	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED
		HAL073003	B. WING		R <b>09/12/2019</b>
NAME OF I			T ADDDESS CITY	CTATE ZID CODE	1 00/12/2010
NAME OF I	PROVIDER OR SUPPLIER		ET ADDRESS, CITY,  DURHAM ROAD	,	
CAMBRI	DGE HILLS ASSISTE	DITIVING	BORO, NC 2757		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
{D 000}	) Initial Comments		{D 000}		
		ensure Section conducted a September 12, 2019.	a		
{D 276}	10A NCAC 13F .09	02(c)(3-4) Health Care	{D 276}		
	following in the residual (3) written procedur a physician or other and (4) implementation	assure documentation of t	om nal; or		
	reviews, the facility orders for bilateral c sampled residents (	et as evidenced by: ions, interviews and record failed to implement physici compression hose for 1 of 8 (Resident #5, who was have and feet after hip surgery).	an 5		
	The findings are:				
	05/22/19 revealed: -Diagnoses included arthroplasty (hip repland muscle weakness)	t #5's current FL-2 dated d type II diabetes, total hip placement), pain in the left ess. semi-ambulatory using a	hip		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		A. BUILDING:					
		HAL073	3003	B. WING			R 12/2019
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMBRINGE HILLS ASSISTED LLIVING			RHAM ROAD O, NC 27574				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
{D 276}	Continued From pa	ge 1		{D 276}			
	Review of Resident 06/04/19 revealed t assistance with am	he resident n	eeded				
	Review of Resident #5's physician's orders revealed an order dated 07/23/19 for bilateral compression hose.  Observation on 09/10/19 at 11:10 am of Resident #5 revealed: -The resident was seated in a lounge chair with her legs in the down positionThe resident was wearing mid-leg length slacks, was barefooted and her lower legs, ankles and feet were swollen.						
	-The resident was r on her legs. -There were no cor Resident #5's room	npression hos	·				
	Interview on 09/10/19 at 11:11 am with Resident #5 revealed:						
	-Her orthopedic phy wear compression legs and feet at her -She thought the ph	hose for the s appointment	swelling in her on 07/23/19.				
	to have compression her legs and feetShe had not been	given compre	ession hose to				
	wear since the phys-No one asked her hose to wear.	about having	compression				
	-No one came to ta compression hose						
	Interview on 09/11/medication aide (MResident #5 did no put on today; she d	A) on 300 Ha ot have compr	Il revealed: ression hose to				

Division of Health Service Regulation

STATE FORM BFW212 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL07300	3	B. WING			२ ∣2/2019
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMBRI	DGE HILLS ASSISTEI	DLLIVING		RHAM ROAD O, NC 27574			
(X4) ID PREFIX TAG		TEMENT OF DEFICII ' MUST BE PRECEDI SC IDENTIFYING INF	ENCIES ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{D 276}	Continued From particles for compression horesident #5 had considered for she was in respective of the was admitted to the was	se. compression hose habilitation after impression hose the facility (05, #5's electronic rds (e-MARs) for 19 revealed ther ssion hose for the facility control of the facilit	r surgery, but a to wear since (28/19).  medication or July, August e was no order he resident to with a second on to take with mmunication ake changes in have the her orthopedics an order for acy on ent Care or surement 5's leg th the y and I did not nents (for one."				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	·		
		HAL073003	B. WING		09/1	२   <mark>2/2019</mark>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
CAMBDI	DGE HILLS ASSISTE	DILLIVING 5660 DU	RHAM ROAD			
CAMBIN	DOL HILLS ASSISTE	ROXBO	RO, NC 27574	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDERSON THE APPROPRIES OF	JLD BE	(X5) COMPLETE DATE
{D 276}	Continued From pa	age 3	{D 276}			
{D 276}	Interview on 09/11/representative from revealed: -An order for comp was received on 07-They did not receive measurements for -The pharmacy couhose order for ResimeasurementsThe physician's on Resident #5 could resident #5 could resident #5's famil Interview on 09/11/#5's orthopedic phy-Resident #5 was appointment on 07/by her family members and pain resident #5 was of the bin her legs and pain resident #5 was plointment on 07/by her family members of the bin her legs and pain resident #5 was plointment on 07/by her family members of the bin her legs and pain resident #5 was plointment or order for bilater Resident #5 was plointment for bilater Resident #5 was plointment for bilater ResidentThe orthopedic phorom the facility concompression hose -The physician exp	in the contracted pharmacy in the compression has form the facility. In the compression has form the contract of the compression has form the contract of th	y			
	wearing the compression hose to assist with treating the edema in her legs and to improve mobility while her hip was healing from surgery.					

Division of Health Service Regulation

STATE FORM BFW212 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL07300	3	B. WING			R 12/2019
CAMBRIDGE HILLS ASSISTED LLIVING 5660 DUR			DRESS, CITY, S RHAM ROAD O, NC 27574				
(X4) ID PREFIX TAG	(EACH DEFICIENCY		D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
{D 276}	Continued From page 4		{D 276}				
	REGULATORY OR LSC IDENTIFYING INFORMATION)						

Division of Health Service Regulation

	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL073003	B. WING		F 09/1	2/2019
			DRESS, CITY, S	STATE, ZIP CODE	•	
CAMBR	IDGE HILLS ASSISTEI	DITIVING	HAM ROAD O, NC 27574			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{D 276}	she should have fol-Resident #5 was no stockings until yester Interview on 09/12/1 #5 revealed: -Her family member physician's appointred appointred to appoint of the RCC came to compression hose of the RCC came to compression hose of the room and put contain the room and put contain the received the re	lowed up with the pharmacy. ot measured for compression erday (09/11/19).  19 at 8:30 am with Resident r took her to the orthopedic ment on 07/23/19. The an order for her to have to wear on both of her legs. The measure her legs for yesterday (09/11/19). The properties of the compression hose on both of the compression hose to g in her legs and feet until this	{D 276}			

Division of Health Service Regulation STATE FORM