident report dated 07/26/20 revealed: -Resident #3 was found sitting on the floor in front of her recliner chair without injuries. -Resident #3's POA was notified. -The MCWD documented that Resident #3 was on thirty-minute checks, would remain on thirty-minute checks until sitters could resume for Resident #3, Resident #3 was encouraged to ask staff for assistance and use call light. Review of Resident #3's electronic charting notes dated 07/26/20 revealed: -Resident #3 was found sitting on the floor in front of her recliner without injuries. -Resident #3 was given the call light to use. Review of Resident #3's July 2020 ADL revealed thirty-minute safety checks were completed from 07/01/20 to 07/31/20. Review of Resident #3's PCP after visit summary dated 07/09/20 revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 270	Continued From page 16 -There was a telehealth visit, but there were no details provided of the evaluation. -There were no interventions indicated for falls prevention. Review of Resident #3's Psychiatric provider visit dated 08/05/20 revealed: -Staff reported resident fell on 07/20/20. -There were no changes made to Resident #3's medications. Attempted telephone interview on 03/12/21 at 12:23pm with the former MA, who completed Resident #3's 07/26/20 incident report, was unsuccessful. Refer to telephone interview with Resident #3's POA on 03/10/21 at 9:11am. Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am. Refer to telephone interview with a MA on 03/11/21 at 11:39am. Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm. Refer to telephone interview with a former MA on 03/10/21 at 12:30pm. Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am. Refer to interview with the facility's RN on 03/11/21 at 4:08. Refer to interview with the ED on 03/11/21 at 4:25pm.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 270	Continued From page 17 Refer to telephone interview with the ED 03/12/21 at 1:47pm. i. Review of Resident #3's incident report dated 07/29/20 revealed: -Resident #3 was found sitting on the floor beside her bed and she reported she was trying to reach down to grab her shoes. -Resident #3 did not have any injuries. -Resident #3's POA and PCP were notified. -The MCWD documented that Resident #3 was currently on thirty-minute checks and will stay until the "COVID band" was lifted and Resident #3's sitters could return to work. -The MCWD also documented she encouraged Resident #3 to use her call bell and ask staff for help. -The MCWD contacted Resident #3's POA and left a message for Resident #3's PCP about the fall and weight loss. -The MCWD documented the "issue" would be revisited in two weeks to determine if Resident #3 was "hospice ready." -The ED reviewed the incident report on 08/13/20 and documented the MCWD would call Resident #3's POA to make him aware that Resident #3's sitters could return to the facility. Review of Resident #3's electronic charting notes dated 07/29/20 revealed: -The MA documented Resident #3 had a fall without an injury and her vital signs were 98.1-56-17 with a blood pressure of 141/93. -The MCWD documented that she spoke with the POA about Resident #3's falls and weight loss. -The POA told the MCWD that Resident #3's PCP was aware, and labs were drawn during Resident #3's last PCP office visit. -There was a second note documented by the	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 18	D 270		

MCWD that noted Resident #3 would continue with thirty- minute safety checks and would revisit the "hospice issue" in two weeks.
-The MCWD documented she encouraged Resident #3 to use the call bell and ask staff for help.

Review of Resident #3's July 2020 ADL revealed thirty-minute safety checks were completed from 07/01/20 to 07/31/20.

Review of Resident #3's PCP after visit summary dated 07/29/20 revealed:
-There was documentation that Resident #3's PCP was made aware of the fall.
-There were no orders for interventions to prevent falls for Resident #3.

Attempted telephone interview on 03/12/21 at 12:23pm with the former MA, who completed Resident #3's 07/29/20 incident report, was unsuccessful.

Refer to telephone interview with Resident #3's POA on 03/10/21 at 9:11am.

Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am.

Refer to telephone interview with a MA on 03/11/21 at 11:39am.

Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm.

Refer to telephone interview with a former MA on 03/10/21 at 12:30pm.

Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 270	Continued From page 19 10:09am. Refer to interview with the facility's RN on 03/11/21 at 4:08. Refer to interview with the ED on 03/11/21 at 4:25pm. Refer to telephone interview with the ED 03/12/21 at 1:47pm. j. Review of Resident #3's incident report dated 08/06/20 revealed: -Resident #3 was found sitting on the floor beside her recliner chair without injury or pain. -Resident #3's POA was notified at 2:30pm on 08/06/20. -The MCWD reviewed the incident report on 08/27/20 at 2:21pm and documented Resident #3 would remain on thirty-minute safety checks. -The MCWD also documented she would determine if Resident #3's POA would agree with sitters coming back to sit with Resident #3. -The ED reviewed the incident report on 09/03/20 at 10:12am. Review of Resident #3's electronic charting notes dated 08/06/20 revealed: -Resident #3 was agitated and refused all medications and breakfast. -Resident #3 had a loud outburst during activities. Review of Resident #3's August 2020 ADL record revealed thirty-minute safety checks were completed from 08/01/20 to 08/31/20. Attempted telephone interview on 03/12/21 at 12:28pm with the MA, who completed Resident #3's 08/06/20 incident report, was unsuccessful.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 270	Continued From page 20	D 270		

Refer to telephone interview with Resident #3's POA on 03/10/21 at 9:11am.

Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am.

Refer to telephone interview with a MA on 03/11/21 at 11:39am.

Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm.

Refer to telephone interview with a former MA on 03/10/21 at 12:30pm.

Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am.

Refer to interview with the facility's RN on 03/11/21 at 4:08.

Refer to interview with the ED on 03/11/21 at 4:25pm.

Refer to telephone interview with the ED 03/12/21 at 1:47pm.

k. Review of Resident #3's incident report dated 08/20/20 revealed:
-Resident #3 was found on the living room floor "hollering" for help in a sitting position.
-Resident #3 did not have any injuries.
-Resident #3's POA was notified and he was concerned that Resident #3 was up so early and dressed.
-Resident #3's POA was concerned that it contributed to the fall.

Review of Resident #3's electronic charting notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 270	Continued From page 21	D 270		

dated 08/20/20 revealed:
-Resident #3 was found on the living room floor at the entryway in a sitting position and she was yelling.
-Resident #3 did not have her walker and she told the MA that it was too early, and she wanted to go to bed.

Review of Resident #3's August 2020 ADL record revealed thirty-minute safety checks were completed from 08/01/20 to 08/31/20.

Review of Resident #3's PCP after visit summary dated 09/21/20 revealed:
-Resident #3's PCP spoke with someone concerning hospice care.
-There was no consultation order for hospice or interventions to prevent falls.
-There were no PCP after visit summaries for August 2020.

Telephone interview on 03/11/21 at 5:16pm with the MA who completed Resident #3's 08/20/20 incident report revealed:
-She thought part of the problem with Resident #3's repeated falls was the time of morning staff were instructed by the MCWD to get residents up out of the bed and dressed for breakfast.
-Staff began getting residents up and out of the bed at 4:30am and she expressed her concerns to the MCWD.
-She was told residents needed to be up to eat breakfast, but breakfast was not served until after 7:15am.
-Staff made rounds to check residents who were in the hot box every thirty-minutes.
-A resident was placed in the hot box after a fall and the resident was monitored for the next 72 hours by taking their vital signs each shift.
-Resident #3 was a fall risk, because she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 22	D 270		

lean back when she stood and fall on the floor.
-Resident #3's PCP was made aware of her falls.
-Resident #3's fall on 08/20/20 was one of those times when she pushed her walker away and walked backwards.
-Resident #3 did not have any injuries.
-She did not recall anything else put into place to prevent Resident #3 from falling.

Refer to telephone interview with Resident #3's POA on 03/10/21 at 9:11am.

Refer to telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am.

Refer to telephone interview with a MA on 03/11/21 at 11:39am.

Refer to interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm.

Refer to telephone interview with a former MA on 03/10/21 at 12:30pm.

Refer to interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am.

Refer to interview with the facility's RN on 03/11/21 at 4:08.

Refer to interview with the ED on 03/11/21 at 4:25pm.

Refer to telephone interview with the ED 03/12/21 at 1:47pm.

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Telephone interview with Resident #3's POA on 03/10/21 at 9:11am revealed:
-He had observed staff in the MCU sitting behind

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 23	D 270		

the nurse's station on their cellphones and not engaging with residents.
-Staff were not attentive and Resident #3 was in a room that was at the end of a hallway which was away from the nurse's station, prior to the coronavirus pandemic.
-He had discussed this with the Administrator.
-These things contributed to Resident #3 falling frequently, because she might get up to walk around room, to the bathroom or to get something out of her dresser and fall.
-Staff were not attentive to Resident #3 and the facility thought sitters were needed to do what staff did not want to do for Resident #3.
-The MCWD pushed to have Resident #3 placed in a skilled nursing facility (SNF).
-Staff were not able to identify the skilled nursing task needed by Resident #3 to constitute her discharge to a SNF.
-Because of the dates of these events, he could not recall specific dates.

Telephone interview with Resident #3's POA's spouse on 03/12/21 at 8:21am revealed:
-Resident #3 fell frequently and her POA was always notified by staff.
-She thought Resident #3's weight loss may have contributed to the falls.
-A meeting was held in February 2020 with the facility staff, the POA, the physician, and herself.
-Resident #3's PCP stated she was open to suggestions for Resident #3.
-Resident #3's PCP was aware of the falls and knew Resident #3 needed closer observation.
-She attempted to speak with the ED, but she would refer her to the MCWD.
-Resident #3 had a fall in the living room because her wheelchair was not locked.
-Staff were not always around to keep Resident #3 engaged.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 24	D 270		

-She thought the facility was short of staff and that contributed to Resident #3's falls.
-Resident #3's POA sent an email dated 02/27/20 to the ED explaining that having a sitter for Resident #3 did not relieve the staff of their duty to care for Resident #3.

Telephone interview with a MA on 03/11/21 at 11:39am revealed:
-She remembered Resident #3.
-She thought staff became frustrated with Resident #3 and would take her down to her room to sit down.
-She thought Resident #3 had a lot of undocumented falls.
-Staff were supposed to make rounds every 2 hours.
-Resident #3's room was at the end of the hallway and she did not recall any discussion of moving her room closer to the nurse's station.
-She thought the facility used bed, and chair alarms and floor mats but she did not recall Resident #3 having any of those items.
-She had seen Resident #3 fall multiple times or found her already on the floor in her room.
-She did not recall Resident #3 having any injuries, but she would call out for help.

Interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm revealed:
-She had worked at the facility since August 2020.
-An incident report was completed by the MA for any resident who fell, was sent to the hospital, injured, or had a significant change.
-The generation of an incident report in the computer system caused an email to be sent to herself, the ALWD, MCWD, and the ED.
-She reviewed residents' incident reports.
-A weekly meeting was held with the ALWD, MCWD, and the ED to review the incident reports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 25	D 270		

together.
-At the weekly meeting, management staff identified residents who fell frequently, discussed implementing interventions, and gave the paperwork to the regional nurse.
-Each week, a list of residents who fell was sent to the regional nurse.

Telephone interview with a former MA on 03/10/21 at 12:30pm revealed:
-MA were responsible for completing an incident report when a resident fell.
-MAs notified the POA and PCP when a resident fell.
-Prior to the coronavirus pandemic, Resident #3's POA visited frequently and after the coronavirus pandemic he was not able to visit but a tablet was set up for Resident #3.
-Resident #3 fell a lot and staff stated she missed the chair.
-Many staff would tell Resident #3 to sit down but did not ensure a chair was directly behind her when they told her to sit down.
-Resident #3 was placed in her recliner chair in her room and sometimes was not able to understand how to get up from the recliner.
-She had contacted Resident #3's POA about falls, but she did not recall anything new put into place to prevent her from falling.

Interview with a MA/former Assisted Living Wellness Director (ALWD) on 03/11/21 at 10:09am revealed:
-He remembered Resident #3 because she was admitted to AL when she first came to the facility.
-When she was in AL, she walked frequently and had a friend she walked with daily.
-As time moved on, Resident #3 became more forgetful and she was moved to the MCU.
-He did not recall the date Resident #3 moved to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 26 the MCU. -He thought that Resident #3 fells because she forgot to use her walker frequently and cognitive changes. -Resident #3 had sitters to stay with her prior to the coronavirus pandemic. Interview with the facility's RN on 03/11/21 at 4:08 revealed: -When a resident fell, the management team tried to find the root cause of the falls. -The management team would discuss interventions as well as if the facility could meet the needs of the resident. -Some of the interventions put into place were safety checks which could be every thirty-minutes, one hour, or two hours. -The MCWD could put the safety checks in to the computer system to make staff aware of the frequency of checks for each resident. -She began reviewing resident incident reports in August 2020 and she did not complete a review of previous falls prior to August 2020 for Resident #3. -Any interventions that were ordered or implemented for a resident were placed under notes on the incident report. -Resident #3 had s sitter but she did not know the exact dates. -By October 2020, she thought the facility had exhausted everything they could do to prevent Resident #3 from falling. -She did not speak with Resident #3's POA and the MCWD would know if any interventions were ordered by Resident #3's PCP. -She did not recall any interventions put into place to prevent Resident #3 from falling. -She did not recall the frequency of safety checks for Resident #3 without referring to Resident #3's record.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 270	Continued From page 27	D 270		

-When staff documented that the safety checks were completed, she trusted the documentation meant that the safety check was done.
-She expected staff to check residents every 2 hours.

Interview with the ED on 03/11/21 at 4:25pm revealed:
-Resident #3 had safety checks and the MCWD planned to investigate possible hospice, and additional staffing in the form of sitters were in place to prevent her from falling.
-She recalled Resident #3's urine was checked frequently to determine if Resident #3 had a urinary tract infection.
-Resident #3's PCP was contacted concerning the falls.
-She did not recall if Resident #3's PCP ordered any interventions.
-The facility held a weekly meeting to review falls for all residents.
-Due to various circumstances, the management team did not always have the weekly meeting.
-She had access to look at all the incident reports for residents.
-She became the interim ED February 2020 and the permanent ED April 2020.
-She had not reviewed Resident #3's incident reports for falls prior to August 2020.
-She missed reviewing some of the incident reports because things were in flux.
-She recalled that there was a care meeting with Resident #3's POA, PCP, and the management team, because of her falls.
-She did not know the date of the meeting with Resident #3's PCP and POA.
-Resident #3's POA did not want to move her to a SNF.
-A hospice recommendation was given by her PCP or there were orders to obtain a urinalysis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 28	D 270		

from Resident #3.
-Resident #3 had a sitter at one point, and that was helpful in preventing her from falling.
-After the COVID-19 restrictions were in place, Resident #3's POA was not comfortable with the sitters because the sitters worked in other facilities.
-After the coronavirus pandemic, Resident #3 did not have a sitter.
-When a resident fell, the MA notified the resident's PCP and if the PCP was not notified the MCWD notified the PCP.

Telephone interview with the ED 03/12/21 at 1:47pm revealed:
-She expected safety checks to be completed and documented in the computer system.
-A safety check was when staff "laid eyes" on a resident and ensured they were safe and not on the floor.
-An unwitnessed fall was when a resident fell, and staff were not present to witness it.
-An incident report was completed for all unwitnessed falls.
-She was not aware of specific unwitnessed falls for Resident #3.
-She thought Resident #3 was admitted to hospice, but she did not know the date of her admission.
-She was not certain of any other interventions used for Resident #3 to prevent her from falling.
-She did not know Resident #3 had 10 unwitnessed falls and she did not know about Resident #3's unwitnessed falls on 04/21/20, 05/05/20, 05/20/20 and 05/24/20 that did not have a coinciding incident report.
-The PCA's were responsible for doing the safety checks, the MAs were responsible for ensuring the documentation was completed for the safety check, the MCWD was responsible for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 29 communicating unwitnessed falls to her. Attempted telephone interview with Resident #3's PCP on 03/10/21 at 8:21am and 03/11/21 at 9:54am was unsuccessful. Attempted telephone interview with the MCWD on 03/11/21 at 1:11pm was unsuccessful. 2. Review of Resident #2's FL-2 dated 12/28/20 revealed: -Resident #2 had a diagnosis of Alzheimer's disease. -Resident #2 was constantly disoriented. -Resident #2 was semi-ambulatory. Review of Resident #2's Resident Register dated 12/28/20 revealed: -Resident #2 was admitted to the facility on 12/28/20. -Resident #2 required assistance with dressing, bathing, and orientation to time and place. -Resident #2 had significant memory loss and needed redirection. Review of Resident #2's assessment and care plan dated 12/30/20 revealed: -Resident #2 was always disoriented. -Resident #2 had significant memory loss and needed redirection. -Resident #2 required supervision with eating. -Resident #2 required limited assistance with toileting, ambulation/locomotion, and transferring. -Resident #2 required extensive assistance with bathing, dressing, and grooming/personal hygiene. Review of Resident #2's activities of daily living (ADLs) log for January 2021 revealed: -Rounds were conducted hourly on Resident #2.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 30	D 270		

-Resident #2 was checked on every two hours to see if he needed assistance with toileting or incontinent care.

Telephone interview with a former staff on 03/08/21 at 4:39pm revealed:
-In January 2021, Resident #2 was found sleeping in his shower.
-The medication aide (MA) took a picture of Resident #2 sleeping in the shower.
-The MA sent the picture to the Memory Care Wellness Director (MCWD) who then provided the picture to the Executive Director (ED).
-The ED showed the picture of Resident #2 to staff during a meeting in January 2021.
-The ED was "upset" and told staff it was unacceptable treatment for the resident.

Telephone interview with a Personal Care Aide (PCA) on 03/10/21 at 2:28pm revealed:
-She came in at 7:00am on 01/24/21.
-She was assisting the residents into the dining room for breakfast.
-She did not see Resident #2 in the dining room so she went to get him from his room.
-Resident #2 was not in his room.
-Resident #2's bed was made and it was undisturbed.
-She went back to the dining room, thinking she had missed seeing Resident #2.
-Resident #2 was not in the dining room so she went back to his room.
-From inside Resident #2's room, she saw Resident #2's feet on the bathroom floor and it looked like Resident #2 was lying in the shower.
-Resident #2 was asleep in the shower with his knees pulled up under the rest of his body.
-The water was not on in the shower.
-Resident #2 was wearing a t-shirt and urine-soaked adult briefs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 31 -Resident #2 must have been sleeping in the shower all night because his bed did not look like anyone had been on it. -She woke up Resident #2; he could not tell her what happened or why he was in the shower. -She reported the situation to the MA and the MA told management about it. -The ED conducted a mandatory staff meeting and told staff it was unacceptable treatment for the resident. -The third shift staff who worked the night Resident #2 slept in the shower were not present at the meeting. Telephone interview with the ED on 03/12/21 at 2:12pm revealed: -She did not know which staff was responsible for completing rounds on Resident #2 during third shift on January 24, 2021. -Shortly after Resident #2 was found asleep in the shower, she conducted a mandatory meeting with the memory care unit (MCU) staff related to conducting rounds on the residents. -She expected staff to "lay eyes on the residents" hourly. -Staff were not to disrupt the residents' sleep during rounds or behave in a way that would agitate the residents. -If a resident was asleep and in a safe location, she expected staff not to disturb the resident and to check on the resident at a later time. -Staff could attempt to move the resident to another location, but it was important to avoid "provoking" the resident. -She was "glad" Resident #2 was in a secure unit and in a secure location when he was sleeping in the shower. -"Dementia patients may do things like this." Resident #2 was not available for interview.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 270	Continued From page 32 Attempted telephone interview on 03/11/21 at 9:55am with a PCA who was on duty during third shift on 01/23/21 was unsuccessful. Attempted telephone interview with the MCWD on 03/11/21 at 1:12pm was unsuccessful. Attempted telephone interview on 03/11/21 at 3:40pm with a MA who was on duty during third shift on 01/23/21 was unsuccessful. _____ The facility failed to provide supervision of a resident who was constantly disoriented, had a diagnosis of Alzheimer's disease, and was found sleeping in the shower in a t-shirt and a pair of urine-soaked adult briefs (#2) and a resident who had a history of falls with a total of 11 unwitnessed fall resulting in right wrist contusion and bruise, right elbow bruise, and right thumb contusion and who was placed on hourly safety checks in January 2020 until May 2020 when safety checks were changed to every thirty minutes but the resident had 4 unwitnessed falls from July 2020 to August 2020 (#3). The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection for this violation on 03/10/21 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 26, 2021.	D 270		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 276	Continued From page 33 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents (#1) regarding an order for a urinalysis (UA). The findings are: Review of Resident #1's current FL-2 dated 03/08/21 revealed diagnoses included dementia, sleep disorder, gastroesophageal reflux disease (GERD), and osteoarthritis. Review of Resident #1's primary care provider's (PCP) consultation notes dated 12/14/20 revealed a urinalysis (UA) was ordered on 12/14/20. Review of Resident #1's PCP's consultation notes dated 12/16/20 revealed the PCP was awaiting the results of the UA.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 34	D 276		

Review of Resident #1's PCP's subsequent consultation notes dated 12/16/20 revealed:
-The PCP visited Resident #1 at the request of staff.
-Resident #1 was exhibiting increased agitation and confusion.
-Staff had requested a UA as a result of Resident #1's behavior.
-The Memory Care Wellness Director (MCWD) told her Resident #1's urine sample was collected on 12/15/20 and the lab was called on 12/15/20 to pick up the sample.

Review of Resident #1's lab results revealed there was no documentation of the results of a UA from December 2020-February 2021.

Interview with the corporate Director of Quality Assurance and Compliance (DQAC) on 03/11/21 at 11:15am revealed:
-The PCP's consultation note dated 12/14/20 referenced the UA, but the PCP did not write an order for the UA.
-The PCP's consultation note was not provided to the facility until 12/21/20.
-The UA was not completed for Resident #1.

Second interview with the DQAC on 03/11/21 at 1:28pm revealed:
-Resident #1 was seen by the PCP on 12/14/20.
-The PCP usually wrote orders while at the facility.
-The PCP normally dictated consultation notes while at the facility.
-The PCP signed the 12/14/20 consultation note on 12/17/20.
-The facility did not receive the consultation note until 12/30/20.
-The MCWD was responsible for reviewing the PCP consultation notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 276	Continued From page 35 Telephone interview with a representative from the lab used by the facility on 03/12/21 at 9:14am revealed the lab did not conduct a urinalysis for Resident #1 in December 2020 or January 2021. Attempted telephone interview with a representative from a second lab used by the facility on 03/12/21 at 9:22am was unsuccessful. Telephone interview with the Executive Director (ED) on 03/12/21 at 2:12pm revealed: -The PCP did not provide a written order for a UA for Resident #1 while at the facility on 12/14/20. -She was not sure if staff followed-up with Resident #1's PCP regarding the UA. -The MCWD should have followed-up on it. -"It must have been an oversight on our part." Telephone interview with Resident #1's PCP on 03/12/21 at 2:56pm revealed: -There was always concern that aggressive behavior and confusion may be signs of a UTI. -Resident #1 was treated for a UTI in early December 2020. -It was unlikely that Resident #1 had another UTI in mid-December 2020, but it needed to be considered based upon her behavior. -An order for a UA on Resident #1 was faxed to the facility on 12/14/20. -On 12/16/20, the MCWD told her the lab was notified on 12/15/20 to pick up the urine sample. -In the same week, the MCWD informed her the urine sample had not been picked up by the lab. -The MCWD also told her staff would obtain another urine sample from Resident #1 and send it to the lab. -"Nothing ever came from that." -She expected orders to be implemented.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 276	Continued From page 36 Based on observation, interviews and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with the MCWD on 03/11/21 at 1:12pm was unsuccessful.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews the facility failed to protect 3 of 6 sampled residents (#1, #4, and #8) in the memory care unit (MCU) from physical and verbal abuse from Staff A, D, B, G, and E; and multiple unidentified residents being verbally abused by the same staff. The findings are: Review of the facility's abuse, neglect, misappropriation of the property of a health care facility, drug diversion, injury of unknown source policy revealed: -Events or allegations of abuse, neglect, and or exploitation should be treated seriously and must be reported to the Executive Director or the designee for investigation and appropriate follow-up. -Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 37	D 338		

mental anguish.
-Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish included verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.
-Injury of an unknown source was defined as an injury that was not observed by a person, or the source of the injury could not be explained, and the injury was suspicious in nature because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time of the incidence of injuries over time.

1. Review of Resident #4's current FL-2 dated 08/20/20 revealed diagnoses included dementia, Alzheimer's disease, hypothyroidism, hypertension, major depressive disorder, heart disease, and a cardiac pacemaker.

Telephone interview with a MA on 03/11/21 at 12:23pm revealed:
-She had witnessed Staff B, personal care aide (PCA), Staff D, medication aide (MA), and another MA (she did not know the MAs name) pushing Resident #4.
-She did not report the incidents to the Administrator because there was favoritism shown to certain staff by the Memory Care Wellness Director.
-She had previously reported incidents to the MCWD and was made "uncomfortable" about it.
-She "learn[ed] quickly not to go against the friends. You end up getting in trouble."

Telephone interview with another MA on 03/11/21 at 12:23pm revealed she never reported any concerns to the MCWD because there was favoritism between the MCWD and other staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 38	D 338		

and reporting made working uncomfortable.

Confidential telephone interview with a staff revealed:
-Resident #4's family member had expressed concern about why Resident #4 was "always bruised up."
-The MCWD had tried to "calm" Resident #4's family member down.
-The MCWD excused Resident #4's bruises because she was combative.

Confidential telephone interview with another staff revealed she had observed Resident #4 with a lot of bruises.

Confidential interview with staff revealed she had seen unexplained bruises on Resident #4's face before and when asked other staff about the bruises the staff always said the resident hit herself.

a. Confidential telephone interview with a staff revealed:
-There were four staff, Staff E, personal care aide (PCA), and three unidentified staff, attempting to toilet Resident #4 in mid-September 2020.
-Resident #4 was scared because there were four staff "going at her at once."
-Resident #4 was pushed toward the toilet and hit her head on the bathroom bar.
-Resident #4 was held down on the toilet.
-There was a staff holding each leg and one staff holding each arm.
-Resident #4 was able to get one of her arms away from Staff E and Staff E put Resident #4 in a "headlock" and said, "you are not going to do this [expletive] today."
-Resident #4's forearms were bleeding from being grabbed so tight.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 39 -She did not tell anyone in management about the incident. Review of Resident #4's chart notes and incident reports revealed there was no documentation of the alleged incident or allegation. Telephone interview with Staff E on 03/11/21 at 1:15pm revealed: -She had held Resident #4 before, but not aggressively. -If Resident #4 refused care, she would try again later. -She had never used force with Resident #4. -She had never used expletive words with Resident #4. -She may have used a loud voice, but never expletive words. Interview with the Memory Care Wellness Director (MCWD) on 03/09/21 at 3:30pm revealed: -Resident #4 for the most part did not understand what was going on. -Resident #4 did not like showers and "freaked out" when her pants were pulled down. -Resident #4 did better with some staff than others. -It took two staff to provide care for Resident #4, one staff to hold her hand, and the other staff to provide the care. -She was not aware more than two staff had been used to provide Resident #4's care and if four staff had been used it may have been to get Resident #4 in and out of the shower safely. -She was not aware of an incident where Resident #4 was being forced into care. Interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 40	D 338		

-Resident #4 could be "feisty."
-If Resident #4 did not want to do something, she was not going to do it and would need to be approached again later.
-She expected staff to try care for Resident #4 individually, a group of 3-4 staff would automatically scare a resident and put the resident on guard.
-She was not aware of an incident where Resident #4 was forced into care.
-She was not aware of 3-4 staff doing any care together and could not think of any instance where this would be necessary.

Interview with the Executive Director (ED) on 03/09/21 at 6:29pm revealed:
-Resident #4 was always smiling, walking, and wanted to kiss you.
-Staff had reported Resident #4 did not want to take showers and refused to toilet.
-If Resident #4 did not want care at that time, she expected staff to walk away and try again later.
-She expected one staff to assist Resident #4 but knew there had been times when it would take two staff to complete personal care for Resident #4.
-She was not aware of any incidents that required more than two staff to toilet Resident #4.

b. Review of Resident #4's charting notes revealed:
-On 08/30/20 at 10:20pm, Staff D, medication aide (MA), documented Resident #4 was in another resident's room and was asked to come out of the room and she would not.
-Resident #4 started to swing and use expletive language at staff.
-Resident #4 swung at staff again and hit her arm on the wall.
-On 08/31/20 at 12:11am, a MA documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 41	D 338		

Resident #4's hand was bruised on the inside and outside of her hand, on the side of her pinky finger and noted swelling. When the MA touched Resident #4's hand the resident screamed in pain.
-On 08/31/20 at 12:45pm, the Memory Care Wellness Director (MCWD) documented Resident #4's power of attorney (POA) had been notified about the resident's hand.
-On 08/31/20 at 2:35pm, a MA documented Resident #4's hand was swollen upon arrival to her shift, the MCWD and POA were notified, and the POA took Resident #4 to urgent care to be evaluated.
-On 08/31/20 at 11:00pm, a MA documented Resident #4 returned to the facility with her hand wrapped but took the wrap off at dinner.
-On 09/01/20 at 4:19pm, the MCWD documented a late entry for 08/31/20, she had spoken to Resident #4's POA on 08/31/20, Resident #4 was evaluated and diagnosed with a fractured hand, and had an orthopedic appointment scheduled for 09/03/20.
-On 09/03/21 at 9:21am, the MCWD documented Resident #4 returned to the facility with a hard cast on her right hand.

Review of Resident #4's incident report completed by the MA on 08/31/20 revealed:
-Resident #4 was in another resident's room and was asked to leave the room by Staff D.
-Resident #4 started to swing at Staff D and hit the wall with her hand.

Telephone interview with a MA on 03/11/21 at 12:23pm revealed:
-Staff D, who was working with Resident #4, reported the injury to her and described the incident of what happened to Resident #4's hand.
-"All I could do is write up what Staff D told me

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 42	D 338		

happened."

Telephone interview with another MA on 03/03/21 at 7:17pm revealed:
-She had worked in the MCU and was familiar with the residents.
-She reported to her shift one day and found Resident #4 "favoring" her arm; she could not recall the date.
-Resident #4 was "whimpering" and holding her arm across her body.
-There had been nothing reported to her at the shift change, and there was nothing documented on the 24- hour report about Resident #4 injuring her arm.
-Resident #4 usually slept well but that night she would not sleep.
-She tried to move Resident #4's arm to look at it but the resident cried out in pain.
-She reported the injury to the MCWD who just said, "thank you".
-When she came to work the next day, Resident #4 had a cast on her arm.

Telephone interview with Staff D on 03/11/21 at 2:07pm revealed:
-Resident #4 was in her room and had urinated on herself and had a bowel movement. (She did not recall the exact date).
-She was trying to get Resident #4 cleaned up when Resident #4 swung at her, she ducked, and Resident #4 hit her hand on the wall.
-The incident occurred in Resident #4's room, right outside of the bathroom.
-Resident #4 did not "holler out or anything that it hurt."
-She had never hurt Resident #4, "I have never hit Resident #4."

Review of Resident #4's physician's summary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 43 dated 08/31/20 revealed: -Resident #4 complained of right-hand swelling, bruising and pain after a witnessed mechanical fall at the facility on 08/30/20. -Resident #4 was diagnosed with a displaced fracture of the base of the fifth finger and a possible fracture of the base of the fourth finger bone. Telephone interview with Resident #4's power of attorney (POA) on 03/08/21 at 2:27pm revealed she was told Resident #4 fell and hit her hand on a grab bar resulting in a broken hand. Interview with Resident #4's family member on 03/11/21 at 2:10pm revealed: -He visited Resident #4 every day; he resided in the Assisted Living (AL) at the facility. -He found she had hurt her arm when he went to hold her hand and she winced. -He looked at her hand and saw bruising on her fingers. -He let the staff know she was hurting and in pain. -Her arms had bruises on them. -He was told by staff Resident #4 fell and that was how she was injured. -Resident #4 had a cast on after that. -He could not remember the date Resident #4 had hurt her arm. Interview with the MCWD on 03/09/21 at 3:30pm revealed: -She "vaguely" recalled something about Resident #4 hitting her hand on the handrail in the bathroom at the facility. -She did not think any staff would intentionally do anything to Resident #4. Interview with the facility's registered nurse (RN)	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 44	D 338		

on 03/09/21 at 4:33pm revealed:
-She was not aware of a hand injury Resident #4 received during care.
-She recalled Resident #4 having a cast when she started working at the facility but did not know anything about the incident.
-She had never been told the staff was aggressive toward Resident #4.

Interview with the Executive Director on 03/09/21 at 5:59pm revealed:
-She knew Resident #4 had a hand injury while out with her family member.
-She was not aware of any other incident related to Resident #4's hand or getting hurt during care at the facility.

Attempted telephone interview with Resident #4's primary care provider on 03/12/21 at 8:09am was unsuccessful.

c. Telephone interview with former staff on 03/10/21 at 9:00am revealed:
-Staff A, medication aide (MA), was always "aggressive" when providing incontinent care to Resident #4.
-She had observed Staff A "holding" Resident #4 down.
-She also observed Staff A "snatching up" Resident #4 when changing the resident.
-It was always a group of two to three staff that approached Resident #4 for personal care.

Telephone interview with another former staff revealed:
-Resident #4 had used the bathroom on the floor and staff would use expletive language toward the resident.
-She had witnessed Staff A tell a resident "do not be [expletive] on the floor."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 45 -She did not report the incident to management. Interview with Staff A on 03/09/21 at 2:03pm revealed: -She had never cursed or spoken to Resident #4 inappropriately. -She had never been rough with Resident #4. -Staff had been accidentally hit by Resident #4, but she had never hit Resident #4. Interview with the facility's registered nurse (RN) on 03/09/21 at 4:33pm revealed no one had reported to her that Staff A had been aggressive with Resident #4. Interview with the Executive Director on 03/09/21 at 6:29pm revealed she was not aware of Staff A being aggressive either verbally or physically with Resident #4. Based on interviews and record reviews it was determined Resident #4 was not interviewable. Refer to confidential interview with staff. Refer to confidential interview with another staff. Refer to confidential interview with a third staff. Refer to confidential interview with a fourth staff. Refer to confidential interview with fifth staff. Refer to confidential telephone interview with a sixth staff. Refer to confidential interview with a seventh staff. Refer to confidential telephone interview with an	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 46 eighth staff. Refer to the interview with the Memory Care Wellness Director (MCWD) on 03/04/21 at 12:32pm. Refer to the interview with the MCWD on 03/09/21 at 3:04pm. Refer to the interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm. Refer to the interview with the Executive Director (ED) on 03/04/21 at 1:27pm. Refer to the interview with the ED on 03/09/21 at 5:58pm. 2. Review of Resident #8's FL-2 dated 09/04/20 revealed diagnoses included dementia, high blood pressure, atrial fibrillation, and intracerebral hemorrhage. a. Telephone interview with a MA on 03/10/21 at 11:36am revealed she had witnessed Staff A, medication aide (MA) "squaring up" (assuming a fighting position) toward residents in the memory care unit (MCU) on unknown dates. Observation of two photographs of Resident #8 revealed: -Resident #8 was sitting on her bed, Staff A was positioned in front of Resident #8, holding Resident #8's left hand. -Staff A had her right hand pulled back to her side and the resident was leaning back away from Staff A. -In the second photograph Staff A had her hand positioned toward Resident #8's chest area and Staff A was leaning in towards Resident #8.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 47 Confidential telephone interview with a staff revealed: -Staff A was trying to get Resident #8 to go to the bathroom and the resident became combative. -Staff A grabbed Resident #8. -Resident #8 was screaming. -Staff A was using expletive language at Resident #8. -Resident #8 threw her shoe at Staff A. -Staff A picked up the shoe and was motioning as if she was going to hit Resident #8 with the shoe. -Staff A was "restraining" Resident #8 by holding her arm. -She did not know if Staff A hit Resident #8 with the shoe because it was happening so fast. Telephone interview with a former staff on 03/10/21 at 9:00am revealed: -She heard screaming when she entered Resident #8's room. -Resident #8 had her shoe in her hand and Staff A took the shoe from the resident and gestured as if she was going to hit the resident. -There were other staff in the room, and everyone was "just watching." Interview with Staff A on 03/09/21 at 2:03pm revealed she had never "cursed, hollered or done anything" to Resident #8. Interview with the Memory Care Wellness Director (MCWD) on 03/09/21 at 3:04pm revealed she was not aware of any incident with Staff A being aggressive with Resident #8. Interview with the facility's registered nurse (RN) on 03/09/21 at 4:33pm revealed she was not aware of any incidents where Resident #8 was aggressive toward Staff A and Staff A responded	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 48 back either physically or verbally. Interview with the Executive Director on 03/09/21 at 5:59pm revealed she was not aware of Staff A being aggressive toward Resident #8 or observing other staff being aggressive toward the resident. b. Telephone interview with a medication aide (MA) on 03/11/21 at 12:23pm revealed: -She had seen Staff D, medication aide (MA) "ready to fight" Resident #8. -She had heard Staff D use expletive language with Resident #8. Telephone interview with a former staff on 03/03/21 at 6:45pm revealed: -Resident #8 threw something at Staff D and the staff observed Staff D threw a plate at the resident. -The incident occurred during dinner on second shift, she did not recall the date. -The Director of Communications saw the incident and reported it to the Memory Care Wellness Director (MCWD) and the Executive Director (ED). Telephone interview with Staff D on 03/11/21 at 2:07pm revealed: -Resident #8 had never thrown anything at her and she had not thrown anything back at the resident. -She did not know why someone would say this incident occurred. Telephone interview with the Communications Director on 03/12/21 at 1:59pm revealed: -She did not witness Resident #8 throw anything at staff. -She had not seen any staff throw a plate or	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 49	D 338		

curse at Resident #8.
-She did not know why someone would say that she had observed the incident.
-She would have told the ED if she had observed the incident.

Interview with the MCWD on 03/09/21 at 3:04pm revealed:
-She recalled an incident where Resident #8 threw a "trinket" at staff, but that was when Resident #8 first moved into the community.
-Staff did not tell her every "little" thing.
-She was not aware of any other incident where Resident #8 threw anything at staff.
-She was not aware of any incident where Staff D threw anything at Resident #8.

Interview with the facility's RN on 03/09/21 at 4:33pm revealed she was not aware of any incidents where Resident #8 was aggressive toward staff and Staff D responded back either physically or verbally.

Interview with the ED on 03/09/21 at 5:59pm revealed she was not aware of Staff D being aggressive toward Resident #8.

Based on record reviews it was determined Resident #8 was not interviewable.

Refer to confidential interview with staff.

Refer to confidential interview with another staff.

Refer to confidential interview with a third staff.

Refer to confidential interview with a fourth staff.

Refer to confidential interview with fifth staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 50 Refer to confidential telephone interview with a sixth staff. Refer to confidential interview with a seventh staff. Refer to confidential telephone interview with an eighth staff. Refer to the interview with the Memory Care Wellness Director (MCWD) on 03/04/21 at 12:32pm. Refer to the interview with the MCWD on 03/09/21 at 3:04pm. Refer to the interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm. Refer to the interview with the Executive Director (ED) on 03/04/21 at 1:27pm. Refer to the interview with the ED on 03/09/21 at 5:58pm. 3. Review of Resident #1's current FL-2 dated 03/08/21 revealed diagnoses included dementia, sleep disorder, gastroesophageal reflux disease (GERD), and osteoarthritis. Review of Resident #1's current assessment and care plan dated 01/31/21 revealed: -Resident #1 was always disoriented, suffered significant memory loss, and needed redirection. -Resident #1 was verbally and physically abusive and exhibited disruptive and socially inappropriate behavior. a. Review of Resident #1's charting note dated 01/14/21 revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 51	D 338		

-Resident #1 was very agitated and was attempting to fight staff and other residents.
-Staff A, medication aide (MA), sat Resident #1 behind the desk in the nursing station to calm down while waiting for Resident #1's medication to take effect.
-Resident #1 "some how [sic]" hurt her left ring finger during the period of agitation.

Review of Resident #1's primary care provider's (PCP) visit note dated 01/15/21 revealed:
-The PCP examined Resident #1's finger on 01/15/21.
-Resident #1 was agitated on 01/14/21 and was aggressive toward another resident.
-Staff was "unsure" how Resident #1 injured her finger.
-Resident #1's left fourth finger was bruised and swollen.
-An x-ray on 01/14/21 was positive for a non-displaced fracture.

Telephone interview with Resident #1's PCP on 03/09/21 at 10:39am revealed Resident #1 did not tell the PCP how her finger was injured.

Telephone interview with a former staff on 03/08/21 at 4:39pm revealed:
-Sometime in January or February 2021 during first shift, Resident #1 was "hitting" another resident and the Activity Director.
-Staff A took Resident #1 into the nursing station.
-Resident #1 tried to hit Staff A and called her a "fat [expletive]."
-Staff A could not get Resident #1 to "calm down."
-Staff A was trying to apply a sedative gel medication to Resident #1's wrist.
-Staff A tried to make Resident #1 sit at the desk in the nursing station.
-Staff A said, "You need to sit down, [expletive]"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 52	D 338		

and then Staff A bent Resident #1's finger back.
-Resident #1 yelled, "Ouch! My finger! You broke it!"
-Staff A's said Resident #1's finger was broken when Resident #1 hit her hand on the wall.
-She did not know what Staff A reported to management about the incident.
-She did not talk with Staff A about the incident.
-She did not report the incident to anyone in management.
-The Memory Care Wellness Director (MCWD) was a personal friend of Staff A and she did not think the MCWD would have believed her if she would have reported the incident.
-She did not "want to start a problem with any of them," meaning the MCWD and her friends.
-Another staff was working on the Memory Care Unit (MCU) that day and may have witnessed the incident.

Telephone interview with Resident #1's responsible person on 03/09/21 at 10:47am revealed:
-The MCWD notified her in January 2021 that Resident #1 got into an "argument" with another resident.
-Resident #1's finger was hurt at some point during a "tussle."

Interview with Staff A on 03/09/21 at 2:03pm revealed:
-Resident #1 was verbally abusive to other residents.
-Sometime in January 2021, maybe on a weekend, Resident #1 was swinging at another resident and the Activity Director.
-Resident #1 hit a dining room table and a half wall in the dining room several times during the period of agitation.
-She took Resident #1 into the nursing station,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 53	D 338		

sat her at the desk, and gave her a snack.
-She took Resident #1 out from the nursing station into the common area but had to take her back into the nursing station after Resident #1 continued to be agitated.
-She told Resident #1 to sit down.
-Resident #1's arms were crossed over her chest.
-Resident #1 said her finger was hurt.
-She notified Resident #1's PCP and gave Resident #1 an ice pack.
-She did not hurt Resident #1 "at all."

Interview with the MCWD on 03/09/21 at 3:04pm revealed:
-Resident #1 was verbally abusive toward the other residents.
-She did not remember being notified about the incident involving Resident #1's finger.
-No one reported any allegations of abuse by Staff A related to the incident involving Resident #1's finger.

Interview with the Executive Director (ED) on 03/09/21 at 5:58pm revealed:
-She did not discuss Resident #1's broken finger with anyone.
-She did not know when it happened or who was involved.
-She did not remember every incident that occurred in the facility.

Telephone interview with a MA on 03/10/21 at 11:36am revealed she had witnessed Staff A "squaring up" (assuming a fighting position) toward residents in the MCU on unknown dates.

Attempted telephone interview with a first shift personal care aide (PCA), who worked on the day of the incident, on 03/08/21 at 5:56pm, 03/10/21 at 11:31am, and 03/11/21 at 3:43pm were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 54 unsuccessful. b. Observation of a video on 03/05/21 at 10:09am revealed: -The video was dated 05/10/20 at 1:39pm, was 26 seconds long, and did not have audio. -Resident #1 was sitting on a bed and another resident was in a wheelchair positioned against the bed. -The resident in the wheelchair grabbed Resident #1's hair on the left side of her head and pulled Resident #1 toward her. -Resident #1 opened her mouth widely, shifted position on the bed, and reached out with her right arm toward the other resident's right arm. -Resident #1 was not able to grab the other resident's arm. -The other resident continued to pull Resident #1's hair and Resident #1's head went off the side of the bed and her right leg went up in the air. -The other resident then released her hold on Resident #1's hair. -Resident #1 was able to position herself back on the bed and was speaking to someone who was not shown in the video. -No staff intervened during the altercation between Resident #1 and the other resident. Interview with a medication aide (MA) on 03/03/21 at 5:50am revealed: -A named staff person had a video of residents fighting each other. -She had heard the residents were encouraged to fight each other. -She did not know the staff involved but thought the staff no longer worked at the facility. Telephone interview with a personal care assistant (PCA) on 03/11/21 at 2:13pm revealed: -First shift staff (unnamed) in the memory care	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 55	D 338		

unit (MCU) "would make" the residents fight with one another.
-She did not report this behavior to the Memory Care Wellness Director (MCWD) because the MCWD showed "favoritism" to staff who were her friends and family members.
-The MCWD denied or "covered up" things that happened on the MCU.
-She did not know if anyone else reported the behavior to the MCWD.

Interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm revealed:
-She heard about a resident being combative toward another resident but could not remember the residents who were involved or when it occurred.
-She had not witnessed residents being combative towards each other.
-She expected staff to provide redirection to residents who were being physically aggressive.

Interview with the Executive Director (ED) on 03/09/21 at 5:58pm revealed she had not heard anything about residents being encouraged by staff to fight one another.

Based on interviews with staff, multiple staff witnessed the physical altercation between Resident #1 and another resident, and a video was recorded by staff who watched and did not intervene.

c. Telephone interview with a personal care aide on 03/12/21 at 2:01pm revealed:
-She had witnessed Staff A tell Resident #1 to sit her [expletive] down. (She did not recall the date).
-She had not told anyone in management what she had witnessed.
-She would have said something to management,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 56 but Staff A was "rough," and she did not want Staff A to beat her up. Based on interviews and record reviews, it was determined Resident #1 was not interviewable. Refer to confidential interview with staff. Refer to confidential interview with another staff. Refer to confidential interview with a third staff. Refer to confidential interview with a fourth staff. Refer to confidential interview with fifth staff. Refer to confidential telephone interview with a sixth staff. Refer to confidential interview with a seventh staff. Refer to confidential telephone interview with an eighth staff. Refer to the interview with the Memory Care Wellness Director (MCWD) on 03/04/21 at 12:32pm. Refer to the interview with the MCWD on 03/09/21 at 3:04pm. Refer to the interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm. Refer to the interview with the Executive Director (ED) on 03/04/21 at 1:27pm. Refer to the interview with the ED on 03/09/21 at 5:58pm.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 57 4. Observation of an electronic message dated 01/02/21 revealed: -The message was sent from the Memory Care Wellness Director (MCWD). -It was documented to put Staff D (medication aide) up front for a while. -"I am sick of all this attitude [expletive] on 2nd, time to break up that crew." Telephone interview with a medication aide (MA) on 03/08/21 at 7:28pm revealed: -A former staff had contacted her about his concerns with the way Staff D treated residents. -The former employee wanted to know who to talk to about concerns. -She gave the former staff a corporate employee's name and telephone number so the staff could discuss his concerns. Telephone interview with a personal care aide (PCA) on 03/11/21 at 1:14pm revealed: -She witnessed Staff D using expletives when speaking to the residents on the Memory Care Unit (MCU). -Three or four months ago, she suggested the Executive Director, the MCWD, and the facility's Registered Nurse (RN) make an unannounced visit on second shift to witness staff behavior; they did not take her suggestion. Telephone interview with former staff person on 03/03/1 at 8:04pm revealed: -The staff had witnessed Staff D using expletive language toward residents. -Staff D had been reported to management multiple times on how she spoke to the residents. -The staff had reported Staff D yelling at residents and using expletive language toward residents to the ED.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 58	D 338		

-The staff talked to a person at the facility's corporate office about his concerns and was told someone would "look into it."
-The staff had never heard back from anyone at the facility or at the corporate office.

Telephone interview with the corporate receptionist on 03/12/21 at 2:39pm revealed:
-She received a call on a Sunday morning, 01/10/21 at around 8:30am from the former staff.
-The former staff expressed concerns about Staff D being rude with residents, hollering and using expletive language, and staff being hostile and aggressive. (Specific residents not identified).
-She reached out to the Executive Director (ED) on Monday morning (01/11/21) and told the ED what had been reported to her.
-She told the ED she should look into it and the ED said "okay."

Refer to confidential interview with staff.

Refer to confidential interview with another staff.

Refer to confidential interview with a third staff.

Refer to confidential interview with a fourth staff.

Refer to confidential interview with fifth staff.

Refer to confidential telephone interview with a sixth staff.

Refer to confidential interview with a seventh staff.

Refer to confidential telephone interview with an eighth staff.

Refer to the interview with the Memory Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 59 Wellness Director (MCWD) on 03/04/21 at 12:32pm. Refer to the interview with the MCWD on 03/09/21 at 3:04pm. Refer to the interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm. Refer to the interview with the Executive Director (ED) on 03/04/21 at 1:27pm. Refer to the interview with the ED on 03/09/21 at 5:58pm. 5. Telephone interview with a personal care aide (PCA) on 03/04/21 at 5:59am revealed she had witnessed Staff G, medication aide (MA), use expletive language toward the residents multiple times. Confidential interview with a former staff revealed: -Staff G was taken off the schedule in November 2020 because Staff G was accused of cursing and threatening a resident. -The ED requested the accusing staff to place a statement about the alleged verbal abuse under the door her after the staff had verbally reported the abuse to the ED. -Staff G had been reported to the ED for the way Staff G had interacted with residents. Confidential telephone interview with a staff revealed: -She witnessed Staff G using expletives when speaking to the residents on the MCU. -The Memory Care Wellness Director (MCWD) and the ED showed favoritism toward staff.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 60 Telephone interview with another former staff on 03/10/21 at 9:00am revealed she had witness Staff G use expletive language when working with the residents. Telephone interview with a MA on 03/10/21 at 11:36am revealed: -Sometime in late 2020, she gave a resident some water, and Staff G told her the resident "can't drink any [expletive] water. Don't give him any water." -She and Staff G were going to assist the resident with incontinent care. -The resident was lying on his bed and Staff G pulled her fist back and positioned herself like she was going to punch the resident; Staff G did not punch the resident. -Staff G said, "This [expletive], nasty [expletive]," and then threw the resident's legs up to change his adult brief. -She reported the incident to the ED and the MCWD. -She did not know what, if any, action was taken by the ED or the MCWD. Confidential telephone interview with another staff revealed: -Staff G was one of the "biggest culprits" of verbal abuse toward the residents. -She had witnessed Staff G at the nurse's station screaming at a resident, the resident was shaking and looked pitiful. -She thought the incident was reported to the former Assisted Living Wellness Director (ALWD) but that person no longer worked at the facility. -She had heard Staff G tell residents to shut the [expletive] up and sit the [expletive] down. -Staff G had been reported to management. Interview with Staff G on 03/04/21 at 5:57am	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 61 revealed: -She worked third shift. -She was accused by another staff in December 2020 of verbally abusing a resident. -She was accused of saying "You are nasty" and "I will hit you in the [expletive] face if you hit me", to a resident. -She was suspended for 3 days while the ED and the MCWD investigated the complaint. -The ED and the MCWD interviewed other staff and watched cameras for the incident. -She could not remember the resident's full name and he no longer resided in the facility. -She returned to work after her 3-day suspension. Refer to confidential interview with staff. Refer to confidential interview with another staff. Refer to confidential interview with a third staff. Refer to confidential interview with a fourth staff. Refer to confidential interview with fifth staff. Refer to confidential telephone interview with a sixth staff. Refer to confidential interview with a seventh staff. Refer to confidential telephone interview with an eighth staff. Refer to the interview with the Memory Care Wellness Director (MCWD) on 03/04/21 at 12:32pm. Refer to the interview with the MCWD on 03/09/21 at 3:04pm.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 62 Refer to the interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm. Refer to the interview with the Executive Director (ED) on 03/04/21 at 1:27pm. Refer to the interview with the ED on 03/09/21 at 5:58pm.. 6. a. Telephone interview with a former staff on 03/03/21 at 6:45pm revealed: -She had witnessed Staff B, personal care aide (PCA) tell multiple residents to "shut the [expletive] up" and "sit your [expletive] down." -Staff B had withheld snacks for residents because Staff B thought it made the residents sundowning worse. (Sundowning is restlessness, agitation, irritability, or confusion that can begin or worsen as daylight begins to fade). Telephone interview with a medication aide (MA) on 03/11/21 at 12:23pm revealed she had seen Staff B be aggressive and use expletive language with residents. (Specific residents were not identified). Telephone interview with a PCA on 03/11/21 at 1:14pm revealed: -On unknown dates, she witnessed Staff B using expletives when speaking to the residents on the Memory Care Unit (MCU). -She did not report Staff B's behavior because the Memory Care Wellness Director (MCWD) and the Executive Director (ED) showed "favoritism" toward certain staff. Telephone interview with Staff B on 03/12/21 at 11:15am revealed: -She had never cursed at a resident.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 63	D 338		

-"I talk loud anyway."
-No one had talked to her about any concerns related to her and her interaction with residents.

b. Confidential interview with a staff revealed:
-At dinner time on 03/09/21 she was assisting with seating residents in the dining room in the MCU.
-She was assisting a resident from her wheelchair to a chair at a table when Staff B pushed the resident from the back.
-Staff B took both hands and placed them on the resident's lower back and pushed the resident to the chair.
-Staff B said "do not let her fool you, she can do better than that, she can go faster" as she pushed the resident towards the chair.
-She told another staff about the incident and they took her to the facility Registered Nurse (RN).
-She reported the incident to the RN and the Executive Director (ED).

Confidential interview with a second staff revealed:
-She was told about the pushing incident with Staff B on 03/09/21 by the staff that had witnessed it.
-She took the staff that witnessed the incident on 03/09/21 to the where the RN and ED offices were so the staff could report the incident.

Interview with the facility's RN on 03/11/21 at 4:15pm revealed:
-She had not had anyone report an incident between Staff B and a resident on the MCU to her in the past week.
-If she had been made aware of an incident, she would have reported it immediately to the ED.

Interview with the ED on 03/11/21 at 5:15pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 64	D 338		

revealed:
-No one had reported an incident to her that occurred on 03/09/21 in the MCU dining room with Staff B and a resident.
-She had not reviewed the footage from the video camera for 03/09/21 because no one had reported anything to her.
-She was not able to look back at video footage in the MCU dining room for the date of 03/09/21.

Refer to confidential interview with staff.

Refer to confidential interview with another staff.

Refer to confidential interview with a third staff.

Refer to confidential interview with a fourth staff.

Refer to confidential interview with fifth staff.

Refer to confidential telephone interview with a sixth staff.

Refer to confidential interview with a seventh staff.

Refer to confidential telephone interview with an eighth staff.

Refer to the interview with the Memory Care Wellness Director (MCWD) on 03/04/21 at 12:32pm.

Refer to the interview with the MCWD on 03/09/21 at 3:04pm.

Refer to the interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm.

Refer to the interview with the Executive Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 65 (ED) on 03/04/21 at 1:27pm. Refer to the interview with the ED on 03/09/21 at 5:58pm. 7. Observation of an electronic message dated 10/27/20 at 12:34pm revealed: -The message was from the Executive Director (ED). -The instructions were to only schedule Staff E, a personal care aide (PCA) in the memory care unit (MCU) going forward. Confidential interview with a staff revealed: -Staff E was accused of verbal abuse toward a resident in the assisted living unit (AL) . -Staff E was moved to the MCU after the alleged incident. -They did not know if the incident was investigated. Telephone interview with Staff E on 03/11/21 at 1:12pm revealed: -She had previously worked in AL. -She was moved to the MCU in November 2020. -A former MA told her she was to work in the MCU because the ED said she had to work in the MCU. -She had never cursed at a resident. -She might have a loud speaking voice. -It was some [expletive] that caused her to have to switch to third shift. -She asked the ED why she was moved and the ED told her she needed the experience in the MCU. Interview with the ED on 03/09/21 at 6:09pm revealed she had not moved any staff from AL to the MCU because of an incident with a resident.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 338	Continued From page 66 Refer to confidential interview with staff. Refer to confidential interview with another staff. Refer to confidential interview with a third staff. Refer to confidential interview with a fourth staff. Refer to confidential interview with fifth staff. Refer to confidential telephone interview with a sixth staff. Refer to confidential interview with a seventh staff. Refer to confidential telephone interview with an eighth staff. Refer to the interview with the Memory Care Wellness Director (MCWD) on 03/04/21 at 12:32pm. Refer to the interview with the MCWD on 03/09/21 at 3:04pm. Refer to the interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm. Refer to the interview with the Executive Director (ED) on 03/04/21 at 1:27pm. Refer to the interview with the ED on 03/09/21 at 5:58pm. _____ Confidential interview with staff revealed the Administrator did not care, "they sweep everything under the rug." Confidential interview with another staff revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 67 -There was a lot of favoritism. -The Administrator never came into the facility after 5:00pm. -There was "a lot that needed to be looked at." -If the Administrator was called and told something, they "did not do anything." Confidential interview with a third staff revealed: -She had not reported any allegations of abuse to the Administrator because she had seen several things as far as a retaliation pattern. -The Memory Care Wellness Director (MCWD) was in the Administrator's office 24/7, so she did not trust talking to the Administrator. -She had reported her concerns about resident's injuries to the Administrator, but she did not feel confident that the Administrator would follow up and she was concerned with retaliation. Confidential interview with a fourth staff revealed: -She could not talk to the Administrator because of all the favoritism. -She did not go to the Administrator or the MCWD because they were "such good friends." -She would have liked to have talked to the Administrator about the MCWD but could not. Confidential interview with fifth staff revealed: -The staff had reported the aggressive staff behavior to the MCWD. -There was a lot of favoritism with the Administrator and certain staff. -The staff did not go to the Administrator because it would get back to the staff she would report. -The staff quickly learned who to talk to and who not to talk to. -"Nothing was going to be done anyway." Confidential telephone interview with a sixth staff revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 68 -All the staff slept in the MCU; the residents were watching the staff sleep. -The Administrator knew about it because it was talked about all the time. -The MCU staff did not like to work in AL because the staff could not change their attitude and residents in AL would tell on them. -Someone told the Administrator to come through the facility at 3:00am and they would find staff asleep. Confidential interview with a seventh staff revealed she had not told the Administrator about staff using expletive language toward the residents because she did not know how the Administrator would act. Confidential telephone interview with an eighth staff revealed: -The staff had seen the MCU staff sleep during their shifts. -"I kept complaining about people sleeping and nothing was done." -Staff were not doing their wellness checks on the residents because the staff was sleeping. -The Administrator never came in to try to catch the staff sleeping. Confidential interview with a ninth staff revealed the MCWD was not approachable, and the Administrator knew it because it had been discussed it with the Administrator and the Administrator agreed. Interview with the Memory Care Wellness Director (MCWD) on 03/04/21 at 12:32pm revealed: -She supervised the staff in the Memory Care Unit (MCU), and she reported directly to the Executive Director (ED).	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 69	D 338		

-She had not received any allegations of resident abuse or concerns from families.
-Residents' families had her number and could call her anytime there were concerns about resident care.
-Staff could come to her or the ED if there were allegations or concerns of other staff abusing a resident.
-All staff were told during their orientation to report any suspicion of staff to resident abuse; staff had been told, "if you see something, say something."
-Staff could come right to her or slide a note under her door if they wanted to report anything anonymously.
-Staff had not reported any allegations of abuse of residents by other staff and she had not had any notes under her door.
-If there were to be a report or allegation of abuse, she would investigate to get to the "root" of the complaint to figure out what was going on.
-She would immediately address a complaint from anyone concerning resident abuse.
-The residents in the MCU could not report abuse so if any staff were aware of the abuse and did not report it, they "were just as guilty as the staff doing the abuse".

Second interview with the MCWD on 03/09/21 at 3:04pm revealed:
-She had not received any reports of allegations of any abuse by staff towards residents who resided in the MCU.
-She would notify the ED if she heard of allegations of verbal or physical abuse of residents.
-She and the ED would follow the facilty policy for what to do after that.
-The residents did not distinguish between the staff so there was no way to see a change in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 70	D 338		

resident's demeanor with various staff.
-Staff were required to document and report the allegations of staff to resident abuse to her or the ED.
-She did not have any concerns about MCU staff's interactions with the residents.
-Incident reports were completed for residents whenever there was a fall, behaviors, sent to the hospital, skin tears, and unexplained bruises.
-Medication aides (MAs) completed incident reports and were required to notify the MCWD, the Registered Nurse (RN), or the Executive Director (ED) when an incident report was done.

Interview with the facility's Registered Nurse (RN) on 03/09/21 at 4:33pm revealed:
-She had not witnessed any staff being physically aggressive toward any of the residents.
-The Executive Director (ED) told her a staff had spoken harshly to a memory care unit (MCU) resident about 1½ weeks ago.
-She did not know any specifics about the incident.
-Incident reports were completed by the medication aides (MAs) when there was a fall, a new injury, a significant change, or when a resident was sent out to the hospital.
-She reviewed incident reports after they were completed; she received email notifications of the incident reports.
-She had never heard complaints or allegations of staff verbally or physically abusing residents.
-A staff meeting was conducted 2 weeks ago on how to speak with the residents.

Interview with the ED on 03/04/21 at 1:27pm revealed:
-The MCWD reported directly to her.
-If there were any concerns about residents brought to her by anyone, she would take the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

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D 338	Continued From page 71	D 338		

concern to the MCWD.
-She had not had any received any allegations about staff verbally or physically abusing residents from families.
-Staff had brought concerns to her about resident care in the last 6 to 8 months and she had immediately addressed the concerns.
-Concerns brought to her attention included a complaint from staff about another staff that verbally abused a resident in the MCU by cursing at the resident and placing her hands on the resident's shoulders.
-The complaint was investigated, and nothing could be verified; she had watched the cameras and interviewed staff.
-When the staff had a concern of resident abuse, they were to report it to their immediate supervisor, then to her, and then to her supervisor in the corporate office if there was not a resolution.

Interview with the ED on 03/09/21 at 5:58pm revealed:
-MCU staff interacted "well" with the residents.
-She had no concerns about the behavior of staff towards residents residing in the MCU.
-She reviewed the facility's incident reports.
-She did not remember every incident that occurred in the facility.

_____

The facility failed to protect 3 of 6 sampled residents (#1, #4, and #8), who resided in the memory care unit and had cognitive impairment, from physical and verbal abuse. Resident #4 was observed to be placed in a headlock by Staff E and her forearms were bleeding from being grabbed by staff during personal care; Resident #1 was observed with another resident pulling her hair while staff recorded the incident and did not intervene; Resident #8 was restrained and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 72 intimidated by Staff A, who motioned at the resident with a shoe while other staff watched and did not intervene, and had a plate thrown at her by Staff D; and multiple unidentified residents being verbally abused by Staff B, Staff D, Staff E, and Staff G. This failure resulted in serious abuse, harm, and neglect, which constitutes at Type A1 Violation. _____ The facility provided a plan of protection for this violation on 03/10/21 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 11, 2021.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the administration of medications as ordered for 2 of 8 residents observed during the medication pass, consisting of errors with a vitamin supplement (#8 and #9), and to administer medication as ordered for 1 of 1 residents sampled for record review	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 73 related to an order for an antibiotic (#2). The findings are: 1. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:00am medication pass on 03/03/21. a. Review of Resident #8's current FL-2 dated 09/04/20 revealed diagnoses included dementia, high blood pressure, chronic atrial fibrillation, and intracerebral hemorrhage. Review of Resident #8's physician's orders dated 09/18/20 revealed an order for chewable calcium 600mg with vitamin D 1,000 international units once daily. Observation of the morning medication pass on 03/03/21 at 7:48am revealed the Medication Aide (MA) administered one chewable calcium 600mg with vitamin D 800 international units to Resident #8. Review of Resident #8's electronic medication administration record (eMAR) for March 2021 revealed there was an entry for chewable calcium 600mg with vitamin D 1,000 international units once daily scheduled for administration at 8:00am. Observation on 03/03/21 at 1:45pm of Resident #8's medication available for administration revealed: -Chewable calcium 600mg with vitamin D 1,000 international units was not available for administration. -Chewable calcium 600mg with vitamin D 800 international units was available for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 74	D 358		

administration.

Interview with the MA on 03/03/21 at 1:45pm revealed:
-Resident #8's responsible person supplied the chewable calcium with vitamin D supplement.
-She never noticed the supplement administered was not the supplement that was ordered.
-The MAs were responsible for checking medications that were delivered to the facility.
-The shift supervisor or the Memory Care Wellness Director (MCWD) conducted a subsequent check of the medications that were delivered to the facility.

Interview with the MCWD on 03/04/21 at 7:46am revealed:
-The MA was responsible for checking the medications that were delivered to the facility.
-The MA on the following shift was responsible for conducting a second check of the medications.

Interview with the facility's Registered Nurse (RN) on 03/11/21 at 9:18am revealed:
-The MA should have noticed the chewable calcium 600mg with vitamin D 800 international units was not the ordered dose.
-The MCWD may have also missed that it was the wrong dose.

Interview with the Executive Director (ED) on 03/12/21 at 2:12pm revealed:
-The MA was responsible for checking medication that was delivered to the facility and placing it on the medication cart.
-The MCWD was responsible for conducting a double-check of the medication available for administration in the memory care unit (MCU).

Telephone interview with Resident #8's primary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

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D 358	Continued From page 75	D 358		

care provider (PCP) on 03/15/21 at 3:33pm revealed:
-He had no concerns about Resident #8 receiving 800 international units daily instead of 1,000 international units.
-Resident #8 would not experience any negative outcome from receiving the lower dose of vitamin D.

Attempted telephone interview with the MCWD on 03/11/21 at 1:12pm was unsuccessful.

Based on observations, interviews and record review, it was determined Resident #8 was not interviewable.

Refer to the interview with the Memory Care Wellness Director on 03/04/21 at 7:46am.

Refer to the interview with the facility's Registered Nurse on 03/11/21 at 9:18am.

b. Review of Resident #9's current FL-2 dated 08/10/20 revealed diagnoses included dementia, high blood pressure, type 2 diabetes, obstructive sleep apnea, and osteoarthritis.

Review of Resident 9's subsequent primary care provider's (PCP) orders revealed there was an order dated 02/11/21 for vitamin D3 1,000 international units once daily.

Observation of the morning medication pass on 03/03/21 at 8:14am revealed the Medication Aide (MA) did not administer vitamin D3 1,000 international units to Resident #9.

Review of Resident #9's electronic medication administration records (eMAR) for February and March 2021 revealed there was no entry for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 358	Continued From page 76 vitamin D3 1,000 international units once daily. Observation on 03/03/21 at 2:06pm of Resident #9's medication available for administration revealed vitamin D3 1,000 international units was not available. Interview with the MA on 03/03/21 at 2:06pm revealed: -The MA was responsible for faxing medication orders to the pharmacy. -The MA and the Memory Care Wellness Director (MCWD) were responsible for calling the pharmacy if a medication was not delivered to the facility. -She did not know Resident #9 had an order for vitamin D3 1,000 units. -The order should not have been filed in Resident #9's record until after the medication was delivered to the facility. -The MCWD knew more than she did about comparing medication orders to the eMAR. Interview with the MCWD on 03/04/21 at 7:46am revealed: -The MA was responsible for faxing medication orders to the pharmacy. -The MA may not have faxed Resident #9's vitamin D3 order to the pharmacy. -The facility's Registered Nurse (RN) was responsible for conducting monthly eMAR audits. -The audit included comparing the orders with the entries on the eMAR. Interview with the facility's RN on 03/11/21 at 9:18am revealed: -The MA was responsible for faxing medication orders to the pharmacy. -The pharmacy staff entered medications into the facility's eMAR system.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 358	Continued From page 77	D 358		

-The MA was responsible for verifying and approving the orders in the facility's eMAR system.
-Medication orders were verified and approved multiple times daily.
-The MCWD was responsible for checking medication orders multiple times daily.
-She checked orders at least once per day.

Telephone interview with the Executive Director (ED) on 03/12/21 at 2:12pm revealed:
-The MA was responsible for faxing orders to the pharmacy.
-The MCWD was responsible for conducting a double-check of the medication available for administration in the memory care unit (MCU).
-No one was responsible for conducting another check of the medication available for administration after the MCWD.

Telephone interview with Resident #9's PCP on 03/12/21 at 2:56pm revealed:
-She ordered the vitamin D3 supplement after Resident #9's lab results indicated a vitamin D deficiency.
-Facility staff should have faxed the order to the pharmacy.
-She expected her written orders to be faxed to the pharmacy and for medication to be administered as ordered.

Based on observations, interviews and record review, it was determined Resident #9 was not interviewable.

Attempted telephone interview with the MCWD on 03/11/21 at 1:12pm was unsuccessful.

Refer to the interview with the Memory Care Wellness Director on 03/04/21 at 7:46am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 78 Refer to the interview with the facility's Registered Nurse on 03/11/21 at 9:18am. 2. Review of Resident #2's FL-2 dated 12/28/20 revealed a diagnosis of Alzheimer's disease. Review of Resident #2's hospital discharge summary dated 01/15/21 revealed: -Resident #2 was admitted to the hospital with a urinary tract infection (UTI) on 01/12/21. -Resident #2 was prescribed a course of antibiotics and was supposed to take the antibiotics as prescribed until there were no more pills left. -There was an order for Omnicef 300mg take every 12 hours for 4 days. -Omnicef 300mg was last administered on 01/15/21 at 9:00am. Review of Resident #2's Physician Discharge Summary dated 01/15/21 revealed: -Resident #2 was hospitalized for a UTI from 01/12/21-01/15/21. -Omnicef 300mg was ordered every 12 hours for 4 days. -There were instructions to ensure completion of the antibiotic course from 01/12/21-01/19/21. Review of Resident #2's signed physician's orders dated 01/20/21 revealed: -There was an order for Omnicef 300mg take one capsule every 12 hours for 4 days. -Someone had hand written "end [0]1/19/21" next to the order. Review of Resident #2's electronic medication administration record (eMAR) for January 2021 revealed: -There was an entry for Omnicef 300mg take 1	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 358	Continued From page 79	D 358		

capsule every 12 hours for 4 days scheduled for administration at 8:00am and 8:00pm.
-Omnicef 300mg was not administered to Resident #2 from 01/15/21-01/17/21.
-Omnicef 300mg was administered to Resident #2 from 01/18/21-01/21/21 at 8:00am and 8:00pm.

Interview with the facility's Registered Nurse (RN) on 03/11/21 at 9:18am revealed:
-The medication aide (MA), the Memory Care Wellness Director (MCWD), and she were responsible for reading hospital discharge summaries.
-Signed discharge summaries with medication orders were faxed to the pharmacy.
-The MA should have approved Resident #2's Omnicef order after it had been processed by the pharmacy.
-The MA was responsible for reviewing medication that was delivered from the pharmacy.
-This was an example of human error.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/21 at 5:15pm revealed:
-Facility staff faxed the Omnicef 300mg order to the pharmacy on 01/15/21.
-The pharmacy dispensed and delivered four days' worth (eight capsules) of Omnicef 300mg on 01/15/21.
-Facility staff did not approve the order in the eMAR system until 01/18/21.
-It normally did not take the facility three days to approve orders in the eMAR system.
-An unknown staff from the facility contacted the pharmacy on 01/18/21 to change the administration start date to 01/18/21.
-The pharmacy changed the administration start date of the Omnicef 300mg to 01/18/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 358	Continued From page 80	D 358		

-The pharmacy did not receive a physician's order to change the start date of the Omnicef.
-Omnicef 300mg was available at the facility to administer to Resident #2 on 01/15/21.

Telephone interview with the ED on 03/12/21 at 2:12pm revealed:
-The MCWD was responsible for reading hospital discharge paperwork.
-The MCWD was responsible for making sure all orders were processed.
-This situation was an error.
-Staff needed further education on processing and following discharge orders.

Telephone interview with Resident #2's primary care provider (PCP) on 03/15/21 at 5:03pm revealed:
-She saw Resident #2 in her office on 01/20/21.
-A list of Resident #2's current orders was brought to the appointment.
-She noticed Omnicef 300mg was listed in the orders.
-Based on her reading of Resident #2's hospital discharge summary dated 01/15/21, Resident #2 should have completed the course of Omnicef 300mg on 01/19/21.
-She hand wrote "end [0]1/19/21" next to the order.
-Antibiotics were supposed to be administered as ordered, without interruption, so the bacteria do not have a chance to become resistant to the antibiotic.
-It was "disappointing" that three days had gone by before Resident #2's antibiotic was again administered.

Resident #2 was not available for interview.

Attempted telephone interview with the MCWD on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 358	Continued From page 81 03/11/21 at 1:12pm was unsuccessful. Refer to the interview with the Memory Care Wellness Director on 03/04/21 at 7:46am. Refer to the interview with the facility's Registered Nurse on 03/11/21 at 9:18am. _____ Interview with the MCWD on 03/04/21 at 7:46am revealed: -The Medication Aide (MA) was responsible for auditing the medication carts weekly. -The audit included comparing the orders with the medication on the cart. -She and the facility's registered Registered Nurse (RN) was responsible for auditing the medication cart monthly. -The last time she audited the medication cart was in January 2021. Interview with the facility's RN on 03/12/21 at 9:18am revealed: -The MA was responsible for checking-in medication and placing it on the medication cart. -The MCWD was responsible for the monthly audit of the medication cart in the memory care unit (MCU). -She audited the medication cart in the MCU quarterly. -The audit process included comparing the orders on the eMAR with the medication available for administration. -The MCWD audited the medication cart in the MCU in February 2021.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 438	Continued From page 82	D 438		

Registry
The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record reviews and interviews, the facility failed to report to the Health Care Personnel Registry (HCPR) within 24 hours injuries of unknown origin involving 2 of 2 sampled residents (#1 and #11) including a fractured finger (#1) and bruising around the eye (#11); Staff G accused of verbally abusing a resident; and injuries of unknown origin of unidentified residents.

The findings are:

1. Review of Resident #1's current FL-2 dated 03/08/21 revealed diagnoses included dementia, sleep disorder, gastroesophageal reflux disease (GERD), and osteoarthritis.

Review of Resident #1's current assessment and care plan dated 01/31/21 revealed:
-Resident #1 was always disoriented, suffered significant memory loss, and needed redirection.
-Resident #1 was verbally and physically abusive and exhibited disruptive and socially inappropriate behavior.

Review of Resident #1's charting note dated 01/14/21 revealed:
-Resident #1 was very agitated and was attempting to fight staff and other residents.
-Staff A, medication aide (MA), sat Resident #1 behind the desk in the nursing station to calm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 438	Continued From page 83	D 438		

down while waiting for Resident #1's medication to take effect.
-Resident #1 "some how [sic]" hurt her left ring finger during the period of agitation.

Review of Resident #1's primary care provider's (PCP) visit note dated 01/15/21 revealed:
-The PCP examined Resident #1's finger on 01/15/21.
-Resident #1 was agitated on 01/14/21 and was aggressive toward another resident.
-Staff was "unsure" how Resident #1 injured her finger.
-Resident #1's left fourth finger was bruised and swollen.
-An x-ray on 01/14/21 was positive for a non-displaced fracture.

Review of Resident #1's incident/accident reports revealed there was no report dated 01/14/21.

Interview with Resident #1 on 03/03/21 at 11:28am revealed she did not know she had a broken finger in January 2021.

Telephone interview with Resident #1's PCP on 03/09/21 at 10:39am revealed Resident #1 did not tell the PCP how her finger was injured.

Interview with Staff A, medication aide (MA), on 03/09/21 at 2:03pm revealed:
-Resident #1 was verbally abusive to the other residents.
-She considered being mean, yelling, and cursing to be verbal abuse.
-Sometime in January 2021, maybe on a weekend, Resident #1 was swinging at another resident and the Activity Director.
-Resident #1 hit a dining room table and a half wall in the dining room several times during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 438	Continued From page 84	D 438		

period of agitation.
-She took Resident #1 into the nursing station, sat her at the desk, and gave her a snack.
-She took Resident #1 out from the nursing station and back into the common area but had to take her back in after Resident #1 continued to be agitated.
-She told Resident #1 to sit down.
-Resident #1 had her arms crossed over her chest.
-She gave Resident #1 a drink.
-Resident #1 said her finger was hurt.
-She notified Resident #1's PCP on the same day of the incident and gave Resident #1 an ice pack.
-She did not hurt Resident #1 "at all."

Interview with the Executive Director (ED) on 03/09/21 at 5:58pm revealed:
-She did not discuss Resident #1's broken finger with anyone.
-She did not know when it happened or who was involved.
-She reviewed incident reports but did not remember every incident that occurred in the facility.
-She was not sure about the types of incidents that needed to be reported to the Health Care Personnel Registry (HCPR).

Telephone interview with the ED on 03/12/21 at 2:12pm revealed she did not report Resident #1's broken finger to the HCPR.

Refer to the telephone interview with the ED on 03/08/21 at 4:11pm.
2. Review of Resident #11's current FL-2 dated 01/04/21 revealed diagnoses included unspecified dementia, allergic rhinitis, unspecified gastro-esophageal reflux disease, and history of falling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 438	Continued From page 85 Review of Resident #11's incident report dated 03/06/21 revealed: -Resident #11 resided on the Assisted Living (AL) unit of the facility -Resident #11 was approached by the medication aide (MA) in her room to administer medication and Resident #11 had a black and blue eye. -Resident #11's Power of Attorney (POA) and primary care provider (PCP) were notified. -On 03/09/21, the Executive Director (ED) and the facility's Registered Nurse (RN) reviewed the incident report. -The ED documented that she spoke with Resident #11 and the resident told her that her POA thought she rolled over and hit her eye on the nightstand. -The ED documented that bumpers would be placed on the nightstand corners. Review of Resident #11's PCP visit notes dated 03/06/21 revealed: -The POA requested a visit for Resident #11. -Resident #11 had a right eye periorbital contusion with no open wounds. -The injury occurred between last night and presentation at 2:00pm. -Resident #11 had a diagnosis of dementia and was a poor historian. -Resident #11 did not recall a fall and staff did not report any falls for Resident #11. -Resident #11 did not have any vision changes, headaches, neck pain, numbness, weakness in extremities, pain at rest, and bruises elsewhere on her body. Review of Resident #11's electronic charting notes revealed: -There was a noted dated 03/08/21 at 9:59am documented by the facility's RN that Resident	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 438	Continued From page 86	D 438		

#11's right eye was black.
-Resident #11 did not know what happened to cause the black right eye.
-Resident #11's PCP was notified for her to be seen on 03/08/21.
-There was another noted dated 03/10/21 at 6:37am documented by a MA that Resident #11 was asked about pain and blurred vision in her right eye, and the resident asked, "why would her eye be in pain."

Review of Resident #11's PCP visit notes dated 03/08/21 revealed:
-Resident #11 was noted to have a periorbital bruising around right eye on 03/06/21.
-Resident #11 did not recall falling or traumatic event that caused the bruising around her right eye.
-Resident #11 did not have a headache, nausea or vomiting, lethargy, focal deficits, or pain.
-The x-ray results of Resident #11's orbits were negative.
-The PCP was planning to discontinue Resident #11's aspirin.

Telephone interview with Resident #11's PCP on 03/09/21 at 10:45am revealed:
-Resident #11 was seen on 03/06/21 by the on-call provider for a black and blue eye.
-Resident #11's POA requested the visit on 3/06/21.
-An orbital series x-ray was ordered on 03/06/21 to be completed onsite and the results were negative for fractures.
-The on-call provider's note was incomplete, and she was not able to see the cause of Resident #11's injured eye.
-Resident #11 was seen again on 03/08/21 by another provider but that provider's note was incomplete.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 438	Continued From page 87 Review of Resident #11's handwritten progress notes revealed: -There was a noted dated 03/09/21 written by a MA that Resident #11 had a purple bruise around her right eye of "unknown origin". -Resident #11 did not know how the injury occurred. Observation of Resident #11 on 03/09/21 at 2:00pm revealed: -The resident's right eye had a circular purple discoloration on the right upper and lower eyelid, and there was a darker hued discoloration below the right lower eyelid's purple discoloration. -The darker hued discoloration extended to Resident #11's right upper cheek and was in the shape of a semi-circle. -Resident #11's right lower eyebrow had a yellowish discoloration and her upper eyebrow had bluish and yellowish discoloration. Interview with Resident #11 on 03/09/21 at 2:00pm revealed: -She had memory issues due to her age. -She resided at the facility for a couple of years and she thought staff treated her well. -She had no recent falls. -Her entire face was bruised but it was getting smaller. -She did not recall falling, but that did not mean it did not happen. -She did not recall the day she woke up with the bruise on the right side of her face and she thought staff could tell the exact date. -She was not in pain and she did recall any event that caused her right eye to be bruised. -No staff harmed her or treated her in a disrespectful manner, but she did not know how her right eye was injured.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 438	Continued From page 88 Telephone interview with Resident #11's POA on 03/11/21 at 4:08pm revealed: -Resident #11 was one of the first residents who moved into the facility. -She was told by Resident #11 on 03/06/21 that she had a black right eye when she awakened. -Resident #11 did not have any other bruises except for her right eye. -Resident #11's memory was bad, but she would recall if staff had hit her. -She called Resident #11's PCP to see Resident #11 on 03/06/21. -Resident #11's PCP saw her on 03/06/21 and stated she had no fractures after an x-ray was completed. Interview with a first shift MA on 03/09/21 at 2:20pm revealed: -She worked on 03/06/21 and she was assigned as a personal care aide (PCA). -She knew the MA went into Resident #11's room at 7:30am and saw that she had a black eye. -Resident #11 did not know how her right eye became injured and black. -The MA spoke with the MA from third shift to ask about Resident #11's eye. -The third shift MA told them that staff did not go all the way into Resident #11's room and only checked on her from the entryway area of her room. -She worked on Friday, 03/05/21, and Resident #11's right eye was not injured. Interview with another first shift MA on 03/09/21 at 2:29pm revealed: -She was the MA on 03/06/21 for first shift on the assisted living side of the facility. -She went into Resident #11's room at 7:30am to administer medications and saw that Resident	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 438	Continued From page 89	D 438		

#11's right eye was black.
-She asked Resident #11 what happened to her right eye, but she did not know.
-She notified Resident #11's POA and they both notified Resident #11's PCP.
-Resident #11's PCP did not come to the facility before the end of her shift.
-She did not know what the PCP assessed as the cause of Resident #11's right eye injury.
-Resident #11 had an x-ray on 03/06/21

Interview with the facility's RN on 03/09/21 at 4:33pm revealed:
-She looked at all unexplained resident injuries.
-She did not know what happened to Resident #11's right eye.
-Resident #11 did not know what happened to her eye.
-Resident #11's PCP saw Resident #11, but she did not know what his assessment was of Resident #11's right eye.
-Staff called her on Saturday or Sunday, 03/06/21 or 03/07/21, to tell her abut Resident #11's right eye.
-She told staff to call Resident #11's PCP and POA.
-Resident #11 had no eye pain or change in vision.
-She had not spoken with the third shift staff from 03/05/21, but no one speculated that staff hit Resident #11.
-She thought Resident #11 would be able to tell staff if someone harmed her.
-She did not report incidents to the HCPR, but she told the ED about incidents.

Interview with the ED on 03/09/21 at 5:58pm revealed:
-She followed up with Resident #11 on 03/09/21 because she had a black right eye.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 438	Continued From page 90	D 438		

-She talked with Resident #11 only about the cause of her black right eye.
-Resident #11 told her that she and her POA discussed that they thought in the middle of the night her head slipped off her satin pillowcase and hit the nightstand.
-Resident #11 did not remember this occurring.
-She reviewed all incident reports as a follow up and she documented what the resident shared with her.
-She had not spoken with any staff concerning Resident #11's black eye.
-She had not completed a 24-hour report for HCPR concerning Resident #11, but she did characterize Resident #11's black eye as a injury of unknown cause.

Refer to the telephone interview with the ED on 03/08/21 at 4:11pm.
3. Interview with Staff G, a medication aide (MA) on 03/04/21 at 5:57am revealed:
-She worked third shift.
-She was accused by another staff in December 2020 of verbally abusing a resident.
-She was accused of saying "You are nasty" and "I will hit you in the [expletive] face if you hit me", to a resident.
-She did not say the things she was accused of saying to the resident.
-She was suspended for 3 days while the Executive Director (ED) and the Memory Care Wellness Director (MCWD) investigated the complaint.
-The ED and the MCWD interviewed other staff and watched cameras for the incident.
-She could not remember the resident's full name and he no longer resided in the facility.
-She returned to work after her 3-day suspension.
-She did not know if the ED reported her to the HCPR; she was not sure what it was.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(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 438	Continued From page 91 Confidential interview with a staff revealed: -The Staff G was taken off the schedule in November 2020 because she was accused of cursing and threatening a resident. -The ED requested the staff making the complaint to place a statement about the alleged verbal abuse under her door after the staff had verbally reported the abuse to the ED. Refer to the telephone interview with the ED on 03/08/21 at 4:11pm. 4. Telephone interview with a former staff on 03/03/21 at 8:04pm revealed: -They had heard multiple staff use expletive language toward residents, but they were new and did not know all the staff by name. -They had asked another staff if they had noticed all the bruises and skin tears on the residents in the memory care unit (MCU) and the staff told them Management knew and did not do anything about it. -There was staff who should be fired because of the way they treated people. -"Nothing was done to the people who did wrong." Telephone interview with another former staff on 03/05/21 at 8:17am revealed: -The Memory Care Wellness Director (MCWD) was aware of the bruises and skin tears and staff were told to complete an unwitnessed incident report. -Incidents were not investigated. Confidential interview with a staff revealed: -There were residents who did not have bruises in assisted living (AL) but as soon as the resident moved to the MCU they would have unexplained bruises.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 438	Continued From page 92 -Allegations of abuse were "swept under the rug." Confidential interview with another staff revealed: -Residents in the MCU had unexplained bruises "all of the time." -A named staff had a video of residents fighting each other. Confidential interview with a third staff revealed: -First and third shift staff were concerned about the care and treatment of residents by second shift staff. -She had reported her concerns about resident injuries to the Executive Director (ED), but she did not feel confident that the ED would follow up and she was concerned with retaliation. -The staff had reported concerns about resident having unexplained injuries to the MCWD, but she was always given the same response of "Okay" or "Thank you". Interview with the ED on 03/04/21 at 1:27pm revealed: -She was made aware of an incident in the MCU and was told by the corporate executive to investigate the incident. -She investigated it the day she was informed (she did not recall the date). -She was not given a staff name, just that staff had cursed at a resident and the staff put their hands on the residents' shoulders. -She looked at the video and talked to everyone and there was no proof of the alleged incident. -She did not do a HCPR 24-hour report because she could not verify it happened. Refer to the telephone interview with the ED on 03/08/21 at 4:11pm. _____ Telephone interview with the Executive Director	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 438	Continued From page 93 (ED) on 03/08/21 at 4:11pm revealed: -The Health Care Personnel Registry (HCPR) was used prior to hiring to determine if a potential staff had any findings reported. -She personally had never reported anything to the HCPR, because she had never had "proof" when there was an allegation. -"Proof" was verification of an allegation by verifying with camera footage or staff interviews. -She would attempt to verify allegations by viewing the camera footage and if she could not view something by camera, she would conduct staff and resident interviews. -If she had reasonable "proof" then she considered it cause to report to the HCPR. -She was not familiar with the rule area or time lines for reporting to the HCPR; she would immediately reference the rule on line if she needed guidance. _____ The facility's failure to report injuries of unknown origin and staff treatment of residents resulted in the delayed reporting to the Health Care Personnel Registry for 2 residents who were found to have injuries from an unknown cause and a medication aide (Staff G) who was suspended after an allegation of verbally abusing a resident but was never reported to the Health Care Personnel Registry, and was allowed to return to work and provide resident care. This failure was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection for this violation on 03/10/21 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 26,	D 438		

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D 438	Continued From page 94 2021.	D 438		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to ensure residents were treated with respect and dignity. The findings are: Based on record reviews and interviews the facility failed to protect 3 of 6 sampled residents (#1, #4, and #8) in the memory care unit (MCU) from physical and verbal abuse from Staff A, D, B, G, and E; and multiple unidentified residents being verbally abused by the same staff. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].	D911		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by:	D914		

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D914	Continued From page 95	D914		

Based on record reviews, interviews and observations, the facility failed to assure each resident was free of mental and physical abuse, and neglect related to resident rights, personal care and supervision, and health care personnel registry (HCPR).

The findings are:

1. Based on record reviews and interviews the facility failed to protect 3 of 6 sampled residents (#1, #4, and #8) in the memory care unit (MCU) from physical and verbal abuse from Staff A, D, B, G, and E; and multiple unidentified residents being verbally abused by the same staff. [Refer to Tag D0338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]

2. Based on record reviews and telephone interviews, the facility failed to provide supervision in accordance with the resident's assessed needs for 2 of 4 sampled residents (#2, #3), including a resident who was found sleeping in his shower in a t-shirt and urine-soaked adult briefs (#2) and a resident with 11 unwitnessed falls resulting in right thumb and wrist contusions, right elbow and wrist bruises (#3). [Refer to Tag D0270, 10A NCAC 13F .0901 b Personal Care and Supervision (Type B Violation)]

3. Based on record reviews and interviews, the facility failed to report to the Health Care Personnel Registry (HCPR) within 24 hours injuries of unknown origin involving 2 of 2 sampled residents (#1 and #11) including a fractured finger (#1) and bruising around the eye (#11); Staff G accused of verbally abusing a resident; and injuries of unknown origin of unidentified residents. [Refer to Tag D0438, 10A NCAC 13F .1205 Health Care Personnel Registry

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D914	Continued From page 96 (Type B Violation)]	D914		