

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL073003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE HILLS ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5660 DURHAM ROAD ROXBORO, NC 27574</b>
--	--

(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 on September 12, 2019.	{D 000}		
{D 276}	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement physician orders for bilateral compression hose for 1 of 5 sampled residents (Resident #5, who was having edema in the legs and feet after hip surgery).</p> <p>The findings are:</p> <p>Review of Resident #5's current FL-2 dated 05/22/19 revealed: -Diagnoses included type II diabetes, total hip arthroplasty (hip replacement), pain in the left hip and muscle weakness. -The resident was semi-ambulatory using a walker.</p>	{D 276}		

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

*Denise Clark*

TITLE

*Adm.*

(X6) DATE

*10-4-19*

STATE FORM

6899

BFW212

If continuation sheet 1 of 6

*Reviewed & accepted  
W. Edwards  
10/17/19*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL073003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE HILLS ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5660 DURHAM ROAD ROXBORO, NC 27574</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

{D 276}	<p>Continued From page 1</p> <p>Review of Resident #5's Care Plan dated 06/04/19 revealed the resident needed assistance with ambulation, toileting and bathing.</p> <p>Review of Resident #5's physician's orders revealed an order dated 07/23/19 for bilateral compression hose.</p> <p>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 position.                      -The resident was wearing mid-leg length slacks, was barefooted and her lower legs, ankles and feet were swollen.                      -The resident was not wearing compression hose on her legs.                      -There were no compression hose observed in Resident #5's room.</p> <p>Interview on 09/10/19 at 11:11 am with Resident #5 revealed:                      -Her orthopedic physician recommended she wear compression hose for the swelling in her legs and feet at her appointment on 07/23/19.                      -She thought the physician wrote an order for her to have compression hose to wear for swelling in her legs and feet.                      -She had not been given compression hose to wear since the physician's appointment.                      -No one asked her about having compression hose to wear.                      -No one came to take her measurements for compression hose for her legs and feet.</p> <p>Interview on 09/11/19 at 9:40 am with the medication aide (MA) on 300 Hall revealed:                      -Resident #5 did not have compression hose to put on today; she did not have a physician's order</p>	{D 276}		
---------	--	---------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL073003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>09/12/2019</b>
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE HILLS ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5660 DURHAM ROAD ROXBORO, NC 27574</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

{D 276} Continued From page 2

for compression hose.

-Resident #5 had compression hose to wear when she was in rehabilitation after surgery, but she did not have compression hose to wear since she was admitted to the facility (05/28/19).

Review of Resident #5's electronic medication administration records (e-MARs) for July, August and September 2019 revealed there was no order for bilateral compression hose for the resident to wear on her legs and feet.

Interview on 09/12/19 at 10:06 am with a second MA revealed:

-Residents had folders of information to take with them to physicians' appointments.

-The physicians used the facility communication forms in the residents' folders to make changes in orders and prescribe new orders to have the facility process.

-When Resident #5 returned from her orthopedic appointment on 07/23/19, there was an order for compression hose.

-She faxed the order to the pharmacy on 07/23/19.

-The order was placed in the Resident Care Coordinator's (RCC) box for review.

-The Pharmacy did not send a measurement form for staff to record Resident #5's leg measurements..

-"It did not dawn on me to check with the pharmacy; I am busy during the day and I did not remember Resident #5's measurements (for compression hose) needed to be done."

-She did not call the pharmacy; she did not get Resident #5's measurements to order the resident's compression hose.

-"I should have gone to check if Resident #5 had compression hose (to wear)."

{D 276}

The following things will be added to our process in addition to the current one.

① The RCC will note TED hose orders and how calendar and follow up the next day to make sure measurements have been done & sent to pharmacy 10-1-19

② The pharmacy has been alerted that all orders for TED hose should be followed up in 24 hours

③ Staff meetings have been held to stress the need to follow through on measurements & orders 10-4-19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL073003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE HILLS ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5660 DURHAM ROAD ROXBORO, NC 27574</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

{D 276}	<p>Continued From page 3</p> <p>Interview on 09/11/19 at 4:20 pm with a representative from the contracted pharmacy revealed:</p> <ul style="list-style-type: none"> <li>-An order for compression hose for Resident #5 was received on 07/23/19.</li> <li>-They did not receive the form with measurements for Resident #5 from the facility.</li> <li>-The pharmacy could not fill the compression hose order for Resident #5 without the measurements.</li> <li>-The physician's order for compression hose for Resident #5 could not be entered in the Resident's e-MAR until the order was processed.</li> </ul> <p>Attempted interview on 09/11/19 at 2:57 pm with Resident #5's family member was unsuccessful.</p> <p>Interview on 09/11/19 at 3:04 pm with Resident #5's orthopedic physician's nurse revealed:</p> <ul style="list-style-type: none"> <li>-Resident #5 was seen for a follow-up hip surgery appointment on 07/23/19; she was accompanied by her family member.</li> <li>-The resident had edema (a condition characterized by an excess of fluid collecting in the tissues of the body) in her legs and pain in her hip due to the surgery.</li> <li>-The compression hose would help to reduce the swelling and pain in her legs and feet and provide support with muscle weakness when ambulating.</li> <li>-An order for bilateral compression hose for Resident #5 was placed into the resident's facility folder and sent back to the facility with the resident.</li> <li>-The orthopedic physician's office had not heard from the facility concerning Resident #5's compression hose order.</li> <li>-The physician expected Resident #5 to be wearing the compression hose to assist with treating the edema in her legs and to improve mobility while her hip was healing from surgery.</li> </ul>	{D 276}	<p>④ chart reviews will be conducted weekly by RCC and STC + M# to assure that all orders are taken care of + followed through including TED hose</p> <p>⑤ HPS nurse will be reviewing TED hose monthly when she reviews charts</p>	<p>10-21-19</p> <p>10-21-19</p>
---------	--	---------	---	---------------------------------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL073003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE HILLS ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5660 DURHAM ROAD ROXBORO, NC 27574</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

{D 276}	<p>Continued From page 4</p> <p>Interview on 09/11/19 at 10:45 am with the RCC revealed:</p> <ul style="list-style-type: none"> <li>-New orders from physician appointments come back to the facility in resident folders.</li> <li>-The MAs, who were taking care of a resident the day of the appointment, were responsible for placing the new orders in the residents' records and making a copy to be put in my box to be reviewed.</li> <li>-New orders were reviewed by the RCC and the Administrator.</li> <li>-The orders would be placed on the resident's e-MAR by the MAs.</li> <li>-She did not remember seeing Resident #5's compression hose order.</li> <li>-The resident had edema in her feet and lower legs when she was first admitted from a rehabilitation facility (05/28/19) and she still had edema in her legs and feet.</li> <li>-Resident #5 did not have compression hose to wear on her legs as per the physician's order.</li> </ul> <p>Interview on 09/12/19 at 9:35 am with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-The order for Resident #5's compression hose was faxed by the MA to the pharmacy on 07/23/29.</li> <li>-The MA signed the fax acknowledgement from the pharmacy for receipt of the compression hose order.</li> <li>-The measurements for the hose should have been done the same day by the MA and faxed to the pharmacy.</li> <li>-If a hose measurements form was not received from the pharmacy, a form from the facility should have been used to notify the pharmacy of Resident #5's leg measurements, they had blank ones to use.</li> <li>-When the new order was checked by the RCC,</li> </ul>	{D 276}		
---------	--	---------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL073003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/12/2019</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CAMBRIDGE HILLS ASSISTED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5660 DURHAM ROAD ROXBORO, NC 27574</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

{D 276}	<p>Continued From page 5</p> <p>she should have followed up with the pharmacy. -Resident #5 was not measured for compression stockings until yesterday (09/11/19).</p> <p>Interview on 09/12/19 at 8:30 am with Resident #5 revealed: -Her family member took her to the orthopedic physician's appointment on 07/23/19. -The physician wrote an order for her to have compression hose to wear on both of her legs. -The RCC came to measure her legs for compression hose yesterday (09/11/19). -This morning, around 7:00 am, a staff came in her room and put compression hose on both of her legs. -She never received the compression hose to wear for the swelling in her legs and feet until this morning (09/12/19).</p>	{D 276}		
---------	---	---------	--	--

## Edwards, Wanda A

---

**From:** Lou Harris <LHarris@CVSLIVING.COM>  
**Sent:** Friday, October 04, 2019 11:34 AM  
**To:** Edwards, Wanda A  
**Subject:** [External] Follow up Survey  
**Attachments:** CCF10042019\_00000.pdf

**CAUTION:** External email. Do not click links or open attachments unless you verify. Send all suspicious email as an attachment to [report.spam@nc.gov](mailto:report.spam@nc.gov)