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	HAL032091	A. BUILDING: _____ B. WING _____	R-C 11/09/2018

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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
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on November 6 - 9, 2018. The complaint investigation was initiated by the Durham County Department of Social Services on October 31, 2018.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have walls, ceilings, and floors for 7 of 13 resident bathrooms on the 300 and 400 halls (#302/304, #305/307, and #308/310, #401/403, #405/407, #408/410, and #409/411), 1 of 3 sampled shower rooms (300 hall shower room), 2 of 4 hall vents (300 and 400 halls), 2 of 4 hall railings (300 and 400 halls), and 2 of 31 resident rooms (#408 and #416) kept clean and in good repair. The findings are: 1. Observation on 11/07/18 at 3:45 pm of the shared bathroom for resident rooms #302 and #304 revealed: -There were black and dark brown stains on the	D 074		

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cracked caulking around the base of the toilet.
-There were dark brown stains on the cracked caulking of the baseboard behind the toilet.
-There were dark brown spots on the wall behind the toilet.

Observation on 11/07/18 at 3:53 pm of the shared bathroom for resident rooms #305 and #307 revealed:
-The baseboard was separated from the side and back walls of the bathroom.
- There were light brown stain spots on the walls in the room.
-There were black and dark brown stains on the cracked caulking around the base of the toilet.
-There was rust on the lower 4 inches of the door frame.
-There was missing veneer on the lower front panel of the sink vanity.

Observation on 11/07/18 at 3:55 pm of the shared bathroom for resident rooms #308 and #310 revealed:
-There were black and dark brown stains on the cracked caulking around the base of the toilet.
-The baseboard was separated from the side walls in the bathroom.
-There was missing paint on the wall above the toilet paper dispenser.
-The ceiling vent was coated with gray dust.
-There were black stains on the grout at the ceiling edges of the room.
-There were black stains on the 2 feet x 3 inch long watermark on the ceiling beside the ceiling vent.

Interview on 11/07/18 at 4:00 pm with a resident in room #310 revealed:
-The bathroom flooring needed to be replaced; there was stained and missing caulk around the

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base of the toilet.
-The bathroom baseboard had pulled away from the wall.
-There was "crud" stuck to the air vent in the bathroom ceiling.
-"The bathroom was in terrible shape and it was not getting any better."

Observation on 11/07/18 at 4:06 pm of the 300 Hall shower room revealed:
-There were black, brown, and tan stains on the tile flooring in the shower.
-There were black stains on the back wall and corners of the shower.
-There was a build-up of dark brown dirt on the grout of the shower tiles.
-There was a 3 feet x 6 inch water mark, with black stains, on the ceiling of the shower.
-There was a ½ inch by 3 inch clump of black hair on the floor at the front of the shower.
-There was a build-up of dark brown dirt at the edges and corners of the tile flooring in the room.

Interview on 11/07/18 at 4:08 pm with a Personal Care Aide (PCA) revealed:
-The PCA used the shower to give residents a bath, but had not noticed the stains on the tiles.
-Housekeeping was responsible for cleaning the resident's shower room.
-Housekeepers worked on first shift; there were no housekeepers on second or third shifts.

Observation on 11/07/18 at 4:12 pm of the 300 Hall ceiling revealed:
-There was a coating of tan dust on the large ceiling fan.
-There was a heavy coating of dark gray dust on the ceiling around the fan.

Observation on 11/07/18 at 4:15 pm of the 300

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D 074	Continued From page 3 Hall revealed there was missing paint and scrape marks on both the upper and lower railings in the hallway. Interview on 11/08/18 at 3:25 pm with the Maintenance Manager revealed: -Maintenance was responsible for painting, replacing toilets and flooring tiles, housekeeping did the cleaning. -There was no more maintenance work to be done on 300 Hall. -The caulking at the base of the toilets and flooring tiles was stained by urine. -The lower hall railing was scraped by wheelchair wheels; the upper railing was scraped by wheelchair arms. Interview on 11/09/18 at 8:50 am with the Environmental Services Manager (ESM) revealed: -She was the manager for the housekeeping staff. -Housekeeping staff cleaned the toilets, sinks, and bathroom floors; they swept and mopped resident areas. -Housekeeping staff scrubbed the showers once a week and used a sanitizer spray to treat the showers after each use. -Housekeeping staff were to clean only, maintenance did the repairs; the caulking around the base of the toilets needed to be scraped off and replaced by maintenance. -The ESM checked housekeeping staff's work for thoroughness before each shift was over. -Communication with housekeeping and maintenance staff was done verbally; there was not a system in place to document cleaning or repair needs. - Physically checking back with staff was the only way to see if a task was done.	D 074		

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D 074	Continued From page 4 -"Housekeeping staff had not cleaned the residents' bathrooms or shower room as they were supposed to do." Interview on 11/08/18 at 5:07 pm with the Administrator and Assistant Administrator revealed: -Housekeeping staff were responsible for cleaning resident rooms, bathrooms and showers. -The ESM was responsible for checking behind the housekeeping staff to ensure resident areas were clean. -Maintenance staff was responsible for making repairs. -Administrative staff walked through the building often (were not specific as to dates or times) to check on housekeeping and maintenance needs. 2. Observation of Rooms 401 and 403 bathroom on 11/06/18 at 10:22 am revealed: -There was a circular shaped portion of the ceiling that was peeling to the left of toilet. -The light flip switch was broken in half. Based on observations, interviews and record reviews it was determined the residents who resided in room 401 and 403 were not interviewable. Observation of Rooms 405 and 407 bathroom on 11/06/18 at 10:34 am revealed there was a circular shaped portion of the ceiling above the toilet that was brownish with missing popcorn plaster in two spots within the brownish stain. Based on observations and interviews it was determined the residents who resided in rooms 405 and 407 was not interviewable. Observation of Room 408 on 11/06/18 at 10:30	D 074		

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am revealed:
-The ceiling was peeling around the heating and air conditioning vent.
-There were two brown stains on the ceiling to the right of the heating and air conditioning vent.
-There were two brown stains on the ceiling above the right closet.
-There were two brown stains on the ceiling directly in front of the bathroom doorway.
-There was a brown stain to the left of the doorway that was not as dark as the other stains on the ceiling.

Observation of Rooms 408 and 410 bathroom on 11/06/18 at 10:33 am revealed:
-There was brown drywall with one area of caulking/plaster directly above the toilet near the light fixture.
-There were remnants of the popcorn ceiling near the fire detector.
-The ceiling was unfinished.

Based on observations and interviews it was determined the residents who resided in rooms 408 and 410 were not interviewable.

Observation of Rooms 409 and 411 bathroom on 11/06/18 at 10:42 am revealed:
-The ceiling was covered with popcorn plaster.
-The corner of the ceiling to the left of the toilet was stained brown with four black spots within the brown stained area.

Based on observations and interviews it was determined the residents who resided in rooms 409 and 411 were not interviewable.

Observation of Room 414 on 11/06/18 at 10:45 am revealed there was a faint brown stain between the twin beds.

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D 074	Continued From page 6 Observation of Room 416 on 11/06/18 at 10:48 am revealed: -There were two large brown stains on the ceiling near the fluorescent light fixture. -There was one brown stain on the ceiling above the doorway. -There was an area with missing popcorn plaster on the ceiling to the right of the doorway. Based on observations and interviews it was determined that the residents who resided in room 416 were not interviewable. Observation of the 400 hall air return vent on the ceiling across from room 414 on 10/06/18 at 10:47 am revealed there was a thick coating of dust that covered the air return vent. Observation on 11/06/18 at 10:50 am of the 400 Hall revealed there was missing paint and scrape marks on both the upper and lower railings in the hallway. Interview with a first shift personal care aide on 11/07/18 at 11:25 am revealed: -She did not know there were stains on the ceilings of the resident bathrooms for resident rooms 401, 407, 409, 408, and 411. -She did not notice because she was busy doing taking care of the residents. Interview with a housekeeper on 11/07/18 at 8:30 am revealed: -His supervisor was the Environmental Services Manager (ESM) and he reported damaged or broken items to the ESM. -He did not know about the stains on the ceilings of bathrooms for resident rooms 401/403, 405/407, 409/411, and 408/410.	D 074		

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D 074	Continued From page 7 -He did not look up at the ceiling while completing his job and focused on cleaning the floors, room doors, and bathroom fixtures. Interview with a maintenance person on 11/07/18 at 3:40 pm revealed: -He had worked for the facility for several years and his supervisor was the Maintenance Manager. -He walked through the facility in the morning and in the evening checking resident rooms and bathrooms to determine if repairs were needed. -The facility staff reported damaged or broken items verbally or after hours by calling him or the Maintenance Manager. -There was no documentation of items or areas in the facility that were reported as needing repair. -He did not know the light switch was broken in the bathroom of resident rooms 401 and 403. -The peeling popcorn on the ceiling of resident bathroom for resident rooms 401 and 403 was from a previous repair he and the Maintenance Manager completed last year. -The Maintenance Manager had started repairing the ceiling in the bathroom of resident room 408/410. -He did not know there were brown stains in the bathrooms of resident rooms 405/407, and 409/411. -He did not know there were brown stains on the ceiling of resident room 408 and 416. -The brown stains on the ceilings were caused by sweating from the heating and air conditioning vents, not leaking from the roof. -The ceilings were not properly protected when the building was built. -He planned to repair the brown stains on the ceilings, and he was going to plaster and paint the areas.	D 074		

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D 074	Continued From page 8 Interview with the Maintenance Manager on 11/07/18 at 4:20 pm revealed: -He was responsible for repairing damaged or broken items inside and outside of the facility. -He and the maintenance person walked through the facility daily, sometimes dividing the building to determine if there were repairs needed. -The staff reported things or areas that needed repairing verbally. -There was no documentation of the repairs that were needed within the facility, sometimes the staff would leave a note on his office door. -The staff also called him or the maintenance person after hours to report any repairs that were needed. -He did not know there were brown stains on the ceilings of bathrooms and resident rooms on the 400 hall. -The maintenance person did the last round on the 400 hall and he was not told that anything needed repairing on the 400 hall. Interview with the Environmental Services Manager on 11/08/18 at 9:07 am revealed: -She was responsible for the housekeeping, laundry services and assisted the Assistant Administrator with specific tasks. -She arrived early to the facility daily and did rounds on a daily basis. -When she did rounds she looked to ensure the trash was emptied, beds were made, bathrooms were clean and the resident rooms were clean. -If she saw things that needed repairing she reported them to the Maintenance Manager. -She reported repairs to the Maintenance Manager or the maintenance person verbally. -There were always repairs ongoing within the facility, and recently the walls were plastered and painted due to holes made in the walls, the sinks were replaced, the ceiling was repaired on the	D 074		

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D 074	Continued From page 9 300 hall. -She knew about the brown stains on the ceilings of resident room 408 and 416 and reported it to the maintenance person. -She told the maintenance person during the week of 11/04/18 but did not recall the specific day. -She did not know about the brown stains in the bathroom for resident rooms 405 and 407. -The brown stains were caused by moisture from the vents not a leak from the roof. Interview with Assistant Administrator on 11/07/18 at 4:50 pm revealed: -He made rounds daily and depending on the situations that were found he completed the rounds of the entire building by the end of the day. -When he made rounds, he first and foremost looked for any issues related to the residents such as their care. -He did not notice everything during each round but may notice it the next time he made rounds. -The Maintenance Manager was responsible for repairing the walls, ceilings, floors, small electrical repairs, and small plumbing repairs. -He hired other companies that completed larger electrical, plumbing, and heating and air conditioning repairs. -The ceilings could and would be repaired. -The Maintenance Manager had made several repairs already such as replacing sinks, lavatories, and lights. -The repairs for the facility were ongoing. Interview with the Administrator on 11/07/18 at 4:35 pm revealed: -She did not know of the brown stains on the ceilings for bathrooms and resident rooms on the 400 hall.	D 074		

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D 074	Continued From page 10 -She did not know what could have caused the brown stains. -The ceiling on the 300 hallway were recently repaired due to an incident with the heating and air conditioning system. -The facility repairs were ongoing due to the size of the facility.	D 074		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to schedule an appointment for an oral surgeon/dentist for 1 of 7 sampled residents (#6). The findings are: Review of Resident #6's current FL-2 dated 04/23/18 revealed diagnoses included dementia with behavioral disturbances, anxiety, depression and psychosis. Review of Resident #6's physician orders revealed an order dated 10/29/18 that was received by fax on 10/29/18 at 1:05pm to be seen by oral surgery/dentist for a periapical abscess without sinus.	D 273		

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D 273	Continued From page 11 Review of Resident #6's record revealed there was no documentation Resident #6 had been seen by a dentist or an oral surgeon. Interview with Resident #6 on 11/08/18 at 10:38am revealed she was not currently in pain and did not recall the last time she saw a dentist or oral surgeon. Interview with the Resident Care Coordinator (RCC) on 11/08/18 at 5:00pm revealed: -Referrals come into the RCC's office and she or the Medication Aide (MA) made the appointment, put the, and address of the appointment on the appointment calendar, and emailed the driver. -A dentist came monthly to the facility, and the last time was 10/29/18. -The dentist's office sent a list of "patients" that needed to be seen and the RCC and MA added residents to the list. -The RCC did not add Resident #6 to the list on 10/29/18 because the list had already been made. -The RCC knew a tooth abscess was an important reason a resident needed to be seen by a dentist. Interview with the MA on 11/09/18 at 9:50am revealed: -A referral did not have to be made for a resident to see the dentist. -Resident #6's family member had requested several days for the resident to be seen by the dentist for pain, before the dentist came on 10/29/18. -She forgot to put Resident #6 on the dental list for 10/29/18. -There was no process in place for residents to be seen by the dentist during monthly onsite visit.	D 273		

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D 273	Continued From page 12 Interview with Resident #6's Nurse Practitioner (NP) on 11/08/18 at 3:10 pm revealed: -Tylenol (an analgesic used to treat mild pain) was prescribed for the tooth abscess on 10/26/18 for Resident #6's pain. -She told the RCC the resident needed to be seen by a dentist or oral surgeon on 10/26/18. -Resident #6 was started on Amoxicillin three times a day for 7 days on 10/26/18. -On 10/29/18, she faxed a referral for Resident #6 to be seen by an oral surgeon or dentist. -She was told Resident #6's pain was not under control by a family member on 10/29/18. -She expressed concern that Resident #6 had not been seen yet by a dentist. -She was going to talk to the RCC again and get Resident #6 sent to a dentist out of the facility, if she was not going to be seen in the immediate future by the dentist that came to the facility. Interview with the NP on 11/09/18 at 9:20am revealed she talked to the RCC and Resident #6 was going to see a dentist today. Interview with Resident #6's Responsible Party on 11/08/18 at 3:27pm revealed: -She heard from 3 different MAs starting mid-October that Resident #6 was having tooth pain and needed to see the dentist, and to put her name on the schedule to be seen. -She was concerned Resident #6 had not been seen by a dentist yet and talked to the RCC on 11/02/18 about her concerns. Interview with the dentist's assistant, on 11/09/18 at 10:33am revealed: -She had no knowledge of Resident #6 having a tooth abscess. -Resident #6 was last seen on 09/27/18. -Resident #6 was not seen on 10/29/18.	D 273		

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D 273	Continued From page 13 -Resident #6 was not on the schedule for the dentist's next visit at the facility, which was to happen the end of November 2018. Interview with the RCC on 11/09/18 at 10:59am revealed: -She had a faxed copy of the referral dated 10/29/18 from the NP that she received on 10/29/18 with a time stamp of 1:05 pm. -She talked with Resident #6's Responsible Party on 11/02/18 about the dental abscess. Interview with the Administrator on 11/09/18 at 3:33pm revealed: -She was not aware Resident #6 had a tooth abscess but she was aware she had tooth pain. -She was not aware that there was a 10/29/18 referral from the NP for Resident #6 to see the dentist. -She knew Resident #6 had been seen at the end of September 2018. After talking to the RCC, she thought Resident #6 was treated then. -The RCC was in charge of scheduling appointments and making the dental schedule. -Residents were seen in the facility by the house dentist that came every 4-6 weeks or were sent to an outside dentist, which was also scheduled by the RCC. -Referrals should be completed within a few weeks. -She would expect the RCC to try to get a resident with a referral seen as soon as possible. -She assumed the resident was on the list to be seen next time, at the end of November 2018 when the dentist came back to the facility.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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	HAL032091	A. BUILDING: _____ B. WING _____	R-C 11/09/2018

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D 358	Continued From page 14 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: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as prescribed to 1 of 7 sampled residents (Resident #1) related to incorrect administration of Tylenol. The findings are: Review of Resident #1's current FL2 dated 5/16/18 revealed diagnoses included dementia, depression, cerebrovascular accident (CVA), urinary tract infection, and aphasia. Review of Resident #1's physician order dated 5/16/18 revealed an order for Tylenol (an analgesic used for mild pain) 325 mg 1 tablet as needed twice a day for pain with food.	D 358		

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D 358	Continued From page 15 Review of Resident #1's September 2018 Medication Administration Record (MAR) revealed: -There was an entry for Tylenol 325 mg 1 tablet as needed twice a day for pain with food. -Tylenol was documented as administered 27 of 30 days. -Two tablets of Tylenol were documented as administered on 09/12/18 at 7:14pm, 09/13/18 at 5:02pm, 09/16/18 at 4:29pm, 09/17/18 4:31pm, and 09/24/18 at 4:13pm. -Tylenol was documented as administered on 09/06/18 at 12:38am, 7:21am, and 5:58pm, 09/14/18 at 1:08am, 3:58pm, and 11:58pm, 09/17/18 at 12:06am, 4:31pm, and 11:55pm, 09/23/18 at 12:46am, 12:48am, and 4:16pm, 11:59pm, 09/26/18 at 1:11am, 4:30pm, and 11:50pm, and 09/29/18 at 12:40am, 3:48pm, and 1:21pm. Review of Resident #1's October 2018 MAR revealed: -There was an entry for Tylenol 325 mg 1 tablet as needed twice a day for pain with food. -Tylenol was documented as administered 22 of 31 days. -Two tablets of Tylenol were documented as administered on 10/01/18 at 3:37am, 10/09/18 at 6:19pm, 10/16/18 at 4:56pm, 10/17/18 at 1:40pm and 8:11pm, 10/21/18 at 3:28pm, and 10/28/18 at 7:46pm. -Tylenol was documented as administered on 10/02/18 at 12:41am, 4:08pm and 11:43pm, and 10/17/18 at 12:55am, 1:40pm, and 8:11pm. Review of Resident #1's November 2018 MAR revealed: -There was an entry for Tylenol 325 mg 1 tablet as needed twice a day for pain with food.	D 358		

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D 358	Continued From page 16 -Tylenol was documented as administered 8 of 8 days. -Tylenol was documented as administered on 11/01/18 at 12:59am, 9:24am 3:26pm, and 11:41pm. Based on observation, interview, and record review it was determined Resident #1 was not interviewable. Interview on 11/08/18 at 9:53am with the Administrator revealed: -She expected one Tylenol to be administered at a time, based on the physician's order. -She expected no more than 2 Tylenol to be administered within a 24 hour period, based on the physician's order. -She expected for the order to be clarified to indicate when the second dose should be administered within the 24 hour period by the Resident Care Coordinator (RCC) or Medication Aide (MA). -She expected if both doses were already given and the resident was still in pain for the MA to call the doctor. Interview on 11/08/18 at 10:18am with the RCC revealed: -She understood the Tylenol could only be administered twice within a 24 hour period. -She expected only one tablet to be administered at a time. -She was not sure when the second dose could be administered, and the Tylenol order needed to be clarified. -She and the MA were responsible for getting clarification orders. -She expected if both doses of Tylenol had been given and the resident was still in pain, the MA should call the doctor.	D 358		

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D 358	Continued From page 17 Interview on 11/08/18 at 9:10am with a MA revealed: -She usually worked first shift and had not heard the resident report pain often. -The resident had pain in his back, legs, and left sided weakness. -She understood only one tablet could be administered at once, and if both doses had already been administered, and the resident was in pain, she would call the doctor. Interview on 11/08/18 at 9:38am with another MA revealed: -She understood the order stated one Tylenol could be administered, not two at a time. -The second dose of Tylenol could be administered in 6-8 hours after the first dose. -If the resident was still in pain, she would call the physician. Telephone interview with a third shift MA on 11/09/18 at 3:03 pm revealed: -She administered as needed medications by reviewing the resident's medication in the computer system, looking at the last time of administration, removing the medication from the drawer, administering the medication, and documenting the time and reason for administration. -The computer system showed the times of administration, how many tablets were administered and who administered the medication. -An as needed medication (prn) could be administered every four to eight hours. -She was taught to administer as needed medications this way by the second shift supervisor. -She recalled Resident #1 and the Tylenol order.	D 358		

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D 358	Continued From page 18 -She knew the Tylenol was ordered twice daily as needed. -She administered doses of Tylenol on 09/23/18, 09/26/18, 09/29/18, 10/02/18 and 11/01/18. -She administered the above doses because the administration time of the prior dose was four to eight hours before each instance and the order indicated as needed (prn). Attempted interview on 11/09/18 at 8:18am with prescribing physician was unsuccessful. Telephone interview with the pharmacist on 11/09/18 at 8:38am revealed MAs could type in any quantity of tablets on as needed dosages. Telephone interview with the pharmacist on 11/09/18 at 10:18am revealed: -She verified the Tylenol had been given more than twice a day, and sometimes had been administered two tablets at once. -The facility staff should review the order on the eMAR before administering another dosage. -The computer eMAR did not provide alerts if more doses of medication were administered than ordered.	D 358		