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 _____	R-C 09/14/2020

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 follow-up survey and a COVID-19 infection control focused survey on site September 3, 2020 and September 11, 2020 and desk review on September 4, 2020 through September 10, 2020 with an exit conference via telephone on September 14, 2020.	{D 000}	It is the policy of Durham Ridge Assisted Living to assure the documentation of the following in the resident's record: written procedures, treatments or orders from a physician or other licensed health professional and implementation of procedures, treatments or orders. Third Shift Medication Technicians will be responsible for ensuring that Ted Hose are in place before signing off that they are on the Electronic Medication Administration Record. The Assistant Administrator and Resident Care Coordinators will be responsible to check randomly each week to ensure Ted Hose are being applied appropriately. October 30, 2020 and On going	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement a physician order for the application of compression stockings for 1 of 1 sampled resident (#4). The findings are: Review of Resident #4's current FL-2 dated 11/22/19 revealed:	D 276		

Reviewed and Accepted on 10/22/20.

Pamela Dailey

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D 276	Continued From page 1 -Diagnoses included dementia, dysphagia, and muscle weakness. -There was an order for the resident to wear compression stockings (used to manage peripheral edema and prevent blood clots) daily. Review of Resident #4's electronic medication administration records (eMARs) for July 2020, August 2020, and September 2020 revealed: -There was an entry to apply compression stockings in the morning and remove in the evening with a scheduled administration time of 6:00am and 8:00pm. -There was documentation from 07/01/20-09/10/20 the compression stockings were applied and removed. -There was no documentation from 07/01/20-09/11/20 Resident #4 ever refused to wear the compression stockings. -On 09/11/20 there was documentation Resident #4's compression stockings had been applied. Observation of Resident #4 on 09/11/2020 at 9:10am revealed: -She was sitting in a wheelchair in the dining room. -She was wearing grey socks. -She was not wearing compression stockings. Second observation of Resident #4 on 09/11/20 at 9:43am revealed she was laying in her bed with one gray sock on her left foot; she was not wearing compression stockings. Interview with a personal care aide (PCA) on 09/11/20 at 9:33am revealed: -He dressed Resident #4 and transferred Resident #4 into her wheelchair. -He did not put compression stockings on Resident #4.	D 276		

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D 276	Continued From page 2 -He had only worked with Resident #4 for the past two days and did not know she had an order for compression stockings. Interview with a second PCA on 09/11/20 at 10:19am revealed: -She had not put compression stockings on Resident #4 lately, "maybe last month." -Resident #4 probably needed the compression stockings because sometimes Resident #4's legs were swollen. -Residents who wore compression stockings were on a list that would be hanging on the wall on each hall. -She did not see a list for compression stockings on the 100-hall where Resident #4's room was. -Third shift staff was responsible for applying compression stockings before residents were out of bed. -If the third shift did not apply the compression stockings, she would be responsible for applying the compression stockings. -She did not recall, "ever" putting compression stockings on Resident #4. -She had not told anyone Resident #4 was not wearing compression stockings, because she did not know Resident #4 was supposed to wear compression stockings. -If Resident #4 had compression stockings, the compression stockings would be in Resident #4's top drawer. Observation of the PCA on 09/11/20 at 10:19am revealed Resident #4 had a pair of white compression stockings in the top drawer of her dresser. Observation of the PCA communication area on the 100-hall on 09/11/20 at 10:19am revealed there was no list for a resident who wore	D 276		

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D 276	Continued From page 3 compression stockings posted. Interview with the medication aide (MA) on 09/11/20 at 11:01am revealed: -Resident #4's order for compression stockings was at 6:00am and therefore the third shift PCA would be responsible for applying the compression stockings. -Usually, the PCA would tell her if a resident did not have compression stockings on if they were supposed to; no one had told her Resident #4 did not have compression stockings on. -No one told her Resident #4 did not have compression stockings on today, 09/11/20. -She had not looked to see if Resident #4 had compression stockings hose on or not. Telephone interview with a third shift MA on 09/11/20 at 11:25am revealed: -The PCA's were responsible for applying compression stockings on residents in the morning. -The PCA was supposed to let the MAs know if the compression stockings were not put on and "why not." -No one had let her know Resident #4's compression stockings had not been applied. -She used to check behind the PCA's to make sure compression stockings had been applied every morning, but she had not lately because she was busy with COVID-19 temperature and oxygen checks every morning. -She documented Resident #4 had compression stockings on because she trusted the PCA's did what they were supposed to do. -She could not recall when she had seen Resident #4 with compression stockings on. Interview with the Resident Care Coordinator (RCC) on 091120 at 11:42am revealed:	D 276		

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D 276	Continued From page 4 -Compression stockings were kept in the resident's rooms. -The third shift MA was responsible for applying compression stockings in the morning before residents were gotten out of bed. -First shift staff should check to make sure the compression stockings were applied. -She expected the MA to apply the compression stockings. -If a first shift MA came on duty and the compression stockings had not been applied, she expected the MA to tell her. -No one had told her Resident #4 did not have compression stockings applied today, 09/11/20, until it had been brought to the MA's attention Resident #4 did not have compression stockings on today, 09/11/20. -She was concerned Resident #4 did not have compression stockings on because there was an order to apply compression stockings daily. -Resident #4 had compression stockings on, yesterday, 09/10/20 because she saw them. -She usually made rounds every day to make sure the compression stockings had been applied and had not had a chance to make rounds today, 09/11/20. Interview with a second MA on 09/11/20 at 11:50am revealed: -Third shift staff was responsible for applying compression stockings before residents were out of the bed. -The first shift usually did not do anything with the compression stockings. -She knew Resident #4 had an order "at one point" for compression stockings. -She did not usually look to see if compression stockings had been applied because the third shift would have already checked off on the task and it would not show up on her medication pass.	D 276		

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D 276	Continued From page 5 -Resident #4 usually wore pants and she had not noticed if Resident #4 had compression stockings applied. -She knew "about a week ago" Resident #4 had compression stockings on because Resident #4 had a dress on, and she had noticed one of the compression stockings needed to be pulled up. Observation of Resident #4 at 12:15pm revealed she was wearing compression stockings. Interview with the Administrator on 09/11/20 at 12:42am revealed: -Compression stockings were put on and off by the third shift PCAs. -He expected the first shift staff to put compression stockings on a resident if the task had not been done by the third shift staff. -He expected the first shift PCA to let the MA know the resident did not have compression stockings on so it could be addressed by the RCC. -The RCC would be responsible for getting in touch with the third shift staff to make sure they knew the task needed to be done. -The MA was ultimately responsible for making sure the compression stockings had been applied. -He did not know why Resident #4 did not have compression stockings on today, 09/11/20, maybe the hose had been soiled, etc., and he would need to research it. Telephone interview with a third shift PCA on 09/14/20 at 5:52am revealed: -She worked on the 100-hall and had taken care of Resident #4. -Resident #4 wore regular socks. -Resident #4 had worn compression stockings but she did not recall when she last put	D 276		

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D 276	Continued From page 6 compression stockings on Resident #4. -She had not been able to find compression stockings for Resident #4. -She had told the MA she could not find compression stockings for Resident #4 but did not recall which MA or when she told a MA but thought it was "about a week ago." Telephone interview with a medical assistant from Resident #4's primary care providers (PCP) office on 09/14/20 at 10:05am revealed: -Resident #4's original order for compression stockings was dated 10/03/17 and was documented as due to congestive heart failure to apply compression stockings daily and encourage the elevation of legs. -She knew "in the past" Resident #4 had a lot of refusals for wearing the compression stockings. -The order should have been followed as ordered and Resident #4 should have been encouraged to wear the compression stockings. -An order to discontinue the compression stockings was initiated on 09/11/20. Telephone interview with Resident #4's PCP on 09/14/20 at 12:02pm revealed: -She had seen Resident #4 today, 09/14/20, and Resident #4 was not wearing compression stockings and did have a trace of edema. -The staff told her Resident #4 had refused to wear the compression stockings "here and there." -Resident with dementia often did not tolerate wearing compression stockings. -She thought Resident #4 was okay without the compression stockings and had discontinued the order. -Prior to today, 09/14/20, she had expected the compression stockings order to have been followed.	D 276		

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D 276	Continued From page 7 Based on observation, record review, and interviews, Resident #4 was not interviewable.	D 276		