Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	C 08/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

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D 000	Initial Comments The Adult Care Licensure Section and the Durham County Department of Social Services conducted an annual survey and complaint investigation on 8/23-26/16 and 8/29/16. The complaint investigation had been initiated by the Durham County Department of Social Services on 8/18/16.	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 observations, interviews and record reviews, the facility failed to provide supervision for 2 of 3 sampled residents (#8, #9) known to have a history of exit seeking behaviors and elopement from the locked Special Care Unit (SCU) and 1 of 3 sampled residents (#3) with an unexplained head injury. The findings are: 1. Review of Resident #8's current FL-2 dated 3/10/16 revealed: -The resident's diagnoses included alcoholic dementia, hepatocellular cancer and high blood pressure. -The resident was constantly disoriented. -The resident's level of care was Special Care	D 270		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Unit (SCU).

Review of Resident #8's Resident Register revealed the resident was admitted to the facility on 8/31/15.

Review of Resident #8's pre-admission screening for the Special Care Unit (SCU) revealed it was completed on 8/31/15.

Review of Resident #8's Care Plan dated 8/1/16 revealed:
-The resident had a diagnoses of Parkinson's disease and was blind in the left eye.
-He wandered and was sometimes disoriented.
-The resident ambulated around the unit independently, sometimes with assistance.
-The resident had eloped from the facility on "several" occasions.
-He had been seen by a mental health provider.

Review of Resident #8's progress notes revealed the following entry made by the Memory Care Coordinator (MCC) on 3/9/16 at 9:30 a.m.:
-The resident had been trying to escape from the facility by opening the windows.
-The resident was redirected by staff.
-At the 9:00 a.m. smoke break, the resident was last to leave outside and refused to come back inside the facility. The resident did come back inside of the facility.
-"At one point, the resident tried to jump the fence, but was unable to actively climb the fence."
- "The resident de-escalated when he came back into the facility and stayed in the television room" until his family arrived.
-The resident was given Xanax as needed and Tramadol for leg cramps.

Review of Resident #8's "72 hour acute

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monitoring report" dated 3/9/16 at 9:00 a.m. revealed:
-The resident tried to leave the unit on several occasions "this morning."
-The resident tried to go out the door and jump over the fence during the smoke break.
-The resident calmed down and was given an as needed medication.

Review of Resident #8's progress notes revealed the following entry made by the MCC on 3/29/16 at 3:00 p.m.:
-The resident insisted he had to leave the unit to attend a substance abuse/alcohol abuse class.
-The resident was told he did not need to attend a class in the facility.
-At 3:15 p.m. the resident was taken to the front of the facility with family members to get money out of his account to help decrease wanting to leave the facility.
-Around 4:00 p.m., a second shift aide reported the resident was in the bathroom checking the windows.
-The resident was redirected.
-The resident said he felt "confined".
-The MCC told the resident she would allow him to go outside, but to be "patient."
-Later, the resident tried pushing on the locked unit doors "claiming he had to go and see a girl."
-The MCC advised staff to "watch resident and monitor for any elopement behaviors".

Review of Resident #8's progress notes revealed the following entry made by the MCC on 4/8/16 at 9:00 a.m.:
-The second shift Medication Aide (MA) and Personal care Aide (PCA) reported on 4/7/16 at 8:30 p.m. they heard something fall in the resident's room.
-The resident had used a board from the empty

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closet in his room and had broken the inner window in his room.
-The resident "claimed" he was trying to open the blinds when the inner window collapsed.
-Housekeeping cleaned the broken glass.
-Resident #8's family member was contacted.
-No one was injured.
-The resident received an as-needed medication for agitation/anxiety.
-The second shift staff was advised to monitor the resident closely, to make sure the front doors are sealed when they enter and leave the unit and to keep the resident's room door open for "easier monitoring."
-The resident was calm and did not make any further attempts to elope.
-The MCC discussed the resident's behavior upon arrival to work with the resident's family member.
-The resident wanted his own apartment. The MCC and the family member expressed to the resident he could not elope again or else he would not be able to go back to his apartment, but to another facility.

Review of Resident #8's "72 hour acute monitoring report" dated 4/7/16 during second shift from 3-11 p.m. revealed:
-The resident had gotten out of the locked special care Unit.
-The resident was found on the 300 hall.
-Will continue to monitor.

Review of Resident #8's "72 hour acute monitoring report" dated 4/8/16 during first shift at 3:00 p.m. revealed:
-The resident was given Xanax .25mg as needed at 8:00 a.m.
-The resident stated he had to go to work.
-The resident calmed down.

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Review of Resident #8's progress notes entry made by the MCC on 5/6/16 at 2:00 p.m. revealed:
-The resident tried to push the double doors opened.
-Staff redirected the resident.
-The resident wanted to go to his old room on the 300 hall.
-Staff informed the resident his belongings were in the unit.
-The resident returned to his room and did not say anything else about the 300 hall.

Review of Resident #8's progress notes entry made by the MCC on 5/25/16 at 6:00 a.m. revealed:
-The resident eloped from the SCU during third shift "and made way up the road around 6:00 a.m."
- The resident was found by a family member and was driven back to the facility.
-The camera footage showed the resident was checking for door latches by the door to the patio.
-The door was not closed "good"; the resident left the building, jumped over the fence and sprinted to the road.
-When the resident returned back to the facility, the resident became agitated and insisted staff call his family members to take him out of the facility.
-The onsite physician was contacted. The resident received "Trazadone".
-The resident made no further attempts to elope.

Confidential interview with a staff member revealed about three months ago, Resident #8 jumped the fence on the 400 hallway (locked SCU) patio and went to a local store.

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Review of Resident #8's progress notes entry made by the MCC on 6/28/16 at 7:00 a.m. revealed:
-The resident eloped from the facility when the aides allowed the resident to sit outside in the patio.
-The resident was found with a beer after coming out of the store.
-"The beer was confiscated and the resident returned back to the facility unharmed and cooperative."
-The resident's family member was contacted and informed of the elopement.
-The residents who were elopement risks had to be supervised by staff when they sat on the patio.

Interview with Resident #8's Responsible Party on 8/29/16 at 12:23 p.m. revealed:
-Around two months ago between 7:00 a.m. and 8:00 a.m. , she was driving to see a family member and saw Resident #8 walking by a railroad track, near a grocery store and two gas stations.
-It would have taken the resident 45 minutes to walk to the location she found him.
-She stopped and talked to the resident. He got inside her car and she took him to her house and gave him something to drink.
-She called the facility and asked about Resident #8. She was on hold for a while.
-She told staff she had Resident #8 with her.
-When she picked up the resident, the resident was sweating.
-The Administrator told her they watched the video and someone had left the door propped open. The resident jumped the fence and "took off."
-The [four lane] road in front of the facility is busy. Resident #8 could have gotten hit by a car.
-Resident #8 was not supposed to go outside

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unsupervised.
-She was not aware of any other times he had left the facility.

Interview with the MCC on 8/29/16 at 4:32 p.m. revealed:
-Staff did hourly checks before Resident #8's last elopement. He required 30 minute checks since his last elopement but, she could not remember when he last eloped.
-He tried to climb the fence and fell in June 2016 or July 2016.
-The resident had a history of trying to open the windows.
-She implemented increased supervision when a family member had seen him off the property unsupervised by staff [5/25/16].
-The resident's family member had seen the resident walking on the side of the road and brought the resident back to the facility by 9:30 a.m.
-An incident happened when an aide, who no longer works at the facility, thought he could sit outside unsupervised by staff.
-The resident was heading towards a shopping center.
-She did not know how long the resident had been gone.
-She was not aware of the elopement until she came to work later that day.
-She called the resident's psychiatrist to see if any of his medications needed to be adjusted.
-She was not aware of any elopement other than when a family member had brought the resident back to the facility.

Review of Resident #8's progress notes entry made by the MCC on 8/18/16 at 7:00 p.m. revealed the resident attempted to elope from the facility when taken outside for a smoke break.

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Interview with a Personal Care Aide (PCA) on 8/29/16 at 3:55 p.m. revealed:
-When she was helping another resident to exit an outside door on the 400 Hall on 08/13/16 sometime between 3:30 p.m. and 5:00 p.m., Resident #8 rushed past her and ran outside of the facility.
-Resident #8 ran to the facility fence and tried to climb over it.
-She had heard Resident #8 had eloped from the facility to a family member's house earlier this month and the police had to bring him back to the facility.
-She was not sure of the date of this elopement.

Observation on 8/24/16 at 3:00 p.m. revealed:
-Resident #8's room was located on the 400 hall (locked SCU) near the front double doors.
-Resident #8 was sleep in the chair in his room.

Observation on 8/25/16 at 10:20 a.m. revealed Resident #8 was walking up and down the hallway in the locked unit.

Observation of Resident #8 on 8/25/16 at 10:45 a.m. revealed:
-The resident tried to get out of the locked SCU.
-Staff redirected the resident.

Interview with Resident #8 on 8/25/16 at 11:21 a.m. revealed:
-The resident tried to go places while at the facility.
-He did not go anywhere he was not supposed to go.
-The resident did not want to talk anymore.

Confidential interview with a staff member revealed:

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-Resident #8 was an elopement risk.
-Resident #8 attempts to go out the front door or hop the fence, because the resident thinks he can live on his own.
-One time during third shift, Resident #8 dragged a bench from the patio to the fence and tried to climb the fence, but the resident did not get over the fence.
-Residents who are elopement risk staff monitor them every 10-15 minutes.

Observation on 8/25/16 at 5:41 p.m. revealed Resident #8 was sitting in a chair in the television (TV) room.

Interview with Resident #8's primary care physician on 8/29/16 at 3:28 p.m. revealed:
-The resident could not be outside unsupervised.
-She was aware of the resident's attempt to climb the fence.
-She was aware of the time he eloped from the facility, and his family member saw him and contacted the facility.

Interview with the Administrator on 8/29/16 at 5:45 p.m. revealed:
-Currently, Resident #8 required 30 minute checks. Staff are required to make sure the resident was not trying to elope from the facility.
-The 30 minute checks were implemented on 8/25/16. Before the 30 minute checks started, staff was required to monitor the resident every two hours unless the 72 hour monitoring was required.
-One time a new employee had left Resident #8 on the porch unsupervised, the resident climbed the fence at the facility made a right towards the street and went towards a community store. The resident did not make it to the store.
-The aide went back to the patio and saw the

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resident had left the facility.
-Staff saw him walking on the grass.
-He was gone 15-20 minutes.
-She could not remember the day or time the incident happened.
-There was another incident when the resident had climbed the fence and was near a shopping center. The resident's family member had seen him in the community and brought him back to the facility. Staff did a 72 hour monitoring. It would have taken Resident #8 15-20 minutes to get to the location where the family member had seen the resident.
-Resident #8's primary care physician and mental health provider were aware of the resident's attempted elopements and elopements.
-Resident #8 should be supervised at all times.

2. Review of Resident #9's current FL-2 dated 10/20/15 revealed:
-The resident's diagnoses included schizoaffective disorder, high blood pressure and neuroleptic induced Parkinsonism.
-The resident was ambulatory and wandered.
-There was nothing listed for the Resident's orientation status.
-The resident's level of care was Special Care Unit (SCU).

Review of Resident #9's Resident Register revealed the resident was admitted to the facility on 10/10/14.

Review of Resident #9's Care Plan dated 8/3/16 revealed:
-The resident was sometimes disoriented and had tremors of unknown source.
-He ambulated around the facility using a rolling walker and required limited assistance with

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activities of daily living.
-The resident had been seen by a mental health provider.

Review of Resident #9's progress notes entry made by the Memory Care Coordinator (MCC) dated 10/26/15 at 3:00pm revealed:
-The resident was re-admitted back to the facility to the Special Care Unit (SCU) from a local hospital.
-"He is aware of his past 'mistakes' and says he will not do them again. By 'mistakes' he means the elopement attempts 9/21/15 and 9/22/15 [from the current facility], as well as the elopement event over at [name of another assisted living facility] on 10/9/15 & 10/10/15, that resulted in a Silver Alert until he was found 10/14/15. Resident was placed back in Rm. [room] 420 [on the SCU], bed A."

Review of Resident #9's progress notes entry made by the Memory Care Coordinator (MCC) revealed:
-An entry dated 1/6/16 at 9:54 a.m. read in part, "Resident remains on unit [SCU] due to elopement risk".
-Entries dated 5/24/16 and 6/29/16 documented Resident #9 had been seen by the mental health provider.
-An entry dated 8/3/16 at 5:41 p.m. documented the resident was seen by the primary care physician.

Observation of the facility during the tour on 8/23/16 at 11:15 a.m. to 12:30 p.m. revealed:
-The residents' windows were all the same.
-The window was 5-6 feet high and 4 feet wide.
-The window started 1 foot from the floor.

A confidential interview with a staff member

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revealed Resident #9 tried to elope from the facility the evening of 8/23/16.

Confidential interview with a staff member revealed:
-Resident #9 tried to leave the facility on 8/23/16 around 9:00 p.m.
-The resident had taken one of the screws out of his window and had gotten out of the building.
-When the resident came back inside of the facility, someone sat with the resident for the entire night.
-The last time the resident tried to elope from the facility was 4-5 months ago. The resident was caught trying to unscrew the screws from the window in his room.
-Staff monitored the resident every two hours.
-The resident's family and primary care physician were aware of the resident's behaviors and attempts to elope.
-The staff member did not know if the resident had been seen by mental health.

Observations of and through the window in Resident #9's room on 8/24/16 at 4:34 p.m. revealed:
-There was a nail in the window to prevent the window from opening wide.
-A chain link fence was located outside, on the side of the resident's room.
-The fence was 30 feet from the building and was 6-10 feet high.
-The fence extended around to the side of the building.
-There were bushes and tall trees behind the chain link fence.

Observation of Resident #9 on 8/24/16 at 4:34 p.m. revealed the resident was standing by the sink in his room.

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Observation on 8/24/16 at 4:35 p.m. revealed:
-A resident, located inside the locked SCU, wanted to go outside to the patio.
-A Medication Aide (MA) told the resident they just had a meeting and residents could not go outside to the patio alone anymore without staff going outside with them.

Observation on 8/25/16 at 10:21 a.m. revealed Resident #9 was in his room sitting in a chair in front of the window.

Interview with a PCA on 8/25/16 at 10:45 a.m. revealed:
-Resident #9 could not go outside without staff supervision.
-She had never known Resident #9 to elope from the facility.
-She had been told to watch Resident #9 closely.
-A couple of residents could go outside unsupervised during the smoke break.
-Resident #9 could not go outside to the patio alone.

Confidential interview with a staff member revealed:
-Resident #9 tried to go out of a window 2-3 months ago.
-The window was fixed in Resident #9's room so the resident could not elope from the window.
-The resident had a history of elopement from a previous facility.
-Staff monitor residents who are elopement risk every 10-15 minutes.
-She was not aware of Resident #9's recent elopement attempt on 8/23/16.

Interview with a MA on 8/25/16 at 5:14 p.m. revealed:

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-She had heard Resident #9 was trying to get out of the window (8/23/16).
-She was not working at the time.
-Resident #9 told her the reason he was trying to leave the facility was because he wanted cigarettes on that day.
-She had never known of Resident #9 to elope from the facility.
-She checked on Resident #9 three to four times within an hour.
-Staff watch him more often since the attempted elopement.

Interview with Resident #9's family member on 8/29/16 at 12:47 p.m. revealed:
-Resident #9 did not have a guardian or legal representative.
-She just tried to help him make decisions.
-She did not have any complaints about the facility.
-She was not aware of any times Resident #9 tried to leave the facility.

Interview with an NA on 8/29/16 at 1:51 p.m. revealed:
-He had seen Resident #9 getting out of the SCU once, but had heard of him eloping twice from the building.
-Sometime last week (8/21-27/16) between 7:00 p.m. to 8:00 p.m., one of the aides, had seen the resident running on the grass behind the facility and reported it to the other staff.
-Bothe aides were working the 300 hall.
-The resident was trying to put his feet on the fence.
-The NA and three other staff went to get the resident.
-The resident was out of breath.
-When the resident came back inside the facility, the resident was placed back in his room and

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staff provided one on one with the resident for the rest of the night until the resident's window was fixed.
-The resident told the NA he was trying to get to the nearest bus stop.
-The last time he had worked with Resident #9 was over one month ago.
-He did not think Resident #9 had special supervision.

Interview with a MA on 8/29/16 at 2:50 p.m. revealed:
-She was working on the 300 hall last week [8/23/16] when the resident got out of the SCU and from the facility around 8:30 p.m.
-She was assigned to the 300 hall. She was giving a resident medications and the NA, who was assigned on the 300 hall, was giving a resident a snack, when the resident eloped from the SCU.
-The NA said, "Is that [Resident #9's name]?"
-The MA looked to see if she could see Resident #9.
-It was dark outside. The MA called for another staff to help get the resident. She ran to try to catch the resident but the resident was walking fast.
-The NA held the resident to prevent him from climbing the fence. Resident #9 had thrown his cane across the fence. He lifted his leg at the fence in an attempt to climb it. After she was able to get to the resident, she called for a Supervisor. It took about 10 minutes to get the resident to come back inside the facility.
-The staff brought him back in the building to the 300 hall. Resident #9 stayed on the 300 hall until his window was fixed.
-No one from the 400 hall, where the resident lived, knew he was missing.
-She had worked with the resident on the 400 hall

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in the past.
-Staff had monitored Resident #9 every two hours.
-Within the past week, the monitoring had changed to every 30 minutes.

Interview with a Personal Care Aide (PCA) on 8/29/16 at 3:55 p.m. revealed:
-Resident #9 eloped from the facility one day last week or the week before.
-She could not remember the exact date Resident #9 had gotten out of the building.
-She was working on the 300 Hall on the night Resident #9 had gotten out of the SCU and the building.
-She saw Resident #9 when he ran past the window of the TV room on the 300 Hall sometime between 8:00 p.m. and 9:00 p.m.
-She and the Medication Aide (MA) ran out the back door of the 300 Hall to get Resident #9.
-Resident #9 was brought back inside the facility and the medication aide notified the supervisor.
-Resident #9 did not have any injuries when he came back inside the facility and was taken back to his room on the 400 Hall.
-She was not sure how Resident #9 had gotten out of the facility but she heard that Resident #9 had gotten out through his room window on the 400 Hall.
-She was not sure if Resident #9 had ever tried to elope from the facility before.
-The 400 Hall was a locked unit with door alarms and is used to house combative residents.
-She did not remember if she was given any instructions from her supervisor to monitor residents more closely to prevent elopement after this event.

Interview with a Medication Aide (MA) on 8/29/16 at 4:18 p.m. revealed:

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-She was working on the 200 hall on 8/23/16 when the resident eloped.
-Staff had seen the resident go by the window
-She received a call on the walkie-talkie that Resident #9 had gotten out of the facility.
-She had seen another aide with the resident at the edge of the fence.
-She did not know how the resident had gotten out of the facility.
-She heard later the resident had gotten out through the window in his room.

Interview with a Supervisor on 8/29/16 at 4:32 p.m. revealed:
-She was the 400 Hall Supervisor during the incident of the evening of 8/23/16 when Resident #9 had gotten out of the facility.
-A staff member had seen Resident #9 go by the window.
-The resident had a leg over the fence, in an effort to scale the fence.
-The Supervisor and another staff member talked the resident back into the facility.
-The resident revealed he was tired of living in the facility.
-She instructed all staff to check on Resident #9 every 15 minutes
-She also instructed a staff person to sit with the resident through the rest of the shift.

Interview with the MCC on 8/29/16 at 4:32 p.m. revealed:
-Staff are required to monitor Resident #9 every 30 minutes since the resident's last elopement, which was last week.
-Last week, the resident did not want to be at the facility, so he opened the window to his room and exited towards the 300 hall.
-When staff brought him back into the facility, they put him in the TV room. The resident said he

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wanted to be in a place where he can smoke all of the time.
-When he eloped last week, there had been no signs he wanted to leave the facility. The resident's psychiatrist and family member were contacted regarding the resident ' s elopement.
-When the resident was first admitted to the facility and was living on the 300 hall, the resident eloped from the facility and was sent to a local hospital. The resident had been living on the 400 hall since November 2015.
-Before the last elopement 1 week ago, the resident was allowed to sit on the porch alone unsupervised by staff.

Interview with Resident #9 on 8/29/16 at 4:52 p.m. revealed:
-The only reason the resident was trying to leave the facility was to smoke a cigarette.
-Smoke breaks are every 4 hours and are not frequent enough.
-The resident denied trying to leave the facility or climb a fence.
-He did not like living in a locked unit.
-The locked unit felt like prison.
-The resident wanted to leave the facility and live in a non-locked facility.

Interview with the Resident Care Coordinator (RCC) on 8/29/16 at 5:18 p.m. revealed:
-She supervised the MCC.
-The MCC put in place to supervise the residents who are at-risk for elopement every 30 minutes for 30 days, then, re-evaluate the resident.
-The resident's physician and mental health provider are contacted when a resident had eloped.
-She did not know what was put in place for Resident #9.

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Interview with the Administrator on 8/29/16 at 5:45 p.m. revealed:
-Currently, Resident #9 required 30 minute checks. Staff are required to make sure the resident was not trying to elope from the facility.
-The 30 minute checks were implemented on 8/25/16. Before the 30 minute checks started, staff was required to monitor the resident every two hours unless the 72 hour monitoring was required.
-One night in November 2015 or December 2015, the resident had gotten out of his window, jumped over the fence and gotten to the front of the building. Maintenance secured the window so it would not open but so wide.
-Another time, Resident #9 had gotten upset with his roommate and "tried" to go out the window. Staff brought him back in. A different roommate was assigned, and there had not been any problems with him since.
-Recently she had been told Resident #9 "tried" to get out the window on 8/23/16 on second shift, but staff caught him. She told staff to monitor the resident until the next shift. A 72 hour acute monitoring was done on the resident and he was fine.
-Resident #9's primary care physician and mental health provider was aware of the resident's attempted elopements and elopements.
-Resident #9 should be supervised at all times.

Resident #9's mental health provider and primary care physician were not available for interview.

3. Review of Resident #3's current FL-2 dated 03/10/16 revealed:
-Diagnoses included Alzheimer's/dementia, hypothyroidism, hypertension.
-The resident was non-ambulatory and constantly

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disoriented.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 5/09/14.

Review of Resident #3's current Care Plan dated 6/29/16 revealed:
- The resident was totally dependent on staff for all activities of daily living (ADL's).
- Resident could feed self with prompting from staff.
- Resident was incontinent of bowel and bladder.
- Resident required extensive assistance with bathing, toileting, dressing and transferring.
- Resident was not oriented to time and place.
- Resident had a wheelchair, but was not able to move independently.
- The Care Plan was signed by the Primary Care Provider (PCP) on 7/08/16.

Review of Resident #3's resident record revealed:
- Order dated 4/11/16, signed by the Nurse Practitioner, to move bed to one side of wall, with a mat on the other side. Resident is to be in a recliner and out of wheelchair while in room.
- Order dated 4/25/16, signed by the Nurse Practitioner, to please have the resident in recliner after breakfast and lunch with legs elevated.
- Resident record entry on 7/31/16 for Resident #3 indicated that the resident was sent to the emergency room for a fall.
- A second resident record entry dated 8/10/16, resident sent out to emergency room for knot on head, called primary doctor, notified family.

Review of Resident #3's record revealed:
- Entry dated 7/31/16 for Resident #3 noted the resident was sent to the emergency room for a

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fall (The location of the fall was not documented).
- Entry dated 7/31/16 noted the resident's Nurse Practitioner and family were contacted.
- Entry dated 7/31/16 noted no new orders were issued by the hospital physicians

Review of Resident #3's Emergency Department report from a local hospital on 7/31/16 revealed:
- On 7/31/16 the resident was admitted to the emergency department after the resident was found in the bed with a bump on the resident's left forehead.
- There was no known fall or other injury noted.
- The report noted that a family member indicated that Resident #3 was not strong enough to get back in bed if a fall occurred.
- On arrival to the emergency department the resident was noted with a fever and tachycardia.
- Further work up revealed a probable UTI (Urinary Tract Infection) and the resident was treated and returned to the facility on 7/31/16.

Review of Resident #3's Discharge Summary report dated 8/12/16 from a local hospital revealed:
-On 8/10/16, the resident was admitted to the hospital from the emergency room with the chief complaint of a bump on the head and a UTI.
-The resident was admitted to the hospital from the emergency department with the chief complaint being a bump on the head and a UTI.
-There was no known fall or other injury noted.
- A CT scan revealed a hematoma but no intraparenchymal bleeding.
-Ecchymosis of the head was noted, although the injury was not significant.
-The resident was treated with a 7 day antibiotic course.
-The resident needed to be monitored for falls.
-The hospital stay was discussed with staff at the

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facility and the facility was planning to implement stronger falls precautions for Resident #3.
-Resident #3 was discharged back to the facility on 8/12/16.
-Resident #3's status was noted on 8/12/16 to require help with all ADLs, she was bedfast and her mobility was very limited.

Review of Incident/Accident reports for Resident #3 revealed:
-There was no Incident/Accident report for 7/31/16.
-On 8/10/16 at 8:00 AM, Resident #3 was found in bed with huge knot on left side of her head. 911 was called and the resident sent to emergency room.

Observation of Resident #3 in the resident's room at room on 8/18/16 at 1:37 PM revealed:
- Resident #3 was alone and sitting in a wheelchair.
- There was no staff present or within visual sight of the resident.

Interview with the Resident Care Coordinator (RCC) on 8/18/16 1:35 PM revealed:
- She was informed that the resident was alone in the wheelchair.
- Resident #3 was normally not left in the wheelchair, but was left in the chair due to a routine nursing assessment being done on the resident.
- The RCC instructed staff to move the resident to a recliner.

Interview with the Medication Aide/Supervisor on 8/24/16 at 1:57 PM revealed:
-She completed the 8/10/16 incident report that documented Resident #3's injury.
-8/10/16 was Resident #3's shower day.

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-Resident #3 was a two-person assist for baths and transferring.
-Resident #3 could not get up independently.
-Resident #3 was placed in the wheelchair for showers.
-Resident #3 was checked on about every 2 hours.
-On 8/10/16 at 7:30 AM, a Personal Care Aide working on the bath team indicated that Resident #3 had a large knot on her forehead, when assisting with personal care/bathing.
-She inspected the large knot on Resident #3's left side of her head.
-She felt the injury "looked fresh" and was only bleeding a small amount.
-She indicated that the staff did not know how exactly the resident's injury occurred.
-The Medication Aide/Supervisor indicated that no staff on 1st shift 7:00 AM - 3:00 PM (8/10/16) or third shift the night before 11:00 PM - 7:00 AM (8/09/16) reported that Resident #3 had fallen.

Interview with a resident on 8/24/16 at 2:10 PM revealed:
-She witnessed Resident #3 about 1-2 weeks ago fall out of a wheelchair while bending over, as if trying to pick up something off the floor.
-The incident occurred in the morning time (time unknown) but she was unsure of the date and time.
-The injury on Resident #3's head occurred about 1-2 weeks ago when she fell out of the wheelchair.
-Resident #3 did not fall out of bed, or hit her head on a bed post.
-She yelled out for staff to come get Resident #3 off the floor when she fell out of the wheelchair.
-The staff from the facility got the resident up from the floor.
-She was unsure which staff members got

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Resident #3 up from the floor.

Interview with the Personal Care Aide (PCA) on 8/24/16 at 2:57 PM revealed:
-He worked on 8/10/16 on the bath team.
-Resident #3 was scheduled to receive a shower on 8/10/16.
-On 8/10/16 around 7:30 AM, he walked into Resident #3's room, noted resident was in the bed, laying on her side.
-He transferred Resident #3 from the bed to the resident's wheel chair without the assistance of any other staff.
-He noticed a large, egg shaped bump was on the resident's left forehead once the resident was taken to the shower room.
-The injury was brought to the attention of the Medication Aide/Supervisor, who called 911.
-The PCA did not know how Resident #3's injury occurred.
-He thought Resident #3 may have struck the edge of the bed frame while the resident was in bed.
-Resident #3 required total assistance with ADLs.

Interview with a second PCA on 8/26/16 at 2:06 PM revealed:
-She worked with Resident #3 on 3rd shift from 11:00 PM - 7:00 AM on 8/9/16.
-Resident #3 was fine all night.
-Resident #3 was awake during the night, which was unusual.
-Resident #3 usually slept through the night.
-Resident #3 was provided incontinence care a few times during the night.
-There were no injuries were noted with the resident.
-Resident #3 was sleeping in the resident's bed when the PCA left at 7:00 AM.

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Interview with a second Medication Aide on 8/26/16 at 2:30 PM revealed:
- Resident #3 was admitted to the hospital with a previous injury on 7/31/16.
- The morning of 7/31/16, she was on duty when Resident #3
was found on the floor by another employee and the incident was brought to her attention. Resident #3 was found shortly after breakfast. Resident #3 fell out of her wheelchair.
- Staff assisted the resident back into the resident's bed.
- She reported calling the resident ' s Nurse Practitioner who advised sending the resident out.
- Resident #3 sustained a knot with swelling and that she administered ice.
- EMS took the resident to a local hospital.
- Resident #3 returned the same day.
-She also worked as the Medication Aide on 8/10/16 on 1st shift 7:00 AM - 3:00 PM.
-The PCA on the bath team found Resident #3 in the bed around 7:30 AM.
-It was unusual for Resident #3 to still be in the bed, 3rd shift was tasked with getting all residents out of bed.
-She was not sure why 3rd shift left Resident #3 in the bed.
-The PCA on the bath team noticed a knot on Resident #3's head and notified her and the Medication Aide/Supervisor.
-She noted the knot to be about the size of an egg with slight bleeding.
-911 was called and Resident #3 was sent to the hospital via ambulance.
-Resident #3 required total care and was not able to turn or roll herself over in the bed.

Interview with the 3rd shift Medication Aide/Supervisor on 8/26/16 at 2:49 PM revealed:

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-He worked with Resident #3 on 3rd shift from 11:00 PM - 7:00 AM on 8/9/16.
-The staff had been instructed to leave Resident #3 either in the resident's bed or recliner.
-There were medications administered to Resident #3 at 6:00 AM, no injuries were noted at that time.
-Later in the day on 8/10/16 he was called by the RCC and asked if anything happened to Resident #3 during 3rd shift from 11:00 PM - 7:00 AM on 8/9/16.
-He was not aware or informed of any incident with Resident #3.

Interview with a third PCA on 8/29/16 at 11:42 AM revealed:
-The PCA worked with Resident #3 on 3rd shift from 11:00 PM - 7:00 AM on 8/9/16.
-Resident #3 was in the bed during the 3rd shift on 8/9/16.
-Resident #3 was laying on her right shoulder.
-The facility called him on 8/10/16 and questioned him regarding a knot on Resident #3's forehead.
-He was unaware of the injury to Resident #3's forehead until the facility called him on 8/10/16.
-The PCA indicated that "I think somebody tried to pick Resident #3 up and the resident fell and they put the resident back in the bed".
-The PCA stated that the resident was not able to roll out of the bed or get up.
-The PCA indicated that they (Management Staff) are saying that Resident #3's injury was a result of hitting her head on the bed rail.
-The PCA did not think that it was possible for Resident #3 to injure her head by hitting it on the bed rail or frame.

Observation of Resident #3 on 8/29/16 at 2:00 PM revealed the resident was lying in her bed, her eyes were closed, she was not moving and

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there was a bedside mat at the right side of the bed.

Review of Resident #3's Physical Therapy Plan of Care on 8/29/16 revealed:
-Resident #3 was assessed on 8/29/16.
-The treatment diagnosis was repeated falls.
-The reason for referral was a documented as recent unwitnessed fall from wheelchair.
-Resident #3 required +2 person assist wheelchair to bed transfers and sit/stand transfers.
-Resident #3 used a hospital bed with side of bed leaning to wall, and a mat in place at the other side on the floor.
-Resident #3 to be placed in safe room with close supervision when patient was sitting up in wheelchair.

Interview with the Administrator on 8/29/16 at 2:05 PM revealed:
-The EMS reported that Resident #3 must have hit her head on the bedframe.
-She was not sure what actually happened that resulted in the knot on Resident #3's forehead.
-The facility did an investigation immediately upon finding the injury on Resident #3.
-The facility interviewed the third shift staff from 8/9/16 and the first shift staff from 8/10/16.
-Resident #3 had a bedside mat beside her bed and a low bed.
-The facility had implemented a new falls policy that went into effect on 8/23/16.
-All residents with falls will be assessed with this falls policy and therapy ordered as indicated by the Primary Care Provider.

Interview with Resident #3's Primary Care Provider on 8/29/16 at 3:12 PM revealed:
-Resident #3 not mentally cognitive.

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-Resident #3 was non-ambulatory.
-Resident #3 was extremely limited, even while in bed or wheelchair.
-The facility reported that Resident #3's injury was the result of the resident's head being hit on the resident's bedframe.
-She felt the interview with a resident on 8/24/16 at 2:10 PM, which reported that she witnessed Resident #3's fall, was valid based on the resident cognitive status.

____

Review of the Plan of Protection provided by the facility on 8/25/16 and 8/29/16 revealed:
-Immediately all residents who may potentially try to elope from the facility will be placed on 30 minute checks until there have been no incidents for 30 days.
-Residents, who are identified as needing closer supervision and are housed on the 400 hall, will be monitored in the TV room by staff.
-The residents who are housed on the other halls will be monitored in the "Redding room."
-The Administrator, the Resident Care Coordinator and the Unit Coordinator will make sure staff are monitoring the residents.

-The facility was in the process of updating policies to reduce risk of injury to residents in the facility.
-The facility had updated their falls prevention policy to include: 72 hour acute monitoring upon admission to assess risk for falls.
-Those residents determined to be at risk for falls will be referred to physical and occupational therapy.
-Physical and Occupational therapy will determine the need for assistive devices, alarms, chair pads and low beds.
-When a fall occurs the surveillance footage will

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D 270	Continued From page 28 be reviewed to see if a cause could be determined and preventative measures put in place for the future. -Any staff that witnessed fall will be interviewed to assist in determining cause of the fall. -If a second fall occurs the resident will be placed in a fall prevention program to include a bracelet to indicate the need for increased supervision and kept in visual area when not in bed, during a meal or receiving personal care or appointments. -If it is determined that a resident is in need of the falls prevention program upon initial assessment upon admission, they will be immediately placed in the program. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 13, 2016.	D 270		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the Personal Care Aides (PCAs) followed sanitation guidelines while providing feeding assistance to residents who required assistance with eating in the front dining room. The findings are: Observation of the lunch meal in the front dining	D 283		

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room on 08/23/16 at 12:44 p.m. revealed:
-There were 3 curved tables located at the back of the dining room.
-At each curved table, there was one PCA and 4 residents seated around the table.
-At one of the curved tables there was one family member seated.

Observation of table #1 on 08/23/16 at 12:45 p.m. revealed:
-The PCA was monitoring, redirecting and feeding 3 of the residents, a family member was feeding one resident.
-Resident #3 was wiping her hands through the food on her plate.
-Resident #3 was redirected by the PCA by removing the resident's hands out of the plated food with her gloved hand.
-The PCA placed Resident #3's spoon in Resident #3's hand.
-Resident #3's eating utensil had food smeared along the handle.
-The PCA's gloves were contaminated with the food particles from Resident #3's hand and eating utensil.
-The PCA continued to feed and assist the other residents at the table without changing the soiled gloves.

Observation of table #2 on 08/23/16 at 12:50 p.m. revealed:
-Resident #20 ate the food on the plate.
-The PCA placed Resident #20's plate under Resident #18's plate.
-Resident #18 continued to be fed by the PCA from her plated food with Resident #20's plate seated underneath.

Observation of table #3 at 1:00 p.m. revealed the PCA was observed changing gloves after soiling

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the gloves she was using between 2 of the residents.

Observation of table #1 at the lunch meal in the front dining room on 08/24/16 at 12:55 p.m. revealed:
-Resident #3 was being fed by the PCA.
-The PCA was wearing gloves.
-Resident #15 had finished her plate of food, the PCA moved the plate and placed the plate on the right hand side of Resident #16.
-Resident #16 was observed occasionally reaching her hand out toward Resident #15's plate.
-The PCA was not observed changing her gloves during the meal.

Observation of table #2 at the lunch meal in the front dining room on 08/24/16 at 12:55 p.m. revealed:
-Resident #20 had his eyes closed at the table, the PCA touched the top of Resident #20's head with a gloved hand in an attempt to wake the resident up.
-The PCA began to assist Resident #17 and touched the resident's bread on the plate and then assisted Resident #20 with his bread.
-The PCA did not change the contaminated gloves between the two residents.

Observation of table #3 at the lunch meal, in the front dining room on 08/24/16 at 12:55 p.m. revealed:
-The PCA was wearing gloves.
-Resident #21 was feeding herself.
-The PCA cut Resident #24's meat up and fed the resident some of the meat.
-The PCA started feeding Resident #22 with the same gloves.
-The PCA did not change gloves between

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residents.

Interview with a PCA on 08/24/16 at 2:20 p.m. revealed:
-The PCA had been employed at the facility for 4 months.
-The facility had used the 3 curved tables in the main dining room for one aide to feed 4 residents since she had worked at the facility.
-The "bath team" was responsible for assisting the residents that required feeding.
-During the 1st shift there were 3 aides assigned to the bath team.
-The "feeders" should be monitored at all times while seated at the curved tables to prevent the residents' from grabbing others food, drinks, and utensils.
-Resident #16, #3, and #15 could mostly feed themselves.
-At the 2nd table Resident #20 was high functioning and could feed himself, Resident #17 was blind, Resident #18 and #19 required to be fed and needed encouragement during a meal.
-She was trained to change gloves and wash her hands between residents.
-She tried to keep napkins to use.
-She did not change her gloves between each resident.
-There was not a place at the curved tables to dispose of the soiled gloves.
-She was unsure how many PCA's and dietary aides were required to monitor and help the residents at each meal.
- It was hectic in the dining room, "feel like you are all over the place".
-It was difficult to feed 4 residents.

Interview with a second PCA in 08/24/16 at 2:55 p.m. revealed:
-She started working at the facility in June of

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2014.
-The PCA's were expected to wash hands and wear gloves while feeding residents.
-She was taught by a speech therapist to feed residents using the "bite, bite, sip" method.
-She found it difficult to meet the needs of all the residents at the table and to keep track of the bite, bite, sip method with each resident being fed.
-The PCAs were expected to encourage the residents to feed themselves if they were able.
-She was not told to change gloves between residents.
-There was not a place designated at the tables to dispose of the used gloves.
-She did receive training on how to feed residents that needed assistance when she was first hired.

Interview with the Resident Care Coordinator (RCC) on 08/24/16 at 4:00 p.m. revealed:
-The PCAs did not have to change gloves unless there was cross contamination between residents.
-There should only be 2 residents to one staff member when feeding residents.
-One staff person cannot feed 4 residents at one time.
-All PCAs were expected to be in the dining room during meals.
-The PCAs would decide among themselves who will assist the residents to eat the meal.
-The PCAs not assisting the resident to eat should be monitoring other residents, pass out plates, open packages, or assist with any other needs of the residents in the dining room.
-If the PCAs needed help feeding residents they could ask for help from the other PCAs in the dining room.

Interview with the Supervisor in Charge (SIC) on

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08/24/16 at 4:10 p.m. revealed there should be 2 residents to one staff person when assisting a resident with eating a meal.

Interview with the Administrator on 08/24/16 at 4:20 p.m. revealed:
-The residents' that do not require assistance with eating should be served first.
-After the trays were out the attention could be given to those residents that required assistance with eating.
-She was not aware that the PCAs were not changing contaminated gloves between residents when assisting them with eating.

Interview with two Dietary staff members on 08/25/16 at 4:00 p.m. revealed:
-There were at least 8 PCAs in the dining room on 1st shift during the meal.
- During meals there were 3 PCAs who fed those residents that needed assistance.

D 358 — 10A NCAC 13F .1004(a) Medication Administration — D 358

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:
TYPE B VIOLATION

Based on observations, interviews, and record

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reviews, the facility failed to assure medications were administered as ordered for 5 of 8 residents (#10,#11, #12, #13, #14) observed during the medication passes, including errors with a short acting insulin (#13,#14), an insulin mixture of short acting and long acting (#11) dementia medication, (#12), pain medication (#12), and a calcium supplement (#10).

The findings are:

The medication error rate was 23% as evidenced by the observation of 6 errors out of 26 opportunities during the 5:00pm medication pass on 8/23/16 and the 8:00am medication pass on 8/24/16.

1. Review of Resident #11's current FL2 dated 4/6/16 revealed diagnoses included diabetes, vascular dementia, and hypertension.

Review of the Resident Register for Resident #11 revealed he was admitted to the facility on 3/7/16.

Review of Physician orders from an office visit for Resident #11 dated 6/13/16 revealed a physician order for Novolin 70/30 insulin injection 48 units 20-30 minutes before breakfast, and 25 units 20-30 minutes before supper (70/30 insulin is a mixture of long acting insulin and fast acting insulin) (insulin helps the body use sugar properly).

Review of the Medication Administration Record (MAR) for Resident #11 revealed Novolin 70/30 insulin injection was scheduled to be administered at 5:00pm.

Observation of the medication pass on 8/23/16 at 4:44pm revealed:

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-Resident #11 received 25 units of Novolin 70/30 via injection.
-Resident #11's blood sugar was collected just prior to insulin administration.
-Resident #11 had a blood sugar of 234.

Observation of resident #11 on 8/23/16 between 4:44pm and 5:45pm revealed:
-Dinner had not been served to residents in the dining room by 5:30pm.
-Resident #11 went into a room off the hallway across from the dining room and brought out a pizza box at 5:45pm.
-Resident #11 sat at a table in the foyer and began to eat the pizza at 5:45pm.

Interview with Resident #11 on 8/23/16 at 5:45pm revealed:
-Staff had not been offered "anything" to eat since the insulin had been administered to her.
-She had not had anything to eat since the time she had been given the insulin injection.
-The residents in the dining room were not eating yet so she went and "took a staff pizza".

Interview with the Resident Care Coordinator (RCC) on 8/24/16 at 3:15pm revealed:
-Resident #11 had eaten a sandwich right before she had eaten pizza.
-She saw Resident #11 on a video camera eating pizza in the foyer, and she felt that was earlier than 5:45pm.

A request was made to the Administrator and RCC on 8/25/16 at 6:00pm to review the video camera with surveyor, but was not provided.

Interview with the Administrator on 8/24/16 at 6:15pm revealed:
-She saw Resident #11 eating a sandwich

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sometime between 3:30pm and 3:45pm.
-She would have Resident #11's insulin order changed from having to eat 20-30 minutes after insulin administration, because Resident #11 was always eating every hour on the hour.

Interview with the medication aide on the 200 hallway on 8/24/16 at 6:20pm revealed:
-She was the medication aide that had been observed on the medication pass on 8/23/16 and administered the medication to Resident #11 at 4:44pm.
-Resident #11 had a sandwich (unknown type) for snack at 3:30pm, she had not had anything to eat after the insulin injection had been administered.
-The next thing she knew, she had pizza in the front hallway (foyer) at 5:45pm.
-The medication aides were able to get food from the kitchen any time they needed for residents that were administered medication before meals.
-She would be sure to get food from the kitchen and make sure residents were fed after insulin injections in the going forward.

2. Review of Resident #13's current FL2 dated 8/27/15 revealed:
-Diagnoses included type 2 diabetes, vascular dementia, polycystic kidney disease, and coronary artery disease.

Review of the Resident Register for Resident #13 revealed she was admitted to the facility on 5/9/14.

A physician order for Novolog Flex pen (replaces the insulin that your body would normally make, starts working faster and lasts for a shorter time than regular insulin) inject 20 units SQ before lunch and dinner (hold for glucose less than 70, call physician for greater than 70).

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Review of the MAR for Resident #13 revealed Novolog insulin injection was scheduled to be administered at 12:00pm.

Observation of the medication pass on 8/24/16 at 11:41am revealed:
-Resident #13 received 20 units of Novolog insulin via flex pen syringe.
-Resident #13's blood sugar was collected just prior to insulin administration.
-Resident #13 had a blood sugar of 165.

Observation of Resident #13 on 8/24/16 between 11:41am and 12:34pm revealed Resident #13 was served in the dining room at 12:34pm.

Refer to interview with the second medication aide in the 200 hallway on 8/24/16 at 12:35pm:

Refer to interview with the RCC on 8/24/16 at 3:15pm:

3. Review of Resident #14's current FL2 dated 3/10/16 revealed:
-Diagnoses included diabetes, senile dementia, and normal pressure hydrocephalus.
-A physician order for Novolog Flex pen (replaces the insulin that your body would normally make, starts working faster and lasts for a shorter time than regular insulin) inject 6 units subcutaneously (SQ) three times a day with meals (Hold if not eating) If blood sugar was less than 75 take a half dose of the scheduled insulin.

Review of the Resident Register for Resident #14 revealed she was admitted to the facility on 1/30/15.

Review of the August 2016 MAR for Resident #14

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DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(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
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revealed Novolog insulin injection was scheduled to be administered at 12:00pm.

Observation of the medication pass on 8/24/16 at 11:41am revealed:
-Resident #14 received 20 units of Novolog insulin via flex pen syringe.
-Resident #14's blood sugar was collected just prior to insulin administration.
-Resident #14 had a blood sugar of 174.
-Resident was not eating food when the 6 units of insulin was injected.

Observation of Resident #14 on 8/24/16 between 11:41am and 12:15pm revealed Resident #14 was served her lunch meal in the dining room at 12:15pm and immediately began eating.

Refer to interview with the second medication aide in the 200 hallway on 8/24/16 at 12:35pm:

4. Review of Resident #12's current FL2 dated 7/19/16 revealed:
Diagnoses included Parkinson's disease, metastatic colon, and obstructing colon mass with colostomy.

Review of the Resident Register for Resident #14 revealed he was admitted to the facility on 7/22/14.

a. Review of subsequent physician orders for Resident #12 dated 7/22/16 revealed an order for Rivastigmine (for the treatment of mild to moderate dementia associated with Parkinson's disease) 1.5mg (2) tablets two times a day before meals given medications strictly at 8:00am, 2:00pm, and 8:00pm as per medication schedule.

Review of the August 2016 EMAR for Resident

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#12 revealed Rivastgmine 1.5mg was scheduled to be administered at 7:30am, 4:30pm and 8:00pm.

Observation of the medication pass on 8/24/16 at 9:30am revealed Resident #12 received 2 tablets of 1.5mg Rivastigmine at 9:30am.

Interview with the medication aide on the 400 hallway on 8/24/16 at 2:32pm revealed:
-She was still administering medications from her 8:00am medication pass.
-Resident #12 usually received his medication earlier in the morning before his breakfast meal.
-The reason he received his medication so late this time was because " things had been so crazy on the back hallway " that morning.
-The Memory Unit Coordinator (MCC) would assist her with medications administration if she asked for help, she "did not ask for help this morning".

Interview with the MCC on 8/24/16 at 4:30pm revealed:
-She was responsible for all of the residents on the locked 400 hallway only.
-The medication aides usually complete their 8:00am medication pass around 8:30am.
-The medication aide in the 400 hallway had a "one time deal today", but today she was finished much later.
-If the medication aide on the 400 hallway "asked her for assistance, she would help her out. She did not ask for assistance this morning".
-She usually completed her 8:00am medication pass around 8:45am -9:00am.
-Breakfast was served in the 400 hallway dining room at 7:45am-8:00am.
-The medication aides understand before meal medication and know who the residents are with

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those orders.
-The medication aides were responsible for arranging to give the medications specified before meals, before the residents eat.

Interview with the Resident Care Coordinator (RCC) and the Supervisor in Charge (SIC) on 08/29/16 at 1:45 p.m. revealed:
-The MCC could answer questions in regards to the printed EMAR administration times for Rivastigmine ordered for Resident #12
-The MCC reviewed all the EMARS for residents that resided on hall 400.
-The RCC reviewed all the EMARS for the other residents at the facility.

Interview with the MCC on 08/29/16 at 4:35 p.m. revealed:
-The Neurologist placed the resident on Rivastigmine.
-The administration times for Rivastigmine did not line up with meals.
-The MCC went into the MAR system and changed the times to tailor the administration times around the meal.
-No prior clarification had been done in regards to the ordered administration times for Rivastigmine but she had left a message for the primary care provider today.

b. Review of Resident #12's current FL2 dated 7/19/16 revealed a physician order for Tylenol (a pain reliever and a fever reducer) 325mg 3 tablets every 8 hours.

Observation of the 8:00 medication pass on 8/24/16 at 9:30am revealed Tylenol 325 (3) tablets were not administered to Resident #12.

Interview with the medication aide on the 400

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hallway on 8/24/16 at 9:35am revealed there was no Tylenol 325mg tablets on the medication cart for Resident #12.

An additional interview with the medication aide on the 400 hallway on 8/24/16 at 2:32pm revealed:
-Resident #12 was out of Tylenol 325mg tablets.
-Sometimes there was an extra supply of medication in overstock.
-There was not any Tylenol 325mg tablets in overstock for Resident #12.
-When there is one week supply of medication left the medication aide would let the MCC know and the MCC would order more.
-She informed the MCC, Resident #12 was out of Tylenol 325mg tablets today and she ordered more.
-The medication should come in within the next 2 days.

Interview with the RCC on 8/24/16 at 3:15pm revealed:
-She was not responsible for anything on the 400 hallway.
-The MCC was in the back all the time and was responsible for the residents on the 400 hallway.

Interview with the MCC on 8/24/16 at 4:30pm revealed:
-The medication aides were supposed to let her know when they "shake the bottle and there were only a few pills left".
-She was informed this morning that Resident #12 was out of Tylenol 325mg tablets, she called and ordered more.
-His physician was called and alerted Resident #12 was out of Tylenol 325mg tablets.

Interview with the MCC on 8/25/16 at 6:50pm

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revealed:
-The Tylenol 325mg tablets for Resident #12 came in today around 11:00am.
-He did not receive the morning dose this morning, but he did get his 2:00pm dose today.

5. Review of Resident #10's current FL2 dated 3/28/16 revealed:
-Diagnoses included osteoporosis, failure to thrive, difficulty walking, and diverticulosis of intestine.
-A physician order for Oyster shell calcium with vitamin D 500/200 (used to treat conditions caused by low calcium levels such as bone loss [osteoporosis]) two times a day with food.

Review of the Resident Register for Resident #10 revealed she was admitted to the facility on 4/6/16.

Observation of the medication pass on 8/24/16 at 9:15am revealed:
-The medication aide administered 1 oyster shell calcium with vitamin D 500/200 tablet to Resident #10.
-Resident #10 was in her room when the medication was administered.
-Resident #10 was not eating and was not offered anything to eat, when the medication was administered.

Interview with the medication aide on the 300 hallway on 8/24/16 at 2:25pm revealed:
-Resident #10 keeps pudding in her room.
-Resident #10 did not eat any pudding when she got her medication this morning.
-She did not offer Resident #10 anything to eat or remind her to eat the pudding the resident had in her room.

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Interview with a second medication aide on the 200 hallway on 8/24/16 at 12:35pm revealed:
-She was aware diabetic residents needed to eat within 30 minutes of receiving insulin.
-She was under the impression diabetic residents were served first in the dining room.

Interview with the RCC on 8/24/16 at 3:15pm revealed:
-Residents "go right into the dining room after receiving their insulin".
-Lunch was served in the dining room at 12:00pm.
-Medication aides should have been administering the morning dose of insulin to residents at 11:45am.
-Dinner was served in the dining room at 6:00pm.
-Medication aides should have been administering the evening dose of insulin to resident's at 5:30pm, "that way" residents could eat 30 minutes after receiving their insulin.
-Residents in the dining room were not served in any particular order, the diabetics were not served first.

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Review of Plan of Protection received from the Administrator on 8/25/16 revealed:
-Crackers would be supplied on all medication carts for medication aides to give residents with medications that require to be given with food.
-All medication aides will be informed of this immediate requirement prior to working on a medication cart, effective immediately.
-Medication aides will be individually in-serviced on administering medications before, during and after meals.
-The RCC and Special Care Unit Coordinator will audit all of the medication carts to ensure that all medications are in the facility.

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D 358	Continued From page 44 -Medications that are not on hand will be called in to the pharmacy and picked up at the back up pharmacy if necessary. -All medication aides will be in-serviced on medication reorder procedures and what to do if a medication is running low. -Medication aides will be in-serviced prior to their next shift administering medications to make sure that residents are given crackers or another food item with their medication if ordered to be given with food. -The process for giving medications before, with or after meals will be reviewed with staff, as well as reminding them to triple check the order before administering medication. -This area will be monitored shift to shift until all medication aides have been in-serviced by the administrator, RCC, or Special Care Unit Coordinator. -Medication administration will be monitored by the RCC and Special Care Unit Coordinator twice weekly for one month and then weekly for six months and monthly ongoing. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 13, 2016.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to initiate a 24 hour report and submit documentation of two incidences that were internally investigated within 5 days to the North Carolina Health Care Personnel Registry for 2 of 2 residents sampled related to unknown injury (#3) and a dislocated shoulder from an unknown source (#2).

The findings are:
1. Review of Resident #2's current FL-2 dated 06/13/16:
-The diagnoses included Alzheimer's dementia, underweight inadequate caloric intake, hypotension, hypokalemia, constipation, hip fracture, vitamin D deficiency, hypertension, and hyperlipidemia.
-The resident was constantly disoriented.
-The resident was not ambulatory.

Review of Resident #2's Resident Register revealed an admission date of 04/04/16.

Review of a Home Health Nurses' note for Resident #2 on 07/05/16 revealed:
-The Resident was lying in bed.
-The shoulder or elbow appeared to be out of place.
- The resident was unable to move the arm without severe pain.
-A family member was present and advised the nurse an x-ray had been ordered.

Review of Resident #2's charting notes revealed:
-On 07/05/16 the resident seemed to be in pain, the primary care provider was called and an x-ray was ordered for the right shoulder.
-On 07/06/16 the x-ray findings showed an

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anterior shoulder dislocation, the resident was sent to the emergency room and a follow-up with an orthopedic clinic was ordered.
-Physical therapy services were initiated on 07/22/16.

Review of Resident #2's authorization note from an orthopedic clinic dated 07/15/16 revealed:
- There was a diagnosis of a right shoulder dislocation.
-There was an ambulatory referral to Physical Therapy.

Interview with Resident #2's family member on 08/23/16 at 1:10 p.m. revealed:
-He attempted to visit daily to feed Resident #2 at lunch.
-Resident #2 had dementia and could not tell anyone how she felt or what had happened during the day.
-He was visiting a few weeks ago and found Resident #2 in the dining room with a pillow positioned under her arm.
-A staff member told the family member the resident got hurt.
-After lunch that day, Resident #2 was wheeled back to her room and positioned in bed by the Personal Care Aide (PCA).
-The Home Health Nurse came in to perform Resident #2's wound care and commented her shoulder did not look right.
-He could not remember the specific occurrences concerning Resident #2's shoulder but another family member would be able to give more information.

Interview with a Physical Therapist on 08/24/16 at 3:08 p.m. who provided therapy services to Resident #2 revealed the resident was back at her baseline in regards to her right shoulder

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mobility and had not appeared to have any residual pain in that joint.

A second interview with Resident #2's family member on 08/24/16 at 3:10 p.m. revealed:
-Resident #2 was unable to turn and reposition herself in bed.
-A pillow was always used when she was in bed, under her right heel, due to a sore which made it hard for her to move or roll over.
-Resident #2 would not attempt to stand up and walk.
-Resident #2 had a previous hip fracture 6 months ago and had not attempted to walk since.

Telephone interview with another family member of Resident #2 on 08/24/16 at 3:34 p.m. revealed:
-The facility informed her by phone when Resident #2's shoulder injury was recognized.
-It took staff a few days to figure out what was going on.
-Staff later speculated the injury could have occurred from Resident #2's roommate.
-Staff reported to her that they had seen the roommate encouraging Resident #2 to get up.
-The roommate was later moved into another room.
-Family had to play a guessing game with Resident #2 because she was unable to talk or recall information.
-The facility was doing a good job taking care of Resident #2.

Interview with the Resident Care Coordinator (RCC) on 08/24/16 at 4:00 p.m. revealed:
-The facility was not given a copy of the orthopedic clinic visit on 07/15/16.
-They had called the clinic and were in the process of obtaining a copy for the resident's

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D 438	Continued From page 48 record. -They felt the injury occurred from the roommate attempting to help the resident get out of bed. -The roommate had been observed attempting to verbally encourage Resident #2 to get out of bed and physically gently pulling on Resident #2's arms. Review of an Incident/ Accident Report and Follow Up revealed: -The date of the incident was documented as 07/06/16 at 7:00 a.m. -The description of the incident was documented that Resident #2 seemed to be in pain, injury described as right shoulder pain, called for x-ray to right shoulder, x-ray came back as a anterior shoulder dislocation. -It was documented that a family member was called and the primary care provider on 07/06/16. -It was documented that the resident was sent to the emergency room. -It was documented to follow up with primary care provider on 07/08/16. Telephone interview attempted with the orthopedic clinic on 08/25/16 at 3:45 p.m. was unsuccessful. Interview with the Home Health Nurse for Resident #2 on 08/25/16 at 4:20 p.m. revealed: -The resident had been a home health client for several months. -The resident was evaluated by an orthopedic clinic and it was determined due to osteoporosis the joint slipped out of place. -The shoulder joint was put back in place at the clinic. -The resident was followed up with physical therapy at the facility. -There did not seem to be any ongoing issues	D 438		

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with the resident's right shoulder.

Interview with the Administrator on 08/29/16 at 3:15 p.m. revealed:
-The Administrator did an internal investigation regarding Resident #2's unexplained injury.
-She was not aware there was a requirement to report unknown injuries to the Heath Care Personnel Registry (HCPR).
-She submitted a report to HCPR on 08/25/16 after speaking to the Adult Home Specialist on 08/25/16.

2. Review of Resident #3's current FL-2 dated 03/10/16 revealed:
-Diagnoses included Alzheimer's/dementia, hypothyroidism, hypertension.
-The resident was non-ambulatory and constantly disoriented.

Review of Resident #3's current Care Plan dated 6/29/16 revealed:
- The resident was totally dependent on staff for all activities of daily living (ADL's).
- Resident could feed self with prompting from staff.
- Resident was incontinent of bowel and bladder.
- Resident required extensive assistance with bathing, toileting, dressing and transferring.
- Resident was not oriented to time and place.
- Resident had a wheelchair, but was not able to move independently.
- The Care Plan was signed by the Primary Care Provider (PCP) on 7/08/16.

Review of Resident #3's physician's orders revealed an order dated 4/11/16, signed by the

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Nurse Practitioner, to move bed to one side of wall, with a mat on the other side. Resident is to be in a recliner and out of wheelchair while in room.

Review of Resident # 3's record revealed a staff entry dated 8/10/16 that the resident sent out to emergency room for knot on head, called primary doctor, notified family.

Review of Resident #3's Discharge Summary report dated 8/12/16 from a local hospital revealed:
-On 8/10/16, the resident was admitted to the hospital from the emergency room with the chief complaint of a bump on the head and a UTI.
-The resident was admitted to the hospital from the emergency department with the chief complaint being a bump on the head and a UTI.
-There was no known fall or other injury noted.
- A CT scan revealed a hematoma but no intraparenchymal bleeding.
-Ecchymosis of the head was noted, although the injury was not significant.
-The resident needed to be monitored for falls.
-The hospital stay was discussed with staff at the facility and the facility was planning to implement stronger falls precautions for Resident #3.
-Resident #3 was discharged back to the facility on 8/12/16.
-Resident #3's status was noted on 8/12/16 to require help with all ADLs, she was bedfast and her mobility was very limited.

Interview with the Medication Aide/Supervisor on 8/24/16 at 1:57 PM revealed:
-She completed the 8/10/16 incident report that documented Resident #3's injury.
-8/10/16 was Resident #3's shower day.
-Resident #3 was a two-person assist for baths

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	C 08/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(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
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and transferring.
-Resident #3 could not get up independently.
-Resident #3 was placed in the wheelchair for showers.
-Resident #3 was checked on about every 2 hours.
-On 8/10/16 at 7:30 AM, a Personal Care Aide working on the bath team indicated that Resident #3 had a large knot on her forehead, when assisting with personal care/bathing.
-She inspected the large knot on Resident #3's left side of her head.
-She felt the injury "looked fresh" and was only bleeding a small amount.
-She indicated that the staff did not know how exactly the resident's injury occurred.
-The Medication Aide/Supervisor indicated that no staff on 1st shift 7:00 AM - 3:00 PM (8/10/16) or third shift the night before 11:00 PM - 7:00 AM (8/09/16) reported that Resident #3 had fallen.

Interview with a resident on 8/24/16 at 2:10 PM revealed:
-She witnessed Resident #3 about 1-2 weeks ago fall out of a wheelchair while bending over, as if trying to pick up something off the floor.
-The incident occurred in the morning time (time unknown) but she was unsure of the date and time.
-The injury on Resident #3's head occurred about 1-2 weeks ago when she fell out of the wheelchair.
-Resident #3 did not fall out of bed, or hit her head on a bed post.
-She yelled out for staff to come get Resident #3 off the floor when she fell out of the wheelchair.
-The staff from the facility got the resident up from the floor.
-She was unsure which staff members got Resident #3 up from the floor.

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DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

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Interview with the Personal Care Aide (PCA) on 8/24/16 at 2:57 PM revealed:
-He worked on 8/10/16 on the bath team.
-Resident #3 was scheduled to receive a shower on 8/10/16.
-On 8/10/16 around 7:30 AM, he walked into Resident #3's room, noted resident was in the bed, laying on her side.
-He transferred Resident #3 from the bed to the resident's wheel chair without the assistance of any other staff.
-He noticed a large, egg shaped bump was on the resident's left forehead once the resident was taken to the shower room.
-The injury was brought to the attention of the Medication Aide/Supervisor, who called 911.
-The PCA did not know how Resident #3's injury occurred.
-He thought Resident #3 may have struck the edge of the bed frame while the resident was in bed.
-Resident #3 required total assistance with ADLs.

Interview with a Medication Aide on 8/26/16 at 2:30 PM revealed:
-She worked as the Medication Aide on 8/10/16 on 1st shift 7:00 AM - 3:00 PM.
-The PCA on the bath team found Resident #3 in the bed around 7:30 AM.
-It was unusual for Resident #3 to still be in the bed, 3rd shift was tasked with getting all residents out of bed.
-She was not sure why 3rd shift left Resident #3 in the bed.
-The PCA on the bath team noticed a knot on Resident #3's head and notified her and the Medication Aide/Supervisor.
-She noted the knot to be about the size of an egg with slight bleeding.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(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
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-911 was called and Resident #3 was sent to the hospital via ambulance.
-Resident #3 required total care and was not able to turn or roll herself over in the bed.

Interview with the 3rd shift Medication Aide/Supervisor on 8/26/16 at 2:49 PM revealed:
-He worked with Resident #3 on 3rd shift from 11:00 PM - 7:00 AM on 8/9/16.
-The staff had been instructed to leave Resident #3 either in the resident's bed or recliner.
-There were medications administered to Resident #3 at 6:00 AM, no injuries were noted at that time.
-Later in the day on 8/10/16 he was called by the RCC and asked if anything happened to Resident #3 during 3rd shift from 11:00 PM - 7:00 AM on 8/9/16.
-He was not aware or informed of any incident with Resident #3.

Observation of Resident #3 on 8/29/16 at 2:00 PM revealed the resident was lying in her bed, her eyes were closed, she was not moving and there was a bedside mat at the right side of the bed.

Interview with the Administrator on 8/29/16 at 2:05 PM revealed:
-The EMS reported that Resident #3 must have hit her head on the bedframe.
-She was not sure what actually happened that resulted in the knot on Resident #3's forehead.
-The facility did an investigation immediately upon finding the injury on Resident #3.
-The facility interviewed the third shift staff from 8/9/16 and the first shift staff from 8/10/16.
-Resident #3 had a bedside mat beside her bed and a low bed.
-She was responsible for reporting incidents to

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DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

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the Health Care Personnel Registry.
-She had not reported these incidents because there was not staff name to report.
-She thought she had to have a staff name to be able to report them to the Health Care Personnel Registry.
-She would report these incidents and future incidents to the Health Care Personnel Registry immediately or within 24 hours.

Interview with Resident #3's Primary Care Provider on 8/29/16 at 3:12 PM revealed:
-Resident #3 not mentally cognitive.
-Resident #3 was non-ambulatory.
-Resident #3 was extremely limited, even while in bed or wheelchair.
-The facility reported that Resident #3's injury was the result of the resident's head being hit on the resident's bedframe.
-She felt the interview with a resident on 8/24/16 at 2:10 PM, which reported that she witnessed Resident #3's fall, was valid based on the resident cognitive status.

D912 G.S. 131D-21(2) Declaration of Residents' Rights D912

G.S. 131D-21 Declaration of Residents' Rights
Every resident shall have the following rights:
2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

This Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to assure residents received care and services which were adequate,

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D912	Continued From page 55 appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and medication administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 3 sampled residents (#8, #9) known to have a history of exit seeking behaviors and elopement from the locked Special Care Unit (SCU) and 1 of 3 sampled residents (#3) with an unexplained head injury. [Refer to Tag D270, 10A NCAC 13F .0901 (b). (Type B Violation)] 2. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered for 5 of 8 residents (#10,#11, #12, #13, #14) observed during the medication passes, including errors with a short acting insulin (#13,#14), an insulin mixture of short acting and long acting (#11) dementia medication, (#12), pain medication (#12), and a calcium supplement (#10). [Refer to Tag D358, 10A NCAC 13F .1004 (a). (Type B Violation)]	D912		