STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 and the Durham County Department of Social Services conducted a complaint investigation on May 11-15 and 18-20, 2020 with an exit conference via telephone on May 20, 2020. The complaint investigation was initiated by the Durham County Department of Social Services on April 28, 2020.	D 000		
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: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure notification of the facility contracted Nurse Practitioner of changes in condition for 2 of 8 sampled residents (#1 and #3) resulting in the death (#1) and hospitalization to the intensive care unit (#3). The findings are: 1.Review of Resident #1's current FL-2 dated 03/10/20 revealed: -Diagnoses included dementia, dysphagia, symbolic dysfunction, muscle weakness and pain. -The resident had orders for Plavix 75 mg take one tablet by mouth every day. (Plavix used for to lower your risk of having a stroke, blood clot, or serious heart problem after you have had a heart attack, severe chest pain, or circulation problems. Serious side effects may include bleeding that will not stop.)	D 273	**It is the policy of Durham Ridge Assisted Living to assure referral and follow-up to meet the routine and acute healthcare needs of residents.** **All Med Techs were in-serviced shift to shift beginning by the Administrator, Resident Care Coordinator and Business Manager, on May 14, 2020 to remind them of when it is necessary to notify the Primary Care Provider of a change in resident's condition and what would be considered a change in condition.** **An all staff meeting was held on June 8, 2020, topics discussed included, but were not limited to changes in resident conditions and when to notify the Primary Care Provider and following orders given on when to notify the PCP in other situations.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Michael Creager TITLE Administrator (X6) DATE 6/29/20

POC revicwed and accepted on July 9, 2020
D. Dawson-Rogers

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D 273	Continued From page 1	D 273	On May 15, 2020, the Administrator and Business Manager, contacted [redacted], the Primary Care Provider and spoke with the Office Manager. She was able to provide documentation showing that calls had been made to [redacted] to document the vitals signs during the time period in question and the fall on April 18, 2020. The facility was unable to present this information to the survey team prior to their exit and they did not speak with anyone in the [redacted] office. Due to a variety of reasons, including but not limited to, not answering calls from the facility or returning messages, [redacted] Services replaced the Nurse Practitioner that was coming to Durham Ridge Assisted Living with a temporary replacement on May 26, 2020 and a long-term replacement on June 9, 2020. The change in provider has allowed for increased communication between Durham Ridge and [redacted] Services.	

Review of Resident #1's Resident Register dated 02/10/20 revealed she was admitted to the facility on 02/10/20.

Review of Resident #1's assessment and care plan dated 03/10/20 revealed:
-The resident was ambulatory with a wheelchair and required supervision for ambulation.
-The resident was always disoriented, had significant memory loss, and must be directed.
-The resident had daily incontinence of bowel and bladder.
-The resident had limited eye-hand coordination.
-The resident required glasses.
-The resident required extensive assistance for bathing and dressing.
-The resident required limited assistance with eating, toileting, grooming/personal hygiene, and transferring.

Initial telephone interview with Resident #1's responsible person (RP) on 04/23/20 at 5:48 pm revealed:
-The RP was called on 04/18/20 around 6:35 pm by a facility staff informing the RP that Resident #1 fell out of her wheelchair.
-The RP asked the staff member was Resident #1 okay and did Resident #1 need to go to the hospital to be seen for further evaluation for her fall.
-The staff member assured the RP that her family member was fine and Resident #1 said she was okay.
-The staff had gotten her up, checked her for possible injuries, and she was okay.
-The RP called back to the facility on 04/19/20 around 9:45 am to check on her family member and was told Resident #1 was doing good, and she had been to breakfast that morning and had

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D 273	Continued From page 2 gone back to her room afterwards. -The staff put the RP on a brief hold to go to Resident #1's room and check on her for RP and returned to the phone and said "I looked in on your family member in her room and she was fine." -The RP later that day on 04/19/20 around 3:15 pm received a call from another facility staff informing that her family member had died. -The RP asked the staff member what happened and was informed that her family member groaned and moaned all day in pain, and that she had not been out of the bed all day. -The staff member proceeded to inform her she went into her family member's room and checked on her around 2:00 pm and applied lotion and rubbed it on her legs, arms and face and it seemed to soothe her. -She said she went back into her family member's room around 2:30 pm. and Resident #1 was about the same and was still breathing when she went in there. -The staff member told the RP that Resident #1 had been declining for the past few weeks and she was moved to the feeding table, because she had stopped eating and feeding herself. -The RP asked the staff member, why they did not get help for Resident #1 when they knew she was moaning and groaning all day. -The RP asked the staff why someone there at that facility did not call the ambulance to send her out to the hospital. -The RP's family member was in the facility for two months. -The RP continued to call out to the facility daily or every other day to check on her family member during COVID-19 and was told, family member was okay and she was doing fine. -No staff member of the facility ever communicated to the RP that her family member	D 273	Durham Ridge Assisted Living will continue to assure the referral and follow-up to meet the routine and acute healthcare needs of residents. Staff will continue to follow all PCP orders and notify them of changes in condition when appropriate. Durham Ridge staff will continue to follow all orders given by the PCP involving reporting vitals signs and wound care. The Resident Care Coordinator will continue to oversee resident care at Durham Ridge on a daily basis. The Administrator will monitor weekly to ensure continued compliance. June 19, 2020 and ongoing.	

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D 273	Continued From page 3 had stopped eating. had declined, or experienced any type of discomfort or pain. -On 04/21/20 at 10:29 am. she and her family were loading Resident #1's personal belongings, and the facility Administrator came out and approached them. -The RP asked the Administrator about the events that led up to Resident #1's death and the Administrator told her he was not aware of the sequence of events related to Resident #1. Confidential interview with a staff member revealed: -She had normally worked on the 200 hall. -Resident #1 had been yelling and moaning in excruciating pain for the past 2-3 weeks. -Resident #1 had not been there long at the facility. -"She suffered physically, she was in a lot of pain, we can only do so much from our end." -She did not moan, groan, and scream like that when she first got here. -She was told Resident #1 was found deceased between the shift change on 04/19/20. Confidential interview with a second staff member revealed: -She normally worked 1st shift on the 200 hall. -The day Resident #1 died on 04/19/20 she worked 7am-3pm on 100 hall where Resident #1 resided and 3pm-9pm on 200 Hall. -She noticed a decline in Resident #1 about 3 weeks ago. -Resident #1 stopped eating, and she was a diabetic. -When a resident stopped eating. they would notify the Nurse Practitioner (NP), Resident Care Coordinator (RCC) and the Administrator. -We would tell them verbally, when passing by them throughout the facility, or slide a note under	D 273		

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their door if after hours, or the weekend.
-Resident #1 moaned and groaned all day on 04/19/20.
-Resident #1 had a hard time swallowing and could not eat.
-She was told by a personal care aide (PCA) that Resident #1 had a fall on last night (04/18/20).
-The third shift Supervisor did not report off anything about Resident #1 having a fall during the shift change at 7:00am on 04/19/20.
-She knew that a medication aide been telling the NP that Resident #1 needed to go out to the hospital for the past week, because the resident couldn't swallow or eat.
-There was a 72 hour acute monitoring report on Resident #1 after her fall on 04/18/20.
-She could not remember completing documentation on the 72 hour acute monitoring report for Resident #1 on 04/19/20, the day Resident #1 died.
-There was a note that would pop up on the computer screen for staff to notify the NP if Resident #1's blood pressure dropped under 100.
-She went into Resident's #1 room around 2:00 pm to rub lotion on her arms, legs, hips, it appeared to soothe her and she calmed down.
-She returned to Resident #1's room around 2:30 pm to check on her "she was still alive when I went in there."
-A coworker who was very upset came up to the nursing station on 100 hall, there were several of staff up there because it was the change of shift.
-The coworker told her and another coworker to come quick because Resident #1 looked like she was not breathing.
-The three of them went to Resident #1's room around 3:15 pm.
-She looked at her chest and she checked the left side of her neck for a pulse and there was no pulse.

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D 273	Continued From page 5 -The staff member looked at her coworkers and they proceeded to check Resident #1's chest and pulse but there was no pulse. -Staff did not perform CPR because Resident #1 had a do not resuscitate order and they all left the room. -She went back to 200 hall and the other coworker called 911 and Resident #1's RP to inform Resident #1 had died. -The paramedics, firemen and law enforcement came to the facility. -The staff acknowledged she did not call Resident #1's RP to tell her of Resident #1's change of condition during her 14 hour shift. -She did not call Resident #1's NP throughout her 14 hour shift. -There were discussions among the MA's that Resident #1 should have been sent out to receive additional help. -There was a note typed in red ink taped on all 4 medicine carts by the Administrator stating "do not send anyone out of this facility without calling NP 1st... with NP's contact (telephone number.)" -The note had been on all medicine carts since the middle of April 2020. -The Administrator had a meeting at the change of shift on 04/27/20 at the 100 hall nursing station that all medication aides (MA) are to call the NP if any residents appeared to be ill. -The staff member observed a MA speak up in the meeting to the Administrator asking why should they call the NP, she never picked up and did not call back or her voicemail was always full and you could not leave her a message. -The Administrator did not reply or respond to the medication aide's statement about the NP not responding back. -The Administrator questioned the staff member on 04/21/20 what happened to Resident #1. -The NP stood behind the Administrator when the	D 273		

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staff member was questioned and the NP said nothing, just observed.
-The staff member felt she should have sent her out, for her better judgement now.
-She believed the reason she did not send her out was her hesitation of the note taped on the medicine cart.
-She was afraid if she sent her out and she would be fired or retaliated against for doing that.

Observation of the medicine cart on 04/28/20 at 1:22 pm revealed:
-There was a piece of white paper with red ink typed all capital letters taped to the wood panel of the medicine cart.
-The instructions were "DO NOT SEND ANYONE OUT OF THIS FACILITY WITHOUT CALLING NP 1st with NP's (telephone number)."

Review of a NP visit note dated 04/16/20 at 9:00 am for Resident #1 revealed:
-Resident #1 presents for follow up of Altered Mental Status.
-The staff called the NP on 04/15/20.
-They reported the resident was lethargic, had a temp of 94, and thought she had a stroke, because she sounded like she was slurring her words.
-Resident #1 was evaluated on 04/16/20 and was sitting in her wheelchair yelling out in pain.
-She was noted with a really bad oropharyngeal candidiasis, (fungal infection of the mouth) to pain on her tongue.
-The physical exam, the resident was sitting in the wheel chair with head leaned back, moaning in pain, with oropharyngeal noted with black furry like tongue, and candidiasis in her esophagus.

Review of a physician's order dated 04/15/20 for Resident #1 revealed:

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-There was a signed physician order to obtain vital signs, blood pressure, pulse, respiration and temperature every 4 hours and call NP.
-The NP's telephone number was written out in the order to call NP with results.

Review of Resident #1's medication administration record (MAR) dated April 2020 revealed:
-There was an entry to check vital signs every 4 hours and call NP with results.
-The NP's telephone number was written out in the order to call NP with results.
-The scheduled times were 12:00am, 4:00am, 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was no documentation on the MAR that the NP had been notified of the vital signs results.

Review of Resident #1's progress notes revealed no documentation that the NP had been notified of the vital signs results.

Interview with the NP on 05/14/20 at 4:01pm revealed:
-Staff reported Resident #1 had a change in altered mental status.
-The NP could not recall which staff contacted her.
-Staff called her on 04/15/20 and reported Resident #1 was lethargic, and thought she had a stroke because she sounded like she was slurring her words.
-She wrote an order for the staff to check her vital signs every 4 hours and call her with the results.
-She wrote her direct telephone number in the order for the staff to call her with the results.
-She wrote the order because the resident had a significant decline.
-No staff ever called the NP with any vital signs results for the resident.

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D 273	Continued From page 8 -The NP did not call back to the facility, to find out why no staff member ever called her with Resident #1's vital signs results. -Her expectations were that the staff would call, notify me and follow my orders. Confidential interview with a third staff member revealed: -She normally worked 2nd shift. -Resident #1 was fairly new to the facility. -Resident #1 could communicate her needs to you. -Resident #1 began to decline she could tell, and she was off for a few days, and when she returned on 04/18/20 Resident #1 had declined and was not talking as much and had a blank stare. -The staff member got Resident #1 up, took her to the dining room for dinner, but Resident #1 ate very little. -The family called daily or every other day to check on Resident #1 and get updates on how she was doing. The RP called mostly. -Resident #1 had a fall around 04/18/20 on second shift. -The staff member believed it was them, or another staff member that was walking by Resident #1's room and that's when staff noticed Resident #1 was slumped over in a kneeled position on the floor. -She was not for certain if Resident #1 was trying to get into the bed. -The staff member explained that was not the "norm" for Resident #1 to be slumped over or slide out of her wheelchair. -The staff member checked Resident #1's head first, asked the resident if they were hurting, and another staff member assisted her in getting Resident #1 up from a kneeling position off the floor.	D 273		

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-The resident was put back in her wheelchair after a range of motion (ROM) assessment was completed.
-Resident #1 did not complain of discomfort or pain during (ROM) assessment.
-The staff member initiated the incident and accident report, 72 hour acute monitoring report, called Resident #1's RP, RCC, and called the NP answering machine and left message.
-The staff member told the RP that a ROM assessment was conducted and Resident #1 would be monitored.
-The staff member acknowledged they did not share with the RP that the RCC and NP would be notified.
-The second shift staff member notified the third shift Supervisor at change of shift that Resident #1 had a fall.

Review of Resident #1's 72 hour acute monitoring report dated 04/18/20 revealed:
-The third shift MA documented Resident #1 was moaning throughout the night as if she was in pain.
-The staff monitored her through the night.
-The first shift (04/19/20) should continue to monitor the resident.
-The first shift staff member documented Resident #1 was moaning all day.
-Staff monitored her. "Resident is having a hard time swallowing."

Review of Resident #1's progress notes dated 5/11/20 revealed no documentation that the NP had been notified of Resident #1 showing signs of pain, moaning and groaning after her fall on 04/18/20.

Attempted telephone interview with 3rd shift Supervisor, (that worked on 04/18/20-04/19/20)

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on 05/14/20 at 11:11 pm and 11:13 pm were unsuccessful.

Interview with the Resident Care Coordinator (RCC) on 04/28/20 at 9:01 am revealed:
-Resident #1 did not go out to the hospital, she died here at the facility.
-She was not eating, she stopped feeding herself.
-We changed her from regular dining to the feeding table and she had declined

Telephone interview with a physical therapist on 05/15/20 at 4:16 pm revealed:
-One week before Resident #1 died, she observed her moaning in her room.
-The resident's tongue was edematous and not moving.
-Resident #1's tongue was just "sticking" and was not able to close her mouth.
-Resident #1 had a "white substance" on tongue and cheek.
-Resident #1 could not talk or form her words, and she could not tell her what was wrong.
-The Nurse Practitioner (NP) was in the room.

Second interview with the RCC on 05/18/20 at 1:56 pm revealed:
-She was responsible for all the orders for Resident #1.
-The RCC "solely" depended on the MA documenting in the resident record on progress notes or on the back of the resident's MAR.
-She was not aware Resident #1 had an order for staff to check her vital signs every 4 hours and call the NP with results.
-She was not aware that no staff documented or called the NP with any vital signs results for Resident #1 per the order.
-She was not aware the NP's direct telephone number was in the order for the staff to call her

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malnourished and on strong antibiotics.
-A determination would be made on 05/14/20 if Resident #3 was strong enough to tolerate dialysis or not.
-The ICU doctor gave Resident #3 a 50/50 chance of living.

Attempted telephone interview with the Nurse Manager of the local hospital ICU on 05/15/20 at 1:40 pm was unsuccessful.

Based on observations, record reviews, and interviews, Resident #3 was not interviewable.

Interview with the Administrator on 05/18/20 at 1:01 pm revealed:
-He expected PCAs to report to him or the RCC anything that was unfamiliar to them such as if a resident was sick or not feeling well.
-He expected MAs to report to him or the RCC any changes to the NP, and he wanted them to document in the shift report or resident record.
-The PCAs were responsible for skin care because they bathe residents three times per week and were the front-line staff.
-He held all staff responsible for relaying changes with a resident's condition to him or the RCC.
-MAs should do rounds to ensure the PCAs were doing the activities of daily living for residents.
-He expected the RCC to make appointments, make transportation arrangements, intervene when there was difficulty with a resident eating, drinking or complying with care, approve orders and ensure the orders were followed.
-The Supervisors should convey all information to the RCC throughout the day.
-He expected staff to follow the orders regarding Resident #3 and keep him clean and dry.
-The NP orders should have been followed and the cream applied properly.

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with the results.
-She was not aware that staff called the NP on 04/15/20 to report that Resident #1 was lethargic, and the staff believed that she had a stroke, because she sounded like she was slurring her words.
-Resident #1 had a significant decline, that she recognized around one week before she passed away.
-She changed Resident #1 to feeding assistance about one week before the resident passed away.
-She did not update her care plan or contact Resident #1's RP to notify them of feeding assistance change and Resident #1 moved to the feeding table.
-She could not recall if she notified the NP or not of Resident #1 feeding assistance change.

Interview with the Administrator on 5/18/20 at 12:58 pm revealed:
-His expectations were for staff to communicate and notify the NP of any changes with any resident.
-The NP was at the facility four times a week to assess residents.
-" I would like for them to document...like the shift report...in the chart."
-He held everyone responsible for reporting pertinent information.
-MAs should be making rounds every two hours.
-The shift reports were very important for communication between the staff.
-The RCC was responsible for all the orders and approving orders and making sure orders were being followed.
-The RCC had a "big" job, she oversaw resident appointments, and resident's requirements with eating.
-The NP was supposed to notify the Administrator of any concerns.

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-He was not aware that Resident #1 had thrush until after she passed away.
-He was not aware that Resident #1 had fallen until 04/20/20.
-He was not aware Resident #1 had an order for staff to check Resident #1's vitals every 4 hours and call the NP with results.
-He was not aware that no staff documented or called the NP with any vital signs results for Resident #1 per the order.
-He was not aware the NP's direct telephone number was in the order for the staff to call NP with the results.
-He was not aware that staff called the NP on 04/15/20 and reported Resident #1 was lethargic and believed that she had a stroke, because she sounded like she was slurring her words.
-He heard Resident #1 moaning on 04/17/20 it appeared she was in discomfort; he knew Resident #1 was to be seen on 04/17/20 by the NP.

2. Review of Resident #3's current FL-2 dated 02/11/20 revealed:
-Diagnoses included Alzheimer's dementia with behaviors, chronic kidney disease stage 3, cerebrovascular accident, and hypertension.
-Resident #3 was semi-ambulatory.
-Resident #3 needed assistance with bathing dressing.

Review of Resident #3's care plan dated 09/11/19 revealed:
-Resident #3 was totally dependent with toileting, ambulation, bathing, dressing, and grooming.
-Resident #3 needed limited assistance with eating.

Observation of Resident #3 on 05/11/20 at 12:00 pm revealed:

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D 273	Continued From page 13 -Resident #3 was lying in bed on his right side. -Resident #3's left arm was bent in a 90-degree angle and he did not move the arm. -Resident #3's legs were bent at the knees and he did not straighten them when moved by staff. -Resident #3 had large oval dressings to his left and right buttock with initials and 05/08 written on each dressing. -Resident #3 had a shirt on and his mid upper back could not be seen. -Resident #3 was repositioned by two staff in preparation for feeding assistance of the lunch meal service, but Resident #3 was not able to sit at a 90-degree angle. -Resident #3 remained lying on his right hip, legs bent at the knees, left arm bent in a 90-degree angle and leaning toward the right side. Review of Resident #3's Nurse Practitioner (NP) visit notes dated 04/14/20 revealed: -Resident #3 was seen on 04/14/20 due to report from staff that Resident #3 needed cream for a rash on his buttocks, inner thighs and scrotum. -On 04/14/20, Resident #3 was assessed to have excoriated skin breakdown to his right inner thigh, buttocks, and perineum area. -The NP was assisted by one staff to transfer Resident #3 from the wheelchair onto the bed and provide incontinent care for stool and urine. -The NP noted ordering zinc oxide 20% and to keep Resident #3 clean and dry every two hours. Review of Resident #3's NP orders dated 04/14/20 revealed there was an order to provide incontinent care every two hours apply zinc oxide 20% generously to groin, buttocks and inner thighs. Review of Resident #3's NP visit notes dated 04/16/20 revealed.	D 273		

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D 273	Continued From page 14 -Resident #3 was seen for follow-up of his chronic conditions. -Resident #3 was in his wheelchair, awake, not in distress and confused. -There was documentation that he was eating well. -Resident #3's was noted to have excoriated skin breakdown in groin area and inner thigh. -There was documentation that staff would need to keep resident clean, dry and apply zinc oxide to affected areas. Review of Resident #3's NP visit notes dated 04/17/20 revealed: -Resident #3 had a fall on 04/17/20 and was seen at the local hospital emergency room. -Resident #3 was alert and conversing with the personal care aide (PCA). -There was no documentation about Resident #3's wounds. Review of Resident #3's NP visit notes dated 05/04/20 revealed: -This was a follow up visit for impaired skin integrity. -Staff reported Resident #3 had a rash on his buttocks. -Upon assessment, Resident #3 had a stage II ulcers to his groin, scrotum and inner thighs with blisters. -The plan was to make a referral to home health to evaluate and treat. -Also, the NP continued the order to apply zinc oxide and keep Resident #3 clean and dry every 2 hours. -There were no notes concerning Resident #3's eating, drinking or if he was bedridden or utilizing wheelchair Review of Resident #3's facility contracted	D 273		

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therapy notes revealed:
-Resident #3 received occupational and physical therapy.
-Resident #3 was discharged from occupational therapy on 05/05/20 due to not progressing toward the goals set for him.
-Resident #3 was discharged from physical therapy on 04/20/20.
-Resident #3 was instructed on activities of daily living, standing, transferring, balancing, and strengthening his left side.
-The certified occupational therapist assistant documented on 05/02/20 Resident #3 was confused and spoke an unintelligible language.
-The Occupational Therapist (OT) documented on 05/05/20 that Resident #3 had new onset wounds and pain in sacral/buttocks and inner thigh region.
-The OT noted Resident #3 had shown decline with therapy due to the wounds and services were not recommended until medical issues were resolved.

Telephone interview with a Physical Therapist on 05/15/20 at 4:19 pm revealed:
-Resident #3 had a history of a stroke, left sided weakness, and utilized a wheelchair.
-Resident #3 was receiving physical therapy due to abnormal gait, muscle weakness, and lack of coordination.
-Resident #3 was able to feed himself with the use of his right arm, stand with assistance from one person, and converse in March 2020.
-Physical Therapist sometimes had to provide incontinent care for Resident #3 prior to starting therapy.
-She last saw Resident #3 in March 2020 and he did not have a wound at that time.

Interview with Resident #3's OT on 05/18/20 at

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10.44 am revealed:
-He saw Resident #3 to evaluate and work with him on activities of daily living beginning in September 2019.
-He did not recall when he first noted Resident #3's wounds in April 2020.
-He recalled that his wound was changed in May 2020.
-He reviewed with staff the need to reposition Resident #3 with the use of a pillow, but this information was only shared with the first shift.
-Resident #3 was discharged because he was not progressing in his therapy.
-He would discuss Resident #3's condition and the wounds with the MA on duty each time he worked with Resident #3.
-He thought the MA would tell the "necessary people".
-He did not discuss the changes noted with Resident #3 or his discharge from services with the RCC or the NP.
-The therapy staff typically did not report anything directly to the NP but, the NP signed all the daily therapy notes and care plans.

Review of Resident #3's Home Health Nurse visit notes dated 05/06/20 revealed:
-Resident #3 received his first visit with the Home Health Nurse.
-On 05/06/20, Resident #3 had a stage II pressure ulcer on his left and right buttocks, back, and blistered areas on his left and right thighs, and scrotum.
-Resident #3's left buttock wound measured 4 X 22 X 0.1 centimeters.
-Resident #3's right buttock wound measured 5.5 X 3 X 0.1 centimeters.
-The mid back wound was not measured.
-Resident #3's family member was notified, and she verbalized concerns that he was not eating

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and declined since the family last visited in March 2020 due to Coronavirus precautions.
-The Home Health Nurse discussed "offloading" and the need for Resident #3 to be turned every two hours.
-Resident #3 was noted to be confused, deconditioned, bedridden and currently being treated with zinc oxide without any improvement.
-Resident #3 had declined within the past few days and was now total care.

Review of Resident #3's Home Health Nurse notes dated 05/08/20 revealed:
-Resident #3 was confused, moaned and groaned in pain in response to movement.
-Tylenol was administered in response to pain.
-Resident #3 was given wound care.
-Staff were taught to speak in soft soothing tones and not rush when providing care to Resident #3 to avoid causing agitation.
-Resident #3 had a Foley catheter inserted and discontinued due to no urine output for one and a half hours.

Review of Resident #3's Home Health Nurse notes dated 05/11/20 revealed:
-There was documentation for 05/11/20 indicating home health service started at 8:50 pm and ended 11:10 pm.
-Resident #3's wound dressings were changed, staff reported Resident #3 had very little urine output that day.
-Resident #3 had shallow, labored breathing and +3 pitting edema in his lower extremities.
-Resident #3's family member was contacted and made aware of his condition at the facility and need for transport to local hospital.
-Resident #3's left buttock wound measured 4 X 6 X 0.1 centimeters.
-Resident #3's right buttock wound measured

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D 273	Continued From page 18 8.75 X 7 X 0.1 centimeters. -Resident #3's mid back wound measured 2 X 1. 75 X 0.1 centimeters. Telephone interview with the Home Health Nurse on 05/15/20 at 9:22 am revealed: -She began caring for Resident #3 on 05/06/20 because of his pressure ulcers. -The pressure ulcers were on Resident #3's right and left buttocks, upper back and mid anterior scrotum. -Resident #3's pressure ulcers were stage II pressure ulcers. -On 05/06/20, Resident #3's pressure ulcers' were assessed and his sheets were wet, but she did not smell the odor of urine. -On 05/08/20, she found Resident #3 wet with urine and notified the NP to request a Foley-catheter insertion. -Resident #3 had the Foley catheter inserted but had no urine output for one hour and a half, so it was discontinued. -She did not visit Resident #3 on 05/07/20 but wrote a progress note. -She spoke with the family member throughout the dates of his care 05/06/20 to 05/11/20. -Resident #3 would groan and moan when moved. -Resident #3 received Tylenol prior to the dressing changes. -She relayed Resident #3's assessment and wound condition to the NP, family member and staff (MAs on duty) each visit. -She taught staff body positioning, how to use a draw sheet to turn Resident #3, offloading, turning Resident #3 every 2 hours and to keep him clean and dry. -She was present when Resident #3 was transferred to the hospital. -She did have to direct staff to notify EMS.	D 273		

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-Resident #3 was breathing rapidly, his blood pressure was low, and he was not responding.
-She was assisted by PCAs during the dressing change on 05/11/20 which required Resident #3 to be repositioned several times.
-If Resident #3 had received early interventions when he had a stage I wound, this may have prevented his change in condition and hospitalization.

Review of Resident #3's NP orders dated 05/04/20 revealed there was an order for home health consult due to alteration in skin integrity.

Review of Resident #3's NP orders dated 05/08/20 revealed:
-There was an order for wound care to cleanse with wound cleanser or soap and water, apply skin prep, apply alginate and foam dressing. Apply a brand name paste for any uncovered wounds.
-There was an order for a physical therapy evaluation and assessment for alternating pressure pad for the bed and wheelchair cushion or incontinence cushion.
-There was an order for a Foley catheter.

Review of Resident #3's NP orders revealed there was an undated order for Tylenol 500 mg take two pills three times a day and to discontinue Foley catheter.

Review of Resident #3's progress notes revealed:
-There were no progress notes written by facility staff.
-There were no progress notes documenting notifying the NP, RCC or Administrator about any changes in condition for Resident #3.

Review of Resident #3's progress notes written

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by Home Health Nurse revealed:
-All the progress notes were written by the Home Health nurse.
-There was a note dated 05/06/20 to assess Resident #3's wounds.
-Resident #3's left buttock wound measured 4 X 22 X 0.1 and was staged as a stage II pressure ulcer.
-Resident #3's left thigh wound measured 5.5 X 3 X 0.1 and was staged as a stage II pressure ulcer.
-Resident #3's mid upper back was a quarter sized pressure ulcer and was not staged.
-Resident #'s scrotum wound could not be measured but was a stage II pressure ulcer.
-Resident #3's pressure ulcers were dressed, and a request would be made for a wound care nurse specialist to evaluate his wound for further recommendations.
-The Home Health nurse documented on 05/06/20 that the family member requested the NP notify her to discuss Resident #3's care.
-The Home Health nurse discussed the information discussed with a second shift MA.
-There was a note dated 05/07/20 that there were orders written for the NP.
-The 05/07/20 also noted the locations of Resident #3's stage II wounds; left buttock/thigh, right buttock, scrotal area and back wounds.
-The wounds were described as denuded (striped of covering, make bare).
-On 05/08/20, Resident #3 was confused, found wet, dressings were changed, and a Foley catheter was placed.
-No urine output was obtained from the Foley-catheter placement after an hour and a half, and the Foley catheter was discontinued.
-There were notes dated 05/11/20 indicated the left thigh wound measure 21 X 6 X 0.1 centimeter, and the right buttock wound measure

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8.75 X(blank)X 0.1 centimeters.
-The dressing changes required the assistance of three people.
-Resident #3's respiration rate was 51 with shallow and labored breathing; Resident #3 was also not verbally responding.
-Resident #3's family member was notified on 05/11/20 as well as the NP.
-Resident #3 was sent to the local hospital on 05/11/20 at 10:35 pm.

Review of Resident #3's incident reports revealed:
-There was an incident report dated 05/11/20 at 10:00 pm.
-Resident #3 had labored breathing and was not responding.
-Resident #3's blood pressure was documented as 75/38.
-Resident #3 was admitted to the local hospital.

Review of Resident #3's local county emergency medical services (EMS) dated 05/11/20 revealed:
-Resident #3's first assessment was completed at 10:11 pm.
-Resident #3's first set of vital signs at 10:12 pm were as follows: blood pressure 73/35, temperature 97.1, and heart rate 62.
-Resident #3 received an intraosseous bolus and intravenous bolus which started at 10:22 pm.
-Resident #3's blood pressure increased to 105/46 at 10:37 pm.
-Hypotension (low blood pressure) was the clinical impression for Resident #3 and tachypnea (elevated rate of breathing) was the chief symptom documented.

Interview with Resident Care Coordinator (RCC) on 05/12/20 at 10:46 am revealed there were no other progress notes for Resident #3 other than

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those filed in his record.

Interview with a personal care aide (PCA) on 05/11/20 at 11:51 am revealed:
-Resident #3 required assistance to eat, move in the bed, and incontinent care.
-Resident #3 was not like this previously, the facility started one on one care on the previous week. but he did not know the exact date.
-Resident #3's one on one care meant that the resident received feeding assistance.
-Resident #3 was in a "bad way" meaning he could no longer sit straight up due to his wounds on his buttocks.
-Prior to the end of April and early May 2020, Resident #3 was able to stand up and sat in his wheelchair.
-Resident #3 went to the dining room to eat and he fed himself.
-However, he thought Resident #3 changed a week ago due to the wounds.
-He thought the wounds started two weeks ago but he was not sure.
-He thought the MAs already knew about the wounds.
-PCAs made two-hour rounds and checked residents to determine if they needed incontinent care performed.
-Resident #3 did not eat 100% of his 05/11/20 lunch, and he told the medication aide.

Interview with a second PCA on 05/11/20 at 12:28 pm revealed.
-Resident #3 changed a month ago not a week ago.
-Resident #3's buttocks were in that condition because he was left wet and not changed.

Confidential telephone interview with staff revealed:

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D 273	Continued From page 23 -Resident #3 was never able to walk and used a wheelchair. -Resident #3 was able to feed himself in April 2020. -Resident #3 was always incontinent but was able to tell staff sometimes if he needed to use the restroom. -Resident #3 could stand with one-person assistance and or use of a rail with his right hand. -His family members were involved in his care since admission and visited him often until the Coronavirus restrictions. -Resident #3 declined over April and May 2020 -Resident #3 was provided with incontinence care three weeks ago and he had little wounds on his buttocks. -Resident #3's wounds on his lower buttocks looked like a water blister. -Resident #3 was seen again approximately a week ago and he was not getting up anymore, only remaining in bed. -Resident #3's wounds looked like a skin tear, red and the skin was peeled off but not bleeding. -The MA on duty was told about the wounds and a white cream was applied to Resident #3's buttocks. -Interview revealed the staff thought that the NP and MAs knew about Resident #3's changes so did not report it to the NP or RCC. Interview with a third PCA on 05/18/20 at 11:13 am revealed: -Resident #3 changed since the middle or the end of April 2020. -Resident #3 was able to sit up in his wheelchair, eat independently, and was not in the bed all day in mid-April 2020. -Resident #3 was bedridden at the end of April 2020 or first of May 2020 -Whenever Resident #3 had incontinent care	D 273		

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performed, the MA was notified so that the MA would complete the care by applying the cream to his buttocks.
-Resident #3 changed because of the wounds.
-MAs told them at the beginning of the shift if there were any changes for the care of a resident.
-He was not told of any change in caring for Resident #3 by the MAs.
-Resident #3 ate 80 % of his meals in April 2020 and by the end of April 2020 he ate 40% of his meals.
-He reported everything he was not familiar with to the MA on duty.
-Resident #3 had fewer bowel movements during his shift since he decreased the amount he ate.
-He reported Resident #3 was not urinating as frequently as he did previously to the MAs.
-He reported everything he noticed but nothing was done until 05/11/20.

Review of Resident #3's 72 hours monitoring facility form revealed:
-The form had Resident #3's name indicated on each page.
-The form was divided into entries that contained spaces for the date, shift, time, reason and staff signature.
-There was were notes written from 05/03/20 second shift to 05/06/20 second shift signed by various MAs.
-The note for 05/03/20 second shift indicated Resident #3 had a wound on his left upper leg and the nurse looked at the wound.
-The note for 05/03/20 third shift indicated Resident #3 was monitored, cream was applied during the night shift and Resident #3 continued to be monitored.
-The note for 05/04/20 first shift indicated Resident #3 was monitored, washed and zinc oxide applied.

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-The note for 05/04/20 second shift indicated Resident #3 stayed in bed, had a "sore" on his buttock with "plenty of zinc oxide on it".
-The note for 05/05/20 first shift indicated Resident #3 was kept clean and dry and zinc oxide applied.
-The note for 05/05/20 second shift indicated Resident #3 was kept clean and dry and in the bed.
-The note for 05/05/20 third shift indicated Resident #3 was monitored every one to two hours, and staff would continue to monitor.
-The note for 05/06/20 first shift indicated Resident #3 was monitored every 15 minutes to ensure he remained dry.
-The note for 05/06/20 second shift indicated Resident #3 was turned every two hours and checked.

Interview with a day shift medication aide (MA) on 05/18/20 at 12:20 pm revealed:
-She was primarily assigned to the 100 hall-way where Resident #3 resided since April 2020.
-She expected the PCAs to keep everyone clean and dry, fed and "well taken care of" which meant that residents have what they need.
-She had a good "crew" to work with and did not have to tell them anything.
-In March 2020, Resident #3 was doing well and up rolling around in his wheelchair.
-In April 2020, Resident #3 developed "sores" on the back of his legs and between his thighs".
-She was not sure of the exact date in April 2020 that she first noted Resident #3's wounds.
-The PCAs came to tell her when he had incontinent care performed so that she could apply zinc oxide to Resident #3's wounds.
-She saw Resident #3's wounds improve in April 2020 and then she was off for two days.
-When she returned to work, his wounds were

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flared back to the original state.
-She did not report anything about his wounds because she thought the RCC and NP already knew.
-The reason she thought the RCC and NP knew was because a 72-hour monitoring form had been initiated.
-She did not remember the dates of the 72- hour monitoring form, but she thought she saw information on the form about Resident #3's wound.
-The 72-hour monitoring report was how MAs communicated with each other.
-She did not know who received the 72-hour monitoring report when it was completed.
-She did not report his decreased amounts of intake because she thought they were aware.
-She thought the 72 hours monitoring form indicated Resident #3 was being watched closely due to his wounds.
-She saw the NP come and see Resident #3 in May 2020 and she ordered Home Health for his wound care.
-She told the PCA to check him every 15 minutes to ensure there was no urine on him.
-The NP and the RCC went in to see Resident #3 at the end of April 2020 or beginning of May 2020 and she thought they saw that Resident #3 was wet with urine at that time.
-She thought Resident #3's wound changed in early May 2020.
-She told the NP on 05/07/20 that he was not eating as much as he used to eat, but there were no changes made in his care.
-MAs were responsible for reporting changes in residents' condition to the RCC.

Interview with a second shift MA on 05/14/20 at 3:56 pm revealed:
-MAs do not process orders from the NP, the

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RCC did this task.
-MAs first saw orders when they appear on the electronic medication administration record (MAR).
-PCAs did showers and all the care for residents except for medications.
-She ensured PCAs did their duties by watching them.
-She expected that after two weeks of working, PCAs should have a routine.
-In March 2020, Resident #3 was up and about in his wheelchair.
-Resident #3 was never able to toilet himself or transfer himself.
-In April 2020, Resident #3's buttocks developed skin breakdown, but she did not know the exact date.
-Resident #3 started "going down more and more" near the end of April 2020.
-He was in pain because his buttocks were "tore up".
-She administered Tylenol to Resident #3 when he was in pain and the NP ordered hydrocodone for Resident #3 on the day he went to the hospital.
-She made sure the PCAs went in to feed him in bed.
-Resident #3 ate 100% of his meals but once he was unable to get out of bed, he ate only 50% of his meals.
-Resident #3 drank the beverages provided with his meal which was one beverage and she gave him a 4-ounce cup of water with his medications during her shift.
-She assumed the RCC and NP knew about his wound so she did not report anything to anyone.
-She knew the Home Health Nurse was coming to see Resident #3, so she thought there was no need to report anything concerning Resident #3.
-She was there when he was transported to the

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hospital on 05/11/20.
-She did not document any change in his condition in April 2020 or May 2020.

Interview with Resident #3's NP on 05/12/20 at 12:20 pm revealed:
-Staff slipped a piece of paper under her door requesting Resident #3 be seen on 04/14/20 for a rash.
-When she examined Resident #3, he had excoriated skin on his buttocks, thighs, and scrotum different from a rash, he had stage I wounds.
-She ordered zinc oxide and to keep Resident #3 clean and dry every two hours.
-She gives all her orders to the RCC.
-On 04/16/20, she saw Resident #3 for a routine follow up and he still had irritation to his right inner thing and groin area.
-She did not change the orders but wrote the same instructions to keep Resident #3 clean and dry and apply zinc oxide.
-When she saw Resident #3 on 04/17/20, he was conversing with the PCA he was near, and he was sitting up in his wheelchair.
-She was not in the facility for about a week and a half, during this time she attempted to do telehealth.
-Telehealth did not work well with the population so she returned to the facility 04/28/20.
-She worked on Monday, Tuesday, Thursday and Friday of each week.
-The next time she examined Resident #3 was on 05/04/20 as a follow up for skin integrity and he had a stage II wound at that time.
-On 05/04/20, she ordered a home health referral for his wounds.
-She also ordered Tylenol for pain control on 05/08/20 to be given as a scheduled dose instead of as needed.

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D 273	Continued From page 29 -She also ordered hydrocodone on 05/11/20 to provide pain control. -In April 2020, Resident #3's wounds were at a stage I and by 05/04/20 the wounds were a stage II. -Between 04/17/20 and 05/04/20, no staff reported any changes in the size or condition of the wound. -Between 04/17/20 and 05/04/20, staff did not report Resident #3's decrease in intake for food or fluids. -She saw Resident #3 on 05/11/20 at around 5:00pm and he needed incontinent care. -She also needed to replace his dressing and called for the RCC to assist her in locating dressing supplies. -She did not feel that he needed to be transferred to the hospital at that time because "he was still responding to pain when she turned him". -She was notified later that evening by the Home Health Nurse informing her that Resident #3 was not responding, respiration rate was 51 and blood pressure low 74/35. -She thought the order to keep Resident #3 clean and dry was not followed by all staff. -She thought Resident #3 was not drinking enough fluids and his wound deterioration caused him to go down this path. Interview with the RCC on 05/18/20 at 1:58 pm revealed: -She expected PCAs to report to her about any changes with residents' care such as skin breakdown, not eating or refusing care. -She expected MAs to report to her any changes in care for residents such as refusing medications, not eating or drinking, residents feeling sick or a rash. -Staff did go directly to the NP to report concerns. -The NP always told her anything that was	D 273		

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reported directly to her by staff and visa-versa.
-She did not document when a resident had changes and she told the NP.
-She took care of all orders written for residents in the facility.
-She was responsible for completing care plans and she observed residents with changes for a week before completing a new care plan.
-She had not updated Resident #3's care plan.
-She made rounds and sometimes initialed disposable briefs to ensure residents were provided with incontinent care.
-MAs were able to document by entering notes on the MAR or on a progress note in the resident record.
-She could not locate a 72-hour monitoring report for Resident #3 for April 2020.
-In April 2020, Resident #3 needed assistance with bathing, dressing and wore disposable briefs.
-Resident #3 developed a rash in April 2020 and she thought home health was ordered at that time, but she was not sure.
-She told staff to keep Resident #3 clean and dry.
-No staff reported to her that Resident #3's wounds were getting worse until May 2020 and home health was ordered.
-She expected staff to follow the NP orders and the Supervisors to report any changes to her.
-Staff did not report that Resident #3 was eating less.
-If she had known he was not eating as well, she would have intervened by trying to feed Resident #3 herself.
-She often assisted with residents who began to eat less by placing syrup on the food to encourage them to eat.
-She noticed residents with dementia still enjoyed sweet foods.
-The Supervisors and PCAs were responsible for

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telling her about Resident #3's changes and if she had known she would get the NP involved.

Telephone interview with Resident #3's family member on 05/14/20 at 8:00 am revealed:
-Prior to the pandemic and visitation restrictions in early March 2020, she visited 3 to 4 times per week.
-Resident #3 had a healthy appetite and was wheeled around in his wheelchair by staff for mobility.
-Resident #3 depended on staff to bathe, toilet and transfer him from bed to chair because of a stroke.
-She did not know the exact date that he stopped using the wheelchair and was placed on in the bed due to his pressure ulcers.
-She was called by a nurse who did not work at the facility and she gave her an update on Resident #3.
-She expressed concerns to the nurse that he would not receive the care he needed by being bedridden.
-She had not heard from the RCC, but another family member spoke with the RCC once Resident #3 was hospitalized.
-She had not heard from the Administrator, but another family member spoke with him after Resident #3 was hospitalized.
-She felt Resident #3 was not being cared for because he was bedridden.
-She was told by staff that Resident #3 was being fed and given fluids.
-Resident #3 was admitted to the ICU because he was not given any nutrition.
-The ICU doctor told her that he could tell that Resident #3 was laying in one area too long which resulted in severe muscle loss and kidney failure.
-The ICU doctor told her Resident #3 was

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D 273	Continued From page 33 -Resident #3 should have been turned as ordered. -He thought Resident #3 was cared for by the staff and that "sometimes things must get worse before they get better". -He did not know exactly when Resident #3's wounds worsened to a stage II. -He saw Resident #3 on 05/11/20 and the wounds looked like blisters/sunburn with the skin peeled off. -Resident #3 was sent out because his blood pressure dropped. -The RCC reported everything to him but he did not recall if she told him Resident #3 had a wound previously. -The NP was supposed to relay changes in residents' conditions to him and he depended upon her to notify him of these changes. -He thought Resident #3 progressed to the ICU because of his age, skin integrity and he stayed in the wheelchair for most of the day. The facility's failure to notify the facility contracted Nurse Practitioner resulted in the delay in care for Resident #1 who sustained a fall, and had documented complaints of pain and distress in the form of moaning, and Resident #3 whose eating had decreased and who had a documented stage I pressure ulcer that progressed to a stage II and resulted in hospitalization to the ICU. This failure resulted in the death of Resident #1 and serious injury to Resident #3 which constitutes a Type A1 Violation for neglect. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 05/14/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 19,	D 273		

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D 443	10A NCAC 13F .1208 (c) Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (c) A written notice containing the information under Paragraph (d) of this Rule shall be made within three days of any death resulting from violence, accident, suicide or homicide. (d) Written notice may be submitted in person or by telefacsimile or electronic mail. If the reporting facility does not have the capacity or capability to submit a written notice immediately, the information contained in the notice may be reported by telephone following the same time requirements under Subparagraphs (b) and (c) of this Rule until such time the written notice may be submitted. The notice shall include at least the following information: (1) Reporting facility: Name, address, county, license number (if applicable), Medicare/Medicaid provider number (if applicable), facility administrator and telephone number, name and title of person preparing report, first person to learn of death and first staff to receive report of death, and date and time report prepared; (2) Resident information: Name, Medicaid number (if applicable), date of birth, age, sex, race, primary admitting diagnoses, and date of most recent admission to an acute care hospital. (3) Circumstances of death: place and address where resident died, date and time death was discovered, physical location decedent was found, cause of death (if known), whether or not decedent was restrained at the time of death or within 7 days of death and if so, a description of	D 443	**D443 Death Reporting Requirements** **It is the policy of Durham Ridge Assisted Living to report within three days any death resulting from violence, accident, suicide or homicide.** **All Med Techs were in-serviced shift to shift beginning by the Administrator and Resident Care Coordinator, on May 14, 2020 to remind them of when it is necessary and how to notify the state of a resident death.** **An all staff meeting was held on June 8, 2020, topics discussed included, but were not limited to when it is necessary and how to notify the state of a resident death.** **The Administrator will follow up on all deaths within 48 hours to determine if they should be reported to the state.** **June 19, 2020 and ongoing.**	

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the type of restraint and its usage, and a description of events surrounding the death; and
(4) Other information. list of other authorities such as law enforcement or the County Department of Social Services that have been notified, have investigated or are in the process of investigating the death or events related to the death.
(e) The facility shall submit a written report, using a form pursuant to G.S. 131D-34.1(e). The facility shall provide, fully and accurately, all information sought on the form. If the facility is unable to obtain any information sought on the form, or if any such information is not yet available, the facility shall so explain on the form.
(f) In addition, the facility shall:
(1) Notify the Division of Facility Services immediately whenever it has reason to believe that information provided may be erroneous, misleading, or otherwise unreliable;
(2) Submit to the Division of Facility Services, immediately after it becomes available, any information required by this rule that was previously unavailable; and
(3) Provide, upon request by the Division of Facility Services, other information the facility obtains regarding the death, including, but not limited to, death certificates, autopsy reports, and reports by other authorities.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to provide a written death notification for 1 of 1 resident (#1) who died within 24 hours of a fall.

The findings are:

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

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D 443	Continued From page 36 Review of the Death Reporting Policy (no date) revealed: - A Death Report Form will be completed within 3 days of any death resulting from violence, accident, suicide or homicide. -The form must be submitted in person, by fax or email to the Department of Health Human Services (DHHS). Review of Resident #1's current FL-2 dated 03/10/20 revealed diagnoses included dementia dysphagia, symbolic dysfunction, muscle weakness and pain. Review of Resident #1's Accident/Incident Report dated 04/18/20 revealed resident fell on 04/18/20 at 5:14 pm and died on 04/19/20 at 3:34 pm. Interview with the Administration on 05/18/20 at 11:03 am revealed: -He followed the facility's policy for Death Reporting. -He did not complete a Death Reporting Form for Resident #1. -He did not think that it was necessary to complete a Death Reporting Form for Resident #1 because she had a Do Not Resuscitate (DNR) order. -He was responsible for ensuring written death reports were completed.	D 443		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by:	D914		

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 05/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY STATE ZIP CODE
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D914	Continued From page 37 Based on record reviews, interviews and observations, the facility failed to assure each resident was free of neglect related to physician follow-up and referral for acute and routine health care needs. The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure notification of the facilty contracted Nurse Practitioner of changes in condition for 2 of 8 sampled residents (#1 and #3) resulting in the death (#1) and hospitalization to the intensive care unit (#3). [Refer to Tag D 273 10A NCAC 13F .0902 (b) Health Care (Type A1 Violation)]	D914	**D914 Declaration of Residents' Rights** **It is the policy of Durham Ridge Assisted Living to assure that all residents be free of mental and physical abuse, neglect, and exploitation.** **An all staff meeting was held on June 8, 2020, topics discussed included, but were not limited to, Resident's Rights and the importance of maintaining them.** **Residents' Rights issues will be monitored by the Administrator weekly.** **June 19, 2020 and ongoing.**	