Page 3 of 3 Durham Ridge Assisted Living HAL-032-091 December 10, 2020

response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **January 6**, **2020**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **January 6**, **2020**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at 984-365-2578. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,

Shonda Stacey, Licensure Consultant

Adult Care Licensure Section

Division of Health Service Regulation

Enclosures: Statement of Deficiencies

c: Matthew Thompson, Supervisor, Durham County DSS

Bridget Rackley, Team 4 Supervisor, Central Branch Region, Adult Care Licensure Section

Facility File

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job.

<u>Please note:</u> Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, Division of Health Service Regulation, at 919-855-3750.

Customer Service Survey web site: http://info.ncdhhs.gov/dhsr/customerservice.html (Survey Max does not work well with all browsers, please access survey with Internet Explorer)

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES - DIVISION OF HEALTH SERVICE REGULATION

ADULT CARE LICENSURE SECTION

LOCATION: 801 Biggs Drive, Brown Building, Raleigh, NC 27603
MAILING ADDRESS: 2708 Mail Service Center, Raleigh, NC 27699-2708
https://info.ncdhhs.gov/dhsr/ • TEL: 919-855-3765 • FAX: 919-733-9379

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Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION ADULT CARE LICENSURE SECTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING: AND PLAN OF CORRECTION RALEIGH 11/17/2020 B. WNG HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG D 000 D 000 Initial Comments The Adult Care Licensure Section and the Durham County Department of Social Services conducted a complaint investigation and a COVID-19 Focused Infection Control survey with onsite visits on November 3, 2020 and November 10, 2020 and a desk review survey on November 4-6, 2020, November 9, 2020, November 12-13. 2020 and November 16-17, 2020. The Durham County Department of Social Services initiated the complaint on October 9, 2020. D 273 It is the policy of Durham Ridge Assisted Living D 273 10A NCAC 13F .0902(b) Health Care to assure referral and follow-up to meet the routine and acute health care needs of residents. 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up Medication Technicians and Shift Supervisors to meet the routine and acute health care needs were in-serviced shift to shift, beginning on 11/4/20, on topics, including but not limited to, of residents. Incident/Accident and Change of Condition Reporting. This Rule is not met as evidenced by: Additional In-services were held by the RN TYPE A1 VIOLATION Consultant with the care staff, on 11/9/20 and 11/10/20 on, topics including but not limited to, Based on observations, interviews, and record Incident/Accident Reporting and how to reviews, the facility failed to ensure coordination recognize a Resident Change in Condition, of health care for 5 of 5 residents sampled (#2, including the procedure for when a change is #4, #8, #12, #13) related to failing to notify the primary care provider (PCP) for a resident with a determined. In-services where held shift to shift beginning on broken hip (#2); to notify the PCP concerning a 12/14/20, on topics including but not limited to resident with discolored and long toenails who resident change in condition, identifying change was not added to the facilty podiatrist visit list n condition and reporting to PCP, Mental Health (#12); to notify the PCP and seek immediate medical evaluation for a resident with symptoms Provider and responsible parties. of COVID-19 who was later hospitalized, diagnosed with COVID-19 and passed away (#4); to notify the PCP of an attempted elopement by a resident with a history of eloping at other facilities (#8); and failing to notify the PCP of a fall for a resident with a history of falls with injuries including a fractured arm (#13). Division of Health Service Regulation ATIVE'S SIGNATURE LABORATORY DIRECTOR'S OR BROY

STATE FORM

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING: _ C B. WING HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) D 273 Continued From page 1 D 273 Durham Ridge Assisted Living was forced to changed Primary Care Providers, on November 30, 2020, due to lack of answering calls, faxes, The findings are: and response in general to requests from the 1. Review of Resident #4's current FL-2 dated facility. The previous provider failed to show up 03/20/20 revealed: at Durham Ridge multiple days in which they -Diagnoses included vascular dementia, atrial were scheduled. The change was made in order fibrillation, lower back pain, anxiety, to provide for a more seamless and organized gastroesophageal reflux disease, constipation, approach to resident care and allow for easier hyperlipidemia, delirium, major depression. contacting and reporting to the primary care psychological condition, generalized weakness, group. The MD is in the facility three times a and mild protein malnutrition. week. There is also at least one PA in the -The resident was intermittently disoriented. facility Monday through Friday. There are days -The resident was ambulatory and required with multiple providers in the facility for Primary assistance with bathing and dressing. A staff meeting was held on December 2, 2020. Review of Resident #4's current assessment and to in-service staff on, topics including but not care plan dated 05/29/20 revealed: limited to, the change in Primary Care Providers -The resident was sometimes disoriented, and the new procedures in notifying the PCP of forgetful, and needed reminders. -The resident required supervision by staff for Incidents, Accidents and Changes in Conditions. An in-service with all care staff is scheduled on eating and transferring. December 30, 2020 with an Outside Consultant -The resident required limited assistance by staff for toileting and ambulation. from the Professional Assisted Living -The resident required extensive assistance by Association on topics including but not limited to, staff for bathing, dressing, and grooming. Medication Administration, Resident Rights, Infection Control and Incident/Accident Report. Review of Resident #4's incident/accident report Issues with the Administrator and the Assistant dated 09/26/20 at 8:30pm revealed: Resident Care Coordinator, that oversaw -The resident was "very sick". incident reporting, had been identified prior to -The resident was coughing, had chest pains. the survey and changes were scheduled to be vomiting, and had a fever of 100.5 degrees made on November 3, 2020. The ARCC was Fahrenheit (F). removed on 11/10/20. The Administrator was -Emergency medical services (EMS) was called replaced on November 13, 2020 by the Assistant and the resident was taken to the hospital. Administrator. The owner of Durham Ridge, who is also a licensed Administrator, returned to Review of Resident #4's progress notes revealed Durham to take a more active role in the facility no progress notes had been documented since operations and plan of correction. 07/14/19. Review of Resident #4's lab results for

Division of	f Health Service Regu				(X3) DATE SURVEY
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AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		
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				DEFICIENCY)	
D 070	0 // 15	- 2	D 273	Floor Managers were hired and begar	working
D 273	Continued From page	e 2	0275	on each shift on December 1, 2020 to	
	coronavirus (COVID-	19) testing revealed:		each shift and assist with communicat	
	-The resident was tes	sted on 09/01/20, 09/08/20,		change. On 12/9/20, Durham Ridge h	
	and 09/14/20 and the	e results were negative each		Infection Control Specialist/Compliand	e Officer.
	time.	-		with an extensive background, knowle	
		COVID-19 test results after		experience in Infection Control/Prever	
	09/14/20.				
			1	Assisted Living Compliance, to impler	
	Review of Resident #	#4's EMS report dated		oversee policies, including but not lim	
	09/26/20 revealed:	•		Infection Control, Personal Care, Hea	
		ne to the resident at 8:36pm.		Follow up and Incident/Accident repor	
		ghtly pale and slightly warm		In addition to all care staff, the Admini	
		resident reported she was		who is also an LPN, will make daily ro	
	not feeling well for a			check on the condition of the resident	
		erature was noted to be		days she is scheduled. On the Admin	istrator's
	100.5 degrees F.			off days, the daily rounds will be cond	ucted by
	-The resident had a	slightly increased respiratory		the floor managers. An information hu	
	rate and she reporte	d chest pain while coughing.		installed behind the front nurse's stati	
	-Facility staff reporte	d the resident had been		for better communication shift to shift.	
	complaining of chest	pain and had nausea,		Care staff will be required to report all	
	vomiting and diarrhe	ea for the "past several		Incident/Accidents and changes in co	
	hours" as well as a	cough for 2 days.		will be reported to the Administrator of	
		resident was in atrial	1	Manager and notate it on the informa	
1	fibrillation (irregular,		1	On 12/8/2020, Durham Ridge hired a	
		aced on oxygen due to		Administrator. The assistant admin w	
		y rate and transported to the		coordinate staff onboarding and traini	
	hospital.	-	T	be responsible for but not limited to e	
			1	new staff on Incident/Accident reporti	
	Review of Resident	#4's hospital emergency			ing and
		d discharge summary dated	()	changes in resident condition.	iding the
	09/26/20 revealed:			There will be an on-call rotation, inclu	
		dmitted to the ER on		Administrator, Assistant Administrato	
	09/26/20.			Care Coordinator, and Compliance C	
		ained of cough, chest pain		on-call person will be notified for ever	У
	when coughing, nau	isea, vomiting, diarrhea, and		incident/accident.	
	was in atrial fibrillati	on at 130 - 150s heart rate on		All Incident/Accident Reports will go	
	scene per EMS.			Compliance Officer to ensure that ap	propriate
	-The resident's oxyg	gen saturation levels were in		follow up is conducted and notificatio	ns were
	the low 90s and the	resident was put on 2 liters of		made.	
	oxygen via nasal ca	nula with levels improving.			
	-The resident report	ed over the last few days she			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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D 273	had developed a cougpain and shortness of -The resident also not last few daysIn the ER, the resident for coronavirusThe scans showed ColungsThe resident also had consistent with the resident also had consistent with the resident was transferred to unit for further careThe resident passed Telephone interview was member on 11/09/20 and was transferred to unit for further careThe resident passed Telephone interview was member on 11/09/20 and the resident would not get out and recall time) either Coordinator (RCC) or called and reported R of her chest hurting ar resident "a little while balance was off and send saff said they did and staff said they did and staff said they did and staff said they did and the pospital who to the safe safe at the hospital who to the safe safe safe safe at the hospital who to the safe safe safe safe safe safe safe saf	gh and she had some chest breath when she coughed. Bed some diarrhea over the ont was found to be positive over the over	D 273	The Administrator will be responsible for assuring continued compliance in this weekly and that all parties above compliance as assigned.	rule area	December 17, 2020 and ongoing

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Division of Health Service Regulation

STATEMEN	or Health Service Regul r OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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D 273	-The resident passed 10/02/20. Interview with a MA orevealed: -Resident #4 had beethe resident had good meaning some days, -The last couple of dato the hospital (09/26, weaker and needed rwith getting out of been substituted by the second site of the provider's (PCP) office assistant who answer resident's weakness, document itShe did not work directly she went to the hospital out the resident's second the staff should. Telephone interview with 11/13/20 at 4:39pm recond she had a temperature and she had been considered and the she had been considered and she had a temperature and she had	away at the hospital on In 11/10/20 at 1:40pm In diagnosed with cancer so days and bad days the resident ached all over. By sefore Resident #4 went (20), the resident was nore assistance from staff d. I called the primary care and notified the medical red the phone about the but she probably did not ectly with the resident before tal, so she was not sure symptoms on 09/26/20. By to make the property of the Administrator call the PCP. With a second MA on everaled: She realized Resident #4 did went to check on the resident rature. Ides (PCAs) also reported to having cough, chest pain, a sometime in the latter part in not recall when). Ent #4 was coughing, pain, and had diarrhea, so	D 273			

NAME OF PROVIDER OR SUPPLIER DURHAM RIDGE ASSISTED LIVING SUMMANY STATEMENT OF DEFICIENCES DURHAM, NC 27703 CAST D		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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PREFIX TAG REGULATORY OR USE DENTIFYING INFORMATION) D 273 Continued From page 5 -The resident had also been vomiting on 09/2/5/20. -When she asked the other MA about it, the MA said Resident #4 always complained. -She told the other MA that the resident should have been sent to the hospital yesterday, 09/2/5/20. -If a resident had a change in condition, the MA was supposed to send the resident should have been sent to the hospital yesterday, 09/2/5/20. -If a resident had a change in condition, the MA was supposed to send the resident to the hospital polycation of fever. Telephone interview with the RCC on 11/12/20 at 4.34pm revealed: -She did not recall the last time she saw Resident #4 year to the resident going to the hospital on 09/2/6/20. -If the resident had a change in condition, the PCA should notify the MA and the MA should notify the PCP. -Staff had not reported to her that Resident #4 was having any symptoms prior to going to the hospital on 09/2/6/20. -The facility's PCP was at the facility almost every day and she expected staff to report symptoms to the PCP as well. Telephone interview with the Administrator on 11/12/20 at 11:50am revealed: -Resident #4 had leukemia so one day she would not be doing well. -She did not know how Resident #4 had symptoms at least 2 days before the resident was sent to the hospital of the should have sent the resident to the hospital when she started	DURHAM	RIDGE ASSISTED LIVING	G		Υ		
The resident had also been vomiting on 09/26/20. -When she asked the other MA about it, the MA said Resident #4 always complainedShe told the other MA that the resident should have been sent to the hospital yesterday, 09/26/20. -If a resident had a change in condition, the MA was supposed to send the resident to the hospital, especially if the resident had chest pains or fever. Telephone interview with the RCC on 11/12/20 at 4:34pm revealed: -She did not recall the last time she saw Resident #4 prior to the resident agoing to the hospital on 09/26/20If the resident had a change in condition, the PCA should notify the PCPStaff had not reported to her that Resident #4 was having any symptoms prior to going to the hospital on 09/26/20The facility's PCP was at the facility almost every day and she expected staff to report symptoms to the PCP as well. Telephone interview with the Administrator on 11/12/20 at 11:50am revealed: -Resident #4 had leukemia so one day she would be up walking around but the next day she would not be doing wellShe did not know how Resident #4 had symptoms at least 2 days before the resident was sent to the hospital on 09/26/20If Resident #4 was having symptoms of COVID-19, staff should have discussed it with her or the RCC, notify the PCP, and they should have sent the resident to the hospital when she started	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETE	
experiencing those symptoms.	D 273	-The resident had also 09/25/20When she asked the said Resident #4 alwa-She told the other Mahave been sent to the 09/25/20If a resident had a chwas supposed to send hospital, especially if or fever. Telephone interview v 4:34pm revealed: -She did not recall the #4 prior to the resident had a PCA should notify the notify the PCPStaff had not reporte was having any symphospital on 09/26/20The facility's PCP was having any symphospital on 09/26/20The facility's PCP was day and she expected the PCP as well. Telephone interview v 11/12/20 at 11:50am in Resident #4 had leuk be up walking around not be doing wellShe did not know how symptoms at least 2 cosent to the hospital or -If Resident #4 was his COVID-19, staff should or the RCC, notify the sent the resident to the	other MA about it, the MA ays complained. A that the resident should hospital yesterday, anange in condition, the MA dithe resident to the the resident had chest pains with the RCC on 11/12/20 at elast time she saw Resident at going to the hospital on change in condition, the MA and the MA should dithe that Resident #4 toms prior to going to the as at the facility almost every distaff to report symptoms to with the Administrator on revealed: kemia so one day she would but the next day she would we Resident #4 had alays before the resident was a 09/26/20, aving symptoms of lid have discussed it with her as PCP, and they should have the hospital when she started	D 273			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE	, ZIP CODE	
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D 273	Continued From page	6	D 273		
	have called the RCC changes in the reside the symptoms started -If the resident was harden.	aving chest pains and should have been sent out			
	on 11/12/20 at 2:15pr -He remembered Reshospital at the end of -He did not recall state was having symptom hospital but staff wou RCC or the facility's r Administrator)If Resident #4 was h COVID-19, the reside	sident #4 being sent to the September 2020. If reporting that the resident s prior to going to the ld have reported that to the nurse (the current			
	Manager (BOM) on 1 -The facility's contract 4 or 5 days per week -He expected staff to	communicate with the PCP ve seen Resident #4 as soon			
	assistant (CMA) at R 11/12/20 at 1:05pm r -She took calls for the the facility could conf -She usually docume facility or the facility or reportShe forwarded all coresident's PCP in the	eir office 24 hours a day and cact them anytime. Ented phone calls with the would send them an incident			

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING:_ C B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 273 Continued From page 7 D 273 from the facility regarding any concerns with Resident #4's condition or symptoms prior to the resident being sent to the hospital on 09/26/20. -They received an incident report dated 09/26/20 at 8:30pm indicating Resident #4 was sent to the hospital. -They were not made aware the resident was experiencing any symptoms prior to the resident being sent to the hospital on 09/26/20. -The PCP expected to be notified of any symptoms or change in a resident's condition. Telephone interview with Resident #4's PCP on 11/09/20 at 4:30pm revealed: -Resident #4 had been ill for a little while as she was seeing a hematologist because she had leukemia. -When she saw Resident #4 at the facility, the resident would up walking in the hallway one day and in the bed sleeping the next day. -The resident would say she did not feel well on the days she was in bed but her vital signs were always stable. A second telephone interview with Resident #4's PCP on 11/13/20 at 1:07pm revealed: -She was not aware Resident #4 was unable to get out of bed independently before going to the hospital on 09/26/20. -It was not normal for the resident because the resident could usually get out of bed independently. -She was not aware Resident #4 was having symptoms of COVID-19 a couple of days before being sent to the hospital.

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-She would have expected the facility staff to notify her immediately or send the resident to the hospital for evaluation when she first presented with symptoms of chest pain, coughing, fever,

nausea, vomiting, and diarrhea.

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ С B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 273 D 273 | Continued From page 8 2. Review of Resident #8's current FL-2 dated 07/02/20 revealed: -Diagnosis included dementia. -The resident was intermittently disoriented. -The resident was ambulatory. Review of Resident #8's Resident Register revealed the resident as admitted to the facility on 07/10/20. Review of Resident #8's current assessment and care plan dated 07/13/20 revealed: -The resident had wandering behavior and the resident did not think she needed to be at the facility. -The resident was receiving mental health services and was very easily redirected. -The resident was oriented and had adequate memory. -The resident was independent with toileting, ambulation, and transferring. -The resident required supervision by staff for eating and grooming. -The resident required limited assistance by staff for dressing. -The resident required extensive assistance by staff for bathing. Review of Resident #8's psychotherapy progress note dated 08/27/20 revealed: -The resident had a history of anxiety, delusions, depression, paranoia, and stress of being in a long term care facility. -The resident wanted to leave the facility to move closer to family. Review of Resident #8's psychotherapy progress note dated 09/02/20 revealed:

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-Symptoms noted included restlessness and

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVING	3420 WAKE	E FOREST HV	VY		
DOMINA	TODOL AGGIOTED LIVING	DURHAM,	NC 27703			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	9	D 273			
D 273	exit-seekingThe resident was frust closer to familyThe resident reported coronavirus (COVID-1-The resident spoke a herself to sneak out of Review of Resident #8 note dated 09/09/20 re-Symptoms noted inclinand suspicious/parance-The resident continue to live closer to familyThe resident reported long-term care.	strated and wanted to move d anxiety over the 9) outbreak at the facility. bout her wish to disguise f the building. B's psychotherapy progress evealed: uded restlessness, anxiety, bid. ed to want leave the facility I "feeling trapped" in	D 273			
Review of Resident #8's psychotherapy progress note dated 09/23/20 revealed: -Symptoms noted included guilt/uselessness and worryStaff reported the resident was threatening to leave the facilityThe resident originally reported wanting to the leave the facility this morning but was feeling calmer and was willing to stay now. Review of Resident #8's psychiatry progress note dated 10/08/20 revealed: -The resident had Parkinson's disease, dementia,						
	psychosis, mood disor-Staff stated the reside swings) and recently trand escape (no date o-The psychiatrist increantipsychotic medication. Review of Resident #8 (PCP) visit note dated	der, and anxiety. ent had labile mood (mood ried to remove her window r time documented). ased the resident's on dosage. 's primary care provider				

PRINTED: 12/10/2020 FORM APPROVED

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					С
		HAL032091	B. WING		11/17/2020
			I.		1171772020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD:	RESS, CITY, STA	TE, ZIP CODE	
DURHAM	RIDGE ASSISTED LIVING	3420 WAKE	FOREST HW	Υ	
D 01 (1) (11)	. NO OL MOOIO I LO LIVII N	DURHAM, I	NC 27703		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	. ,
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG	TEGGE TI GITT GITE	So IDEITH THE I'M CTAIN THE I'M	IAG	DEFICIENCY)	
			5.070		
D 273	Continued From page	± 10	D 273		
	positive but was curre	ntly asymptomatic.			
	-Staff denied any acut				
		sychiatric concerns had no			
	documentation regard	ling the resident trying to			
	remove her window a	nd escaping.			
		cation aide (MA) on 11/10/20			
	at 4:23pm revealed:				
		ding on 200 hall when she			
		(could not recall date).			
		esident #8 had gotten out of			
	the facility so she wer	•			
		e, she saw Resident #8 and	9		
	_	utside by the resident's	l i		
	window.	d abiff but abo could not			
		d shift but she could not			
	recall when or how lor	on 200 hall that day so she			
		e reported the incident to the			
	resident's PCP or if ar				
	completed.	Thousant report was			
	completed,	90			
	Interview with a secon	nd MA on 11/10/20 at			
	5:20pm revealed:				
	-A couple of months a	go (not sure of date),			
		wanted to get off the hall			
	because her roommat	te had tested positive for			
	COVID-19 and Reside	ent #8 was afraid she would			
	get COVID-19.				
		nt outside and let her call her			
	-	sually helped when the			
	resident was upset.				
	•	de (PCA) heard a lot of			
		8's room (could not recall			
	,	PCA went in the room and			
		one leg out of the window.			
		since she was the MA on			
	duty.	log out of the window but			
	the window was not b	e leg out of the window but			
N. 1.1 614	the Window was not b	IUNCII.			

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ С 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY D 273 D 273 | Continued From page 11 -She let the resident talk to the Administrator. -She did not know if the PCP was notified of the incident. Telephone interview with a third MA on 11/13/20 at 4:39pm revealed: -She was working as a supervisor on the day when Resident #8 attempted to get out of the window. -She thought it occurred in September 2020 but she could not recall the date. -The MA working on the 400 hall saw Resident #8 coming out of the window on the 200 hall. -The MA on the 400 hall came running to let her know about it. -They ran down to the resident's room and the resident had one leg out of the window. -She told the resident to come back inside the facility and the resident complied. -The window was not broken but the screen had been kicked out. -She reported it to the former Administrator and the current Administrator because she was the supervisor on duty. -The MA on 200 hall would have been responsible for completing an incident report so she did not know if one was done. -The resident was upset because her roommate had COVID-19 and the resident was negative for COVID-19. -She did not contact the PCP or MHP because the Administrator would have handled that.

Division of Health Service Regulation

was not successful.

Attempted telephone interview on 11/13/20 at 11:59am with the PCA who heard the noise and saw Resident #8 with one leg out of the window

Telephone interview with the Resident Care Coordinator (RCC) on 11/12/20 at 4:34pm

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		1, 33,53,13,		l .		
HAL032091		B. WING		ı	, 7/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
		3420 WAKI	FOREST HW			
DURHAM	RIDGE ASSISTED LIVING	DURHAM,				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETE DATE
D 273	Continued From page	: 12	D 273			
	revealed:					
	_	at #8 tried to bust out a				
		aware the resident tried to				
	get out of the windowStaff on second shift	had reported the incident to				
	her.	nad repetited the modern to				
	-She knew it was repo	orted to the mental health				
		he was "pretty sure" it was				
		nts' PCP but she could not				
	locate the incident rep	οιτ. write an incident report and				
	•	liately, in addition to the				
	MHP.	,				
	Telephone interview w	vith the Administrator on				
	11/12/20 at 11:50am r					
	-Resident #8 was tryir	ng to force the window open				
	in her room but she no	_				
		when the incident happened				
	and she could not loc	ed on a Sunday and staff				
	called and told her ab	-				
	-The resident tried to					
	resident "feels like sho					
		istory of eloping at her				
	previous facility. The mental health the	erapist and the psychiatrist				
		acility on Wednesdays and				
		act with the psychiatrist and				
	she notified him when	he came on-site unless it				
		d she would notify him				
	immediately.	ve been notified of Resident				
		when they came for their				
	on-site visits.					
		e resident's attempt to elope				
		e replied that she could not				
	answer that and would					
		er the specific details of the not know if the PCP was				
	modent and she did r	IOURNOW II LIIC FOF WAS				

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: _ C B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY D 273 D 273 | Continued From page 13 notified. -All incidents were supposed to be reported to the PCP in addition to the MHP within 24 hours. -She could not locate an incident report for Resident #4's attempted elopement. Telephone interview with the former Administrator on 11/12/20 at 2:15pm revealed: -He thought the incident involving Resident #8 trying to get out of a window was reported to him during a stand-up meeting. -He did not have a date of the incident and he could not find the incident report. -The resident was living on the 200 hall when it happened and he thought it occurred around the first of October 2020. -The resident had mentioned wanting to go where her family was located but he was not aware of the resident trying to leave prior to this incident. -The incident should have been reported to the resident's PCP in addition to the MHP but he did not know if that was done. Telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am revealed: -If a resident attempted to get out of the facility, staff should notify the PCP and MHP to see if anything could be done to alleviate the underlying factor. -Primarily, the MA would be responsible for notifying the RCC and the RCC would follow-up. -He was not sure if an incident report was done for Resident #8 or what the former RCC did regarding the incident. Telephone interview with Resident #8's psychiatrist on 11/13/20 at 8:16am revealed: -He usually went to the facility for on-site visits

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every Wednesday and most Thursdays.
-He was notified during his on-site visit to the

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		HAL032091	B. WNG		11/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVING		FOREST HW NC 27703	Υ		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	facility on 10/08/20 th remove a window and like the in week before his visit of the resident had fu aggressive, staff coul incident occurred. The Administrator also number and could could could could be the Administrator also number and could could could be would let the Administrator also number and could could could be would let the Administrator also number and could could be would let the Administrator also number and could could be would let the Administrator also number and to have staff usually updated staff reported to her facility that Resident window (did not knowned the bolt of the resident told her unscrewed the bolt of the resident was unand two hours away for the resident was unand two hours away for the facility had be reached out to they princident. Telephone interview was sistant (CMA) at Refull 1/12/20 at 1:05pm reshe took calls for the the facility could controlled to the usually docume	at Resident #8 had tried to descape. cident had occurred the on 10/08/20. rther issues or had gotten descaped him when the so had his cell phone intact him if needed. Ininistrator know that it was him. with Resident #8's mental /13/20 at 10:52am revealed: e facility for weekly visits, her about the residents. on her 10/14/20 visit to the #8 got one leg out of the retidate. In the date). In the window and the resident had in the woods and happy being at the facility from her family. an acute issue like agitation items, the facility would have sychiatrist at the time of the with the certified medical esident #8's PCP office on evealed: with the certified medical esident #8's PCP office on evealed: per office 24 hours a day and	D 273			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED			
						
		HAL032091	B. WING	B. WNG		7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
DUDUAM	RIDGE ASSISTED LIVING		E FOREST HW	ſ		
DURHAM	RIDGE ASSISTED LIVING	DURHAM,	NC 27703			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	÷ 15	D 273			
D 273	-She forwarded all co resident's PCP in thei -They did not receive reports from the facilit attempting to elope from the PCP expected to regarding a resident, Telephone interview who the facility had not report for Resider facility had not report with the facility multiple days endeaded. The expected the factorial coordinate care and the factorial will notify the resignificant of the Resident Care. An incident report with the Resident Care. Review of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed: -There was no date of the facility revealed:	rrespondences to the ir practice. any phone calls or incident ty regarding Resident #8 om the facility. It is be notified of any incidents no matter the issue. With Resident #8's PCP on evealed: eported any exit-seeking in the and she was at the each week. Resident #8 had attempted it tried to escape from the exitivity to notify her so she is with the MHP if needed. With the medication aide on that ponsible party and the exitivity and the exitivity and the exitivity and the exitivity. The completed and turned the coordinator (RCC). The policy on the policy and the policy. The medication aide on that ponsible party and the exitivity and the exitivity and the exitivity and the exitic that needs additional the policy. The policy of the policy and the policy and the policy. The policy of the policy and the policy and the policy. The policy of the policy and the policy and the policy. The policy of the policy and the policy and the policy. The policy of the policy and the policy and the policy. The policy of the policy and the policy and the policy. The policy of the policy and the policy and the policy. The policy of the policy and the policy and the policy.	D 273			
	each shift will monitor resident and their cor	ndition or behaviors. tionally be placed on 72-hour dent/accident at the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL032091	B. WING		11/1	7/2020
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	DIDOE ACCIOTED INVINI	3420 WAK	E FOREST HW	Υ		
DURHAM	RIDGE ASSISTED LIVING	G Durham,	NC 27703			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETE DATE
D 273	Continued From page	e 16	D 273			
		he last monitoring period, n a binder in the RCC's				
	01/16/20 revealed: -Diagnoses included / glaucoma, irritable bo depressionThe resident was ser Review of Resident # plan dated 10/29/19 n -The resident was am required limited assist -The resident was alw significant memory los Review of an incident Resident #2 revealed -The time of incident	wel syndrome, anxiety and mi-ambulatory with a walker. 2's assessment and care evealed: wholatory with a walker and tance for ambulation. ways disoriented, had ss, and must be directed.	·			
	-There was no visible -The RCC was notifie -The Primary Care Pr Interview with a secon (MA) on 11/9/20 at 2:4 -The MA normally wor residedResident #2 had a fa 09/27/20The MA was walking dining area, when Re mobility." -The MA caught Resid before she hit the floo -The MA laid the resid -Resident #2 said she	injury. d option was circled yes. ovider (PCP) was notified. and shift medication aide 42pm revealed: rked the hall Resident #2 III, around supper time on beside Resident #2 to the sident #2's leg "lost dent #2, broke the fall or. dent down on the floor.	:			

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ C B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 273 D 273 Continued From page 17 and helped her with Resident #2. -The former Administrator picked Resident #2 up off the floor and placed her in a regular chair -The MA had gotten her up from the regular chair, and walked Resident #2 to her room. -The MA and former Administrator checked her for possible injuries and performed a full range of motion on Resident #2, but did not note any injuries. -The MA did not recall reporting off to the oncoming shift MA. -The MA did not recall notifying Resident #2's -The MA did not recall notifying Resident #2's PCP. Review of second incident report dated 09/28/20 for Resident #2 revealed: -The time of incident was 7:00am. -Resident #2 complained of pain and discomfort. -Resident #2 was taken to the hospital. -The RCC was notified option was circled yes. -The PCP was notified option was circled yes. Review of an emergency medical service (EMS) for Resident #2 report dated 09/28/20 at 7:36am revealed: -EMS arrived at the facility, and observed Resident #2 lying in bed. -The facility staff reported Resident #2 was in respiratory distress, but EMS did not observe Resident #2 to be respiratory distress. -The facility staff were finishing dressing Resident -Resident #2's left leg was shortened and internally rotated. -No staff knew of a recent fall for the resident. -Staff reported that the resident was "weak" the previous day when she was up walking with staff.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A, BUILDING:		JOHN CETES
		HAL032091	B. WING		C 11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
			FOREST HW	Υ	
DURHAM	RIDGE ASSISTED LIVING	DURHAM,	NC 27703		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	÷ 18	D 273		
D 2/3	Telephone interview of 11:20am revealed: -She responded to a complex of the responded to a complex of the resident #2 was lying rotated out and lying resident #2's left leggether the right legStaff told them that the right legStaff told them that the right of the right of the right of the night or day before. Staff told EMS staff the night or day before. Staff told her Reside when they tried to ware staff reported the result of the resident #2 groaned hands when EMS attended when they tried to ware staff reported the result of the resident #2 groaned hands when EMS attended when they tried to ware staff reported the result of the resident #2 on 09/28 resident #2 on 09/28 resident #2 on 09/28 resident #2 on 09/28 resident #2 moaned should be observed Resident #2 moaned EMT's hands away we touchedShe recalled Reside shortened and internations. She asked facility staff or m.	call to the facility on t #2. g in bed with her left foot flat on the bed. g was noticeably shorter than they had tried to get Resident 8/20. Resident #2 may have fallen re, on 09/27/20. It #2 was "really weak" Ik with her the day before. Sident was in pain but was ion. I loudly and reached for her empted a physical with another emergency EMT) on 11/12/20 at 1:02pm on the emergency call for 6/20. ed Resident #2 was in I. ent #2's room. ent #2 laid flat on her back empted to put shoes on her I deeply and pushed the when her left leg was ally rotated. aff to return to Resident #2's			
	-She showed the faci leg.	lity staff Resident #2's left			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OI CORRECTION	IDENTI IOATION NOMBER.	A. BUILDING: _		00	
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		HAL032091	B. WING		11/17/2020	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
DURHAM	RIDGE ASSISTED LIVIN	G	FOREST HW	Y		
		DURHAM, I				_
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	Έ
D 273	Continued From page	19	D 273			
	-It was the worst inter observed.	nally rotated legs they had				
	there was no docume	2's progress notes revealed entation that the PCP had dent #2's fall on 09/27/20 or pital on 9/28/20.				
	Telephone interview we Responsible Person (revealed: -She was called on 00 local hospital anesthe consent for surgery to severe left hip fracture. She was unaware the and been hospitalized. The hospital anesthe RP's daughter not know hospitalization and neurons and severe was called on 00 facility staff informing	with Resident #2's (RP) on 11/05/20 at 2:20pm 9/28/20 midmorning by a esiologist who requested o repair Resident #2's e. at Resident #2 had fallen d. esiologist apologized for owing of Resident #2's fall,				
	-The staff member provent into Resident #2 around 7:00am when the resident told the staff knew that we resident #2; she was and pleasantThe staff checked he Resident #2 was take -She called to the fact 1:00pm to speak with -She asked the forme events that led up to -He was aware of Resident #2.	ething was wrong, because staff "help me, help me." was out of character for s normally quiet, reserved er vitals, called 911 and en to the local hospital. eility on 10/07/20 around in the former Administrator. er Administrator about the Resident #2's fall.				

PRINTED: 12/10/2020

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C B. WING 11/17/2020 HAL032091 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 273 D 273 Continued From page 20 heard her when she fell. -He came down the hall and saw Resident #2 on the floor. -He picked Resident #2 up off the floor, placed her in a regular chair, and performed a full range of motion assessment on Resident #2. -He left Resident #2 with another staff member at the facility. -She asked the former Administrator was he qualified to complete a full range of motion assessment on Resident #2 after her fall. -The former Administrator gave no response to -She asked the former Administrator, why they did not get help for Resident #2 when, they knew she had fell. -She was disappointed in the facility staff for not obtaining assistance for nearly 13 hours for Resident #2. -No staff ever communicated to the RP that Resident #2 had a fall on 09/27/20, experienced any type of discomfort or pain, or was sent to the local hospital. -She was informed by the orthopedic surgeon Resident #2's fracture was so severe that a metal rod was placed from her left hip to right above her knee. -She was told by the hospital medical team that Resident #2's prognosis did not look promising. Confidential interview with a staff member revealed: -Staff went into Resident's #2 room a little after 7:00am, while doing rounds.

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with Resident #2.

-Resident #2 asked for help.

-Staff realized right away something was wrong

-Resident #2 was in severe pain and distress. -Resident #2's vital signs were checked, and Resident #2 was lying flat on her back in the bed.

AND PLAN OF CORRECTION IDENTIFIC	CATION NUMBER:	A. BUILDING:			(X3) DATE SURVEY COMPLETED	
HALO	32091	B. WING		C 11/17/20	020	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
DURHAM RIDGE ASSISTED LIVING 3420 WAKE DURHAM, I		FOREST HW NC 27703	Y			
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PRECIDENT OR LSC IDENTIFYING REGULATORY OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CC	(X5) OMPLETE DATE	
-Staff informed the RCC and calledThe paramedics came to the facil Resident #2, and asked staff to rei #2's roomResident #2's leg was turned inwit was "pigeon toed." -Resident #2's left big toe was turn 3:00-4:00 O'clock positionThe third shift Supervisor did not about Resident #2 having a fall du -On 09/28/20, the shift report from first shift did not occurThere was no 72-hour acute mon completed on Resident #2 after he 09/27/20When a resident had an incident, notify the Nurse Practitioner (NP), AdministratorStaff would tell them verbally, whe them throughout the facility, or slid their door if after hours, or the weel-He recalled he completed an incidereport for Resident #2. Confidential interview with a secon revealed: -Resident #2 was quiet and slept thinghtStaff remembered being assigned #2 on 09/27/20Staff went into Resident #2's room 11:00pm to check on herResident #2 slid from the bed to the Resident #2 back to bedThe staff got Resident #2 up from "Clearly she was hurt, because set stand up." -Resident #2's right leg looked like the socket." -Staff felt like Resident #2 was in procession of the complete the socket."	ity, assessed turn to Resident ard, as if she hed to a report anything ring the shift. Third shift to itoring report er fall on they would RCC and the en passing by le a note under exend. Ident/accident hroughout the distance of the floor and put the floor. The could not eit was "out of	D 273				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL032091	B. WING		C 11/17/2020	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1111112020	
DURHAM	RIDGE ASSISTED LIVING	G	E FOREST HW NC 27703	Υ		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	the way Resident #2's -Staff told the 3rd shif -Staff did not recall if Resident #2's room to -Staff did not recall he that Resident #2 fell e -Staff recalled not hav was observed and wh toldStaff checked on Res 3:00am, and 5:00am, asleepStaff went into Resid 5:30am and put her p -Staff rotated Resider motion while she pulle -Resident #2 looked f Interview with the 3rd 9:22am revealed: -Resident #2 slept thr shift, and needed ass daily livingShe did not recall an any incident for Resid -She did not recall an her any incident or co -She could not remen documentation on the report for Resident #2 -The MA could not re with the PCP on 3rd s -The former Administ week of 11/3/20 ques	s leg looked. It MA at 12:00am. Ithe 3rd shift MA went into oncheck on her. Iterating from second shift staff earlier that day. Iterating any urgency in what hen the 3rd shift MA was seident #2 at 1:00am, and Resident #2 was sent #2's room around earlies on for the day. It #2's hips in a left to right each her pants up. Iterating from second shift. Iterating from second shift and shift and shift. Iterating from second shift and shift and shift. Iterating from second shift and shift and shift. Iterating from second shift shift and shift shift and shift shift and shift. Iterating from second shift shift shift and shift shif	D 273			

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDFORK	OI COIMEONON	IDENTI IOATION NOMBER.	A. BUILDING:		301111 22123	
		HAL032091	B. WING		C 11/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DUBUAR	DIDGE AGGICTED I DANG	3420 WAKI	E FOREST HW	Y		
DURHAM	RIDGE ASSISTED LIVING	DURHAM,	NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
	revealed: -She was the point of normally had daily confacility's Administrator -The facility normally of incidents, or other uphone calls, voice meanswering service, or -There were no notific Resident #2 on 09/27The facility faxed over Resident #2 on 10/01. Interview with Resider 4:37pm revealed: -Staff did not notify he 9/27/20 or 9/28/20.	RCC and MAs. communicated notifications urgent matters through ssages left on the PCP's via fax. cations to the PCP regarding /20 or 9/28/20. cr two incident reports for /20. Int #2's PCP on 11/12/20 at er of Resident #2's fall on				
	-Staff did not notify her of Resident #2's fall on					

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		HAL032091	B. WING		C 11/17/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVING		(E FOREST HW)	Y		
	DUILANA DV OT		NC 27703	DDO//DEDIC DLAN OF GODDEOTIC		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE COMPLETE	
D 273	Continued From page	24	D 273			
	notified.					
	12:07pm revealed: -He was aware of Res 09/27/20He was informed by the Resident #2 had a fall -He was told by the for assisted the 2nd shift up off the floorHe was aware that the performed a range of Resident #2He was not aware the the PCPHe was not aware the staff while doing round after the 09/27/20 fall for Resident #2.					
		:47pm and 11/13/20 at				
	Attempted telephone interviews with the former Administrator on 11/13/20 at 11:11 am and 4:47 pm were unsuccessful.					
		#12's current FL-2 dated gnoses included dementia, nuscle weakness and				
	plan dated 10/21/20 rd -The resident was am required limited assist -The resident was alw	bulatory with a walker and ance for ambulation.				

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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		HAL032091	B. WING		11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
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DURHAM	RIDGE ASSISTED LIVING	G DURHAN	i, NC 27703		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
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D 273	Continued From page	25	D 273		
	3:40pm revealed: -All her toenails were ragged nailsThere was a brownisi skin particles in between the right big toenail with the Alministrator propertiesThe Administrator properties were resident #12's she went to the facilit with the AdministratorShe was told Resident with the AdministratorShe was upset and experiencedShe showed the Administrator achieved and brittle to the Administrator achieved the resident #12's feet experiencedShe showed the Administrator achieved the RP that she would resident #12's toenail the RP that she would resident #12's toenail the Administrator achieved the Administrator achieved the reform the task the with Administrator con 11/03/20.	dministrator around the expressed concern to the expressed concern regarding the expressed concern to expressed the expression to express the expression to expression the expression to express the expression to express the expression to express the expression to express the expression to expression the expression to express the expression to expression the expression to expression the expression that the expression that the expression that the expression the expression that the expression			
	Interview with second (MA)on 11/10/20 at 4:0 -The MA normally work				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		HAL032091	B. WING		C 11/17/2020	
NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVING	G 3420 WAKI DURHAM,	E FOREST HV NC 27703	W		
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D 273	residedResident #12 refused Confidential interview revealed: -Resident #12's toena -Her toenails were lon color. Interview with the Prim Business Office Mana 2:14pm revealed: -She was the point of -She normally had dai facility Administrator, F (RCC) and MAs on the -The facility normally of incidents or other up phone calls, voice med Care Provider's (PCP) faxThere were no notifica Resident #12 on 11/03 -The PCP last saw Re Interview with the facil at 1:26pm revealed: -They come out to the -The last 3 visits to the 07/28/20 and 08/25/20 -Resident #12 was not -She did not see Resident	d personal care frequently. with a staff member alls needed to be trimmed. ng, thick and yellowish in mary Care Provider's ager (BOM) on 11/13/20 at contact for the facility. ily communication with the Resident Care Coordinator e halls. communicated notifications rgent matters through ssages left on the Primary) answering service, or via eations to the PCP regarding 3/20 for podiatry referral. esident #12 on 11/09/20. Ity's Podiatrist on 11/12/20 e facility every 9-11 weeks. e facility were 07/13/20, 0 to the facility. It seen by the Podiatrist. It dent #12 in their data base. It is the prodiatrist to It is the prodiatrist to It is the prodiatrist to	D 273	DEFIGIENCY)		
	revealed: -No staff had notified the need for a podiatry core	on 11/12/20 at 4:37pm the PCP of Resident #12's nsult. tesident #12 on 11/09/20.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		С	
	HAL032091	B. WING		1	, 7/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
DURHAM RIDGE ASSISTED LIVING	3420 WA	KE FOREST HW	Υ		
DORHAM RIDGE ASSISTED LIVING	DURHAM	, NC 27703			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
podiatry referral. Review of Resident #12's revealed only two entries 05/26/19 revealed no do PCP had been notified o podiatry consult. Interview with the RCC of revealed: -She recalled Resident # the facility regarding toer -She had not received an notes slid under her door Resident #12 refusing to -She was not aware that had onychomycosis and referral. -She was not aware that documented on Residen Living log from 10/1/20 the contract of the sident was referral.	mely long. nycosis (a nail fungus e, crumbly, or ragged d needed a podiatry aff to call Primary Care e a message on her that the staff would call, rorders. ress notes for Resident ealed: e slight dry skin on her homycosis and needed a 's progress notes s dated 04/04/19 and boumentation that the of Resident #12's need for and the RP came to nail care concerns. ny verbal notifications or or from staff regarding benail care. t Resident #12's toenails needed a podiatry at 31 staff entries were at #12's Activities Daily hrough 11/10/20 that ding face, hand and feet)	D 273			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		HAL032091	B. WING		11/17/2020	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
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	OLDANADY OT		NC 27703			
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D 273	Continued From page	28	D 273			
	document the notification in the resident's record on the progress notes.					
	4:46pm revealed:	ninistrator on 11/13/20 at				
	week of 10/18/20.	oke with the RP around the				
		omised Resident #12's RP cut Resident #12's toenails				
	-Resident #12's RP came to the facility on 11/03/20.					
	concern regarding Re	as upset and expressed sident #12's toenail care.				
	the RP that she would	knowledged she promised I personally check and cut Is the week of 10/18/20.				
		got to perform the task the				
	-The Administrator co 11/03/20.					
	RP for not cutting Res	ologized to Resident #12's sident #12's toenails as				
		d the RCC on 11/03/20 to the facility podiatry list for				
	the next scheduled vis					
	RCC on 11/13/20 to a	ade a second request to the dd Resident #12 to the				
	facility podiatry list. -The Administrator was not aware the RCC did not add Resident #12 to the facility podiatry list					
	next scheduled clinic					
	12's PCP assessed he - Resident #12 neede	er on 11/09/20.				
	12:33pm revealed:	lity's BOM on 11/17/20 at miliar with Resident #12				
	-i ie was somewnat la	miliai willi Nesidelil#12				

HAL032091 HAL032091 B. WING		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 29 and toenail care concerns. -He was aware Resident #12's RP had a discussion with the Administrator regarding toenail care. -He was not aware that Resident #12's PCP			A. BUILDING:				
DURHAM RIDGE ASSISTED LIVING X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 273 Continued From page 29 D 273 and toenail care concerns.		HAL032091	B. WING		-		
DURHAM, NC 27703 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 29 and toenail care concerns. -He was aware Resident #12's RP had a discussion with the Administrator regarding toenail care. -He was not aware that Resident #12's PCP	NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 29 and toenail care concerns. -He was aware Resident #12's RP had a discussion with the Administrator regarding toenail care. -He was not aware that Resident #12's PCP	DURHAM RIDGE ASSISTED LIVIN	IG		Υ			
and toenail care concernsHe was aware Resident #12's RP had a discussion with the Administrator regarding toenail careHe was not aware that Resident #12's PCP	PREFIX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE	
assessed her on 11/09/20. He was not aware Resident #12 had onychomycosis and needed a podiatry referral. He was not aware that staff did not notify the PCP or add Resident #12 to the facility podiatry list for the next scheduled visit for 11/19/20. 5. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dementia, glaucoma, depression, arthritis, hypothyroidism, insomnia and restless leg syndrome. Observation of the 100 Hall on 11/10/20 at 2:30pm revealed: Housekeeping staff alerted a personal care aide (PCA) that Resident #13 was observed on his knees beside his bed with his elbows and forearms resting on the bed wearing a shirt and an adult incontinent brief. Resident #13 had a cast on his left arm. Two PCAs assisted Resident #13 up and back into bed. A fall mat was placed on the floor beside the resident's bed. The medication aide (MA) assigned to 100 Hall was not on the 100 Hall at the time of the incident. There was no notification made to the MA assigned to the 100 Hall when their shift ended at 3:00pm and the MA had not returned to the 100 Hall at that time. Interview with a PCA assigned to the 100 Hall on	and toenail care con- He was aware Resid discussion with the Atoenail care. He was not aware it assessed her on 11/6. He was not aware Fronychomycosis and He was not aware it PCP or add Residen list for the next scheolist for the	dent #12's RP had a administrator regarding that Resident #12's PCP 09/20. Resident #12 had needed a podiatry referral hat staff did not notify the at #12 to the facility podiatry duled visit for 11/19/20. The #13's current FL-2 dated agnoses included dementia, on, arthritis, hypothyroidism, is leg syndrome. The property of the facility at the facility podiatry duled visit for 11/19/20. The #13's current FL-2 dated agnoses included dementia, on, arthritis, hypothyroidism, is leg syndrome. The property of the facility podiatry date was on the floor. The beserved on his knees beside was and forearms resting on hirt and an adult incontinent cast on his left arm. Resident #13 up and back do not the floor beside the facility of the floor beside the facility assigned to 100 Hall fall at the time of the facility of the MA Hall by the PCAs. The property of the floor facility of the floor facility of the floor facility of the floor facility of the MA Hall by the PCAs. The floor f	D 273				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		HAL032091	B. WING		11/17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE	
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D 273	Continued From page	30	D 273		
	11/10/20 at 2:35pm re-She had responded a back to bed when aler the resident was on th-She was not aware or Resident #13. -When asked if the resistated the resident was linterview with the MA 11/10/20 at 3:05pm re-All the PCAs assigners shift had left for the da-She had not received Resident #13 falling or either PCA. -PCAs were supposed incidences to the MA in linterview with the current 11/10/20 at 3:20pm re-She expected the PC. MA on duty when the instructional transfer of the man of the flood by a surveyor. -Resident #13 has a him recently on 10/19/20, recently on 10/19/20, recently on 10/19/20, recently on facility failed to no #2, who had a broken symptoms of pain and required surgery to represent #4's PCP and resident #4's PCP a	vealed: and assisted Resident #13 ted by housekeeping that te floor. If any previous falls for sident was injured, the PCA is "okay". assigned to the 100 Hall on vealed: d to the 100 Hall on first ty. a report regarding being found on the floor by I to report falls and other mmediately. ent Administrator on vealed: As to report incidents to the incident occurred. ed her of Resident #13 or after the MA was notified distory of frequent falls, most resulting in a fracture. tify the PCP for Resident hip and was exhibiting a leg deformity and later pair the hip and to notify	D 273		
	symptoms of COVID-1 diagnosed with COVID	9, was later hospitalized, -19 and passed away. The d in serious physical harm,			
	serious injury and serio constitutes a Type A1	ous neglect which			
ivision of Heal	Ith Service Regulation				

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 273 Continued From page 31 D 273 The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/10/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 17, 2020. D 338 10A NCAC 13F .0909 Resident Rights D 338 It is the policy of Durham Ridge Assisted Living to assure that the rights of all residents 10A NCAC 13F .0909 Resident Rights guaranteed under G.S. 131D-21, Declaration An adult care home shall assure that the rights of Residents' Rights, are maintained and exercised all residents guaranteed under G.S. 131D-21, without hindrance. Declaration of Residents' Rights, are maintained At the direction of the County Health and may be exercised without hindrance. Department, Residents were able to begin dining at the ends of each of the hallways while This Rule is not met as evidenced by: **TYPE A2 VIOLATION** remaining at least 6 feet apart from each other beginning on 11/6/20. Residents that are able to Based on observations, record reviews and eat in their rooms are allowed to do so. interviews, the facility failed to cohort staff and Residents that need assistance or residents, quarantine staff as indicated by the encouragement during meal service will be feed local health department (LHD) once they tested in the dining room, unless they remain negative positive for COVID-19; and failed to provide and then they will eat in their room. Sixty residents on two hallways with over the bed overbed tables were ordered on 11/6/20 and tables for in-room meal service after stopping arrived on 11/9/20. Fifteen additional tables communal dining, as recommended by the were received on 12/6/20, ensuring that there Centers for Disease Control (CDC), the North are enough tables in the facility to accommodate Carolina Department of Health and Human meal service. Services (NC DHHS), and directives from the LHD. The findings are: Review of the local health department (LHD) COVID-19 Death Reporting documentation for the facility revealed:

-There was a resident who tested positive for

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 338 Continued From page 32 D 338 All residents that have never tested positive are being moved into rooms with other COVID-19 COVID-19 on 09/26/20, hospitalized on 09/26/20 negative residents or are in a room by and died at the hospital on 10/02/20 with cause of themselves. All staff was in serviced shift to shift, death of COVID-19. beginning on 11/4/20, and given handouts on -There was another resident who tested positive infection controls measures, including but not on 08/24/20, hospitalized on 10/07/20, and died on 10/20/20 at the hospital with cause of death of limited to, wearing masks, gloves, and gowns appropriately, when to change them, and how to -There were two residents who died on 10/23/20 discard them. The handouts are posted on the at the facility with cause of death of COVID-19. shower room and tv room doors, in the -There was a fifth resident who tested positive for breakroom by the time clock and on the fire COVID-19 on 10/05/20, hospitalized from doors at the end of each hallway. All department 10/07/20 to 10/14/20, and died on 10/29/20 at a heads and management staff will routinely skilled nursing facility with cause of death of monitor staff throughout the day to ensure that COVID-19. they are using PPE appropriately. COVID-19 related information and updates were placed on Review of the facility's resident COVID-19 tracing the Spectrio scrolling monitors in the lobby and spreadsheet revealed: breakrooms. -In the month of September 2020, there was an An in-service, including but not limited COVID-19 average census of 120. -In the month of September 2020, 22 residents and Infection Control, with all care staff was held tested positive for COVID-19 and 1 resident with a RN on 11/9/20 and 11/10/20. During this tested inconclusive for COVID-19. time, staff was be in-serviced on topics including -The final day of quarantine for residents who but not limited to, how dining is to be handled tested positive in September 2020 was 10/16/20. moving forward, use of PPE and Infection Control. Review of the LHD COVID-19 task force resident All staff will continue to use PPE appropriately. spreadsheet revealed: Residents that are tested negative or have been -16 of the 22 residents who tested positive for through the health department directed COVID-19 in September 2020 resided on the quarantine period will not be placed in rooms 100-hall. with residents that are currently positive and in -3 of the 22 residents who tested positive for COVID-19 in September 2020 resided on the quarantine. All staff are being reassigned the 200-hall. COVID-19 and Infection Control related trainings -2 of the 22 residents who tested positive for on Fels & Associates. COVID-19 in September 2020 resided on the -1 of the 22 residents who tested positive for COVID-19 in September 2020 resided on the

400-hall.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 338 | Continued From page 33 D 338 A staff meeting was held on December 2, 2020, Review of the facility's resident COVID-19 tracing to in-service staff on, topics including but not spreadsheet revealed: limited to, meal service, use of PPE and -In the month of October 2020, there was an average census of 112. Infection Control. -During the month of October 2020, 91 residents An in-service with all care staff is scheduled on tested positive for COVID-19 and 3 residents December 30, 2020 with an Outside Consultant tested inconclusive for COVID-19. -The final day of quarantine for residents who from the Professional Assisted Living tested positive for COVID-19 in October 2020 Association on topics including but not limited to. was 11/06/20. Medication Administration, Resident Rights, Review of the LHD COVID-19 task force resident Infection Control and Incident/Accident Report. spreadsheet revealed: Issues with the Administrator and the Assistant -12 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the Resident Care Coordinator, had been identified 100-hall. -26 of the 91 residents who tested positive for prior to the survey and changes were scheduled COVID-19 in October 2020 resided on the to be made on November 3, 2020. The ARCC 200-hall. was removed on 11/10/20. The Administrator -25 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the was replaced on November 13, 2020 by the Assistant Administrator. The owner of Durham -28 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the Ridge, who is also a licensed Administrator, 400-hall. returned to Durham to take a more active role in 1. Review of the Centers for Disease Control the facility operations and plan of correction. (CDC) guidelines for the prevention and spread of Floor Managers were hired and began working the COVID-19 in long term care (LTC) facilities on each shift on December 1, 2020 to oversee dated 04/30/20 revealed: -Facilities could continue admitting residents but each shift and assist with communication among needed to ensure new residents were other things. quarantined away from other residents for 14 days depending on the prevalence of COVID-19 in the community. -The facility should consider testing new admissions at the end of the quarantine. -Facilities should cohort residents according to COVID-19 test results, and exposure to COVID-19.

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-Facilitie resident resident resident resident resident resident resident until the clarified Review communities dent of the confective Review Expect: Outbrea revealed placemes cohortin Review Septemi resident Septemi Review October admitted Review LHD CO-There versident septemi resident CDC guitransmis	ts who tested ts who tested ts who tested ts who tested tes should considered and intervent of NC DHHS nal dining, and tial settings do ore principles to cohorting of the NC DH Response to the LHD wordent of residenting of staff and of the facility I ber 2020 revealed the LHD wordent of the facility I ber 2020 revealed during the moof the timeline ov ID-19 task for COVID-19 task for COVID-19 te visit on 09/2 to on residents idelines to redission.	gn specific staff to work with positive for COVID-19 and negative. sider halting admissions transmission could be ions implemented. guidance on visitation, d indoor activities for larger ated 10/16/20 revealed one of infection prevention was residents. HS guidance on What to New COVID-19 Cases or sings dated 09/04/20 ald guide facilities on s within the facility, and residents. ist of admissions for aled there were three ring the month of ist of admissions for d there were three residents onth of October 2020. Is documentation from the orce revealed: 19 outbreak within the th two residents who tested	D 338	On 12/9/20, Durham Ridge hired an Infection Control Specialist/Complia Officer, with an extensive background, knowledge, and experience in Infection Control/Prevention and Assisted Living Compliance, to implement and oversee including but not limited to Infection Co Personal Care, Health Care Follow up Incident/Accident reporting. On 12/8/2020, Durham Ridge hired an Administrator. The assistant admin will coordinate staff onboarding and training be responsible for educating new staff of Resident Rights. The Administrator will audit weekly to econtinued compliance. December 11, 2020 and ongoing	n e policies, ntrol, and Assistant g, and will on	

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 338 Continued From page 35 D 338 among the residents on 09/30/20. -There were 91 residents who tested positive for COVID-19 between 10/04/20 and 10/27/20. a. Review of Resident #9's Resident Register revealed she was admitted on 09/11/20. Review of Resident #9's Primary Care Provider (PCP) notes revealed: -On 10/01/20 Resident #9 was exposed to COVID-19 and would be monitored for symptoms. -On 10/08/20 Resident #9 was on guarantine for close exposure to a resident who tested positive for COVID-19. -On 10/19/20 Resident #9 was tested weekly for COVID-19. Review of the facility resident room roster revealed Resident #9 had a roommate who tested positive for COVID-19 on 10/05/20 and resided on the 200-hall. Review of the documentation from the LHD COVID-19 task force revealed Resident #9 tested positive for COVID-19 on 10/19/20. Telephone interview with Resident #9's family member on 11/12/20 at 1:21pm revealed: -She was told by the former Administrator that Resident #9 was in a room alone since admission. -She was not told the room number, but Resident #9 liked to keep to herself. -She was told by the former Administrator that the facility had a few residents who tested positive for COVID-19. Refer to telephone interview with one of the LHD

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STATE FORM

COVID-19 task force leads on 11/04/20 at

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 338 Continued From page 36 D 338 9:56am. Refer to telephone interviews with another LHD COVID-19 task force lead on 11/09/20 at 11:53am and 1:05pm. Refer to telephone interview with the same LHD COVID-19 task force lead on 11/17/20 at 8:31am. Refer to telephone interview with a personal care aide (PCA) on 11/06/20 at 3:02pm. Refer to telephone interview with a medication aide (MA) on 11/16/20 at 3:26pm. Refer to confidential interview with a staff. Refer to telephone interview with the PCP on 11/09/20 at 4:31pm. Refer to interview with the Resident Care Coordinator (RCC) on 11/10/20 at 4:23pm. Refer to interview with the RCC on 11/10/20 at 5:00pm. Refer to telephone interview with the former Administrator on 11/04/20 at 11:00am. Refer to interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm. Refer to telephone interview with the Business Office Manager (BOM) on 11/04/20 at 11:00am. Refer to telephone interview with the BOM on 11/12/20 at 4:41pm.

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b. Review of Resident #10's Resident Register revealed he was admitted on 09/30/20.

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D 338	Continued From page	37	D 338		
	Review of the COVID- 10/22/20 to 11/03/20 r tested positive on 10/2				
		esident room roster O had a roommate who 12/20 and resided on the			
	Review of the documentation from the LHD COVID-19 task force revealed Resident #10 tested positive for COVID-19 on 10/26/20 and resided on the 100-hall.				
	Attempted interview with Resident #10's family member on 11/12/20 at 1:05pm was unsuccessful.				
	Refer to telephone interview with one of the LHD COVID-19 task force leads on 11/04/20 at 9:56am.				
		erviews with another LHD on 11/09/20 at 11:53am and			
		erview with the same LHD ead on 11/17/20 at 8:31am.			
	Refer to telephone into 11/06/20 at 3:02pm.	erview with a PCA on			
	Refer to telephone into 11/16/20 at 3:26pm.	erview with a MA on			
	Refer to confidential in	terview with a staff.			
	Refer to telephone into 11/09/20 at 4:31pm.	erview with the PCP on			

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D 338	Continued From page	38	D 338		
	Refer to interview with 4:23pm.	n the RCC on 11/10/20 at			
	Refer to interview with 5:00pm.	n the RCC on 11/10/20 at			
	Refer to telephone int Administrator on 11/0-	erview with the former 4/20 at 11:00am.			
	11/10/20 at 4:50pm ar				
	Office Manager (BOM	erview with the Business I) on 11/04/20 at 11:00am.			
	11/12/20 at 4:41pm.	erview with the BOM on			
	c. Review of Resident revealed she was adn	t #11's Resident Register nitted on 10/09/20.			
	10/22/20 to 11/03/20 i	-19 laboratory reports from revealed Resident #11 VID-19 on 10/26/20 and all.			
	Review of the facility revealed Resident #1 roommate and resident	1 was in a room without a			
	tested positive for CO	revealed Resident #11 VID-19 on 10/26/20.			
	Attempted interview w member on 11/12/20 a unsuccessful.	vith Resident #11's family at 1:10pm was			
	Refer to telephone int	erview with one of the LHD			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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D 338	Continued From page	39	D 338		
	COVID-19 task force 9:56am .	leads on 11/04/20 at			
	Refer to telephone int representative from the force on 11/09/20 at 1	ne LHD COVID-19 task			
		erview with the same LHD lead on 11/17/20 at 8:31am.			
	Refer to telephone int 11/06/20 at 3:02pm.	erview with a PCA on			
	Refer to telephone int 11/16/20 at 3:26pm.	erview with a MA on			
	Refer to confidential in	nterview with a staff.			
	Refer to telephone int 11/09/20 at 4:31pm.	erview with the PCP on			
	Refer to interview with 4:23pm.	1 the RCC on 11/10/20 at			
	Refer to interview with 5:00pm.	n the RCC on 11/10/20 at			
	Refer to telephone int Administrator on 11/0	erview with the former 4/20 at 11:00am.			
	Refer to interviews wi 11/10/20 at 4:50pm ar	th the Administrator on nd 5:58pm.			
		erview with the Business I) on 11/04/20 at 11:00am.			
	Refer to telephone int 11/12/20 at 4:41pm.	erview with the BOM on			
	Telephone interview v	vith one of the LHD			

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D 338 Continued From page 40 D 338	
COVID-19 task force leads on 11/04/20 at 9:58am revealed: -She and another task force lead conducted an onsite visit on 09/29/20. -She recommended to the former Administrator and BOM on 09/29/20 to not take any new admissions due to the observation of continued communal dining, difficulty "cohorting" positive cases, exposed cases, and regative cases, and inconsistent use of personal protective equipment (PPE). -She did not provide any written recommendations concerning admissions to the facility, but the facility was supposed to follow the CDC recommendations and guidelines. Telephone interviews with another LHD COVID-19 task force leads on 11/09/20 at 11:53am and 1:05pm revealed: -Facility management was informed they needed to have a quarantine system in place for new admissions. -She spoke with the Administrator two weeks ago and was told the Administrator did not know anything about the quarantine system and would get back to her. -The Administrator did not get back to her about the quarantine system. -In late October 2020, around the 28th, the LHD advised facility management to refrain from accepting new admissions. Telephone interview with the same LHD COVID-19 task force lead on 11/17/20 at 8:31am revealed: -The former Administrator and the former RCC were told to attempt to "cohort" the residents in August 2020 and September 2020 when there were fewer residents who tested positive for COVID-19.	

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D 338 Continued From page 41 D 338	
-Cohort meant to group residents who tested positive for COVID-19 with other residents who tested positive for COVID-19, group residents who tested negative for COVID-19 with other residents who tested negative for COVID-19, and residents who were exposed to COVID-19, and residents who were exposed to COVID-19. -The former Administrator was told to cohort residents but he expressed concerns because the residents were memory care residents and were affected by sudden changes in their environment. -The former Administrator was sent guidance for memory care units. Telephone interview with a PCA on 11/06/20 at 3:02pm revealed: -When the outbreak began, the residents who tested positive for COVID-19 were moved to the 200-hall, and were quarantined for ten days. -As the number of COVID-19 were moved to the residents on the 200-hall. -Not many of the halls had enough rooms to contain the residents who tested positive for COVID-19. -Residents who tested positive for COVID-19 and who tested negative for COVID-19 were assigned to the same room. Telephone interview with a MA on 11/16/20 at 3:26pm revealed: -No instructions were given on providing care to residents who tested positive for COVID-19. -Hearts were placed on the doorposts of residents who tested positive for COVID-19.	
-The heart on the doorpost did not indicate which resident was COVID-19 positive if there were two residents in the roomResidents who tested positive were placed in the	

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went into the hallway.

outbreak worsened every week.

-The doors to each hall were kept closed, but the

-Facility management did not implement any

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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D 338	Continued From page	÷ 43	D 338			
D 338	safeguards to stop the instruction. -Residents were not rehall to contain the spreasidents who tested were roomed with residents for COVID-19. -She was informed by Administrator, and RC would be worse to most those who tested post another room. Interview with the RC revealed: -Residents who tested were previously quarasidents who tested positive for COVID-19. -Newly admitted residents who tested to covid another room presidents who tested to covid another room presidents who tested to covid a designated from the LHD instructed for the LHD advised the former RCC (on a move residents whos positive for COVID-19 residents were alread for the covid and the former RCC (on a move residents were alread for the covid and the covid and the former RCC (on a move residents were alread for the covid and the cov	noved to another room or ead of COVID-19. d positive for COVID-19 idents who tested negative or the Administrator, former CC that the LHD advised it tove exposed residents or itive for COVID-19 to C on 11/10/20 at 4:23pm d positive for COVID-19 antined on the 200-hall. The residents who tested on the same room as positive for COVID-19. The same room as positive for COVID-19. Tacility management to place the for ten days after testing	D 338			
	revealed: -She was not involved	d with the decision to admit				
	new residents.	former Administrator when				
	residents were arriving					
		rator assigned the rooms to				
	alth Sensine Begulation					

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 338 | Continued From page 44 D 338 Telephone interview with the former Administrator on 11/04/20 at 11:00am revealed: -No resident admitted to the facility resided where there was an active case of COVID-19 in September 2020. -He did not know the exact rooms the new residents resided within the facility in September 2020 or October 2020. -Admissions were continued because they thought they could keep new residents safe. Interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm revealed: -She participated in conference calls with representatives from the LHD. -The LHD did not put guidance in writing. -"When they (the LHD) say to do it, we do it." -Residents who tested positive for COVID-19 were supposed to be quarantined for ten days. and longer if they continued to be symptomatic. -Residents who had been exposed to COVID-19 were supposed to be guarantined for 14 days. -Sometime around August or September 2020, the LHD advised not to remove residents who tested negative for COVID-19 out of the rooms of residents who tested positive for COVID-19. Telephone interview with the BOM on 11/04/20 at 11:00am revealed: -The LHD COVID-19 task force had not provided anything in writing about discontinuing admissions. -The facility continued admitting residents

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because they thought if they followed the recommendations of the LHD the residents would

-The facility discontinued admissions between 10/09/20 and 10/22/20 because the number of positive COVID-19 cases within the facility

not become positive for COVID-19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
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	HAL032091	B. WING		11/1	; 7/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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positive resident cases were contained on the -In October 2020, the who tested positive for quarantinedHe thought the new a assigned to rooms who exposure to COVID-19: The LHD COVID-19 the put residents on one has facilityThe facility placed a padoor of residents who COVID-19 in mid to lateWhen the facility adm September 2020 and there was a room avait the resident to active the did not know the late residents admitted in Structure of the country of the coun	although there were some is of COVID-19, the majority of 200-hall. If acility had more residents in COVID-19 but were admissions were not ere they were at risk for 19. If a different area of the collastic covering over the steed positive for the september 2020. In a different area of the collastic covering over the steed positive for the september 2020. In a different area of the collastic covering over the steed positive for the september 2020. In a different area of the collastic covering over the steed positive for the september 2020, he ensured aliable that did not expose COVID-19. In a different area of the covering over the steed of the covering over the steed of the covering over the steed over the september 2020, he ensured aliable that did not expose COVID-19. In a different covering over the september 2020 and the cover precaution to cover the september 2020 and the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 and the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 at the cover precaution to cover the september 2020 at the cover precaution to cover precaution to cover precaution to cover precaution to cove	D 338			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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D 338	Continued From page	÷ 46	D 338		
D 338	who tested positive for Residents who tested were quarantined for continued to be symp-Residents who had be who tested positive for quarantined for 14 da - The former Administr room assignment for 12. Review of the Cent (CDC) guidelines for COVID-19 in long terr revealed personnel structure for residents who test and re	d positive for COVID-19 ten days unless they tomatic. Deen exposed to roommates or COVID-19 were ys. Trator was responsible for new admissions. The prevention and spread of m care (LTC) facilities hould be designated to care ted positive for COVID-19 Sted negative for COVID-19. Idaily staffing sheets from 10/05/20, from 10/14/20 to 120 to 11/05/20, and for assignments, first, is. It assignments, there were medication aide (MA), a all MA, a 400-hall MA, three te aides (PCA), three 300-half PCAs, and three Idaily staffing sheet were or staff based on half Inctions concerning to rooms for residents based results.	D 338		
	-The memo's topic wa	d staff memo revealed: as COVID-19 100-hall. staff signatures at the without dates.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLI	
		74, 201221140.		l c	;	
		HAL032091	B. WING		11/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	-There were 12 bullet include: staff were to assignment, one staff who tested positive for two staff were to care keep residents in their Based on record revised documentation was proposed memory related to CO halls within the facility. Review of emails from department (LHD) CO an email was sent to from the Deputy Public 06/10/20 providing the memory care units from the CDC guida in LTC facilities dated Due to the challenge residents to their room wear a N-95 or face in protection. -Personnel should fol and Control guidance. Telephone interview we COVID-19 task force 8:31am revealed -She recommended to they were assigned to she also recommend there were designate who tested positive for the care to care the staff of the	statements on the memo to go to their designated hall was to care for the resident or COVID-19 and the other for all other residents and rooms. Bews and interviews, no other rovided for staff training or VID-19 and the other three of the local health ovID-19 task force revealed the former Administrator ic Health Director on the link for guidance for om the CDC. Ince for memory care units 05/12/20 revealed: of restricting memory care and, all personnel should mask and universal eye. It with one of the LHD leads on 11/04/20 at the staff remain on the hall of the entire shift. It ded "cohorting" staff so that do staff to care for residents who DVID-19, and residents who DVID-19, and residents who	D 338			
		ommendation was not done alled the facility to gather				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		HAL032091	B. WING		C 11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	
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DURHAM	RIDGE ASSISTED LIVING	DURHAM	I, NC 27703		
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D 338	Continued From page	48	D 338		
	information in Octobe answered the phone t she could walk over to				
	(PCA) on 11/09/20 at -She worked with all t was not assigned to r or negativeNo one had ever told COVID-19 and who to	he residents on the hall and esidents who tested positive Ther who tested positive for			
	COVID-19. Confidential interview with a staff revealed: -One staff was supposed to interact with the residents on the hall who tested positive for COVID-19. -The Resident Care Coordinator (RCC) or the MA would let the PCAs know which residents tested positive for COVID-19.				
	2:52pm revealed: -She worked on the h the RCC and worked -She was not assigne residents who tested	with a MA on 11/09/20 at all she was assigned to by with all residents on the hall. ad to work with either positive for COVID-19 only ed negative for COVID-19			
	-Staff needed more g to contain the spread residents had tested COVID-19. -There needed to be contain the spread of	with the primary care /09/20 at 4:31pm revealed: uidance from management of COVID-19 and which positive or negative for better training of staff to COVID-19 in the facility. k of October 2020, she			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A, BUILDING:	COMPLETED			
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
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240.15	CLIMMANDV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (X5)	
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D 338	Continued From page	2 49	D 338			
	staff she replied, "The who was positive or n					
	revealed: -She did the staff assi -Staff were assigned lonlyThere were four halls	based on the hall number				
	Manager (BOM) on 1 revealed: -The facility had designesidents who tested -The RCC and the HF	with the Business Office 1/04/20 at 11:00am gnated staff assigned to positive for COVID-19. R Office Manager did staff ided which staff took care of				
	4:41pm revealed staff their interaction between	with the BOM on 11/12/20 at f were encouraged to limit een residents who tested and residents who tested 9.				
	(CDC) guidelines for the coronavirus diseated: facilities revealed: -Personnel should statePersonnel with mild to the who were not immunous thome 10 days since to appeared.	to moderate symptoms and ocompromised should stay the date of symptoms first coughing, shortness of				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED			
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HAL032091		B. WING		11/17/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE	E, ZIP CODE		
DUDUAN	RIDGE ASSISTED LIVING	C	E FOREST HWY			
DUKHAIVI	KIDGE ASSISTED LIVIN	DURHAM,	NC 27703			
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D 338	Continued From page	e 50	D 338			
D 338	Review of a letter give revealed: -The letter was regard was dated 10/19/20. -There was a release isolation and she may Review of the local he COVID-19 task force -Staff B, a personal copositive on 09/30/20 a 09/28/20. -Staff B was released 10/19/20. Review of the facility positive for COVID-19. -Staff B tested positive-Staff B was to return Review of the facility 10/15/20 for Staff B row 7 hours on 10/12/20. Review of the facility 10/12/20 revealed Stavitten under the sec assigned to the 400-hunterview with the Add 2:30 pm revealed: -Staff were tested we tested positive for CO-Once staff tested poquarantined for 10 dasymptoms of COVID-	ding monitoring release and date of 10/19/20 from return to work. Bealth department (LHD) documents revealed: are aide (PCA), tested and had symptoms on from monitoring on list of staff who tested Prevealed: re on 09/27/20. To work on 10/11/20. To work on 10/11/20 to evealed Staff B was paid for staff B's name was hand ond shift column and nall. Indicate the column and shift	D 338			
	-The LHD contacted guidelines for when s	staff returned to work.				
	Telephone interview	with Staff B on 11/10/20 at				

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 338 Continued From page 51 D 338 12:43pm revealed: -She had symptoms of migraine headaches, diarrhea, loss of taste and smell during her quarantine and she had a history of asthma. -She tested positive on 09/30/20 but the Resident Care Coordinator (RCC) called her on 10/03/20 to tell her she had tested positive for COVID-19. -She spoke with a person from the LHD daily. -She received a letter via the United States Postal Service and a text message that indicated her release date to return to work. -Her release date was 10/19/20, and she had not received any other letters from the LHD. -The Human Resource (HR) Office Manager called her on 10/12/20 to tell her she had to come to work or she would lose her job. -She reported to work late on 10/12/20 and she thought she worked on the 400-hall. Telephone interview with the LHD COVID-19 task force lead on 11/12/20 at 1:58pm revealed: -Staff B tested positive on 09/30/20 but Staff B reported symptoms of COVID-19 started on 09/28/20. -Staff B was given an extended release date of 10/19/20 because she was still symptomatic. Interview with the facility's HR Office Manager on 11/10/20 at 3:15pm revealed -None of the staff had worked during their quarantine time. -Staff guarantined due to a positive COVID-19 test for 10 days. -The former RCC kept a spreadsheet with all staff who tested positive for COVID-19 and their

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staff.

release dates.

-The former RCC spoke with the LHD daily to gather the information about release dates for

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING HAL032091 11/17/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 338 D 338 Continued From page 52 Telephone interview with the RCC on 11/12/20 at 5:00pm revealed: -She called staff who were out on quarantine status daily. -She asked staff how they were doing and if they needed anything. -She checked on Staff B and Staff B never reported any symptoms to her. -She did not see the letter from the LHD for Staff B. -The former RCC kept up with the release to work dates of staff. -She did not know why Staff B returned to work on 10/12/20 and then did not work again until 10/19/20. Telephone interview with the facility's HR Office Manager on 11/16/20 at 2:58pm revealed: -The RCC told her that Staff B worked on 10/12/20 and did not work again until 10/19/20. -She and the former RCC called Staff B on 10/12/20. -The reason she and the former RCC called Staff B was because Staff B was scheduled to work on 10/12/20. -When Staff B answered the telephone, she did not report any symptoms and stated she was fine. -Staff B was told she was scheduled to work on 10/12/20 and was expected to report to work. -She thought Staff B called the LHD on 10/13/20 and reported symptoms of COVID-19 to extend her release date. -She thought Staff B knew staff were paid for quarantining and did not want to return to work. -She and the former RCC telephoned the LHD

10/19/20.

Staff B's release date.

task force lead on 10/13/20 and inquired about

-The LHD told them Staff B's release date was

-The former RCC had a release date of 10/11/20

AND DI AN OF CORRECTION		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		HAL032091	B. WING		11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	E, ZIP CODE	
DURHAM	RIDGE ASSISTED LIVING	G	E FOREST HWY NC 27703	·	
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D 338	Continued From page	53	D 338		
	for Staff B documente for quarantine release	ed on the staff spreadsheet e dates.			
	11/17/20 at 9:27am re -She was made aware	e on 11/16/20 of Staff B			
	Office ManagerThe LHD provided th	em with the release dates			
	for staff to return to w	ork.			
	Manager (BOM) on 17 revealed:				
		ger and/or the RCC told him /12/20 and her release date			
	their quarantine.	return to work at the end of			
	-The RCC and HR Of responsible for ensuri once quarantine ende	ing staff returned to work			
		rom the local health DVID-19 task force revealed: n members of the task force			
	county Department of	8/20 at 12:16pm to the local f Social Services (DSS) staff urce for over the bed tables.			
	sent to the task force	local county DSS staff was lead team member on indicating locations to			
	purchase over the be	d tables. om the local county DSS			
	member on 10/08/20				
	tables.				
	-These emails were s Administrator, Admini	ent to the former strator and former Resident			

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FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 338 | Continued From page 54 D 338 Care Coordinator (RCC) on 10/21/20 at 9:17am. Review of the facility invoices and receipts for over the bed tables revealed: -An order was placed on 11/06/20 from an online vendor for 30 over the bed tables. -The over the bed tables were shipped on 11/07/20 to the address for the facility. Review of the facility's resident roster revealed: -There were 29 residents who resided on the 200-hall. -There were 27 residents who resided on the 400-hall. Observations of the 200-hall on 11/03/20 from 11:07am - 12:16pm revealed: -There were 16 residents who ate lunch in the living room/dining area at the end of the hall. -There were 10 residents who ate lunch in their rooms. -At 11:53am, the food cart was delivered to the 200 hall. -At 11:54am, a personal care aide (PCA) near the entrance to 200 hall started passing plates to some residents who were in their rooms. -The PCA delivered food travs to residents in rooms 201, 207, 210, 211, 213, 215, 218, and 220. -At 11:55am, the PCA went into room 211 and delivered lunch to the resident on a night stand as there was no over the bed table for the resident. -At 11:58am, the PCA went in room 220 and delivered lunch to the resident by the window on her bed as there was no over the bed table for

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this resident.

-At 12:03pm, the PCA went into room 213 and delivered lunch to the resident on a night stand as there was no over the bed table for the resident. -At 12:09pm, the PCA went into room 215 and

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		HAL032091	B. WING		11/17/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT		
DURHAM	RIDGE ASSISTED LIVIN	G	E FOREST HW	Y	
		DURHAM,	NC 27703		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 338	Continued From page	e 55	D 338		
D 338	delivered lunch to a reas there was no over resident. -At 12:10pm, the PCA delivered lunch to a reas there was no over resident. -At 12:13pm, the PCA delivered lunch to a reas there was no over resident. Observation of reside lunch meal service or 12:49pm revealed: -There was a resident bed. -The resident slumpe of the two-drawer nig. -The resident attempt across the top of the two-drawer service. -The resident attempt across the top of the two-drawer service. -The resident's left let backside of the two-drawer no space to place nightstand.	esident on her night stand the bed table for the a went into room 207 and esident on her night stand the bed table for the a went into room 201 and esident on her night stand the bed table for the esident on her night stand the bed table for the ents on the 400-hall during a 11/03/20 from 12:14pm to a 11/03/20 from 12:14pm to a sitting on the side of the esident towards the back that and. In the bed table is the ents of the esident or side the plate of food two-drawer nightstand and there is the ent left foot beneath the eg and foot were extended	D 338		
	nightstandAnother resident was sitting in her wheelchair				
	l ·	of the bed. of food was on her bed, near			
	the footboard.	to the means alone of the			
		ted to move closer to the			
	plate of food on the b	ed in her wheelchair. away from the bed in her			
	- The resident backed	away IIOIII tile bed III nei			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		COMPLETED	
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		HAL032091	B. WING		11/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STATE	E, ZIP CODE		
		3420 WAK	E FOREST HWY			
DURHAM	RIDGE ASSISTED LIVING	DURHAM,	NC 27703			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	56	D 338			
	wheelchair. -The resident did not nightstand, or bedside. Telephone interview was force lead on 11/04/21. -The facility was enco communal dining whe released by the Center (CDC) in April 2020. -There was discussion enough over the bedrassistance in locating a reasonable price and the county DSS responder of the facility and the properties of the facility and the f	have an over the bed table, e table. with the LHD COVID-19 task of at 9:56 am revealed: euraged to discontinue en the guidance was ers for Disease Control en that there were not tables for all residents. Eval county DSS to request the over the bed tables for ad locally in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various eity to obtain the over the ices in October 2020. Evonded with various evonded with various evonded with various evonded eity to obtain the over the ices in October 2020. Evonded eity to obtain the over the ices in October 2020. Evonded eity to obtain the over the ices in October 2020. Evonded eity to obtain the over the ices in October 2020. Evonded eity to obtain the over the ices in the ices in October 2020. Evonded eity to obtain the over the ices in				
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A, BUILDING:			
		HAL032091	B. WING		C 11/17/2020	
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	NTE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVIN	3420 WAKI DURHAM,	E FOREST HW	Y		
OV A) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	58	D 338			
	-Some residents had to turn to the side to eat their plates because of the position of the tableShe thought this was uncomfortable for residents because of the position residents were in while eating.					
	-Several residents did tables.					
	-The former Administration resident nightstands to serviceStaff asked the formethe residents suppose nightstands?	with a third staff revealed: rator told staff to use the o serve plates for meal er Administrator, "how were ed to eat their meals on the because the nightstands				
	-The facility called ab -The facility inquired a pricingThe facility never pla bedside tablesThe facility was told i from the date of order tables to the facility. Interview with the RC revealed:	6/20 at 11:45am revealed:				

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING:		COMPLETED			
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		HAL032091	B. WNG		11/17/2	020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	TE, ZIP CODE		
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 338	the former RCC would-She had not monitore. She did not purchase Telephone interview v 11/13/20 at 11:49am reshe remembered red LHD COVID-19 task for she remembered distributed the bed tables in a madid not think the Busin was at the meeting. She did not tell the Busin was at the meeting. She did not tell the Busin was at the meeting. Telephone interview v 9:26 am revealed: Staff usually told him worked in the busines was needed. If it was a special red decision made by the Residents who residincreased supervision related to health care. He thought all the reor nightstand to use for He knew the plates we tables or nightstands. He did not know whin needed an over the both the standard over the both the reduction of the standard over the both the standard over the	d monitor the 400-hall. ed the 200-hall recently. e equipment for the facility. with the Administrator on revealed: ceiving the email from the force lead. coussing the need for over anagement meeting, but she ness Office Manager (BOM) BOM the facility needed over see she did not know it was with the BOM on 11/06/20 at a certain or the other staff who as office what equipment anagement team. ed on the 400-hall needed on, or had specific restrictions such as fluid restrictions. sidents had a bedside table or meal service. were served on the bedside of the bed tables over from a	D 338	DEFICIENCY)		
	needed to order more -He ordered over the he thought, but the co according to the num	de for the residents but be. bed tables in October 2020, bemmunal dining changed ber of residents who tested and the guidance from the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COMPLETED
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		HAL032091	B. WNG		11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE	
DUDUAN	DIDOE AGGICTED LIVER	3420 WAK	E FOREST HW	(
DUKHAM	RIDGE ASSISTED LIVING	DURHAM,	NC 27703		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 338	Continued From page	÷ 60	D 338		
D 338	-It took a week or two tables to arrive to the -The original order for much earlier and anot the bed table when th serving meals in grou -The 200-hall was cle he thought the LHD a now, 11/06/20. Telephone interview w 9:45am revealed: -No one from the mar facility needed more control -The former Administr had access to purchain residentsNo one told him the Lilead had shared a plabed tables in October -He ordered the overland the items were deand 11/09/20. Attempted telephone Administrator on 11/1: unsuccessful. The facility failed to make the commendations est Disease Control (CDC Department (LHD), and Department of Health DHHS) for infection plating the COVID-19 returned to work prior	weeks for the over the bed facility. To over the bed tables was ther order was done for over the LHD recommended not ps. ared from quarantine and flowed for communal dining with the BOM on 11/17/20 at the agament team told him the over the bed tables. Fator and another office staff is eitems needed by the LHD COVID-19 task force for the purchase the over the 2020. The bed tables on 11/06/20 delivered between 11/07/20 del	D 338		
	_	e for residents who tested and designate staff to care			

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		HAL032091	B. WING		C 11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	
DURHAM	RIDGE ASSISTED LIVIN		FOREST HW	Υ	
	CHMMADYCT			PROVIDER'S PLAN OF CORRECTION	1 (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 338	Continued From page	61	D 338		
	for residents who test This failure placed the for transmission and i resulting in substantia harm, and serious ne A2 Violation. The facility provided a accordance with G.S. this violation and an a protection was provid	ted negative for COVID-19. The residents at increased risk infection from COVID-19, all risk of serious physical glect, and constitutes a Type Taplan of protection in 131D-34 on 11/13/20 for addendum to the plan of led on 11/17/20.			
D 358	(a) An adult care hor preparation and admit prescription and non-by staff are in accord. (1) orders by a licens which are maintained. (2) rules in this Section and procedures. This Rule is not met Based on observation reviews, the facility famedications as order #14) sampled who be	Medication Administration me shall assure that the inistration of medications, prescription, and treatments ance with: sed prescribing practitioner I in the resident's record; and on and the facility's policies as evidenced by: ns, interviews, and record	D 358	It is the policy of Durham Ridge Assist to assure that the preparation and adnof medications, prescription and non-prescription, and treatments by staff a accordance with orders by a licensed practitioner which are maintained in the resident's records, the rules in 10A NC .1004, and the facilities policies and predication Technicians and Shift Supwere in-serviced shift to shift, beginning 11/4/20, on topics, including but not liming Medication Administration, Narcotics of ordering of Medication. Additional In-services were held by the Consultant with the care staff, on 11/9 11/10/20 on, topics including but not liming Medication Administration, Narcotics of ordering of Medication.	ninistration re in prescribing e CAC 13F procedures. ervisors g on nited to, pounts and e RN //20 and mited to,

MAIL DESCRIPTION BATTER TAPOPERS, CITY STATE, 2P CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
DURHAM RIDGE ASSISTED LIVING CAG-ID DRAFFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION SHOULD BE PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE PROVIDER'S PLAN OF CORRECTION CHARLES AS A CHARLES PLAN OF CORRECTION CHARLES PLAN OF CO			HAL032091	B. WING		1 1
The findings are: 1. Review of Resident #14's current FL-2 dated O7/07/20 revealed: -Diagnoses included unspecified dementia, arthritis, and schizophrenia - paranoid typeThere was an order for Hydrocodone/Acetaminophen 5/325mg is a controlled substance (CS) used to treat moderate to severe pain.) Review of Resident #14's physician's orders revealed the primary care provider (PCP) wrote a prescription on 09/09/20 for 90/09/20	NAME OF PROVIDER OR SUPPLIER STREET ADD 3420 WAKI DURHAM RIDGE ASSISTED LIVING (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			FOREST HW NC 27703 ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	N (X5) BE COMPLETE
order for 90 Hydrocodone/Acetaminophen	D 358	The findings are: 1. Review of Residen 07/07/20 revealed: -Diagnoses included arthritis, and schizoph-There was an order of Hydrocodone/Acetam tablet 3 times a day. (Hydrocodone/Acetam controlled substance to severe pain.) Review of Resident # revealed the primary prescription on 09/09/Hydrocodone/Acetam tablet 3 times a day. Review of Resident # dated 10/20/20 at 12: -Staff went to get back Hydrocodone/Acetam Resident #14When the Resident Called the pharmacy, pharmacy delivered 9-There was "no injury-Staff noted it was represented by Resident # Registry (HCPR)The incident/accident signed by Resident # 5:03pm. Review of Resident # therapy prescription of the Resident # the Resident # therapy prescription of the Resident # the Resi	t #14's current FL-2 dated unspecified dementia, brenia - paranoid type. for inophen 5/325mg take 1 ninophen 5/325mg is a (CS) used to treat moderate 14's physician's orders care provider (PCP) wrote a /20 for 90 tablets of inophen 5/325mg take 1 14's incident/accident report 00pm revealed: k up supply of inophen 5/325mg for Care Coordinator (RCC) they told the RCC that the 10 tablets on 10/08/20. s of inophen 5/325mg missing. To the resident. Forted to the police dealth Care Personnel t report was electronically 14's CS continuance of lated 10/08/20 revealed an	D 358	change Primary Care Providers, on N 30, 2020, due to lack of answering ca and response in general to requests if facility. The previous provider failed that Durham Ridge multiple days in white were scheduled. The change was made to provide for a more seamless and of approach to resident care and allow if contacting and reporting to the primare group. The MD is in the facility three week. There is also at least one PA if facility Monday through Friday. There with multiple providers in the facility if Care. This change allows for medical needing hard prescriptions to be refill. A staff meeting was held on December to in-service staff on, topics including limited to, the change in Primary Care and the new for getting refills and Me Administration. An in-service for Medication Technicic held by a consultant from the long-ter pharmacy on December 29, 2020 on, including but not limited to, medication	lls, faxes, rom the o show up ch they de in order rganized or easier ry care times a n the e are days or Primary tion ed timely. er 2, 2020, but not e Providers dication ans will be m care topics

Division of Health Service Regulation

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED		
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		HAL032091	B. WNG		C 11/1 7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	
DUDUAM	DIDGE ASSISTED LIVING	3420 WAKE	FOREST HV	VY	
DURHAM	RIDGE ASSISTED LIVING	DURHAM, I	NC 27703		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 358	5/325mg tablets take Review of Resident # dispense prescription order for 60 Hydrocod 5/325mg tablets take Review of Resident # records from Septemb revealed: -There were 90 tablets Hydrocodone/Acetam dispensed on 09/08/20 -There were 90 tablets Hydrocodone/Acetam dispensed on 10/08/20 -There were 60 tablets Hydrocodone/Acetam dispensed on 10/21/20 Review of Resident #* electronic medication (e-MAR) revealed: -There was an entry for Hydrocodone/Acetam tablet 3 times a day w times of 9:00am, 1:00 -Hydrocodone/Acetam documented as admin 09/01/20 - 09/30/20 ex -Hydrocodone/Acetam documented as admin 1:00pm due to "awaitii -There were 89 tablets Hydrocodone/Acetam There were 89 tablets Hydrocodone/Acetam	1 tablet 3 times a day. 14's CS emergency dated 10/20/20 revealed an lone/Acetaminophen 1 tablet 3 times a day. 14's pharmacy dispensing per 2020 - November 2020 so of inophen 5/325mg 0. so of inophen 5/325mg inophen 5/325mg take 1 ith scheduled administration pm, and 9:00pm. ninophen 5/325mg was nistered 3 times daily from except for 1 occasion. ninophen 5/325mg was not nistered on 09/08/20 at ng pharmacy delivery".	D 358	An in-service with all care staff is sched December 30, 2020 with an Outside Cofrom the Professional Assisted Living Association on topics including but not Medication Administration, Resident Ri Infection Control and Incident/Accident A Medication Administration in-service scheduled on January 7, 2021 with a p from the long-term care pharmacy, on including but not limited to medication administration and controlled substance Issues with the Administrator and the A Resident Care Coordinator, that oversal incident reporting, had been identified put the survey and changes were scheduled made on November 3, 2020. The ARC removed on 11/10/20. The Administrator replaced on November 13, 2020 by the Administrator. The owner of Durham Richard who is also a licensed Administrator, replaced on November 1, 2020 to overshift and assist with communication at schange. On 12/9/20, Durham Ridge hill Infection Control Specialist/Compliance with an extensive background, knowled experience in Infection Control/Prevent Assisted Living Compliance, to impleme oversee policies, including but not limited Infection Control, Personal Care, Health Follow up and Incident/Accident reportion.	limited to, ghts, Report. is harmacist ropics es. essistant raw orior to ray do be facility or ray on resee each shift red an ray officer, lige, and rand ent and red to red to ray and red to red to ray on ray on ray of
	Review of Resident #1 revealed:	14's October 2020 e-MAR			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED	
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	020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
DURHAM RIDGE ASSISTED LIVING 3420 WAKE FOREST HWY DURHAM, NC 27703	
DOMESTIC DI ANI OF DEPOSITION	OVE)
(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	(X5) COMPLETE DATE
-Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 10/21/20 at 9:00am and 1:00pm due to "awaiting pharmacy" and	ecember 7, 2020 id agoing

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	CONSTRUCTION	(X3) DATE S COMPLE	
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		HAL032091	B. WING		C 11/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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DURHAW	MDGE ASSISTED EIVING	DURHAM, I	NC 27703			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	documented as admir 8:00am and the last of was on 09/28/20 at 9: -The second page ha with 30 tablets "place -The first dose of those documented as admir 9:00am and the last of leaving a balance of a Review of Resident # supply dispensed on -The prescription laber the page was for 90 to Hydrocodone/Acetam tablet 3 times a day. -The section on the unhad date received document received as 9	nistered on 09/19/20 at lose on the second page 00pm. d an entry for the third card d on cart" on 09/28/20. se 30 tablets was nistered on 09/29/20 at lose on 10/08/20 at 9:00pm, zero. 14's CS record for the 10/08/20 revealed: el on the upper left side of	D 358			
	cart" on 10/08/20 with the 90 had been writte with no initials to indicate on 10/09/20 at 9:00 are documented as 89 but over and changed to who made the change. The second dose was administered on 10/0 remaining documente written over and chartindicate who made the The third dose was con 10/09/20 at 9:00 predocumented as 27. The rest of the doses declining from 26 to 0.0.	as documented as 9/20 at 1:00pm with amount ed as 88 but the 88 had been aged to 28 with no initials to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		HAL032091	B. WING		1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BUBUAN	DIDGE AGGICTED I IVIIVI	3420 WAK	E FOREST HW	Υ		
DURHAM	RIDGE ASSISTED LIVING	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 358	Continued From page	÷ 66	D 358			
	-There were no doses Hydrocodone/Acetam administered from 10					
	supply dispensed on -Documentation on th cart" on 10/22/20 with tabletsThe first dose of thos documented as admir 9:00am and the last of -The second page ha card with 30 tablets "p at 3:00pmThe first dose of thos documented as admir	e first row noted "placed on a starting amount of 30 se 30 tablets was nistered on 10/22/20 at lose on 10/31/20 at 8:00am. d an entry for the second placed on cart" on 10/28/20 se 30 tablets was nistered on 10/29/20 at lose on 11/10/20 at 8:00am,				
	hand on 11/10/20 rev Hydrocodone/Acetam hand for the resident. Interview with a mediat 2:43pm revealed: -She administered Re Hydrocodone/Acetam morning, 11/10/20. -The medication bubb	cation aide (MA) on 11/10/20 esident #14's last hinophen 5/325mg tablet this ble card had been thrown				
	5/325mg available for #14. -Resident #14 missed Hydrocodone/Acetam	codone/Acetaminophen administration to Resident his 1:00pm dose of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NUMBEO:		(X3) DATE SURVEY COMPLETED	
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		HAL032091	B. WING			7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	TE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVING	3	FOREST HW	r		
				PROVIDERIS DI ANI OF CORRECTION	N.	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 67	D 358			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					
	11/09/20 at 4:30pm re	with Resident #14's PCP on evealed:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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HAL032091		B. WNG	11/17/2020			
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	E, ZIP CODE		
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DOTTIDATE		DURHAM,	NC 27703			
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D 358	Continued From page	68	D 358			
D 358	-She wrote the prescr Resident #14's Hydro 5/325mg tabletsWhen she got a requisibstances, she usual and counted to see we and if it was time for a second counted to see we and if it was time for a second counted to see we and if it was time for a second counted to see we and if it was time for a second counted to see we and if it was time for a second counted to see we and if it was time for a second counted to see we and if it was time for a second counted to see we and if it was time for a second counted to see we and if it was time for a second counted to see we and if it was time for a second counted to see we and if it was to the facility of the second counted to the facility of the second counted to second counted to second counted to second counted to work on second counter to	ription dated 10/08/20 for codone/Acetaminophen rest for a refill for controlled ally took out her calendar hat the resident was allotted a refill. Figure 1. The second of the second was missing and the second MA on executed a remorning that Resident to the second management of the second was allotted as remorning that Resident to the second was allotted as morning that Resident to the second was allotted as a morning that Resident to the second was allotted as a morning that Resident to the second was allotted as a morning that Resident to the second was allotted as a morning that Resident to the second was allotted as a morning that Resident to the second was allotted as allotted as allotted as a morning that Resident to the second was allotted as a	D 358			
	-The RCC asked her	where the tablets were but				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND LEVIA OF CONNECTION			A. BUILDING:				
HAL032091		HAL032091	B. WING		C 11/17/2020		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
DUBHAN	DIDGE ASSISTED LIVING	3420 WAK	E FOREST HW	Y			
DURHAM	RIDGE ASSISTED LIVING	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	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMMAND APPROPRIATE DEFICIENCY)		
D 358	she did not know what ok the medication for some doses when the She did not remember of pain when he did not medication. Telephone interview what was out of his Hydroc 5/325mg tablets (coulsale She usually kept the medications in her off She checked the filling did not have any in the She called the pharm had been sent to the resident should have she was on the CS resident should have she was on the CS resident was received. A second MA also responsible to the medication of the	at kind of pain the resident or but the resident missed emedications were missing. For if the resident complained of receive the pain with the RCC on 11/12/20 at an additional control of the resident with the RCC on 11/12/20 at and reported Resident #14 and one/Acetaminophen and not recall date). Supply of back up fice in a locked filing cabinet. If a graph cabinet we cabinet was told 90 tablets facility previously and the facility previously and the factor of the cord and changed it. For delivery of the crecall date) reported all 90 and the form of the other MA put all lication cart.	D 358				
	-She reported it to the know date) but the phomore medication beca-The PCP called anot pharmacy and more to thought on the same she thought the residual medication.	e PCP the same day (did not larmacy could not send larmacy could not send lause it had just been filled. The prescription to the lablets were sent she lablets missed one dose of the labelets where send she labelets were sent she					

Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING DURHAM, NC 27703** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) D 358 D 358 Continued From page 70 -They received batch medications monthly from the pharmacy except they had to order some controlled substances. -The MAs were supposed to call the pharmacy once the medication got down to the blue section on the bubble card to see if a new prescription was needed. -If the medication was not received, the MAs should follow-up with a call to the pharmacy. Telephone interview with the certified medical assistant (CMA) at Resident #14's PCP office on 11/12/20 at 1:05pm revealed: -On 10/20/20 at 12:00pm, the RCC called and stated the facility was missing 60 Hydrocodone/Acetaminophen 5/325mg tablets (2 bubble cards of 30 tablets each) for Resident #14. -She told the RCC to notify the police and the HCPR. -There had been 90 tablets refilled on 10/08/20 and 60 tablets of that supply were missing. -The pharmacy sent an emergency refill request form on 10/20/20 at 1:28pm and a new prescription for 60 tablets was provided to the pharmacy. -The RCC did not report the resident had missed any doses of the pain medication. Telephone interview with the Administrator on 11/17/20 at 8:08am revealed: -They never found Resident #14's missing pain medication. -She did not recall any reports of pain or withdrawal symptoms when the resident missed

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2:59pm revealed:

the doses of pain medication.

Telephone interview with the RCC on 11/13/20 at

-She thought she told the PCP's office about

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE \$ COMPLI	
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		HAL032091	B. WING		11/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT			
DURHAM	RIDGE ASSISTED LIVIN		E FOREST HW NC 27703	Y		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 358	Resident #14 missing medication when she missing tablets. -She did not rememb complained of pain of he missed the doses Telephone interview of Manager (BOM) on 1-lt should not have ta #14's missing medication and the medication of the MAs were responsively of the MAS were re	er if Resident #14 r withdrawal symptoms when of medication. with the Business Office 1/17/20 at 9:48am revealed: ken 3 days for Resident titions to be replaced. not have missed any doses. onsible for letting the RCC ons were running low and a needed. with Resident #14's PCP on evealed: ydrocodone/Acetaminophen anding, chronic back pain and Resident #14 missed 9 when his medications were 220. the resident would have ad withdrawal symptoms king the medication routinely and record review, Resident wable. at #13's current FL-2 dated agnoses included dementia, glaucoma, hypothyroidism, as leg syndrome.	D 358	7.		
	Hydrocodone/Acetan	ninophen 5/325mg take 1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A, BUILDING:		COMPLETED	
					c
		HAL032091	B. WNG	x	11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STATI	E, ZIP CODE	
DURHAM	RIDGE ASSISTED LIVING	3420 WAK DURHAM,	E FOREST HWY NC 27703		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	: 72	D 358		
·	5/325mg is a controlle treat moderate to sev	odrocodone/Acetaminophen ed substance (CS) used to ere pain.) 13's physician's orders			
	prescription on 09/09/	inophen 5/325mg take 1			
	09/09/20 revealed: -The resident had chr well except the reside Hydrocodone/Acetam couple of days"There were no comp	inophen 5/325mg for "a laints of pain noted.			
		e a new prescription for inophen 5/325mg 1 tablet			
	after visit summary da -The resident was see a fall and was diagnos the left forearm. -The resident's medic	ocodone/Acetaminophen			
	dated 10/21/20 revea Hydrocodone/Acetam tablet at bedtime and	iinophen 5/325mg take 1 an order for iinophen 5/325mg 1 tablet at			
	11/05/20 revealed an	13's physician's order dated order to discontinue all e/Acetaminophen 5/325mg			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE COMP	SURVEY LETED		
						С	
		HAL032091	B. WING		11/	17/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
DURHAM	RIDGE ASSISTED LIVIN	G	KE FOREST HWY 1, NC 27703				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE	
D 358	Continued From page	e 73	D 358				
	orders and start Hydr 5/325mg 1 tablet eve	ocodone/Acetaminophen ry day at bedtime.					
		13's pharmacy dispensing 2020 - November 2020					
	-There were 30 table	ts of					
	Hydrocodone/Acetan dispensed on 08/03/2						
	-There were 30 table	ts of					
	Hydrocodone/Acetan dispensed on 09/08/2						
	-There were 15 table	ts of					
	Hydrocodone/Acetan						
	dispensed on 09/09/2 -There were 30 table						
	Hydrocodone/Acetan dispensed on 11/05/2	-					
ì		#13's September 2020					
		administration record					
	(e-MAR) revealed: -There was an entry	for					
	tablet at bedtime with	ninophen 5/325mg take 1 n a scheduled administration					
	documented as admi - 09/03/20, 09/06/20,	minophen 5/325mg was inistered daily from 09/01/20 09/07/20, and 09/09/20 -					
		minophen 5/325mg was not					
	09/05/20, and 09/08/ pharmacy delivery".	inistered on 09/04/20 - 20 due to "awaiting					
	Review of Resident a	#13's October 2020 e-MAR					
	-There was an entry						
		ninophen 5/325mg take 1 n a scheduled administration					

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		HAL032091	B. WING		C 11/17/2020	
NAME OF D			RESS, CITY, STAT	E ZIP CODE	-70	٦
NAME OF P	ROVIDER OR SUPPLIER		E FOREST HWY			
DURHAM	RIDGE ASSISTED LIVING					
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 358	Continued From page	e 74	D 358			1
D 358	time of 9:00pmHydrocodone/Acetar documented as admir - 10/18/20 and 10/20/-Hydrocodone/Acetar documented as admir from 10/26/20 - 10/31 being out of the facilit Review of Resident # revealed: -There was an entry from the Hydrocodone/Acetar tablet at bedtime with time of 8:00pmHydrocodone/Acetar documented as admired 11/09/20There was a note documented as admired 11/09/20There was a note documented as admired 11/03/20 due to the refacilityHydrocodone/Acetar documented as admired 11/03/20 due to the refacility.	minophen 5/325mg was nistered daily from 10/01/20 /20 - 10/25/20. minophen 5/325mg was not nistered on 10/19/20 and 1/20 due to the resident ry. 213's November 2020 e-MAR for ninophen 5/325mg take 1 n a scheduled administration minophen 5/325mg was nistered daily from 11/05/20 recumented on 11/06/20 at red to come in, meds arrived minophen 5/325mg was not nistered from 11/01/20 - resident being out of the minophen 5/325mg was not nistered on 11/04/20 due to delivery".	D 358			
	Review of Resident # supply dispensed on					

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL032091	B. WING		C 11/17/2020	0
	ROVIDER OR SUPPLIER	3420 WAK	DRESS, CITY, STATE FOREST HW NC 27703			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	X5) IPLETE ATE
D 358	-Documentation on the cart" on 09/08/20 with tabletsThe first dose was don 09/09/20 at 9:00pmThere were no dosest Hydrocodone/Acetarradministered from 09 of 6 missed doses. Review of Resident # supply dispensed on -Documentation on the cart" on 09/09/20 with tabletsThe first dose was don 10/09/20 at 9:00pmThere were no dosest Hydrocodone/Acetarradministered on 10/1 -There were 15 tables administered from 10/1 -There would have no remaining in this suppresident on 10/25/20. Review of Resident # supply dispensed on -Documentation on the cart" on 11/06/20 with tabletsThere were 5 tablets administered from 11 balance of 25 tablets	the first row noted "placed on a starting amount of 30 coumented as administered in and the last dose on as of almophen 5/325mg tablets //03/20 - 09/08/20 for a total coumented as administered in a starting amount of 15 cocumented as administered in and the last dose on as of almophen 5/325mg tablets 9/20 or 10/25/20 - 10/31/20. Its documented as //09/20 - 10/24/20. Its documented as //09/20 revealed: If all almost row noted "placed on a starting amount of 30 documented as //06/20 - 11/09/20, leaving a //06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20 - 10/06/20	D 358			

Division of Health Service Regulation

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C. 11/17/2020 B. WING HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 76 Hydrocodone/Acetaminophen 5/325mg tablets with 30 tablets dispensed on 11/05/20. -There were 25 of 30 tablets remaining in the bubble card. Telephone interview with the Resident Care Coordinator (RCC) on 11/17/20 at 2:16pm revealed she did not recall Resident #13 running out of Hydrocodone/Acetaminophen 5/325mg from 09/04/20 - 09/08/20. Telephone interview with the Administrator on 11/17/20 at 8:08am revealed: -She was not aware Resident #13 missed any doses of his pain medication. -The MAs should reorder medications when they got down to the blue strip on the bubble card. -She did not know how often the RCC was auditing the med carts to make sure medications were available. -Resident #13 was in pain because of a wrist fracture. -She did not know if the resident was in pain when he missed doses of the pain medication. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/17/20 at 9:04am revealed: -The supply of Hydrocodone/Acetaminophen dispensed for Resident #13 on 09/08/20 was delivered to the facility and signed for by a medication aide (MA) on 09/09/20 at 12:06am. -The supply of Hydrocodone/Acetaminophen dispensed for Resident #13 on 09/09/20 was delivered to the facility and signed for by a MA on

09/10/20 (time not specified).

11/06/20 at 1:26am.

-The supply of Hydrocodone/Acetaminophen dispensed for Resident #13 on 11/05/20 was delivered to the facility and signed for by a MA on

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SU COMPLE	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _			
		HAL032091	B. WING		C 11/17	/2020
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	TE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVIN		FOREST HW' NC 27703	Y		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 77	D 358			
	assistant (CMA) at Re 11/17/20 at 9:24am re -She took calls for the the facility could controlled the facility or the facility or reportShe forwarded all coresident's PCP in the -The facility requeste Hydrocodone/Acetam Friday, 09/04/20A prescription was so 09/08/20 at 7:55amThere may have been weekend and a holidative recommendation of the country of the	eir office 24 hours a day and act them anytime. Inted phone calls with the would send them an incident errespondences to the ir practice. If a refill for Resident #13's eninophen 5/325mg tablets on ent to the pharmacy on en a delay due to the ay on Monday, 09/07/20.				
	11/13/20 at 1:07pm r -Resident #13 was ta Hydrocodone/Acetan fractured arm.					
		ns, interviews, and record 3 was not interviewable.				
D 372	10A NCAC 13F .100 Administration	4 (o) Medication	D 372			
	10A NCAC 13F .100	4 Medication Administration				
	(o) A resident's med	lication shall not be				

		(X3) DATE SURVEY COMPLETED			
7,115 1 1 11 1	3. 33.4.23.13.1		A, BUILDING:		
		HAL032091	B. WING		C 11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	
DURHAM	RIDGE ASSISTED LIVING	G	FOREST HV	VY	
		DURHAM,	NC 27703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 372	Continued From page	e 78	D 372	It is the policy of Durham Ridge Assist	ed Living
		ner resident except in an		to assure that a resident's medication	s not
	emergency. In the event of an emergency, the borrowed medications shall be replaced promptly			given to another resident except in the	event of
	and the borrowing an	d replacement of the		an emergency and that in the event of	an
	medication shall be d	ocumented.		emergency, the borrowed medication i	s replaced
				promptly, and the borrowing and replace	cement of
				the medication is documented.	
This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were		as evidenced by:		Medication Technicians and Shift Supe	ervisors
			were in-serviced shift to shift, beginnin	g on	
	-	e medications were emergency and replaced		11/4/20, on topics, including but not lin	nited to,
	promptly and docume	ented for 2 of 2 residents		Medication Administration, Narcotics of	ounts and
		elated to staff borrowing a for moderate to severe pain		ordering and borrowing of Medication.	
	from Resident #14 ar			Additional In-services were held by the	RN
	Resident #13.			Consultant with the care staff, on 11/9	'20 and
	The findings are:			11/10/20 on, topics including but not li	mited to,
	4. Daview of Bosiden	+ #44 dia aurrant El 2 datad		Medication Administration, Narcotics of	ounts and
	07/07/20 revealed:	t #14's current FL-2 dated		ordering and borrowing of Medication.	
	_	unspecified dementia,		In the event a medication is borrowed,	the
	arthritis, and schizopl	hrenia - paranoid type. for		Medication Technician must notify the	RCC or
	Hydrocodone/Acetam	ninophen 5/325mg take 1		Administrator. The RCC will follow up	to make
	tablet 3 times a day.	minophen 5/325mg is a		sure appropriate documentation is con	apleted.
		(CS) used to treat moderate		Durham Ridge Assisted Living was for	ced to
	to severe pain.)			changed Primary Care Providers, on N	lovember
	Telephone interview	with a medication aide (MA)		30, 2020, due to lack of answering cal	s, faxes,
	on 11/13/20 at 3:14pr	m revealed:		and response in general to requests fr	om the
		as working on second shift Il when she was told via		facility. The previous provider failed to	show up
		lity's nurse (now the current one of Resident #14's			
		ninophen tablets to another			

DIVISION	Thealth Service Regu					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 '	CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	
			1		с	
		HAL032091	B. WING		ı	7/2020
		IMLU32091			1 1011	12020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
			E FOREST HV	Υ		I
DURHAM	RIDGE ASSISTED LIVING					- 1
				PROVIDEDIC DI ANI DE CORRECTION		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
1,10				DEFICIENCY)		
			D 070			
D 372	Continued From page	79	D 372	at Durham Ridge multiple days in whic	h thev	
	-She told the Adminis	trator she was not supposed		were scheduled. The change was made	- 1	- 1
		s but the Administrator said		-		- 1
	the other resident nee			to provide for a more seamless and or		- 1
		ng 1 tablet on the CS record		approach to resident care and allow fo		- 1
		beside that row on the CS		contacting and reporting to the primary		ı
		ent Care Coordinator (RCC)		group. The MD is in the facility three to	mes a	I
	would handle it the ne			week. There is also at least one PA in	the facility	
		initialed the note on the CS		Monday through Friday. There are day	vs with	1
	record.	initialized the flotte on the op-		multiple providers in the facility for Prin		- 1
		nt that she had borrowed the		This change allows for medication nee		- 1
	medication for anothe				ulig natu	
		d or paid back the pain		prescriptions to be refilled timely.		- 1
		nt #14 and she did not know		A staff meeting was held on December	r 2, 2020,	- 1
	if anyone else had do			o in-service staff on, topics including b	ut not	- 1
	Il allyone else nad de			limited to, the change in Primary Care	Providers	- 1
	Review of Resident #	14's October 2020		and the new for getting refills and Med		- 1
		administration record		Administration.		
	(e-MAR) revealed:	administration rosora		An in-service for Medication Technicia	ne will be	
	-There was an entry t	for				
		ninophen 5/325mg take 1		held by a consultant from the long-term		
		with scheduled administration		pharmacy on December 29, 2020 on,	topics	- 1
	times of 9:00am, 1:00			including but not limited to, medication	handling	- 1
		minophen 5/325mg was		policies and procedures.		I
		nistered 3 times a day from		An in-service with all care staff is sche	duled on	
		and 10/22/20 - 10/31/20 and		December 30, 2020 with an Outside C	onsultant	- 1
	once on 10/19/20 at 9		li .	from the Professional Assisted Living	1	
		lydrocodone/Acetaminophen				
		on 6 occasions with no		on topics including but not limited to, M		
	_	ons on 10/19/20 at 9:00am		Administration, Resident Rights, Infect	ion Control	
		0 at 9:00am, 1:00pm, and		and Incident/Accident Report.		
	9:00pm; and 10/21/20			A Medication Administration in-service	is	
		minophen 5/325mg was not		scheduled on January 7, 2021 with a p	harmacist	l
		nistered on 10/21/20 at		from the long-term care pharmacy, on		I
		due to "awaiting pharmacy		including but not limited to medication		- 1
	delivery".	J		administration and controlled substance	200	I
	-There were 85 table	ts of		auministration and controlled substant	<i>.</i>	
	Hydrocodone/Acetan					1
		nistered from 10/01/20 -				
	10/31/20.					
		nentation any medication				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B WING		C	
		HAL032091	B. WNG		11/17/2020	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, ST			
DURHAM	RIDGE ASSISTED LIVIN		E FOREST HV	VY		
				PROVIDER'S PLAN OF CORRECTION	I (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
	Review of Resident # supply dispensed on -There was a row bet on 10/25/20 at 9:00p that had no staff sign documented but amo and the amount rema -There was a handwi initialed by two MAsThe MAs documente the current Administr RCC said to leave it handle it when she g -The note did not ind borrowed from Resid another residentThere was no docur borrowed from Resid another resident on Resident #14. Telephone interview care provider (PCP) revealed: -On 11/02/20 when s RCC asked if she co	desident #14. Inentation any medication back to Resident #14. #14's CS record for the 10/21/20 revealed: tween doses administered m and 10/26/20 at 9:00am ature, no date and no time bunt given was recorded as 1 aining declined to 16 tablets. Fitten note beside this row ator) called the RCC and the blank and the RCC would of there in the morning. icate that a dose had been lent #14 and administered to 10/25/20 was paid back to with Resident #14's primary on 11/09/20 at 4:30pm she came to the facility, the ould write another prescription	D 372	Issues with the Administrator and the A Resident Care Coordinator, that oversa reporting, had been identified prior to the and changes were scheduled to be man November 3, 2020. The ARCC was resulted 11/10/20. The Administrator was replay November 13, 2020 by the Assistant Administrator. The owner of Durham Fis also a licensed Administrator, return Durham to take a more active role in the operations and plan of correction. Flow Managers were hired and began work each shift on December 1, 2020 to overshift and assist with communication at change. On 12/9/20, Durham Ridge hired an In Control Specialist/Compliance Officer, extensive background, knowledge, and experience in Infection Control/Prevent Assisted Living Compliance, to implem oversee policies, including but not limit Infection Control, Personal Care, Heal Follow up and Incident/Accident report On 12/8/2020, Durham Ridge hired an Administrator. The assistant admin will coordinate staff onboarding and training be responsible for educating new Med Technicians on procedures concerning	aw incident ne survey de on moved on ced on Ridge, who ed to the facility or ang on the shift fection with an ed to the Care ting. Assistant of the grand will incation incident and the ced to the care ting.	
	5/325mg tablets bed couple of pain tablet	ydrocodone/Acetaminophen ause they had to borrow a s from Resident #14 and		medications and medication administr The Resident Care Coordinator or De- monitor the Narcotics Counts and sup	ation. signee will	
	pain medicationShe told the RCC s prescription at that ti medication because repercussions.	tresident who ran out of the he could not write another ime for Resident #14's pain of possible legal was too soon to refill		non-batch medications, that must by c twice a week.		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
					(
		HAL032091	B. WING		11/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
DURHAM	RIDGE ASSISTED LIVIN		E FOREST HW NC 27703	,1		
OVA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
	write a new prescription Telephone interview of 2:59pm revealed: -She did not know what tablet deducted on CS recordShe did not recall the would handle the docrecord for Resident #-She did not know if a borrowing of Resident anyone replaced it or Telephone interview of 11/12/20 at 11:50am-Staff (could not recall	with the RCC on 11/13/20 at my there was a blank line with 10/25/20 for Resident #14's are note indicating that she cumentation on the CS 14. anyone documented the at #14's pain medication or if a paid it back.		monitor weekly for continued complian	ce.	December 17, 2020 and ongoing
	medicationShe did not want the pain so they borrowe Resident #14 to adm -The facility only borr "dire need"She did not know if the been replaced and particleThe RCC would know medications. Based on interviews #14 was not interview. Refer to telephone in Administrator on 11/2.	e resident to suffer or be in d pain medication from inister to the other resident. owed medications if it was a the borrowed medication had aid back to Resident #14. w the process for borrowing and record review, Resident wable.				

6899

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: ____ С B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 372 D 372 Continued From page 82 Office Manager (BOM) on 11/17/20 at 9:48am. 2. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dementia, arthritis, depression, glaucoma, hypothyroidism, insomnia, and restless leg syndrome. Review of Resident #13's physician's order dated 03/31/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime. (Hydrocodone/Acetaminophen 5/325mg is a controlled substance (CS) used to treat moderate to severe pain.) Review of Resident #13's physician's orders revealed the primary care provider (PCP) wrote a prescription on 09/09/20 for 15 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime as needed for pain. Review of Resident #13's emergency room (ER) after visit summary dated 10/19/20 revealed: -The resident was seen at the ER on 10/19/20 for a fall and was diagnosed with a closed fracture of the left forearm. -The resident's medication list included to continue taking Hydrocodone/Acetaminophen 5/325mg 1 tablet at bedtime. Review of Resident #13's physician's order sheet dated 10/21/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime and an order for Hydrocodone/Acetaminophen 5/325mg 1 tablet at bedtime as needed for pain. Interview with a medication aide (MA) on 11/10/20 at 5:20pm revealed: -About 2 weeks ago, Resident #13 ran out of his Hydrocodone/Acetaminophen 5/325mg tablets.

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ C 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 372 D 372 Continued From page 83 -She got permission from the Administrator to borrow one Hydrocodone/Acetaminophen 5/325mg tablet from another resident. -She did not know if the medication borrowed for Resident #13 had been replaced and paid back to the other resident. -She was not sure if she documented borrowing the medication for Resident #13. Review of Resident #13's October 2020 electronic medication administration record (e-MAR) revealed: -There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime with a scheduled administration time of 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was documented as administered daily from 10/01/20 - 10/18/20 and 10/20/20 - 10/25/20. -There was no documentation a dose of Hydrocodone/Acetaminophen 5/325mg was borrowed from another resident and administered to Resident #13 on 10/25/20. -There was no documentation at dose was paid back to the other resident from Resident #13's supply. Review of Resident #13's CS record for the supply dispensed on 09/09/20 revealed: -There were 15 tablets documented as administered from 10/09/20 - 10/24/20. -There would have not been any tablets remaining in this supply to administer to the resident on 10/25/20. -There was no documentation on the CS record that Hydrocodone/Acetaminophen 5/325mg was borrowed from another resident and administered to Resident #13 on 10/25/20.

Telephone interview with the Administrator on

NAME OF PROVIDER OR SUPPLIER DURHAM RIDGE ASSISTED LIVING SAMMANY STATEMENT OF DEPTICIENCIES GENERAL PROPERTY MS SAMMANY STATEMENT OF DEPTICIENCIES GENERAL PROPERTY MS REGULATORY OR LSC IDENTIFYING INFORMATION) D 372 Continued From page 84 1/1/12/20 at 11:50am revealed: Staff (could not recall who) contacted her when Resided not surins resident to administor to Resident #13 and out of his pain medication. She did not want Resident #13 to suffer or be in pain so they borrowed pain medication from another resident to administor to Resident #13. The facility only borrowed medications if it was a "dire need" She was not sure if the facility had a policy for borrowing medications. She did not know if the borrowed medication had been replaced and paid back to the other resident. The Resident Care Coordinator (RCC) would know the process for borrowing medications. She was not aware Resident #13 ran out of Hydrocodone/Acetaminophen. She wad not tall anyone to borrow medication. She would have called the pharmacy and the PCP. Telephone interview with Resident #13's PCP on 11/13/20 at 1.07pm revealed: On 11/02/20, the RCC asked for a refill for another resident's medication for Resident #13. Resident #13 was called the pharmacy and the PCP. Telephone interview with Resident #13's PCP on 11/13/20 at 1.07pm revealed: On 11/02/20, the RCC asked for a refill for another resident's Hydrocodone/Acetaminophen at bedtime for a fractured arm. Based on observations, interviews, and record	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER DURHAM RIDGE ASSISTED LIVING PREFIX TAG DOWNER FOREST HWY DURHAM, NC 27703 D 372 Continued From page 84 11/12/20 at 11:50am revealed: -Staff (could not recall who) contacted her when Resident #13 ran out of his pain medicationShe did not know if the borrowed medication is borrowing medicationsShe did not know if the borrowed medication had been replaced and paid back to the other residentThe Resident Care Coordinator (RCC) would know the process for borrowing medicationsThe reality's policy was they were not allowed to borrow medicationShe did not know if the borrowed medicationThe Resident Care Coordinator (RCC) would know the process for borrowing medicationsThe reality's policy was they were not allowed to borrow medicationShe did not know if the borrowed medicationThe Resident #13 ran out of Hydrocodone/AcetaminophenShe did not know if the borrow medicationThe Recility's policy was they were not allowed to borrow medicationShe would have called the pharmacy and the PCP. Telephone interview with Resident #13's PCP on 11/12/20 at 1/07pm revealed: -On 11/02/20, the RCC asked for a refill for another residents Hydrocodone/Acetaminophen at bedtime for a fractured arm.				A. BOILDING.		
DURHAM RIDGE ASSISTED LIVING PREFIX 740 PREFIX TAG PROVIDERS PLAN OF CORRECTION PREFIX TAG D 372 Continued From page 84 1/1/1/2/D at 11:50am revealed: -Staff (could not recall who) contacted her when Resident #13 ran out of his pain medication from another resident to administer to Resident #13The facility only borrowed medication from another resident to administer to Resident #13The facility only borrowed medication from another resident to administer to Resident #13The facility only borrowed medication from another resident to administer to Resident #13The facility only borrowed medication from another resident to administer to Resident #13The facility only borrowed medication had been replaced and paid back to the other residentThe Resident Care Coordinator (RCC) would know the process for borrowing medicationsShe did not know if the Borrowed medications. Telephone interview with the RCC on 11/12/20 at 4:34pm revealed: -The facility's policy was they were not allowed to borrow medicationsShe was not aware Resident #13 ran out of Hydrocodone/AcetaminophenShe did not that growed to perform the process was for another resident that the process of the p			HAL032091	B. WING		I I
DURHAM, NC 27703 DATE DAT	NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	
PREFIX TAG D 372 Continued From page 84 11/12/20 at 11:50am revealed: -Staff (could not recall who) contacted her when Resident #13 ran out of his pain medicationShe did not want Resident #13 to suffer or be in pain so they borrowed pain medication from another resident to administer to Resident #13The facility only borrowed medications if it was a "dire need"She was not sure if the facility had a policy for borrowing medication or what the process was for borrowing medication or what the process was for borrowing medication or what the process was for borrowing medicationsShe did not want with the RCC on 11/12/20 at 4:34pm revealed: -The Resident Care Coordinator (RCC) would know the process for borrowing medications. Telephone interview with the RCC on 11/12/20 at 4:34pm revealed: -The facility's policy was they were not allowed to borrow medicationsShe was not aware Resident #13 ran out of Hydrocodone/AcetaminophenShe did not tell anyone to borrow medicationShe would have called the pharmacy and the PCP. Telephone interview with Resident #13's PCP on 11/13/20 at 1:07pm revealed: -On 11/02/20, the RCC asked for a refill for another resident's Hydrocodone/Acataminophen 5/325mg tablest because they had borrowed that resident's medication for Resident #13Resident #13 was taking Hydrocodone/Acetaminophen at bedtime for a fractured arm.	DURHAM	RIDGE ASSISTED LIVING	G			
1/1/2/20 at 11:50am revealed: -Staff (could not recall who) contacted her when Resident #13 ran out of his pain medicationShe did not want Resident #13 to suffer or be in pain so they borrowed pain medication from another resident to administer to Resident #13The facility only borrowed medications if it was a "dire need"She was not sure if the facility had a policy for borrowing medication or what the process was for borrowing medication or what the process was for borrowing medicationsShe did not know if the borrowed medication had been replaced and paid back to the other residentThe Resident Care Coordinator (RCC) would know the process for borrowing medications. Telephone interview with the RCC on 11/12/20 at 4:34pm revealed: -The facility's policy was they were not allowed to borrow medicationsShe was not aware Resident #13 ran out of Hydrocodone/AcetaminophenShe did not tell anyone to borrow medicationShe would have called the pharmacy and the PCP. Telephone interview with Resident #13's PCP on 11/13/20 at 1:07pm revealed: -On 11/02/20, the RCC asked for a refill for another resident's Hydrocodone/Acetaminophen 5/325mg tablets because they had borrowed that resident's medication for Resident #13Resident #13 was taking Hydrocodone/Acetaminophen at bedtime for a fractured arm.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETE
review, Resident #13 was not interviewable.	D 372	11/12/20 at 11:50am -Staff (could not recal Resident #13 ran out -She did not want Re pain so they borrowe another resident to ac -The facility only borr "dire need"She was not sure if the borrowing medication borrowing medication -She did not know if the been replaced and paresidentThe Resident Care of know the process for Telephone interview 4:34pm revealed: -The facility's policy of borrow medicationsShe was not aware Hydrocodone/Acetan -She did not tell anyon -She would have call PCP. Telephone interview 11/13/20 at 1:07pm r -On 11/02/20, the Ro another resident's Hy 5/325mg tablets becomes ident's medication -Resident #13 was to Hydrocodone/Acetar fractured arm. Based on observation	revealed: Il who) contacted her when of his pain medication. sident #13 to suffer or be in d pain medication from diminister to Resident #13. owed medications if it was a the facility had a policy for nor what the process was for its. the borrowed medication had aid back to the other Coordinator (RCC) would borrowing medications. with the RCC on 11/12/20 at was they were not allowed to Resident #13 ran out of minophen. The to borrow medication had enter the pharmacy and the with Resident #13's PCP on evealed: CC asked for a refill for ydrocodone/Acetaminophen ause they had borrowed that in for Resident #13. aking minophen at bedtime for a sins, interviews, and record	D 372		

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	Administrator on 11/1 Refer to a second tell former Administrator Refer to telephone in Office Manager (BOM Telephone interview on 11/12/20 at 2:15pr. He was not aware a borrowed at the facility and document replication it and document replication because borrow medications because borrow medications. It was a verbal policity of the was not aware a medication and staff resident. The facility did not he madication and staff resident.	terview with the former 2/20 at 2:15pm. ephone interview with the on 11/12/20 at 6:20pm. terview with the Business // on 11/17/20 at 9:48am. with the former Administrator m revealed: ny medications had been ty. nedications if it was an eekends and they could not refilled but they had to report acing it. interview with the former fi2/20 at 6:20pm revealed: have a policy for borrowing e they were not allowed to y, not written. with the Business Office fi1/17/20 at 9:48am revealed: have a policy for borrowing the tresident ran out of pain borrowed from another have a policy for borrowing aff to follow proper procedure	D 372				
D 392		8(a) Controlled Substances 8 Controlled Substances	D 392				
		me shall assure a readily					

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: ___ C 11/17/2020 B. WING HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) It is the policy of Durham Ridge Assisted Living D 392 D 392 Continued From page 86 to assure a readily retrievable record of retrievable record of controlled substances by controlled substances by documenting the documenting the receipt, administration and receipt, administration, and disposition of disposition of controlled substances. These controlled substances. records shall be maintained with the resident's Medication Technicians and Shift Supervisors record and in such an order that there can be were in-serviced shift to shift, beginning on accurate reconciliation. 11/4/20, on topics, including but not limited to, This Rule is not met as evidenced by: Medication Administration, Narcotics counts and Based on observations, interviews, and record ordering of Medication. reviews, the facility failed to ensure readily Additional In-services were held by the RN retrievable records that accurately reconciled the Consultant with the care staff, on 11/9/20 and receipt and administration of controlled 11/10/20 on, topics including but not limited to, substances for 2 of 2 residents sampled (#13, #14) who both received medication for moderate Medication Administration, Narcotics counts and to severe pain. ordering of Medication. Durham Ridge Assisted Living was forced to The findings are: changed Primary Care Providers, on November 30, 2020, due to lack of answering calls, faxes, 1. Review of Resident #14's current FL-2 dated and response in general to requests from the 07/07/20 revealed: facility. The previous provider failed to show up -Diagnoses included unspecified dementia, at Durham Ridge multiple days in which they arthritis, and schizophrenia - paranoid type. -There was an order for were scheduled. The change was made in order Hydrocodone/Acetaminophen 5/325mg take 1 to provide for a more seamless and organized tablet 3 times a day. approach to resident care and allow for easier (Hydrocodone/Acetaminophen 5/325mg is a contacting and reporting to the primary care controlled substance (CS) used to treat moderate group. The MD is in the facility three times a to severe pain.) week. There is also at least one PA in the facility Monday through Friday. There are days Review of Resident #14's physician's orders revealed the primary care provider (PCP) wrote a with multiple providers in the facility for Primary prescription on 09/09/20 for 90 tablets of Care. This change allows for medication Hydrocodone/Acetaminophen 5/325mg take 1 needing hard prescriptions to be refilled timely. tablet 3 times a day. Review of Resident #14's incident/accident report

Resident #14.

dated 10/20/20 at 12:00pm revealed: -Staff went to get back up supply of Hydrocodone/Acetaminophen 5/325mg for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	COM		(X3) DATE SURVEY COMPLETED	
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called the pharmacy, pharmacy delivered 9 -There were 60 table! Hydrocodone/Acetam -There was "no injury -Staff noted it was rej department and the harmonia an	Care Coordinator (RCC) they told the RCC that the 20 tablets on 10/08/20. ts of ninophen 5/325mg missing. "To the resident. ported to the police Health Care Personnel Interport was electronically 214's PCP on 10/23/20 at 214's CS continuance of dated 10/08/20 revealed an done/Acetaminophen 21 tablet 3 times a day. 214's CS emergency 21 dated 10/20/20 revealed an done/Acetaminophen 21 tablet 3 times a day. 214's pharmacy dispensing aber 2020 - November 2020 225 of minophen 5/325mg 20. 226 of minophen 5/325mg 20. 227 of 228 of minophen 5/325mg 20. 2414's September 2020 258 of minophen 5/325mg 20. 268 of minophen 5/325mg 20. 269 of minophen 5/325mg 20. 261 of minophen 5/325mg 20. 262 of minophen 5/325mg 20. 263 of minophen 5/325mg 20. 264 of minophen 5/325mg 20. 265 of minophen 5/325mg 20. 266 of minophen 5/325mg 20. 267 of minophen 5/325mg 20. 268 of minophen 5/325mg 20. 269 of minophen 5/325mg 20. 270 of minophen 5/325mg 20. 281 of minophen 5/325mg 20. 200 of minophen 5/325mg	D 392	A staff meeting was held on Decembe to in-service staff on, topics including be limited to, the change in Primary Care and the new for getting refills, Narcotic and Medication Administration. An in-service for Medication Technicia held by a consultant from the long-terr pharmacy on December 29, 2020 on, including but not limited to, medication policies and procedures. An in-service with all care staff is sche December 30, 2020 with an Outside C from the Professional Assisted Living Association on topics including but not Medication Administration, Resident Form the long-term care pharmacy, on including but not limited to medication administration and controlled substant Issues with the Administrator and the Resident Care Coordinator, that overs incident reporting, had been identified the survey and changes were schedul made on November 3, 2020. The AR removed on 11/10/20. The Administrator. The owner of Durham who is also a licensed Administrator, in Ourham to take a more active role in toperations and plan of correction. Flo Managers were hired and began work each shift on December 1, 2020 to ov shift and assist with communication at change.	out not Providers Counts In will be in care topics handling duled on consultant I limited to, lights, it Report. Is is charmacist topics Ces. Assistant law prior to led to be CC was lator was le Assistant Ridge, returned to the facility for cling on lersee each

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
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D 392	Hydrocodone/Acetam tablet 3 times a day witimes of 9:00am, 1:00-Hydrocodone/Acetam documented as admi 09/01/20 - 09/30/20 e-Hydrocodone/Acetam documented as admi 1:00pm due to "await-There were 89 table Hydrocodone/Acetam documented as admi 09/30/20. Review of Resident # revealed: -There was an entry Hydrocodone/Acetam tablet 3 times a day witimes of 9:00am, 1:00-Hydrocodone/Acetam documented as admi 10/01/20 - 10/18/20 at -Documentation for H5/325mg was blank or reason for the omiss and 1:00pm; 10/20/2 9:00pm; and 10/21/2 - Hydrocodone/Acetam documented as admi 9:00am and 1:00pm delivery"There were 85 table Hydrocodone/Acetam documented as admi 10/31/20.	ninophen 5/325mg take 1 with scheduled administration Dpm, and 9:00pm. minophen 5/325mg was nistered 3 times daily from except for 1 occasion. minophen 5/325mg was not nistered on 09/08/20 at ing pharmacy delivery". Its of ninophen 5/325mg nistered from 09/01/20 - 14's October 2020 e-MAR for ninophen 5/325mg take 1 with scheduled administration Dpm, and 9:00pm. minophen 5/325mg was nistered 3 times a day from and 10/22/20 - 10/31/20 and 9:00pm. Hydrocodone/Acetaminophen on 6 occasions with no ions on 10/19/20 at 9:00am 0 at 9:00pm. minophen 5/325mg was not inistered on 10/21/20 at due to "awaiting pharmacy wits of	D 392	On 12/9/20, Durham Ridge hired an In Control Specialist/Compliance Officer, extensive background, knowledge, and experience in Infection Control/Prevent Assisted Living Compliance, to implem oversee policies, including but not limit Infection Control, Personal Care, Heal Follow up and Incident/Accident report On 12/8/2020, Durham Ridge hired an Administrator. The assistant admin will coordinate staff onboarding and training the responsible for educating new Med Technicians on procedures concerning medications and medication administrator. The Resident Care Coordinator will make Narcotics Counts and supply of all nor medications, that must by ordered, twith The Administrator and Compliance Of monitor weekly for continued compliance.	with an tion and tent and ted to th Care ting. Assistant I tig, and will ication g ordering ation. conitor the theatch the a week. ficer will	

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 392 D 392 Continued From page 89 -There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day with a scheduled administration times of 9:00am, 1:00pm, and -Hydrocodone/Acetaminophen 5/325mg was documented as administered as ordered from 11/01/20 - 11/10/20. -There were 28 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 11/01/20 -11/10/20 at 9:00am. Review of Resident #14's CS record for the supply dispensed on 09/08/20 revealed: -The first page had a prescription label on the upper left side of the page for 90 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day. -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 09/09/20 with a starting amount of 30 tablets. -The first dose of those 30 tablets was documented as administered on 09/09/20 at 9:00am and the last dose on 09/18/20 at 9:00pm. -The next row noted a second card with 30 tablets was "placed on cart" on 09/18/20. -The first dose of those 30 tablets was documented as administered on 09/19/20 at 8:00am and the last dose on the second page was on 09/28/20 at 9:00pm. -The second page had an entry for the third card with 30 tablets "placed on cart" on 09/28/20. -The first dose of those 30 tablets was

documented as administered on 09/29/20 at 9:00am and the last dose on 10/08/20 at 9:00pm.

leaving a balance of zero.

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D 392	Continued From page	90	D 392	BETTOLINOT		
D 392	-There were 66 tablet administered from 09 -There were 24 tablet administered from 10 Review of Resident # supply dispensed on -The prescription labet the page was for 90 thydrocodone/Acetamtablet 3 times a dayThe section on the unhad date received do amount received as 9 blankDocumentation on the cart" on 10/08/20 with the 90 had been writt with no initials to indirect on 10/09/20 at 9:00ard documented as 89 brower and changed to who made the changer the second dose was administered on 10/09 remaining documented written over and changed to who made the changer the third dose was on 10/09/20 at 9:00p documented as 27The rest of the dose declining from 26 to 10/10/20 at 9:00am the transport of the other dispensed on 10/08/20.	is documented as //09/20 - 09/30/20. Its documented as //01/20 - 10/08/20. Its CS record for the 10/08/20 revealed: Its on the upper left side of ablets of ablets of all the upper left side of ablets of all the upper left side of ablets of all the upper left side of ablets of all the upper right side of the page cumented as 10/08/20, 20, but received by line was the first row noted "placed on a starting amount of 90 but the upper and changed to 30 cate who made the change. Occumented as administered in with amount remaining that the 89 had been written 29 with no initials to indicate the upper left of 28 with no initials to indicate the upper left of 28 with no initials to the change. Indicate the upper left of 28 with no initials to the change. Indicate the upper left of 28 with no initials to the change. In our left of 28 with no initials to the change. In our left of 28 with no initials to the change. In our left of 28 with no initials to the change. In our left of 30 and administered from through 10/18/20 at 9:00pm. In on the CS record the foor of 90 tablets	D 392			
		dispensed on 10/08/20.				

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C 11/17/2020 B. WING. HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 392 Continued From page 91 D 392 -There were no doses of Hydrocodone/Acetaminophen 5/325mg tablets administered from 10/19/20 - 10/21/20 due to no medication being on hand for a total of 9 missed doses. Review of Resident #14's CS record for the supply dispensed on 10/21/20 revealed: -The first page had a prescription label on the upper left side of the page for 60 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day. -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 10/22/20 with a starting amount of 30 tablets. -The first dose of those 30 tablets was documented as administered on 10/22/20 at 9:00am and the last dose on 10/31/20 at 8:00am. -There was documentation of 1 tablet being administered on 10/25/20 at 9:00am leaving a balance of 20 tablets and the next entry was for 10/25/20 at 1:00pm with 1 tablet administered but the balance remaining was documented at 18 instead of 19 tablets. -There was no documentation on the CS record to account for that one tablet. -There was a row between doses administered on 10/25/20 at 9:00pm and 10/26/20 at 9:00am that had no staff signature, no date and no time documented but amount given was recorded as 1 and the amount remaining declined to 16 tablets. -There was a handwritten note beside this row initialed by two medication aides (MAs). -The MAs documented beside this row that the facility's nurse (now the current Administrator) called the Resident Care Coordinator (RCC) and the RCC said to leave it blank and the RCC would

INAME OF PROMIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY DURHAM RIDGE ASSISTED LIVING SUMMARY STATEMENT OF DEFICIENCIES RECHATORY OR LOS IDENTIFYING INFORMATION) DISTANCE OF PROMIDER'S PLAN OF CORRECTION PRETIX TAG CROSS-REFERENCED TO THE APPROMINATE DEFICIENCY TAG D PROMIDER'S PLAN OF CORRECTION PRETIX TAG D PROMIDER'S PLAN OF CORRECTION CRACH CONFECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROMINATE D 392 Continued From page 92 handle it when she got there in the morning. The note did not indicate that a dose had been borrowed from Resident #14 and administered to another resident. There was no documentation on the CS record to account for the tablet or to reconcile what happened to this tablet. The first dose of those 30 tablets was documented as administered on 10/28/20 at 1:00pm and the last dose on 11/10/20 at 8:00am, leaving a balance of zero. A dose for 10/28/20 at 1:00pm was already documented by a summistered at 1:00pm on 10/31/20 but it was documented as administered on the e-MAR at that time. There was not documentation for a dose being administered on 10/29/20 at 1:00pm on 10/31/20 but it was documented as administered on the properties of the pro	STATEMENT	of Deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED	
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10/08/20 for Resident #14 that were delivered to the facility and signed for by a MA on 10/08/20 at	D 392	handle it when she go -The note did not indi borrowed from Reside another residentThere was no docum to account for the tab happened to this tabl -The second page ha card with 30 tablets " at 3:00pmThe first dose of tho documented as admi 1:00pm and the last of leaving a balance of: -A dose for 10/29/20 documented by anote both entries declined -There was not docus administered at 1:00 documented as admi that timeThere were 59 of 60 administered from 10 but there was a balan the amount remainin Observation of Resid hand on 11/10/20 rev Hydrocodone/Acetar hand for the resident Telephone interview facility's contracted p 1:22pm revealed: -The pharmacy dispe Hydrocodone/Acetar 10/08/20 for Resider	ot there in the morning. cate that a dose had been ent #14 and administered to mentation on the CS record let or to reconcile what et. Id an entry for the second placed on cart" on 10/28/20 se 30 tablets was nistered on 10/29/20 at dose on 11/10/20 at 8:00am, zero. at 1:00pm was already her MA on the first page but the count. mentation for a dose being pm on 10/31/20 but it was inistered on the e-MAR at It tablets documented as 0/22/20 - 11/10/20 at 8:00am nice of zero documented as g. Ident #14's medications on wealed there was no minophen 5/325mg tablets on the ensed 90 minophen 5/325mg tablets on int #14 that were delivered to				

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: C B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY DURHAM RIDGE ASSISTED LIVING DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 392 D 392 | Continued From page 93 30 tablets each, for a total of 90 tablets. -There was a supply of 60 Hydrocodone/Acetaminophen 5/325mg tablets dispensed on 10/21/20 that were delivered to the facility and signed for by a MA on 10/22/20 at 12:32am. A second telephone interview with a pharmacist at the facility's contracted pharmacy on 11/17/20 at 9:04am revealed the pharmacy sent a CS record sheet with each 30-count blister card to the facility when the medication was dispensed. Telephone interview with a MA on 11/13/20 at 3:14pm revealed: -She remembered Resident #14 having 3 bubble cards of Hydrocodone/Acetaminophen 5/325mg in the medication cart (could not recall the date). -The next day (could not recall date) when she came to work on second shift, 60 tablets (2 cards of 30) were gone and there was one card left with less than 30 tablets (did not know how many). -The RCC asked her where the tablets were but she did not know what happened to them. -She did not know what kind of pain the resident took the medication for but the resident missed some doses when the medications were missing. -She did not remember why she documented the dose on 10/19/20 at 9:00pm was administered on the e-MAR when there was no medication available to administer. -The MAs did shift counts of the CS medications each time they changed shifts. -The MAs documented on the CS record when a CS medication was administered. -On 10/25/20, she was working on second shift on Resident #14's hall when she was told via telephone by the facility's nurse (now the current Administrator) to give one of Resident #14's

Hydrocodone/Acetaminophen tablets to another

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 94 MA for a resident on another hall. -She documented using 1 tablet on the CS record and she wrote a note beside that row on the CS record. -The CS record count usually started with the amount of medication received. -When they first got Resident #14's Hydrocodone/Acetaminophen (dispensed and received on 10/08/20), she and the other MA counted off and there were 90 tablets in the medication cart. -The CS record initially had 90 tablets as the starting count but someone marked over it and changed it to 30. -She did not know who changed it or why the documentation was not accurate.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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Telephone interview with a second MA on 11/16/20 at 1:38pm revealed: -She was working the morning that Resident #14's card with 30 tablets of Hydrocodone/Acetaminophen ran out. -Someone had changed the 90 on the CS record to 30. -She went to the RCC and the RCC told her this was not right because 90 tablets had been delivered to the facility for Resident #14. -The MAs were supposed to document administration of CS medications on the CS record. -She thought they usually started the balance on the CS record with the amount received, like 90 tablets for example. -The MAs did shift counts for the CS medications each shift and when she checked the count that morning, the CS record showed zero for the balance for Resident #14 and there was none on	D 392	MA for a resident on a She documented usi and she wrote a note record that the RCC value and she wrote another MA record. The CS record count amount of medication -When they first got F Hydrocodone/Acetam received on 10/08/20 counted off and there medication cart. The CS record initial starting count but sor changed it to 30. She did not know wh documentation was more she was working the #14's card with 30 tal Hydrocodone/Acetam -Someone had change to 30. She went to the RCC was not right becaus delivered to the facilitation of CS record. She thought they us the CS record with the tablets for example. The MAs did shift coeach shift and when morning, the CS record.	another hall. Ing 1 tablet on the CS record beside that row on the CS would handle it the next day. Initialed the note on the CS It usually started with the received. Resident #14's Ininophen (dispensed and I), she and the other MA Is were 90 tablets in the Illy had 90 tablets as the meone marked over it and Ino changed it or why the not accurate. With a second MA on evealed: In morning that Resident blets of Ininophen ran out. Iged the 90 on the CS record IC and the RCC told her this Ininophen the companies of the companies	D 392			

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			-	<u> </u>		-
D 392	Continued From page	95	D 392			
	-Δ few months ago, th	nere was a problem with the				
		ng but it was because				
	someone forgot to sig					
	Someone lorgot to sig	gri the 66 record.				
	Telephone interview v	with a third MA on 11/16/20				
	at 2:10pm revealed:					
		ted 10/29/20 on Resident				
	#14's CS record for					
	Hvdrocodone/Acetam	ninophen, it was probably a				
	documentation error.	, , , ,				
	-She would have adm	ninistered the dosage when				
	she initialed on the e-					
	Telephone interview v	with the RCC on 11/12/20 at				
	4:34pm revealed:					
		nd reported Resident #14				
	was out of his Hydrod	codone/Acetaminophen				
	5/325mg tablets (cou					
	-She usually kept the		1			
		fice in a locked filing cabinet.				
		ng cabinet but Resident #14				
	did not have any in th					
		nacy and was told 90 tablets				
		facility previously and the				
	resident should have	ne had written over the				
		ecord and changed it.				
	-The MA who signed					
	_	t recall date) reported all 90				
	,	ne active medication cart				
	when it was received					
		eported the other MA put all				
	90 tablets on the med					
		ssing medication to the				
	Administrator and the					
		e PCP the same day (did not				
		narmacy could not send				
		ause it had just been filled.				
		ther prescription to the				
		tablets were sent she				
D1 111	alth Service Pegulation					

Division of Health Service Regulation

MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY DURHAM RIDGE ASSISTED LIVING SUMMAYS SAIRMENT OF DEPTICIENCIES 16ACH REPRICIANCY MAYS TE PRECEDED BY SYLL PRETAL TAG CONTINUED FROM THE SAME PROCEDED BY SYLL THE MAS HE SHE PROLEDED WITHING INFORMATION) D 392 Continued From page 96 thought on the same night. -The MAS were required to do shift counts for the CS medications each time they changed shifts. -The MAS had not reported any discrepancies with the shift counts or any issues with documentation on the CS records heet for a supply of medication, they would start the count with the amount received, such as 90. -If the pharmacy only sent 1 CS record sheet for a supply of medication, they would start the count with the amount received in the back up supply cabinet. -If saif documented "place on car" on the CS record sheet for the supply received. -The other 2 bubble cards and CS record sheet for each bubble card, they would start store one bubble card and 1 CS records sheet for each bubble card, they would start store one bubble card may 1 the pharmacy son't so Foreord sheet for the supply received. -The MAS were supposed to document who received in the back up supply cabinet. -If staff documented "place on car" on the CS record sheet for the supply received. -The MAS were supposed to document who received the medication, date received, and amount received in the upper right come of the CS record. -She did not know why there was a blank line with 1 tablet deducted on 10/2/S/20 for Resident #14's CS record. -She did not know with the Business Office Manager (BOM) on 11/17/20 at 9:48am 2. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dimentia, arthritis, depression, glaucoma, hypothyroidism, insommia, and residens included dimentia, insommia, and residens lieg syndrome.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 3420 WAKE FOREST HWY DURHAM, NC 27703 PROVIDER PILAY OF CORRECTION ON JUNEAU TO CHECKENDY MUST SEE PRECEDED BY FULL PRETIX TAG CONTINUED FROM THE APPROPRIATE CONTINUED FROM THE APPR						c
DURHAM RIDGE ASSISTED LIVING DURHAM, NC 27703 MANUARY STATEMENT OF DEFICIENCIES DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (PLACH COMPRECTIVE) PREPRIX PROVIDER'S PLAN OF CORRECTION (PLACH COMPRECTIVE) PROVIDENT (PLACH COMPRECTIVE) PROVIDER'S PLAN OF CORRECTION (PLACH COMPRECTIVE) PROVIDER'S PLAN OF CORRECTION (PLACH COMPRECTIVE) PROVIDER'S PLAN OF CORRECTION (PLACH COMPRECTIVE) PROVIDER'S PLAN OF COMPRECTION (PLACH COMPRECTIVE) PROVIDER'S PLAN OF COMPRECTIVE PROVIDER'S PLAN OF COMPRECTION (PLACH COMPRECTIVE) PROV	HAL032091			B. WING		11/17/2020
DURHAM, NC 27703 DURHAM, NC	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	E, ZIP CODE	
MAID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX TAG D392 Continued From page 96 thought on the same night. -The MAs were required to do shift counts for the CS medications each time they changed shifts. -The MAs were required to the CS record sheet for a supply of medication, they would start the count with the amount received, such as 90. -If the pharmacy only sent 1 CS record sheet for as upply of medication, they would start the count with the amount received, such as 90. -If the pharmacy sent a CS record sheet for as upply of medication, they would start the count with the amount received in the back up supply cabinet. -If staff documented 'place on card' on the CS record' sheet for the supply received. -If the pharmacy supposed to document who received the medication, date received, and amount received in the back up supply cabinet. -If staff documented 'place on card' on the CS record sheet for the supply received. -The MAs were supposed to document who received the medication, date received, and amount received in the upper right corner of the CS record sheet. -She did not know why there was a blank line with 1 tablet deducted on 10/25/20 for Resident #14's CS record. -She did not recall the note indicating that she would handle the documentation on the CS record for Resident #14. Refer to telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9.48am 2. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dementia, arthritis, depression, glaucoma, hypothyroidism,	DURHAM	RIDGE ASSISTED LIVING	G.		(
PRETIX TAG D 392 Continued From page 96 thought on the same nightThe MAs were required to do shift counts for the CS medications each time they changed shiftsThe MAs had not reported any discrepancies with the shift counts or any issues with documentation on the CS record sheet for a supply of medication, they would start the count with the annuant received, such as 90If the pharmacy only sent 1 CS record sheet for as upply of medication, they would start the count with the annuant received, such as 90If the pharmacy sent a CS record sheet for as 40 multiple or the pharmacy only sent 1 CS record sheet for any to the pharmacy sent a CS record sheet for any to the pharmacy sent a CS record sheet for any to the pharmacy sent a CS record sheet for any to the pharmacy sent a CS record sheet for any to the pharmacy sent a CS record sheet for the supply receivedIf staff documented "place on cart" on the CS record sheet for the supply receivedThe MAs were supposed to document who received in the upper right corner of the CS record sheetShe did not know why there was a blank line with 1 tablet deducted on 10/25/20 for Resident #14's CS record for Resident #14's CS record for Resident #14. Refer to telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9.48am 2. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dementia, arthritis, depression, glaucoma, hypothyroidism.				DROVIDER'S BLANCE CORRECTIO	N (Y5)	
thought on the same night. The MAs were required to do shift counts for the CS medications each time they changed shifts. The MAs had not reported any discrepancies with the shift counts or any issues with documentation on the CS records. A second telephone interview with the RCC on 11/13/20 at 2:59pm revealed: If the pharmacy only sent 1 CS record sheet for a supply of medication, they would start the count with the amount received, such as 90. If the pharmacy sent a CS record sheet for each bubble card, they would start store one bubble card and 1 CS record sheet in the medication cart. The other 2 bubble cards and CS record sheets should be stored in the back up supply cabinet. If staff documented "place on cart" on the CS record, it meant there was only 1 CS record sheet for the supply received. The MAs were supposed to document who received the medication, date received, and amount received in the upper right corner of the CS record sheet. She did not know why there was a blank line with 1 tablet deducted on 10/25/20 for Resident #14's CS record. She did not know why there was a blank line with 1 tablet deducted on 10/25/20 for Resident #14's CS record of Resident #14. Refer to telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am 2. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dementia, arrhiritis, depression, glaucoma, hypothyroidism,	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE
record for Resident #14. Refer to telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am 2. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dementia, arthritis, depression, glaucoma, hypothyroidism,	D 392	thought on the same -The MAs were requir CS medications each -The MAs had not reg with the shift counts of documentation on the A second telephone i 11/13/20 at 2:59pm re -If the pharmacy only a supply of medicatio with the amount rece -If the pharmacy sent bubble card, they wo card and 1 CS record cartThe other 2 bubble of should be stored in the -If staff documented record, it meant there for the supply received -The MAs were supply received the medicate amount received in the CS record sheetShe did not know with 1 tablet deducted on CS recordShe did not recall the	night. red to do shift counts for the a time they changed shifts. corted any discrepancies or any issues with a CS records. Interview with the RCC on evealed: It sent 1 CS record sheet for on, they would start the count inved, such as 90. It a CS record sheet for each uld start store one bubble disheet in the medication cards and CS record sheets he back up supply cabinet. I'place on cart' on the CS as was only 1 CS record sheet ed. I osed to document who tion, date received, and he upper right corner of the only there was a blank line with 10/25/20 for Resident #14's are note indicating that she	D 392		
		record for Resident # Refer to telephone ir Office Manager (BOI 2. Review of Resider 03/18/20 revealed di arthritis, depression,	#14. Interview with the Business M) on 11/17/20 at 9:48am Int #13's current FL-2 dated agnoses included dementia, glaucoma, hypothyroidism,			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 97 Review of Resident #13's physician's order dated 03/31/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg is a controlled substance (CS) used to treat moderate to severe pain.) Review of Resident #13's physician's orders	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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Review of Resident #13's physician's order dated 03/31/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime. (Hydrocodone/Acetaminophen 5/325mg is a controlled substance (CS) used to treat moderate to severe pain.) Review of Resident #13's physician's orders	PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETE	
revealed the primary care provider (PCP) wrote a prescription on 09/09/20 for 15 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime as needed for pain. Review of Resident #13's emergency room (ER) after visit summary dated 10/19/20 revealed: -The resident was seen at the ER on 10/19/20 for a fall and was diagnosed with a closed fracture of the left forearmThe resident's medication list included to continue taking Hydrocodone/Acetaminophen 5/325mg 1 tablet at bedtime. Review of Resident #13's physician's order sheet dated 10/21/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg tablet at bedtime and an order for Hydrocodone/Acetaminophen 5/325mg 1 tablet at bedtime as needed for pain. Review of Resident #13's physician's order dated 11/05/20 revealed an order to discontinue all previous Hydrocodone/Acetaminophen 5/325mg orders and start Hydrocodone/Acetaminophen 5/325mg orders and start Hydrocodone/Acetaminophen 5/325mg orders and start Hydrocodone/Acetaminophen 5/325mg records from August 2020 - November 2020 revealed: -There were 30 tablets of Hydrocodone/Acetaminophen 5/325mg	Review of Resident 03/31/20 revealed a Hydrocodone/Aceta tablet at bedtime. (5/325mg is a controt treat moderate to see Review of Resident revealed the primar prescription on 09/0 Hydrocodone/Aceta tablet at bedtime as Review of Resident after visit summary -The resident was a fall and was diagnthe left forearmThe resident's mecontinue taking Hydrocodone/Aceta tablet at bedtime at Review of Resident dated 10/21/20 revelydrocodone/Aceta tablet at bedtime at Hydrocodone/Aceta tablet at bedtime as needed Review of Resident 11/05/20 revealed a previous Hydrocodone/Aceta tablet at the second at the	#13's physician's order dated in order for minophen 5/325mg take 1 Hydrocodone/Acetaminophen lled substance (CS) used to evere pain.) #13's physician's orders y care provider (PCP) wrote a 9/20 for 15 tablets of minophen 5/325mg take 1 needed for pain. #13's emergency room (ER) dated 10/19/20 revealed: een at the ER on 10/19/20 for osed with a closed fracture of ication list included to rocodone/Acetaminophen bedtime. #13's physician's order sheet ealed an order for minophen 5/325mg 1 tablet at for pain. #13's physician's order dated an order to discontinue all one/Acetaminophen 5/325mg drocodone/Acetaminophen erry day at bedtime. #13's pharmacy dispensing at 2020 - November 2020 lets of	D 392			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
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D 392	dispensed on 08/03/2 -There were 30 tablet Hydrocodone/Acetam dispensed on 09/08/2 -There were 15 tablet Hydrocodone/Acetam dispensed on 09/09/2 -There were 30 tablet Hydrocodone/Acetam dispensed on 11/05/2 Review of Resident # electronic medication (e-MAR) revealed: -There was an entry f Hydrocodone/Acetam tablet at bedtime with time of 9:00pmHydrocodone/Acetam documented as admi - 09/03/20, 09/06/20, 09/30/20Hydrocodone/Acetam documented as admi 09/05/20, and 09/08/2 pharmacy delivery"There was a second Hydrocodone/Acetam bedtime as needed (I grams of Acetaminop hoursOne prn dose of Hyd was documented as -There were 27 table Hydrocodone/Acetam documented as admi 09/30/20.	so of hinophen 5/325mg 20. Its September 2020 administration record for hinophen 5/325mg take 1 if a scheduled administration minophen 5/325mg was nistered daily from 09/01/20 09/07/20, and 09/09/20 - minophen 5/325mg was not histered on 09/04/20 - 20 due to "awaiting 1 entry for hinophen 5/325mg 1 table at prn) for pain, not to exceed 4 other from all sources in 24 drocodone/Acetaminophen administered on 09/18/20. Its of hinophen 5/325mg inistered from 09/01/20 -	D 392			
	Review of Resident # revealed:	#13's October 2020 e-MAR				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
D 392	-There was an entry f Hydrocodone/Acetam tablet at bedtime with time of 9:00pmHydrocodone/Acetam documented as admi - 10/18/20 and 10/20/ -Hydrocodone/Acetam documented as admi from 10/26/20 - 10/31 being out of the facilit -There was a second Hydrocodone/Acetam bedtime as needed (I) grams of Acetaminop hoursNo prn doses of Hydrocodone/Acetam documented as -There were 24 table Hydrocodone/Acetam documented as admi 10/31/20. Review of Resident # revealed: -There was an entry Hydrocodone/Acetam tablet at bedtime with time of 8:00pmHydrocodone/Acetam documented as admi - 11/09/20There was a note do 1:37am, "awaiting ma at 1:30"Hydrocodone/Acetam documented as admi - Hydrocodone/Acetam documented as admi	innophen 5/325mg take 1 a scheduled administration minophen 5/325mg was nistered daily from 10/01/20 /20 - 10/25/20. minophen 5/325mg was not nistered on 10/19/20 and 1/20 due to the resident ry. entry for ninophen 5/325mg 1 table at orn) for pain, not to exceed 4 when from all sources in 24 Irocodone/Acetaminophen administered. ts of ninophen 5/325mg nistered from 10/01/20 -	D 392	DEFICIENCY)	
	-Hydrocodone/Aceta	minophen 5/325mg was not			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY DURHAM RIDGE ASSISTED LIVING PREPROVIDER'S SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 100 documented as administered on 11/04/20 due to "awaiting pharmacy delivery". -There was a second entry for Hydrocodone/Acetaminophen for mall sources in 24 hours. -No prn doses of Hydrocodone/Acetaminophen were documented as administered. -There were 5 tablets of Hydrocodone/Acetaminophen fo/325mg documented as administered from 11/01/20 - 11/09/20. Review of Resident #13's CS record for the supply dispensed on 08/03/20 revealed: -The prescription label on the upper left side of the page was for 30 tablets of Hydrocodone/Acetaminophen S/325mg take 1 tablet at bedtime. -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 08/03/20 with a starting amount of 30 tablets. -The first dose was documented as administered on 08/04/20 at 9:00pm and the last dose on	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
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DURHAM RIDGE ASSISTED LIVING O(A) ID PREPIX SUMMARY STATEMENT OF DEFICIENCIES DEPLOY SUMMARY STATEMENT OF DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION) TAG D 392 D 392 Continued From page 100 documented as administered on 11/04/20 due to "awaiting pharmacy delivery". -There was a second entry for Hydrocodone/Acetaminophen 5/325mg 1 table at bedtime as needed (pm) for pain, not to exceed 4 grams of Acetaminophen from all sources in 24 hours. -No prin doses of Hydrocodone/Acetaminophen swere documented as administered. -There were 5 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 11/01/20 - 11/09/20. Review of Resident #13's CS record for the supply dispensed on 08/03/20 revealed: -The prescription label on the upper left side of the page was for 30 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime. -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 08/03/20 with a starting amount of 30 tablets. -The first dose was documented as administered on 08/04/20 at 9:00pm and the last dose on	HAL032091			B. WING	41		
DURHAM RIDGE ASSISTED LIVING Q(4) ID Q(4) ID Q(4) ID Q(5) ID Q(5) ID Q(6) ID	NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE	, ZIP CODE		
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PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 392 Continued From page 100 documented as administered on 11/04/20 due to "awaiting pharmacy delivery".	DURHAM	RIDGE ASSISTED LIVING	DURHAM,	NC 27703			
documented as administered on 11/04/20 due to "awaiting pharmacy delivery". -There was a second entry for Hydrocodone/Acetaminophen 5/325mg 1 table at bedtime as needed (pm) for pain, not to exceed 4 grams of Acetaminophen from all sources in 24 hours. -No prn doses of Hydrocodone/Acetaminophen were documented as administered. -There were 5 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 11/01/20 - 11/09/20. Review of Resident #13's CS record for the supply dispensed on 08/03/20 revealed: -The prescription label on the upper left side of the page was for 30 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime. -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 08/03/20 with a starting amount of 30 tablets. -The first dose was documented as administered on 08/04/20 at 9:00pm and the last dose on	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	
There were 28 tablets documented as administered from 08/04/20 - 08/31/20. There were 2 tablets documented as administered from 09/01/20 - 09/02/20. Review of Resident #13's CS record for the supply dispensed on 09/08/20 revealed: The prescription label on the upper left side of the page was for 30 tablets of Hydrocodone/Acetaminophen 5/325mg take 1	D 392	documented as administered from 08/03/20 at 9:00p 09/02/20 at 9:00p 09/02/20 at 9:00p 09/02/20 at grams of Resident as administered from 08 Review of Resident as administered from 08 Review of Resident as a no 8/04/20 at 9:00p 09/02/20 at 9:00p 0	nistered on 11/04/20 due to lelivery". entry for ninophen 5/325mg 1 table at orn) for pain, not to exceed 4 then from all sources in 24 Irocodone/Acetaminophen administered. s of ninophen 5/325mg nistered from 11/01/20 - #13's CS record for the 08/03/20 revealed: el on the upper left side of riablets of ninophen 5/325mg take 1 Ipper right side of the page received, amount received, blank. The first row noted "placed on the a starting amount of 30 Ilocumented as administered m and the last dose on the starting amount of 30 Ilocumented as 8/04/20 - 08/31/20. S documented as 8/04/20 - 09/02/20. #13's CS record for the 09/08/20 revealed: el on the upper left side of tablets of	D 392	DEFICIENCY		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED		
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D 392	Continued From page	e 101	D 392			
D 392	-The section on the uto document the date and received by was -Documentation on the cart" on 09/08/20 with tabletsThe first dose was don 09/09/20 at 9:00pmThere were no dose Hydrocodone/Acetan administered from 09 of 6 missed dosesThere were 22 table administered from 09 -There were 8 tablets administered from 100 -There were 8 tablets administered from 100 -The prescription lab the page was for 15 Hydrocodone/Acetan tablet at bedtime as 100 -The section on the uto document the date and received by was	pper right side of the page received, amount received, blank. The first row noted "placed on a starting amount of 30 ocumented as administered and the last dose on sof minophen 5/325mg tablets 1/03/20 - 09/08/20 for a total ocumented as 1/09/20 - 09/30/20. The documented as 1/09/20 - 10/08/20. The documented as 1/09/20 revealed: The op/09/20 revealed: The op/09/20 revealed: The of the upper left side of tablets of minophen 5/325mg take 1 needed for pain. The upper right side of the page of received, amount received, blank.	D 392			
		he first row noted "placed on h a starting amount of 15				
	tablets.					
		locumented as administered m and the last dose on				
	10/24/20 at 9:00pm.	illi aliu tile iast uose oli				
	-There were no dose					
		ninophen 5/325mg tablets 19/20 or 10/25/20 - 10/31/20.				
	-There were 15 table					
	administered from 10					
	-There would have n	ot been any tablets				
	remaining in this sup	pply to administer to the				

FORM APPROVED Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: С 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY D 392 D 392 Continued From page 102 resident on 10/25/20. -There was no documentation on the CS record that Hydrocodone/Acetaminophen 5/325mg was borrowed from another resident and administered to Resident #13 on 10/25/20. Review of Resident #13's CS record for the supply dispensed on 11/05/20 revealed: -The prescription label on the upper left side of the page was for 30 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime. -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 11/06/20 with a starting amount of 30 tablets. -The first dose was documented as administered on 11/06/20 at 1:37am and the last entry was documented on 11/09/20 at 9:00pm. -There were two entries with one dose each of Hydrocodone/Acetaminophen 5/325mg being administered on 11/07/20 at 9:00pm by two different medication aides (MAs). -There was no documentation of a dose of Hydrocodone/Acetaminophen being administered on 11/08/20 as indicated on the e-MAR. -There were 5 tablets documented as administered from 11/06/20 - 11/09/20, leaving a balance of 25 tablets. Observation of Resident #13's medications on hand on 11/10/20 at 4:23pm revealed: -There was one supply of

bubble card.

Hydrocodone/Acetaminophen 5/325mg tablets with 30 tablets dispensed on 11/05/20. -There were 25 of 30 tablets remaining in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A RULE DIAG.			(X3) DATE SURVEY COMPLETED				
AND PLAN OF CORRECTION			A. BUILDING:		c				
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D 392	Continued From page 103		D 392						
	Office Manager (BON	terview with the Business /l) on 11/17/20 at 9:48am.							
	Manager (BOM) on 1 -Nothing should be a recordsThe CS records sho	nsible for checking the CS							
D 454	D 454 10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.		It is the policy of Durham Ridge Assisted to assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of any to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon possible but no later than 24 hours from the or illness by staff and documented in the resident's file; and any incident of the resident's file; and any incident of the resident's requiring medical treatment or referement emergency medical evaluation, with notification to be as soon as possible but not later the hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except elopement requiring immediate notification according to Rule 10A NCAC 13F .09066		as, as f any injury nedical nedical nedical neon as om the time of the injury the resident resident referral for notification or than 48 y or d rept for cation				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED			
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	This Rule is not met a Based on record revie facility failed to contact of 10 residents sampl concerning the facility coronavirus (COVID-19 required hospitalization). The findings are: 1. Review of Resident dated 04/05/16 revealed and a responsible person (Frevealed: -She was admitted to -She was called on 09 local hospital anesthe consent for surgery to severe left hip fracture. She was called on 09 local hospitalized: -She was called on 09 facility staff informing fall and was sent out observationShe asked the staff in Resident #2 and why -The staff apologized immediately after the	as evidenced by: ews and interviews, the ext the responsible party of 5 ed (#2, #3, #5, #6, and #9) 's response to the 19) outbreak, positive test (#3), and after incidents that on (#2 and #5). It #2's Resident Register led: the facility on 04/05/16. le person. With Resident #2's RP) on 11/05/20 at 2:20pm 19/28/20 midmorning by a resiologist who requested or repair Resident #2's e. at Resident #2 had fallen d. 19/28/20 around 1:00pm by a her that Resident #2 had a to the hospital for further member what happened to she was not notified. for not notifying her	D 454	Medication Technicians and Shift Sup were in-serviced shift to shift, beginning 11/4/20, on topics, including but not limited Incident/Accident and Change of Company Additional In-services were held by the Consultant with the care staff, on 11/9 11/10/20 on, topics including but not limited Incident/Accident Reporting. A staff meeting was held on December to in-service staff on, topics including limited to, tonotifying the Responsible Incidents, Accidents and Changes in Consultant change in condition, identification, id	ervisors ag on nited to, dition e RN /20 and mited to, or 2, 2020, but not Party of Conditions ginning ot limited fying PCP, le parties. eduled on Consultant t limited nt Rights, at Assistant saw prior to led to be CC was ator was ae f Durham	DATE		
	-She RP asked the fo	the former administrator. ormer Administrator about to Resident #2's fall. er Administrator why she was		Ridge, who is also a licensed Administraturned to Durham to take a more at the facility operations and plan of corrections.	tive role in			

Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: С 11/17/2020 B. WING HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 454 Continued From page 105 D 454 Floor Managers were hired and began working not notified of Resident #2's fall, and on each shift on December 1, 2020 to oversee hospitalization. each shift and assist with communication at -No staff member of the facility ever communicated to her that Resident #2 had a fall shift change. On 12/9/20, Durham Ridge hired on 09/27/20, had been sent, or experienced any an Infection Control Specialist/Compliance type of discomfort or pain. Officer, with an extensive background, Interview with Business Office Manager (BOM) knowledge, and experience in Infection on 11/17/20 at 12:07pm revealed: Control/Prevention and Assisted Living -He was aware of Resident #2 had a fall around Compliance, to implement and oversee policies, -The 2nd shift MA did not notify the RP for including but not limited to Infection Control, Resident #2's fall on 09/27/20. Personal Care, Health Care Follow up and 2. Review of Resident #3's Resident Register Incident/Accident reporting. revealed an admission date of 04/05/18. In addition to all care staff, the Administrator, Review of the local county health department who is also an LPN, will make daily rounds to COVID-19 revealed Resident #3 tested positive check on the condition of the residents, on the for COVID-19 on 10/19/20. days she is scheduled. On the Administrator's A telephone interview with a family member for off days, the daily rounds will be conducted by Resident #3 on 11/05/20 at 10:00am revealed: -She had been to the facility for a bedside visit the floor managers. An information hub was with Resident #3 on 10/22/20. installed behind the front nurse's station to allow -The Resident Care Coordinator (RCC) had told for better communication shift to shift. Care staff her that Resident #3 was negative for COVID-19 when she asked upon entering the facility on will be required to report all Incident/Accidents 10/22/20. and changes in conditions will be reported to the -The RCC returned to let her know Resident #3 had in fact tested positive upon her entering his Administrator or Floor Manager and notate it on the information hub. -There was no red heart on the door of Resident #3 to indicate that he had tested positive for COVID-19. -She was told by staff on the 100 hall that they had "run out" of red hearts so not all residents that had tested positive had one on their door.

A telephone interview with a second family

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	COM		(X3) DATE SI COMPLE		
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member and Power of Att Resident #3 on 11/05/20 a -The facility did not notify for COVID-19 for Resider -He learned of Resident # 10/20/20 from another far -He received an undated 10/13/20 informing him of facility. Interview with the current 11/10/20 at 3:20pm reveal -Resident #3 tested positi 10/19/20She thought the former A letter out to families to infoutbreak sometime in Selectory -There was no time frame families when a resident for COVID-19 but would "call other things". Attempted telephone inte Administrator on 11/13/20 unsuccessful. 3. Review of Resident #5 revealed: -There was a phone num for Resident #5's respons -Resident #5's family men RP and signed the Resid Review of Resident #5's administration record (eN a different phone number Resident #5's RP. Review of Resident #5's medication administration revealed there was docu	torney (POA) for at 11:50am revealed: him of positive results in #3. #3 testing positive on mily member. letter from the facility on f COVID-19 in the former for outlined for notifying find tested positive for for facility of the facility o		On 12/8/2020, Durham Ridge hired an Administrator. The assistant admin will coordinate staff onboarding and trainin will be responsible for but not limited to educating new staff on Incident/Accide reporting and changes in resident condithere will be an on-call rotation, includ Administrator, Assistant Administrator, Care Coordinator, and Compliance Off on-call person will be notified for every incident/accident. All Incident/Accident Reports will go to Compliance Officer to ensure that appropriate appropriate and notifications. The Administrator will be responsible from this weekly and that all parties above commutates as assigned.	g, and ont dition. ing the Resident ficer. The the ropriate s made. or rule area plete their	December 17, 2020 and ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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D 454	#5 was out of the faci 10/14/20. Review of Resident # reports revealed: -There was an incide 10/09/20Resident #5 was ser fever of 104 degrees -Resident #5's RP was number on the eMAR-There was document the line for the RP not 11/09/20 at 3:10pr-MAs were responsible members or RPs as sometimes of the time she telephone and had lesshe thought the Resident big or srevealed: -RPs were contacted injured, hospitalized, the resident big or sreshe used the profile sometimes the profile sometimes the profile for the RP, she used listed on the face shelf the RP did not and	Sistem 10/09/20 to Sistem 10/09/	D 454		

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STATEMENT	of Health Service Regul For Deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
AND PLAN (TOT CONNECTION		A. BUILDING:		
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D 454	Continued From page	e 108	D 454		
	a resident's RP or shi-She had not contact. Confidential interviewRPs were contacted occurred with a resident a phone number to confidential was left there was no answered there was no answered the eMAR systemestaff did not know with the eMAR systemestaff did not speak with the employer with the employer with the employer was contacted the employer was contacted the employer with the employer was contacted the employer with the employer was contacted the employer was contacted to the employer was c	with staff revealed: for any incident that ent. as the preferable way to find ontact a responsible person. for the responsible person if the placed the information for the resident profile. with Resident #5's RP. In 11/10/20 at 5:00pm As to contact the RP when a hospital or anytime an completed.			
	she came to the facil former Administrator -She did not know th visited the facilityShe did not know R notified concerning half someone, the MA RP was not contacte out to Resident #5's -She or the former A responsible for enter eMAR profileShe did not know th #5's eMAR profile was expected staff resident register to enumber was used to	e date Resident #5's RP esident #5's RP was not his hospitalization. had told her Resident #5's hed she would have reached RP. dministrator were ring the information into the his incorrect. to check the face sheet or ensure the correct phone			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE	
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D 454	Continued From page	109	D 454		
	11/13/20 at 11:49am				
	 She expected the Mannembers or RPs as s 				
		to contact the RP, the MA			
	needed to tell her or t				
		esident #5's RP was not pitalizations due to using an			
		per documented on the			
	eMAR profile.	N. I. Communication			
		re responsible for ensuring oncerning hospitalizations.			
	the Ki was notified o	onoching hospitalizatione.			
		with the Business Office			
	Manager (BOM) on 1 revealed:	1/1//20 at 10:00am			
		cess in contacting Resident			
	#5's RP concerning fi				
		s sent to Resident #5's RP yee in the past and the			
		returned to the facility.			
		d not provide an updated			
	address after moving	sident #5's RP was not			
		desident #5's 10/09/20			
	hospitalization.	and a superior of the second			
	-The former Administ ensuring resident's R	rator was responsible for P was notified of			
	hospitalizations.				
	Attempted telephone	interview with Resident #5's			
		26pm was unsuccessful.			
		to to a discoverable the conformation			
		interview with the former 13/20 at 12:59pm was			
	unsuccessful.				
	4 Paview of the facil	ity letter regarding COVID-19			
	outbreak within the fa				
	-There was no date of	on the letter.			
	-The letter stated the	re were some residents who			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	COMPLETED
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D 454	families were notified steroid, and an antibilitreatments given to recoronavirus, encourad add elderberry to thei window visits with resolution notify them when inderesumed. The letter was signered Administrator and the a. Review of Resident revealed: There was a family resolution with the resolution of the resolut	r COVID-19 and those , a list of specific vitamins, offic were listed as esidents to fight the ged the family members to r daily regimen, encouraged sidents, and the facility would for or outdoor visitation d by the former are were no other signatures. It #9's Resident Register In the sident was a sident who cared for evealed: Psychiatrist who cared for espital about the facility as a sident #9. It rator spoke with her prior to sion and told her the facility	D 454	DEPICIENCITY	
	address the pandemination -She had received bit pharmacy, but she had correspondence from	lls from the facility contracted ad received no			
		interview with the former 13/20 at 12:59pm was			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 454	Continued From page	e 111	D 454		
	unsuccessful.				
	Refer to the interview Administrator on 11/0				
	Refer to the interview 11/03/20 at 3:21pm.	with the Staff Developer on	>		
	Refer to the telephon Administrator on 11/1				
	Refer to the telephon Business Office Mana 9:50am.	e interview with the ager (BOM) on 11/17/20 at			
	revealed: -Resident #6's admis	nt #6's Resident Register sion date was 09/06/17. egal guardian assigned.			
	on 10/07/20.	f6's record revealed: nsferred to the local hospital positive for the coronavirus			
	(RCC) on 11/03/20 a -Resident #6 was tra -Resident #6 did not admitted to a skilled town within the state -She was not involve	nsferred to the local hospital. return to the facility and was nursing facility in another . d with the letters sent to e persons; the former			
	on 11/04/20 at 11:13	with Resident #6's guardian am revealed: ent #6 was transferred to the			

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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D 454	Continued From page	112	D 454		
	-She did not receive t COVID-19 outbreak v	he letter concerning the vithin the facility.			
		interview with the former 3/20 at 12:59pm was			
	Refer to the interview Administrator on 11/0				
	Refer to the interview 11/03/20 at 3:21pm.	with the Staff Developer on			
	Refer to the telephon Administrator on 11/1				
	Refer to the telephon Business Office Mana 9:50am.	e interview with the ager (BOM) on 11/17/20 at			
	familiesThe letter discussed contracted the COVI regiment and facility -Those families were -He forgot to date the mailed around the se	evealed: be sent out to the residents' that some facility residents D-19 virus, medication visitation.			
	3:21pm revealed: -The former Adminis' residents' families ar COVID-19 pandemid	aff Developer on 11/03/20 at trator wrote a letter to the and RPs regarding the and its effects on the facility. trator asked her to mail the			

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ С 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 454 Continued From page 113 D 454 letters out to the families. -She placed a copy of the letter in the residents' business file. -She mailed the letters out around 10/08/20. Telephone interview with the Administrator on 11/13/20 at 11:49am revealed: -The management team mentioned sending a letter to RPs concerning the status of COVID-19 within the facility. -She had not been involved with sending letters to residents' responsible persons notifying them of the COVID-19 outbreak within the facility. -She did not know the process used to distribute the letters. Telephone interview with the BOM on 11/17/20 at 9:50am revealed: -He was informed that a letter would be sent to resident's responsible person concerning COVID-19 within the facility. -He did not know when the letters were mailed, the process used to mail the letters nor the content of the letters. -The former Administrator was responsible for ensuring the letter was sent to responsible persons. D 465 D 465 10A NCAC 13F .1308(a) Special Care Unit Staff It is the policy of Durham Ridge Assisted Living to assure that staff shall be present in the unit 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in at all times in sufficient number to meet the sufficient number to meet the needs of the needs of the residents; but at no time shall there residents; but at no time shall there be less than one staff person, who meets the orientation and be less than one staff person, who meets the training requirements in Rule .1309 of this orientation and training requirements in Rule Section, for up to eight residents on first and

second shifts and 1 hour of staff time for each

additional resident; and one staff person for up to

10A NCAC 13F .1309, for up to eight residents

on first and second shifts and 1 hour of staff time

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: С B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) for each additional resident; and one staff D 465 Continued From page 114 D 465 person for up to 10 residents on third shift and .8 hours of staff time for each additional 10 residents on third shift and .8 hours of staff time for each additional resident. resident. Durham Ridge has and will continue to staff in accordance to Rule 10A NCAC 13F .1308. If a CNA, PCA or Med Tech calls in or fails to come This Rule is not met as evidenced by: in as scheduled, a replacement will be called in. TYPE B VIOLATION If there is not another employee available, the Administrator, Assistant Administrator, RCC. Based on record reviews and interviews, the facility failed to ensure the required staffing hours Office Assistant, Human Resources Specialist for the Special Care Unit (SCU) with a census of or Activity Director will fill in (all of whom are 106 to 118 were met for 25 of 57 shifts sampled checked off to work on the floor or pass on 10/05/20, from 10/11/20 to 10/25/20, and from medications). 11/06/20 to 11/08/20 after assistance with staffing Recruitment efforts will continue in order to was offered to the facility by the local county have additional staff available in the event of a health department task force and another local call out or no call no show. Ads are currently county government agency. running on Indeed.com, Facebook.com, and The findings are: with the Employee Security Commission. Durham Ridge has been hosting weekly job Review of the facility's current license effective fairs in order to hire additional staff. January 1, 2020 revealed the facility was licensed for a Special Care Unit (SCU) with a capacity of Issues with the Administrator and the Assistant 142 beds. Resident Care Coordinator had been identified prior to the survey and changes were scheduled Review of the facility's Resident Bed List Report dated 10/05/20 revealed there was a SCU census to be made on November 3, 2020. The ARCC of 118 residents, which required 118 staff hours was removed on 11/10/20. The Administrator on first and second shift and 94.4 staff hours on was replaced on November 13, 2020 by the third shift. Assistant Administrator. The owner of Durham Ridge, who is also a licensed Administrator, Review of the individual employee time cards returned to Durham to take a more active role in dated 10/05/20 revealed there was a total of the facility operations and plan of correction. 85.25 staff hours provided on third shift with a Floor Managers were hired and began working shortage of 9 hours.

Division of Health Service Regulation

Review of the facility's resident COVID-19 test

of 118 remained on quarantine due to testing

tracing spreadsheet revealed 26 of 118 residents

tested positive for COVID-19 on 10/04/20 and 19

on each shift on December 1, 2020 to oversee

shift change. On 12/9/20, Durham Ridge hired

each shift and assist with communication at

an Infection Control Specialist/Compliance

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D 465	positive for COVID-19 Review of the facility's spreadsheet revealed -There were 8 staff ar were within the 10 datesting positive for CO-There were 6 staff w COVID-19 on 10/04/2-There were 15 staff 10/05/20 due to testing Review of the facility's dated 10/11/20 and 1 a SCU census of 112 112 staff hours on first staff hours on third shaded 10/11/20 and 1-On 10/11/20, there whours provided on first 5.50 hoursOn 10/13/20, there whours provided on this 25.35 hours. Review of the facility's tracing spreadsheet retested positive for COVID-19 Review of the facility's spreadsheet revealed -There were six staff of quarantine due to COVID-19 on 10/04/2	s staff COVID-19 test tracing l: nd the Administrator that ys of quarantine due to DVID-19 on 10/05/20. ho tested positive for 20. not available to work ng positive for COVID-19. s Resident Bed List Report 0/13/20 revealed there was residents, which required at and second shift, and 89.6 nift. ual employee time cards 0/13/20 revealed: was a total of 106.50 staff at shift with a shortage of vas a total of 63.25 staff rd shift with a shortage of s resident COVID-19 test revealed 35 of 112 residents 0/ID-19 on 10/11/20 and 26 quarantine due to testing 9 on 10/04/20. Is staff COVID-19 test tracing d: that were within the 10 days testing positive for 20. aff who tested positive for	D 465	Officer, with an extensive background, knowledge, and experience in Infection Control/Prevention and Assisted Living Compliance, to implement and oversee including but not limited to Infection Co Personal Care, Health Care Follow up Incident/Accident reporting. On 12/8/2020, Durham Ridge hired an Administrator. The assistant admin will coordinate staff onboarding and trainin be responsible for educating new and the new staff. The Administrator spoke with represent from the County Health Department and County Emergency Management groupensure that if necessary Durham Ridge access the emergency staffing that is at The Floor Managers are responsible for providing an additional layer of coveragensure that each shift is staffed to regulate the staffing is monitored daily by the Reside Coordinator and Human Resources Sp. Business Manager will audit Monday the Friday to ensure continued compliances.	e policies, ntrol, and Assistant g, and will training tatives d from the portol e would be available. For ge and will alation. Ident Care pecialist.	

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NAME OF PROVIDER OR SUPPLIER DURHAM RIDGE ASSISTED LIVING SUMMARY STATEMENT OF DESIGNATIONS SUMMARY STATEMENT OF DESIGNATION OF DESIGNATION OF DESIGNATIO	*	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		COMPLETED
MAKE OF PROVIDER OR SUPPLIER DURHAM RIDGE ASSISTED LIVING 3420 WAKE FOREST HWY DURHAM, NC 27703 AND 12 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY AUST ER PRECEDED BY FULL TAG) PREFIX TAG O(4) ID PREFIX (FROM DEPICIENCY AUST ER PRECEDED BY FULL TAG) PREFIX TAG D 465 Continued From page 116 -There were 14 staff not available to work on 10/11/20 and 10/13/20. Review of the facility's Resident Bed List Report dated 10/12/20 revealed there was a SCU census on first and second shift, and 88.8 staff hours on third shift. Review of the individual employee time cards dated 10/12/20 revealed there was a total of 71.75 staff hours provided on third shift with a shortage of 17 hours. Review of the facility's resident COVID-19 test tracing spreadsheet revealed 36 of 111 residents tested positive for COVID-19 on 10/04/20. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: -There were 6 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/04/20. -There were 8 staff who tested positive for COVID-19 on 10/11/20. -There were 14 staff not available to work on 10/12/20. -Review of the Resident Bed List Report dated 10/15/20 and 10/17/20 revealed there was a SCU census of 114 residents, which required 114 staff hours on 10/12/20.						
DURHAM RIDGE ASSISTED LIVING O(4) ID PRETIX TAG O(4) ID PRETIX TAG O(5) PRETIX TAG D(6) PRETIX TAG D(7)			HAL032091	B. WING		11/17/2020
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RECH DEFICIENCY AUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PAGE D 465 Continued From page 116 There were 14 staff not available to work on 10/11/20 and 10/13/20. Review of the facility's Resident Bed List Report dated 10/12/20 revealed there was a SCU census of 111 residents, which required 111 staff hours on third shift. Review of the individual employee time cards dated 10/12/20 revealed there was a total of 71.75 staff hours provided on third shift with a shortage of 17 hours. Review of the facility's resident COVID-19 test tracing spreadsheet revealed 35 of 111 residents tested positive for COVID-19 on 10/11/20 and 26 of 111 remained on quarantine due to testing positive for COVID-19 on 10/04/20. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: There were 6 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/04/20. There were 8 staff who tested positive for COVID-19 on 10/11/20. There were 14 staff not available to work on 10/12/20. Review of the Resident Bad List Report dated 10/15/20 and 10/17/20 revealed there was a SCU census of 114 residents, which required 114 staff hours on first and second shift, and 91.2 hours on	DURHAM	RIDGE ASSISTED LIVING	3			
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		vere 72 staff hours provided nortage of 19 staff hours.			
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	dated 10/16/20 revea -There were 99.25 str second shift with a sh	aff hours provided on nortage of 16.75 staff hours. aff hours provided on third			
	tracing spreadsheet r tested positive for CC	s resident COVID-19 test revealed 26 of 116 residents OVID-19 on 10/18/20 and 35 uarantine due to testing 9 on 10/11/20.			
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Division of Health Service Regulation

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	-There were 8 staff no 10/16/20.	ot available to work on				
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	Review of the facility's resident COVID-19 test tracing spreadsheet revealed 26 of 116 residents tested positive for COVID-19 on 10/18/20.					
	spreadsheet revealed -There were 8 staff th of quarantine due to t COVID-19 on 10/11/2 -There were 7 staff th COVID-19 on 10/18/2	at were within the 10 days esting positive for 0. at tested positive for				
	dated 10/19/20, 10/21 there was a SCU cen	s Resident Bed List Reports //20, and 10/22/20 revealed sus of 113 residents, which ars on first and second shift on third shift.				
	dated 10/19/20, 10/21 -On 10/19/20, there w	ual employee time cards 1/20, and 10/22/20 revealed: vas a total of 94 staff hours with a shortage of 19 hours.				

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D 465	-On 10/19/20, there we hours provided on thi 18.35 hoursOn 10/21/20, there we hours provided on thi 15.75 hoursOn 10/22/20, there we hours provided on thi 8.88 hours. Review of the facility' spreadsheet revealedThere were 8 staff the for quarantine due to 10 COVID-19 on 10/11/2	vas a total of 72.05 staff rd shift with a shortage of vas a total of 74.65 staff rd shift with a shortage of vas a total of 81.52 staff rd shift with a shortage of s staff COVID-19 test tracing d: nat were within the 10 days testing positive for			
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Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: С 11/17/2020 B. WING. HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 465 D 465 Continued From page 120 COVID-19 on 10/11/20. -There were 7 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/18/20 -There were 15 staff not available to work on 10/20/20. Review of the facility's Resident Bed List Reports dated 10/23/20 and 10/25/20 revealed there was a SCU census of 110 residents, which required 110 staff hours on first and second shift and 88 staff hours on third shift. Review of the individual employee time cards dated 10/23/20 and 10/25/20 revealed: -On 10/23/20, there was a total of 80.75 staff hours provided on third shift with a shortage of 7.25 hours. -On 10/25/20, there was a total of 64 staff hours provided on third shift with a shortage of 24 hours. Review of the facility's resident COVID-19 test tracing spreadsheet revealed 4 of 110 residents tested positive for COVID-19 on 10/25/20. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: -There were 7 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/18/20. -There were 3 staff that tested positive for COVID-19 on 10/25/20. -There were 7 staff not available to work on 10/23/20 due to COVID-19. -There were 10 staff not available to work on 10/25/20 due to COVID-19. Review of the facility's Resident Bed List Report

dated 10/24/20 revealed there was a SCU census

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 465 D 465 Continued From page 121 of 109 residents, which required 109 staff hours on first and second shift and 87.2 staff hours on third shift. Review of the individual employee time cards dated 10/24/20 revealed: -There was a total of 104.4 staff hours provided on first shift with a shortage of 4.6 hours. -There was a total of 72.12 staff hours provided on third shift with a shortage of 15.08 hours. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: -There were 7 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/18/20. -There were 7 staff not available to work on 10/24/20 due to COVID-19. Review of the facility's Resident Bed List Report dated 11/06/20 revealed there was a SCU census of 110 residents, which required 110 staff hours on first and second shift and 88 staff hours on third shift. Review of the individual employee time cards dated 11/06/20 revealed there was a total of 72.5 staff hours provided on third shift with a shortage of 15.5 hours. Review of the facility's staff COVID-19 test tracing spreadsheet revealed there were two staff on quarantine due to testing positive for COVID-19 on 10/27/20. Review of the facility's Resident Bed List Report dated 11/07/20 revealed there was a SCU census of 108 residents, which required 108 staff hours

third shift.

on first and second shift and 86.4 staff hours on

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	dated 11/07/20 revea -There was a total of second shift with a sh -There was a total of on third shift with a sh Review of the facility' spreadsheet revealed quarantine due to tes on 10/27/20. Review of the facility' dated 11/08/20 revea of 106 residents, which on first and second si third shift. Review of the individed dated 11/08/20 revea -There was a total of on second shift with a -There was a total of on third shift with a sl Review of the emails department (LHD) Co -An email dated 10/1 the local county Divis Management from th about the process to the facility.	102 staff hours provided on nortage of 6 hours. 72.25 staff hours provided nortage of 14.15 hours. Is staff COVID-19 test tracing of there were two staff on ting positive for COVID-19 Is Resident Bed List Report led there was a SCU census ch required 106 staff hours hift and 84.8 staff hours on ual employee time cards led: 96.25 staff hours provided a shortage of 9.75 hours. 72.25 staff hours provided hortage of 12.55 hours. If rom the local county health DVID-19 task force revealed: 9/20 at 10:26am was sent to sion Chief of Emergency e task force lead inquiring obtain staffing assistance for			
	-A reply was sent from Chief of Emergency In 11:16am with the sew with staffing at the faurity at the task force leaded Division Chief of Emergency In 1997.	m the local county Division Management on 10/19/20 at yen items needed to assist cility. sent the email from the ergency Management to the e Coordinator (RCC), the			

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ C 11/17/2020 R. WING HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 465 D 465 Continued From page 123 former Administrator, and the Administrator on 10/19/20 at 11:23am. -The 10/19/20 at 11:23am email explained that the information was needed in order to provide the staffing assistance. Telephone interview with the LHD COVID-19 task force lead on 11/13/20 at 8:26am revealed: -Staffing assistance was offered to the facility multiple times verbally and via email. -The local county Division Chief of Emergency Management was organizing staffing for facilities who needed assistance due to the pandemic. Telephone interview with the local county Division Chief of Emergency Management on 11/13/20 at 1:51pm revealed: -During the past summer of 2020, staffing assistance was made available to aggregate living facilities in response to the pandemic. -She needed specific information from the facility and she could get staffing assistants to the facility within two hours. -Staffing assistance was available for administrative jobs and certified nurse assistance for any shift. -She understood that when the staffing assistance was first offered the facility reported they did not need any assistance. -Then later the facility reported they needed help, help was offered, and the facility reported again that they did not need the help. -She was notified again on 10/19/20 by the COVID-19 task force lead and reported the facility had 95% positive COVID-19 cases among the residents. -On 10/19/20, she told the task force lead what information was needed to give staffing assistance to the facility but she never received a

response from the facility.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
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D 465	Continued From page	124	D 465		
D 465	-She provided her mothe facility could call it anyone at the facilityShe checked back won 10/21/20 and 10/2 response from the facilityShe assumed the job 2020She and the RCC mand second shift, she residents and divided she knew the number shift was different that needed on first and second to schedule 15 people of the census increases scheduled 18 to 19 second 2 people "show she had sometimes only 2 people "show she had sometimes only 2 people "show she thought the panhiring of new staff be the work of the could be staff called out determine if they coule arlyShe did not know the missing on the third staff.	obile phone number so that but she did not hear from with the LHD task force lead 2/20 but received no cility. In an Resource (HR) office at 3:15pm revealed: of scheduling in June and the schedule for staff. In the of staff needed for first at took the total number of at that number by 8. For of staff needed for third in the number of staff econd shift. For she was 111 or 112, she was 111 or 112, she was 113 to 14 staff, but she tried to be first and second shift. For staff on first and second shift. For a staff on first and second shift. For a staff on the staff on the staff of the staff to lid cover the shift or come in the number of staffing hours shift were as high as 25.35.	D 465		
	-She thought maybe correctly.				
	-Staff were asked to	antly to hire for third shift. do overtime, but she tried to ed too many overtime shifts			
	III Consider Providence				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBÉR:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		HAL032091	B. WING		11/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	E, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVIN	G	E FOREST HW NC 27703	ſ		
0/4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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D 465	Continued From page	125	D 465			
	-The RCC was constructed provide coverage for a coverage for the RCC came to will during third shift and helped staff with what she thought maybe assistance, but she will have a came in early "light resident care. -She came in early "light resident careShe tried to get staff scheduled extra staff scheduled extra staff she scheduled 14 stand 12 staff on third staff on third staff on third staff sometimes asked how many residents.	antly trying to get staff to all shifts. ork early in the morning she was sure the RCC to she could. the LHD offered staffing was not sure. Con 11/10/20 at 5:00pm ke 3:00am" to help with to come in early or to cover call outs. saff on first and second shift shift based on a census of early to the former Administrator were within the building to	82.			
	Interview with the Business Office Manager (BOM) 11/10/20 at 5:31pm revealed: -The HR office manager had shared the time card staffing hours with him. -He thought staff who no longer worked at the facility were filed under archives in the time card system. -He planned to look at the time cards for staff who no longer worked at the facility to determine if there were additional staffing hours for the time period from 10/11/20 to 10/25/20. -He would provide the time cards if there were additional staffing hours. -He found it hard to believe that there were 25.35 staffing hours not provided on 10/13/20 third shift. Telephone interview with a medication aide (MA)					
	on 11/16/20 at 3:26p					

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 11/17/2020 HAL032091 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 465 D 465 | Continued From page 126 aides (PCAs) and one MA assigned to each hall. -Sometimes there would be one or two PCAs and one MA on each hall. -Sufficient staff was not always provided; staff would "just need to work the shift." -The Administrator, RCC, and former RCC did not help with providing care to the residents. -The Administrator would check in with the PCAs, but never provided care on the halls. Confidential staff interview revealed: -Around 10/19/20, when the facility had so many residents who tested positive for COVID-19, the facility was "so shorthanded". -They usually had 3 PCAs and 1 MA on each hall but during that time, they only had 2 PCAs and 1 MA on each hall. -Sometimes they only had 1 PCA and 1 MA on a hall and they would have to call someone to come -Sometimes staff had to wait 2 to 2 and ½ hours before another PCA was available to help with resident care. Telephone interview with a PCA on 11/06/20 at 3:10pm revealed: -There was usually 1 MA and 2 PCAs on each hall and sometimes possibly 3 PCAs. -There was an assignment sheet at the front desk so staff would know their hall assignments when they arrived to work. -The facility was sometimes short staffed on second shift and they tried to cover the shift by calling in staff or by asking other staff from the previous shift to work a double shift. -He did not know how many staff usually worked

Division of Health Service Regulation

shift staff left.

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on third shift because as soon as one staff person showed up to work on their hall, second

IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	3420 WAK	DRESS, CITY, STAT E FOREST HWY NC 27703		
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D 465	4:25pm revealed: -She was currently we 1 MA to care for 28 re evening shiftIt was common to we during the evening shiftThere had been time and 1 MA working on recall the dateShe has requested to that were short staffe deniedThe former RCC and the hall to assist with was short. Telephone interview was short. Telephone interview was short. Telephone interview was short. Telephone interview was short. -She was assigned to two monthsWhen she worked or to another hallStaffing for the 200-1 MA and three PCAs, one other person son -She had trained sev months, but sometim to work againWhen there was only with her, it made mea it was had to monitor watch the hall and th roomsShe had not observe management team was -A member of the ma	orking with 1 other PCA and esidents on the 200 hall on ork with 2 PCAs and 1 MA iff. Is when there was 1 PCA the 200 hall but could not owork overtime on shifts do but her requests had been of the RCC did not work on the sident care when staffing with a third PCA on 11/09/20 of the 200- hall for the past overtime, she was assigned the worked with only netimes. The past few eas staff did not come back of one other PCA on the hall all time more difficult because the television room and the other residents in their and anyone from the orking on the halls. In agement team might come and yell down the hall to ask	D 465		

Division of Health Service Regulation STATE FORM

HAL032091 B. WING B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	7/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
DURHAM RIDGE ASSISTED LIVING DURHAM, NC 27703	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Interview with a second MA on 11/10/20 at 4:44pm revealed: -She thought there should be 4 PCAs and 1 MA working each hallMost days there were only 2 PCAs and 1 MA. Telephone interview with the BOM on 11/06/20 at 12:44pm revealed: -The HR office manager and the RCC were responsible for doing the staffing schedule and they knew the ratios and how many staff were required to be at the facility each shift based on the censusNo concerns had been expressed to him about the facility being short staffedIt was a large facility and they were constantly hiring staff each weekSome staff had been out due to COVID-19 and it had been harder to staff but he was not aware of any certain shift being a problem with staffingThey could call someone in to cover a shift if they were short staffedOne of the Department Heads (the RCC, the former RCC, the Administrator, or the Activities Director, who is a PCA) would cover shifts if they were short staffed. Telephone interview with the RCC on 11/12/20 at 4:34pm revealed: -She and the HR office manager made the staff schedule and assignment sheetsShe was responsible for going over the schedule and if someone called out, she got coverageOn Fridays, Saturdays, and Sundays, a manager was on call to cover for call outsShe was always successful in finding a replacement when she was the manager on dutyStaff was supposed to let them know 2 hours before their shift if they could not come into work but sometimes that did not happen and staff	

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING:__ С B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE. (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 465 Continued From page 129 D 465 would call 5 minutes before their shift. -Staff were supposed to report to a supervisor if they could not make their shift but sometimes staff would just tell another staff person instead of the supervisor and that staff would forget to report the call out. -They sometimes had call outs on third shift and sometimes third shift staff would come in late. -Third shift staff would say they missed the bus or had to catch another bus. -Sometimes second shift staff would stay over and help if third shift was short staffed. -Sometimes third shift staff would text her about a call out and she may not see the text until she woke up in the morning, then she would go in early to help them. -They made the staff schedule based on the census and she scheduled one extra staff in case someone called out. -The facility had not been offered any staffing assistance by outside agencies to her knowledge. -The former RCC never mentioned the LHD offered staffing assistance. Telephone interview with the Administrator on 11/17/20 at 8:08am revealed: -The facility's census had gone down so she thought the short-staffing had gotten better. -They always had call outs but if someone called out, they should get someone to cover the shift. -She or the RCC could cover shifts if needed. Telephone interview with the Administrator on 11/16/20 at 2:31 pm revealed: -She did not know there was a staffing shortage

on third shift.

-She was in the process of learning the

the job responsibilities on 11/13/20. -She remembered the email from the LHD

Administrator's job duties, because she assumed

AND DUAN OF CORDECTION IN IMPER-		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
70101001			A. BUILDING:			
		HAL032091	B. WING		C 11/17/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVIN	G	E FOREST HWY			
	OLIMANADY CT.	DURHAM,		PROVIDER'S PLAN OF CORRECTIO	N (X5)	
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D 465	Continued From page	e 130	D 465			
<i>B</i> 400	concerning staffing as -She called the LHD to about the details of the educationShe had never experies assistance from a locus she wanted to know heard to know heard to the facility was not in assistance was not not she did not share the else on the management.	ask force lead to inquire the offer for her own rienced an offer for staffing al government agency and how the process worked. The Administrator stating that a staffing crisis and the eleded. The information with anyone ment team.				
		ere was no additional staffing a facility for 10/11/20 to				
	Refer to Tag D0273 1 Health Care (Type A1	0A NCAC 13F. 0902(b) Violation)				
	Refer to Tag D0338 10A NCAC 13F. 0909 Resident Rights (Type A2 Violation) Refer to Tag D0601 10A NCAC 13F. 1801(a)(b)					
	Infection Prevention a A2 Violation)	and Control Program (Type				
	for a census of 106-1 shifts resulted in diffic during meal service, to care for 27 to 36 m first, second and third primary care provider resident's falls and ar symptoms of COVID-	o provide adequate staffing 18 residents for 25 of 57 culty monitoring residents two PCAs scheduled per hall memory care residents on d shifts; MAs not notifying the r (PCP) concerning a mother resident's signs and r19, resulting in delay in care lizing PPE inappropriately				

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:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		HAL032091	B. WING	8	11/17	7/2020
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
DURHAM	RIDGE ASSISTED LIVIN		E FOREST HW NC 27703	Y		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 465	between residents what admissions testing portion of accepting special by the local county D Management to work outbreak of COVID-1 staff unable to work of COVID-19, resulting during the outbreak. To the health, safety, constitutes a Type B The facility provided accordance with G.S this violation.	nen providing care; new ositive for COVID-19; and staffing assistance offered ivision of Emergency any needed shift during an 9 when there were 2 to 15 lue to testing positive for in order staffing shortages This failure was detrimental and welfare of residents and Violation. a plan of protection in . 131D-34 on 11/13/20 for	D 465			
D 601	and Control Program 10A NCAC 13F .180 Control Program (a) In accordance wit Subchapter and G.S. shall establish and implement a compre and control program federal Centers for Disease Control and guidelines on infectio (b) The facility shall the facility's IPCP, re procedures, and guidelines	1 Infection Prevention and th Rule 13F .1211 of this 131D-4.4A(b)(1), the facility whensive infection prevention (IPCP) consistent with the I Prevention (CDC) on prevention and control. ensure implementation of lated policies and dance or the CDC, the local health the North Carolina	D 601	It is the policy of Durham Ridge Assist to establish and implement a compreh infection prevention and control prograconsistent with the federal Centers for Control and Prevention (CDC) guidelic infection prevention and control, and cimplementation of the facility's IPCP, a policies and procedures, and guidance directives issued by the CDC, the located department, and/or the North Carolina Department of Health and Human Ser	nensive am (IPCP) Disease nes on ensure related e or al health	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		HAL032091	B. WING		11/17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
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DOTTIAN		DURHAM,	NC 27703		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 601	Continued From page	e 132	D 601	All residents that have never tested po	
	Services.			being moved into rooms with other CC	DVID-19
				negative residents or are in a room by	'
				themselves. All staff was in -serviced	shift to
	This Rule is not met	as evidenced by:		shift beginning on 11/4/20 and given h	nandouts
	TYPE A2 VIOLATION			on infection controls measures, include	ling but not
	D d the am indicate	record roydowo and		limited to, wearing masks, gloves, and	d gowns
	interviews, the facility	ns, record reviews, and rfailed to ensure		appropriately, when to change them,	and how to
re	recommendations an	d guidance established by		discard them. The handouts are post	ed on the
		se Control (CDC), the North of Health and Human		shower room and tv room doors, in th	e
		and directives from the		break room by the time clock and on t	he fire
	Local Health Departn			doors at the end of each hallway. CC	VID
	implemented and ma	dents during the global		related information and updates were	placed on
	coronavirus (COVID-	19) pandemic as related to		the Spectrio scrolling monitors in the I	obby and
		of which residents tested 9 thereby failing to use		breakrooms.	
	personal protective e	quipment (PPE) as directed		Residents that are able to eat in their	rooms are
	by CDC guidelines; g appropriately by staff			allowed to do so. Residents that need	d assistance or
		ection; a resident admitted on		encouragement during meal service v	vill be
		in the room of a resident or COVID-19; and communal		socially distanced and fed in the dinin	g room.
		distancing 6 feet on one		Sixty overbed tables were ordered on	11/6/20
	hallway of the facility			and arrived on 11/9/20. Fifteen additi	onal tables
	The findings are:			were received on 12/6/20, ensuring the	nat there
				are enough tables in the facility to acc	commodate
	Review of the local h	ealth department (LHD) porting documentation for		meal service.	
	the facility revealed:			Management staff will take turns mon	itoring
	-There were two resi	dents who died on 10/23/20		meal service to ensure compliance at	least three
		use of death of COVID-19. sident who tested positive for		times a week.	
	COVID-19 on 10/05/	20, hospitalized from			
	10/07/20 to 10/14/20 a skilled nursing facil	, and she died on 10/29/20 at lity (SNF) with cause of death			

AND DIAM OF CORDECTION		[' ' '		(X3) DATE SURVEY COMPLETED		
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DURHAM	RIDGE ASSISTED LIVING			• •		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
D 601	Continued From page	133	D 601	An in-service, including but not limited		
	of COVID-19.			COVID-19 and Infection Control, with a		
	01 COVID-19.			staff was held by the RN Consultant or		
	Review of the facility's	s resident COVID-19 tracing		and 11/10/20. During this time, staff w		
	spreadsheet revealed			in-serviced on topics including but not		
	-In the month of Octo	ber 2020, there was an		how dining is to be handled moving for	ward,	
	average census of 11			use of PPE and Infection Control.		
		October 2020, 91 residents		All staff will continue to use PPE appro		
	-	VID-19 and 3 residents		Residents that are tested negative will		
	tested inconclusive for	r COVID-19.		placed in rooms with residents that are	•	
	Boulow of the LUD Co	OVID-19 task force resident		positive and in quarantine. All staff are	e being	
	spreadsheet revealed			reassigned the COVID-19 and Infection	n Control	
		s who tested positive for		related trainings on Fels & Associates		
	COVID-19 in October			A staff meeting was held on Decembe	r 2, 2020,	
	100-hall.			to in-service staff on, topics including t	out not	
	-26 of the 91 resident	s who tested positive for		limited to, meal service, use of PPE ar	nd the new	
	COVID-19 in October	2020 resided on the		facility Infection Control policy.		
	200-hall.			An in-service with all care staff is sche	duled on	
		s who tested positive for		December 30, 2020 with an Outside C	onsultant	
	COVID-19 in October 300-hall.	2020 resided on the		from the Professional Assisted Living		
		s who tested positive for		Association on topics including but not	: limited to,	
	COVID-19 in October			Medication Administration, Resident R	ights,	
	400-hall.			Infection Control and Incident/Acciden	t Report.	
				Issues with the Administrator and the	Assistant	
		ters for Disease Control and		Resident Care Coordinator, that overs	aw	
		delines for the prevention		incident reporting, had been identified		
		0-19 disease in long term		the survey and changes were schedul		
	care (LTC) facilities re			made on November 3, 2020. The ARG		
		ts should be quarantined al resident population for 14		removed on 11/10/20. The Administra		
	days.	a resident population for 14		replaced on November 13, 2020 by the		
		hould be quarantined		Administrator. The owner of Durham		
	separately from other			who is also a licensed Administrator, r	-	
		ontact with COVID-19.		Durham to take a more active role in the		
				operations and plan of correction. Flo		
		Carolina Department of		Managers were hired and began work		
	Health and Human S			each shift on December 1, 2020 to over		
		vention and spread of				
	COVID-19 in LTC fac	liities dated 09/28/20		shift and assist with communication at	smit change.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SI	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A, BUILDING:		001111 22	
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NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STATE FOREST HW			
DURHAM	RIDGE ASSISTED LIVING			•		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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D 601	revealed a core princi was the effective cohe areas dedicated for Control Review of Resident # 11/03/20 revealed dia schizophrenia, inteller and high blood pression Review of Resident #1 on 10/23/20. Review of an undated COVID-19 test results release dates revealed. There was a "P" (post 10/18 (no year) for Resident #1's roomn release date was 10/30. Review of Resident # discharge summary of Resident #1's roomn hospital on 10/21/20. Diagnoses included Resident #1's roomn remain under COVID precautions until 10/30 recommendations. Interview with a mediat 11:30am revealed: New admissions wor private room if one worksidents were quarreturning to the facility.	iple of infection prevention orting of residents (separate iOVID-19 care). 1's current FL-2 dated agnoses included dementia, ctual development disorder, ure. 1's Resident Register was admitted to the facility If document indicating and estimated quarantine and estimated quarantine and esident #1's roommate. It is roommate was a mate's estimated quarantine and estimated quarantine and esident #1's roommate was anate's estimated quarantine and esident #1's roommate was anate's estimated quarantine and 10/27/20 revealed: anate was admitted to the covid-19 droplet/isolation esi/20 based on CDC cation aide (MA) on 11/03/20 and ideally be placed in a	D 601	On 12/9/20, Durham Ridge hired an In Control Specialist/Compliance Officer, extensive background, knowledge, and experience in Infection Control/Preven Assisted Living Compliance, to implem oversee policies, including but not limit Infection Control, Personal Care, Healt Follow up and Incident/Accident report On 12/8/2020, Durham Ridge hired an Administrator. The assistant admin will coordinate staff onboarding and training be responsible for educating staff on, the including but not limited to, Infection CCOVID-19 and PPE use. The Compliance Office and Administration a minimum of three days each continued compliance.	with an d tion and nent and ted to th Care ting. Assistant l ng, and will copics ontrol, ator will week for	

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 A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	FE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVIN		E FOREST HW NC 27703	Y		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 601	kept in the same roor been exposed to COV-Resident #1 was in a couple of days after h-She thought Resider COVID-19 negative wadmitted to the facility was hospitalized and COVID-19 when Resfacility.) Telephone interview of COVID-19 task force 9:56am revealed she recommendations confacility, but the facility CDC recommendation. Telephone interview of (PCA) on 11/06/20 at Resident #1's roomn before Resident #1 wand placed in the samenesident #1 wand placed in the same	in if he or she had already VID-19. A private room for the first his admission on 10/23/20. In #1's roommate was when Resident #1 was y. (Resident #1's roommate had tested positive for ident #1 was admitted to the with one of the LHD leads on 11/04/20 at did not provide any written incerning admissions to the was supposed to follow the ins and guidelines. With a personal care aide 3:02pm revealed: In ate was assigned the room was admitted to the facility incernom. In ate was in the hospital as admitted to the facility. facility's policy related to admissions.	D 601			

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: C B. WING 11/17/2020 HAL032091 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 601 D 601 Continued From page 136 -The Administrator did not get back to her about the quarantine system. -No one at the LHD would have recommended placing a newly admitted resident who tested negative for COVID-19 in the same room with a resident who tested positive for COVID-19 and had been recently discharged from the hospital. Telephone interview with a second MA on 11/09/20 at 2:58pm revealed: -She did not read the hospital discharge paperwork when Resident #1's roommate returned to the facility from the hospital on 10/27/20. -She gave the discharge paperwork to the Resident Care Coordinator (RCC). -The RCC and the Administrator were responsible for reading the hospital discharge summary. -Resident #1's roommate was returned to the same room he was in before he went to the hospital. -The new admission, Resident #1, was in the room also. -The facility's procedure was to return hospitalized residents to their previous room. -She did not know if Resident #1's roommate was COVID-19 positive or negative when he returned from the hospital. -She did not know if Resident #1's roommate needed to be guarantined when he returned to the facility from the hospital. Telephone interview with Resident #1's primary care provider (PCP) on 11/09/20 at 4:31pm

revealed:

COVID-19 positive.

-Resident #1 was never COVID-19 positive. -She did not know why Resident #1 was placed on a hall with COVID-19 positive residents. -She was not aware Resident #1's roommate was

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		HAL032091	B. WING		C 11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	; ZIP CODE	
DURHAM	RIDGE ASSISTED LIVIN	G	KE FOREST HWY 1, NC 27703		
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D 601	Continued From page	137	D 601		
	Second interview with a MA on 11/10/20 at 1:42pm revealed she was not aware of any resident who was positive for COVID-19 sharing a room with a resident who was negative for COVID-19.				
	Interview with a third MA on 11/10/20 at 3:20pm revealed: -Resident #1's roommate may have been hospitalized when Resident #1 was admittedResident #1's roommate was returned to the same room after he was discharged from the hospital. -The RCC was responsible for reviewing the hospital discharge summaryNew admissions to the facility were not placed on quarantineShe did not know if residents returning to the facility after hospitalization were supposed to be placed on quarantineThe Administrator was responsible for resident room assignments.				
Interview with the RCC on 11/10/20 at 4:23pm revealed: -She thought newly admitted residents who were COVID-19 negative were not put in the same room as residents who were positive for COVID-19She, the Administrator, and the former Administrator were responsible for resident room assignmentsShe could not remember if there was a heart on the doorpost (signifying the resident was COVID-19 positive) of Resident #1's roommate's room before Resident #1 was admitted and assigned to the same roomThere were too many occurrences of COVID-19 in the facility for her to be able to remember the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A, BUILDING:	(X3) DATE SURVEY COMPLETED			
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE CO	(X5) DMPLETE DATE
D 601	to be placed in the maif she was not onsite the facility after hospital cashed in the facility after hospital cashed in the facility after hospital cashed in the hospital discharge in the hospital in the ho	ge summary was supposed ailbox outside her office door when a resident returned to talization. To read Resident #1's discharge summary. The remaining on COVID-19 autions until 10/31/20 at the interest of the return of the placed in a room with I positive for COVID-19. The resident #1, TOVID-19, share a room ested positive for COVID-19.	D 601	DEPICIENC 1)		
	Manager (BOM) on 1 -Newly admitted residence of the control of the	with the Business Office 1/12/20 at 4:41pm revealed: dents who were COVID-19 o a room with a resident who negative or had already				

Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: ___ C B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY DURHAM RIDGE ASSISTED LIVING DURHAM, NC 27703 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 601 D 601 Continued From page 139 completed quarantine. -When a resident who tested positive for COVID-19 returned from the hospital, he or she would be guarantined from anyone who was negative. -The duration of quarantine would be ten days after a positive test as long as the resident was asymptomatic or 24 hours after last showing symptoms. -Room assignments were made by the former Administrator and the RCC. -The former Administrator typically read hospital discharge summaries and provided the information to the RCC and the current Administrator. -Residents who tested negative for COVID-19 were never intentionally placed with residents who tested positive for COVID-19. -Resident #1 should not have been placed in the same room as his roommate, who tested positive for COVID-19. -Less than a week ago, Resident #1 was moved into a room with a resident who tested negative for COVID-19; Resident #1's most recent COVID-19 test result (no date provided) was negative. Telephone interview with the former Administrator on 11/13/20 at 11:01am revealed: -He typically assigned resident rooms, but staff sometimes moved the residents to other rooms. -Newly admitted residents who had a previous negative COVID-19 test were not typically quarantined. -Residents who returned to the facility after hospitalization were typically returned to their previous room. -A resident who tested positive for COVID-19 and was returning from the hospital would not be

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placed in the same room as a resident who

Division of Health Service Regulation (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ С 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 601 D 601 Continued From page 140 tested negative for COVID-19. -He could not remember the details of Resident #1's admission. -He did not read Resident #1's roommate's hospital discharge summary. -The current Administrator, the current RCC, or the former RCC were responsible for reading hospital discharge summaries. -He was not aware Resident #1's roommate was COVID-19 positive when he returned from the hospital. -All of Resident #1's COVID-19 tests at the facility were negative. -Resident #1's roommate tested positive for COVID-19 on 10/18/20 and should have come off guarantine on 10/28/20. Telephone interview with a MA on 11/16/20 at 3:32pm revealed there were residents who tested positive for COVID-19 sharing a room with residents who tested negative for COVID-19. Based on interviews and observations, it was determined Resident #1 was not interviewable. 2. Review of the Centers for Disease Control and Prevention (CDC) guidelines for the prevention and spread of the coronavirus (COVID-19) disease in long term care (LTC) facilities revealed: -Personnel should always wear a face mask while in the facility. -Personnel should remove and discard personal protective equipment (PPE), other than respirators, upon completing a task before leaving a [resident's] room or care area. -Personnel should wear gloves, gowns, facemasks, and eye protection when caring for

status.

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new admissions due to unknown COVID-19

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: С B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 601 D 601 | Continued From page 141 Review of the NC DHHS guidance on What to Expect: Response to New COVID-19 Cases or Outbreaks in LTC settings dated 09/04/20 -Facility staff should wear appropriate PPE when caring for residents with undiagnosed respiratory infections or confirmed positive for COVID-19. -As required by NC Executive Order 131, facilities should implement the universal use of face masks for all staff while they were in the facility. -Facilities should consider the use of gloves for all resident interactions and the use eye protection was recommended in areas with moderate to substantial community transmission. Review of the North Carolina Department of Health and Human Services (NC DHHS) guidelines for the prevention and spread of COVID-19 in LTC facilities dated 09/28/20 revealed a core principle of infection prevention was the appropriate use of PPE by staff. Telephone interview with a representative from the Local Health Department (LHD) on 11/09/20 at 1:05pm revealed the facility management was advised to refer to the CDC guidelines for PPE Review of two facility sign in logs for review of documents about wearing and removing PPE within the quarantine area revealed: -Nineteen staff signed the log 08/31/20. -There were no other sign-in logs provided by the facility.

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Observations of the facility's storage room on

-There were 18 boxes of isolation gowns. -There were two boxes of N-95 masks.

11/03/20 at 10:57 am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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D 601	Continued From page 142		D 601			
	-There was one box of -There were 23 gallor -There were 7 boxes -There was a large strainly shields.	ns of hand sanitizer.				
	COVID-19 test results dates for each resider and resider tested positive for CC -There was a "P" (pos 10/25 (no year) for bot -The test date for bot	lents on the 100-hall who VID-19. sitive) in the column dated				
	-The memo's topic wa -There were six staff the memo without dat -There were 12 bullet	d staff memo revealed: as COVID-19 100-hall. signatures at the bottom of tes. statements on the memo to put on personal protective				
	1:35pm revealed: -A personal care aide from the bin containing glove on one handTwo staff walked throbreak wearing only a -Housekeeping staff and face shield that we protect her face and expenses.	was wearing a face mask was flipped up so it did not				
	2:50pm revealed: -A PCA wearing a ma	ask and face shield walked the hall to a room, hand in				

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: _ С 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 601 D 601 Continued From page 143 hand. -The PCA was not wearing gloves during this observation. -The PCA left the resident in the room and walked down the hall into another resident room. -The PCA did not use hand sanitizer between interactions with the residents. Interview with a PCA on the 100-hall on 11/03/20 at 10:57am revealed that the red hearts on the door of residents' rooms were to indicate that a resident was COVID-19 positive. Interview with a second PCA on the 100 hall on 11/03/20 at 11:25am revealed: -The red heart on the resident room doors were used to indicate that a resident in the room had tested positive for COVID-19 at some time during their stay. -The red hearts were to be taken down once the resident had recovered. -She did not know which residents had tested positive when there were 2 residents in the room. Interview with the second PCA on 11/10/20 at 2:19pm revealed that PCAs must ask the medication aide (MA) on duty which residents had tested positive. Telephone interview with a hospice nurse on 11/13/20 at 8:50am revealed: -Staff on the 100-hall did not appropriately use PPE when there were residents who tested positive for COVID-19.

their chin.

-She observed staff wearing face masks under

-She observed staff going in and out of rooms without changing gloves or other PPE. -She observed many staff not wearing gloves.

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		HAL032091	B. WING		11/17/2020	
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	member on 11/06/20	e interview with a family				
	Refer to telephone interview with another PCA on 11/09/20 at 3:47pm.					
	Refer to the confident	tial interview with staff.				
	Refer to the telephone Administrator on 11/0	e interview with the former 4/20 at 11:00am.				
	Refer to the interview Administrator on 11/1					
		e interview with a primary on 11/09/20 at 4:31pm.				
	Refer to another telephone interview with a primary care provider (PCP) on 11/16/20 at 8:02am.					
	Refer to the telephone 11/16/20 at 3:32pm.	e interview with a MA on				
	Refer to the second in 11/10/20 at 1:42pm.	nterview with a MA on				
		e interview with emergency S) staff on 11/12/20 at				
	Refer to the telephone EMS staff on 11/12/20	e interview with a second 0 at 1:20pm.				
	Refer to the telephonistaff on 11/17/20 at 8	e interview with a third EMS :00am.				

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ C 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY D 601 Continued From page 145 D 601 Refer to the telephone interview with the Resident Care Coordinator (RCC) on 11/12/20 at 4:34pm. Refer to the interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm. Refer to the telephone interview with the Administrator on 11/17/20 at 8:08am. Refer to the telephone interview with the Business Office Manager (BOM) on 11/04/20 at 11:00am. Refer to the telephone interview with the BOM on 11/12/20 at 4:41pm. Refer to the telephone interview with the BOM on 11/17/20 at 9:48am. b. Review of the facility's COVID-19 tracking log for residents revealed: -The 25 of 26 residents currently residing on the 200-hall who previously tested positive for COVID-19 were beyond their established quarantine time. -The last established release date for quarantine time for the 25 residents who previously tested postive for COVID-19 was 10/30/20. -The 1 of 26 residents currently residing on the 200-hall who tested negative for COVID-19 on 11/01/20. Observations of the 200-hall on 11/03/20 -At 11:39am, a PCA walked out of the dining room and across the hall to Room 220 with her

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mask pulled down below her nose.

-The PCA handed some food condiments to the resident near the window and then helped the other resident adjust the oxygen tubing on the

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D 601	Continued From page	e 146	D 601			
	resident's face.					
		d around, she had pulled				
	the mask back up on					
		who was passing plates to				
		ns, had her mask below her				
	nose all the way to he	•				
		ood trays to residents in				.
		215, 218, and 220 with her				
		low her nose all the way to				
	her bottom lip.					
		room 220, the PCA assisted				
	another staff pull up a	a resident in bed then the				
	PCA went back to the	e dining room and changed				
		was still below her nose.				
		A started passing plates to				
		nall dining room with the				
	mask under her nose					
		A pushed the food cart back				
		entrance doors and her mask				
		se as she went into room				
	213.	0				
		A went into room 220 and				
		package, picked up one of				
	the resident's French	ded it to the resident and the				
	resident ate it.	To the resident and the				
		A went into room 218 to				
		g without changing gloves or				
	washing her hands.					
		A went into room 215 and				
		ver her nose before she				
	came out of the room					
		A took off her gloves while in				
	room 207, assisted th	ne resident with a transfer				
	from bed to wheel ch					
		resident's night stand near				
		use the resident's food tray				
	was on the night star				.	
		e resident a napkin, a spoon,				
	and opened condime	ent packages without wearing				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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the resident's room, ther gown with clean her gown with clean her get to her pockets for the resident with the resident's food plastand. Interview with the PCA on 11/03/20 at 2:43pm - Staff were required to gloves; face shields words wasks should cover the resident with a resident sperspired. -Staff was supposed to incontinence care or a contact with a resident staff should always hemeals. -If staff left the hall, the and gloves but they contact with a second 200-hall on 11/03/20 and face shields. Interview with a second 200-hall on 11/03/20 and face shields. -They usually had end run out. -Once staff got to their supposed to stay on the gowns and gloves and near the entrance documents.	and her hands at the sink in then she touched the front of lands to pull the gown back for a new pair of gloves. It went in room 201 and the attransfer to a chair near late that was on a night. A assigned to the 200-hall in revealed: In wear gowns, masks, and were optional. It mouth and nose. It is slid off because she in the mouth and nose. It is slid off because she in the mattransfer to when serving levels on when serving levels and to change gowns ould use the same masks and PCA assigned to the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11:46am revealed: It halls, staff was supposed in the late 11	D 601			

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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 601	Continued From page	2 148	D 601			
	on new gowns and gl -Staff were tested for -All residents on the 2 positive to her knowle room to room, they di Observation on the 2 12:18pm revealed: -The MA was standing	oves. COVID-19 once a week. 200-hall were COVID-19 edge so if staff went from d not have to change PPE. 00-hall on 11/03/20 at g at the medication cart with				
	her face mask pulled under her nose. -The MA was preparing medications to administer to a resident with the mask pulled under her nose. Interview with the MA assigned to the 200-hall on 11/03/20 at 12:25pm revealed: -The facility had plenty of PPE but she had observed staff on second shift only wearing masks and gloves, not gowns or face shields. -Those staff would say that was what they were told to do by the Resident Care Coordinator (RCC) and the former Administrator. -If staff left the hall, they were supposed to change gowns and gloves and use the trash can near the entrance doors of 200-hall to dispose of them. -Staff had no formal in-service on how to put on and take off PPE. -She pulled her mask down sometimes to "get a breath". -Staff were supposed to keep masks over their noses and mouths at all times. Observation on the 200-hall on 11/03/20 revealed:					
	215 and went across changing gloves or a -At 11:33am, the hou	sekeeper came out of room the hall to room 216 without ny other PPE. sekeeper came out of room o room 215 without changing				

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FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ C B. WING 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 601 Continued From page 149 D 601 gloves or any other PPE. Interview with the housekeeper on 11/03/20 at 3:20pm revealed: -Staff was required to wear gowns, masks, and gloves. -When staff came off of a hall, they were supposed to change gowns and gloves. -He used the same PPE while on a hall whether there were residents who tested positive or negative for COVID-19. Refer to the telephone interview with a family member on 11/06/20 at 10:31am. Refer to the telephone interview with a PCA on 11/06/20 at 3:02pm. Refer to telephone interview with another PCA on 11/09/20 at 3:47pm. Refer to the confidential interview with staff. Refer to the telephone interview with the former Administrator on 11/04/20 at 11:00am. Refer to the interview with the former Administrator on 11/10/20 at 1:07pm. Refer to the telephone interview with a primary care provider (PCP) on 11/09/20 at 4:31pm. Refer to another telephone interview with a PCP on 11/16/20 at 8:02am. Refer to the telephone interview with a MA on 11/16/20 at 3:32pm.

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11/10/20 at 1:42pm.

Refer to the second interview with a MA on

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	COMPLETED		
			С		
		HAL032091	B. WING		11/17/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
DURHAM	RIDGE ASSISTED LIVING	G	E FOREST HW NC 27703	Y	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 601	Continued From page	150	D 601	>	
	Refer to the telephone interview with emergency medical services (EMS) staff on 11/12/20 at 11:20am.				
	Refer to the telephone EMS staff on 11/12/20	e interview with a second 0 at 1:20pm.			
	Refer to the telephone interview with a third EMS staff on 11/17/20 at 8:00am.				
	Refer to the telephone interview with the RCC on 11/12/20 at 4:34pm. Refer to the interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm.				
	Refer to the telephone Administrator on 11/1				
	Refer to the telephone 11/04/20 at 11:00am.	e interview with the BOM on			
	Refer to the telephone 11/12/20 at 4:41pm.	e interview with the BOM on			
	Refer to the telephone 11/17/20 at 9:48am.	e interview with the BOM on			
	COVID-19 test results dates for each reside -There were two reside tested positive for CC -There was a "P" (pos 10/25 (no year) for bot -The test date for bot	dents on the 300-hall who NVID-19. sitive) in the column dated			

STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL032091 B. WNG		11/1	7/2020		
	ROVIDER OR SUPPLIER RIDGE ASSISTED LIVIN	3420 WAKE	RESS, CITY, STA FOREST HW NC 27703			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
D 601	Observations on the 3 10:50am-12:21pm reThere was an overflot disposal next to the half of the residents who were liftenessed on the document was a MA came out of a surgical mask that was a MA repositioned nose. -The MA repositioned nose. -The MA left the half of discarding her gown and the same goven and the s	as one-hall on 11/03/20 from wealed: bywing trash can for PPE all doors. leart attached to the t's room. (Neither of the two sted as COVID-19 positive assigned to the room.) resident's room wearing a as not covering her nose. If the mask to cover her without removing and and gloves. The hall and continued to who. I staff entered every resident ing utensils and lunch trays; dafter staff entered the swho were COVID-19 on the 300-hall on 11/03/20 there were no residents who wID-19 on the 300-hall. Ind PCA on the 300-hall on revealed: The residents on the 300-hall tive. In the doorpost of one of the esident was COVID-19 twas "from a long time ago." Thirty Director on 11/03/20 at any residents on the 300-hall	D 601			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
			755.25.115.		c
		HAL032091	B. WNG		11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	, ZIP CODE	
DUDHAM	RIDGE ASSISTED LIVING		KE FOREST HWY		
DUNHAM	RIDGE ASSISTED LIVIN	DURHAM	I, NC 27703		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE
D 601	Continued From page	152	D 601		
	11/03/20 at 11:11am in a residents who tested a heart on the doorpool red was never told to entering the hall or go rooms.	d positive for COVID-19 had			
	at 11:19am and 2:48p -There were no reside were COVID-19 posit -Residents on the hal COVID-19 positive ha 10/23/20 and 10/30/2 -An administrative sta	om revealed: ents on the 300-hall who ive. Il who were previously ad come off quarantine on			
	-The MAs were given them know which res positiveThe most recent list -Residents were encoroomsShe did not discard she left the hall earlie administer medication was not on the 300-hall staff. (There 300-hall who tested partners were two residuals of the facility that were staff.	was dated 10/25/20. buraged to stay in their ther gown and gloves when ar because she went to in to a resident whose room all but was assigned to the were two residents on the positive for COVID-19.) dent rooms in another area are assigned to the 300-hall			
	they left the hall. Telephone interview of 11/05/20 at 9:15am references.	with a hospice nurse on			

FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: __ C 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 601 D 601 | Continued From page 153 the passing of a resident on the 300-hall. -There was no red heart on the bedroom door at the time of her visit. Telephone interview with a resident's family member on 11/05/20 at 10:00am revealed: -She had been to the facility for a bedside visit with the resident on 10/22/20. -She observed staff going in and out of different resident rooms without changing gloves or other PPE. A second telephone interview with a resident's family member on 11/06/20 at 9:26am revealed: -She had taken the resident a charger for his computer on 10/09/20. -The staff that brought the resident outside to collect the charger was wearing his face mask below his chin and she asked him to raise it as he approached her. -She observed residents' room doors opened on the 300-Hall when she visited the resident on 10/20/20. Telephone interview with a second MA who worked on the 300-hall on 11/09/20 at 2:58pm revealed: -A heart was placed on the resident's doorpost if the resident was COVID-19 positive and was on quarantine. -The hearts on the doorposts of the residents' rooms were placed by the RCC or the Administrator. -Staff were normally told which residents were COVID-19 positive when they reported to their -She was not told today about who was

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one has it."

COVID-19 positive on the 300-hall; "maybe no

-Kitchen staff asked the MA or PCA which

FORM APPROVED Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ C 11/17/2020 HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETÉ SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 601 D 601 Continued From page 154 residents were COVID-19 positive. -Kitchen staff passed out the meal trays on the -She was instructed on PPE use when she was hired. -Staff were supposed to remove PPE before leaving the hall. -Trash cans for PPE disposal were next to the hall doors. -Staff were supposed to change gowns, gloves, face shield, masks, and booties when going between COVID-19 positive and negative resident rooms. Interview with a third MA on the 300-hall on 11/10/20 at 3:20pm revealed: -She was not informed if there were any residents who were positive for COVID-19 on the 300-hall today. -She did not know how often the document indicating which residents were COVID-19 positive was updated. -The most recent document was dated 11/04/20. -Residents who were positive for COVID-19 were moved to rooms with other residents who were positive or were placed in a private room. -She was "pretty sure" there were four residents on the hall who had not contracted COVID-19. -She could not exactly remember when the PPE stations had been put into place but they had been in place for months. -Staff were supposed to wear a gown, mask, face shield, and gloves when going into a resident's

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training.

missed it.

-Staff was not provided specific COVID-19

-She did not know if a resident who tested positive could share a room with a resident who

-There was some sort of training today, but she

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		HAL032091	B. WNG		11/17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DURHAM	RIDGE ASSISTED LIVING		E FOREST HW	Y	
DUKITAW	NIDOL AGGISTED LIVING	DURHAM,	NC 27703		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 601	Continued From page	155	D 601		
D 601	tested negativeManagement instruct has COVID[-19]." Telephone interview w 4:41pm revealed: -The kitchen staff did residentsKitchen staff did not e meal trays on a cart o -Staff assigned to the delivering the trays to -Before coming out of tested positive for CO supposed to remove a -Staff should not have residents who tested then entering the roor negative for COVID-1 -Staff knew there was medication cart indicatested positive for CO had negative test resulted the covid of t	with the BOM on 11/12/20 at not directly interact with the enter the halls; they left the outside the hall doors. hall were responsible for the residents' rooms. If the room of a resident who evID-19, staff were and discard the PPE. It is been entering the rooms of positive for COVID-19 and more of a resident who tested 9 without changing PPE. It is a room roster on every string which residents had evID-19 and which residents sults.	D 601		
	positive for COVID-19 released from quarant	on the 300-hall would be tine on 11/06/20.)			
	Refer to the telephone member on 11/06/20	e interview with a family at 10:31am.			
	Refer to the telephone 11/06/20 at 3:02pm.	e interview with a PCA on			
	Refer to telephone int 11/09/20 at 3:47pm.	rerview with another PCA on			
	Refer to the confident	tial interview with staff.			

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AND BLAN OF CORRECTION DENTIFICATION NUMBERS			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.	A. BUILDING:		
		HAL032091	B. WING		11/17	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVING	G	FOREST HW	Υ		
		DURHAM,		DECOMPEDIO DI ANI GE GODDECTIO	N	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 601	Continued From page	÷ 156	D 601			
	Refer to the telephone Administrator on 11/0	e interview with the former 4/20 at 11:00am.				
	Refer to the interview Administrator on 11/1					
	Refer to the telephone interview with a PCP on 11/09/20 at 4:31pm.					
	Refer to another telep on 11/16/20 at 8:02ar	ohone interview with a PCP n.				
	Refer to the telephone interview with a MA on 11/16/20 at 3:32pm.					
	Refer to the second in 11/10/20 at 1:42pm.	nterview with a MA on				
	Refer to the telephone interview with emergency medical services (EMS) staff on 11/12/20 at 11:20am.					
	Refer to the telephone interview with a second EMS staff on 11/12/20 at 1:20pm.					
	Refer to the telephon staff on 11/17/20 at 8	e interview with a third EMS :00am.				
	Refer to the telephon 11/12/20 at 4:34pm.	e interview with the RCC on				
	Refer to the interview 11/10/20 at 4:50pm a	rs with the Administrator on nd 5:58pm.				
	Refer to the telephon Administrator on 11/1					
	Refer to the telephon 11/04/20 at 11:00am.	e interview with the BOM on				

AND DUAN OF CORRECTION IDENTIFICATION NUMBERS		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		HAL032091	B. WING		11/17/2020	
NAME OF PROVIDER OR SUPF	LIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DURHAM RIDGE ASSISTE	אועו ו מי	3420 WAK	E FOREST HW	Υ		
DOMINII NIDOL ASSISTE	-D LIVIN	DURHAM,	NC 27703			
PREFIX (EACH D	EFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERÊNCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 601 Continued Fro	om page	157	D 601			
Refer to the to 11/12/20 at 4:		e interview with the BOM on				
Refer to the to 11/17/20 at 9:		e interview with the BOM on				
11/06/20 at 10 -He had gone	Telephone interview with a family member on 11/06/20 at 10:31am revealed: -He had gone to the facility to pick up the					
10/23/20.	resident's wallet after he passed away on 10/23/20. -The residents were not socially distanced; they were seated two feet or less from each other. -A staff delivered the wallet to his car with a cloth mask worn below the nose.					
-A staff delive						
3:02pm revea	iled:	vith a PCA on 11/06/20 at				
meant the res -He did not kr and removing	 -A heart on the doorpost of a resident's room meant the resident was on quarantine. -He did not know who was responsible for placing and removing the hearts from the residents' 					
room were no	t curren					
indicating whi	ich resid	n the medication cart ents were on quarantine. et at the beginning of his				
-He would als from the staff	who wo	ord of mouth information rked the previous shift. ents as if they were				
11/09/20 at 3 -She had obs to speak with	:47pm re erved st each ot	vith another PCA on evealed: aff remove their face masks her because they could not agh the face mask.				

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PRINTED: 12/10/2020 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID PREFIX TAG COMPLETED OF PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 601 Continued From page 158 Complete Comp	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 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) D 601 Continued From page 158 -Staff tried to keep their masks in place over their nose and mouthThe PPE was hot to wear sometimesShe did not think it was her job to correct staff it they wore PPE incorrectlyThe supervisor was the person who should tell other staff when PPE was not worn correctly. Confidential interview with a staff revealed:		
DURHAM RIDGE ASSISTED LIVING 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 601 Continued From page 158 -Staff tried to keep their masks in place over their nose and mouth. -The PPE was hot to wear sometimesShe did not think it was her job to correct staff it they wore PPE incorrectlyThe supervisor was the person who should tell other staff when PPE was not worn correctly. Confidential interview with a staff revealed:		
DURHAM, NC 27703 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 601 Continued From page 158 -Staff tried to keep their masks in place over their nose and mouth. -The PPE was hot to wear sometimes. -She did not think it was her job to correct staff it they wore PPE incorrectly. -The supervisor was the person who should tell other staff when PPE was not worn correctly. Confidential interview with a staff revealed:	NAME OF PROVIDER OR SUPPLI	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 601 Continued From page 158 -Staff tried to keep their masks in place over their nose and mouthThe PPE was hot to wear sometimesShe did not think it was her job to correct staff it they wore PPE incorrectlyThe supervisor was the person who should tell other staff when PPE was not worn correctly. Confidential interview with a staff revealed:	DURHAM RIDGE ASSISTED	
-Staff tried to keep their masks in place over their nose and mouth. -The PPE was hot to wear sometimesShe did not think it was her job to correct staff it they wore PPE incorrectlyThe supervisor was the person who should tell other staff when PPE was not worn correctly. Confidential interview with a staff revealed:	PREFIX (EACH DEF	
-COVID-19 spread throughout the facility because of staffSome staff were not wearing masks while working and some staff would pull their masks below their nosesSome staff would pull down their masks when they talked to other staff and residents Telephone interview with the former Administrator on 11/04/20 at 11:00am revealed he and management were constantly reminding staff to pull up and readjust their masks if they saw staff coming down the hall and their masks were hanging off or under their noses. Interview with the former Administrator on 11/10/20 at 1:07pm revealed: -There were no residents with COVID-19 in the facility at that timeThe LHD informed him on 11/06/20 that staff were supposed to wear masks, face shields, and gloves while on the halls; gowns were optional since there were no residents with COVID-19 at that timeStaff were to continue to change gloves after providing care to residents. Telephone interview with the primary care provider (PCP) on 11/09/20 at 4:31pm revealed: -She was "taken aback" by the lack of PPE use by facility staff.	-Staff tried to ke nose and moutled -The PPE was leaded not thin they wore PPE -The supervisor other staff where Confidential integrates of staff -Some staff were working and so below their nose -Some staff working and readed coming down the hanging off or underwise with the time working at that time -The LHD inform were supposed gloves while on since there were that timeStaff were to controlled the provider (PCP) -She was "taken"	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.,		С	
		HAL032091	B. WING			17/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVING	G 3420 WAKI DURHAM,	E FOREST HW NC 27703	Y		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 601	-She noticed in mid-C signage in the facility there was no signage -She expected staff to shield, and gloves wha resident who tested -She expected staff to the room of a resident COVID-19. -PPE was not being use -She had to remind staff wore glove-Staff did not wear fact gowns when providing tested positive for CO-When COVID-19 cask new staff were not for guidelines. -She asked staff if the anyone had taught the -A MA informed her thand staff was not instreppe stations were plaround the third week -Seventy-five percent already COVID-19 po stations were in place Another telephone interprovider (PCP) on 11/-She began seeing recovered. -She had expressed of doors being opened for covider of covider c	about mask usage, but about any other PPE. wear a gown, mask, face en they entered the room of positive for COVID-19. The remove PPE before exiting the who tested positive for seed by all staff. The seed of the residents who had the seed of the residents who had the seed of the residents who had the residents were sit to residents were sit to residents were sit to residents were sit to be fore the PPE. The residents were sit to residents were sit to be fore the PPE. The residents were sit to residents at the facility in June and the residents at the facility in June and the residents on quarantine and the room or residents on quarantine histrator and with the BOM to be left opened.	D 601			

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WNG HAL032091 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3420 WAKE FOREST HWY **DURHAM RIDGE ASSISTED LIVING** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 601 Continued From page 160 D 601 appropriately in all areas of the facility. -She observed staff not wearing gowns and face shields on the resident halls. -She observed staff not changing PPE between resident rooms. Telephone interview with a MA on 11/16/20 at 3:32pm revealed: -She was not given instructions on admitting new residents to the facility. -She was aware of times when there was a red heart placed on a residents' door when only one of the roommates tested positive. -Staff wore the same gown, face shield and mask from room to room but would change gloves and the process had "always been that way". -There were some weeks they wore face shields and others they did not. Second interview with a MA on 11/10/20 at 1:42pm revealed: -Red paper hearts on the door were part of an old system and had not been taken down. -When one roommate tested positive then both roommates would quarantine together for 14 days and if the second resident did not test positive after the 14-day quarantine, he/she would be moved to a room to themselves. Telephone interview with emergency medical services (EMS) staff on 11/12/20 at 11:20am revealed: -She responded to a call to the facility on

09/28/20.

-She observed staff were not changing PPE when

Telephone interview with a second EMS staff on

-She responded to a call to the facility on

going to different resident rooms.

11/12/20 at 1:20pm revealed:

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
			B. WING		C	
		HAL032091	b. WINO		11/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVING	G	E FOREST HV	Υ		
		DURHAM,	NC 27703	·		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 601	Continued From page	e 161	D 601			
	09/20/20 for a resider breathShe observed a MA a two residents while we	nt experiencing shortness of administering medications to earing gloves but did not				
	change the gloves be -She had observed Po different resident room					
	11/17/20 at 8:00am relevance -He responded to a caresidentWhen he responded roommate was wearing because she said she COVID-19 but that the tested positiveHe last responded to observed a staff on a shield and no gloves of staff informed him that transporting on the nigpositive for COVID-19 -EMS staff found out of medical facility that the transported 2-3 days is COVID-19 positive at -The facility frequently COVID-19 positive and -He observed staff going rooms without changing when he responded to -There were times whe facility "3-4 times a nigonal form of the coverage of the co	to the call, the resident's and a mask in the room had tested negative for a resident he transported the facility on 11/16/20 and resident hall wearing a face or mask. The resident he was gone of 11/16/20 had tested to but had recovered. The during transport to the local teresident had been prior and had tested the time. That residents that were do negative sharing a room. The golves or other PPE to other calls to the facility. The new was called to the got. The contract of the resident of the golves or other prior and had tested the time. The contract of the facility. The contract of the golves or other prior and he was called to the got. The contract of the resident of the golves or other prior and the golves				
	-Staff referred to the h the residents' rooms a COVID-19 status.	earts on the doorposts of as an indication of				

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED.
			1		1	
		HAL032091	B. WING			
		Integration			11/1	7/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE		
DURHAM	RIDGE ASSISTED LIVING	3420 WAK	E FOREST HV	VY		
		DURHAM,	NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 601	Continued From page	162	D 601			
2001	-The previous RCC pl hearts from the reside -Staff also verbally infresidents were COVID Telephone interview was 4:34pm revealed: -She tried to make roumake sure staff were valid talk with them a important, then she with implement suspension residents and staff saft-She had talked to a comight have been halfweto pull them back up.	aced and removed the ints' doorposts. ormed each other which 0-19 positive. with the RCC on 11/12/20 at ands on the hallways to wearing their PPE. Ing PPE as instructed, she and tell them it was build write warnings or as if needed to keep the	D 601			
	4:50pm and 5:58pm re-Staff knew who was 0 hearts on the doorpost-The previous RCC water and removing the heart doorposts. -The MAs were supported to the hall water and the hall water supported to the hall water are port indicating which covided to the shift supervisor sates are sidents were current staff should not have	COVID-19 positive by the ts. as responsible for placing ts from the residents' sed to let staff know if any ere COVID-19 positive. as provided with a copy of ch residents were hould have told staff which ly COVID-19 positive. been going between sitive for COVID-19 and gative for COVID-19				

	T OF DEFICIENCIES OF CORRECTION	A, BUILDING: HAL032091 STREET ADDRESS, CITY, STATE, ZIP CODE STED LIVING STED LIVING SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL CH DEFICIENCY MUST BE PRECEDED BY FULL CH DEFICIENCY OR LSC IDENTIFYING INFORMATION) A, BUILDING: COMPLET C C 11/17/ C C 11/17/ C C 11/17/ C C 11/17/ C C 11/17/ C C 11/17/ C C 11/17/ C C 11/17/				
		IDENTIFICATION TO THE TOTAL TO THE TOTAL TOTAL TOTAL TOTAL TO THE TOTAL	A. BUILDING:		COMP	LETED
		HAL032091	B. WING		1	C 17/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE. ZIP CODE		
DURHAM	RIDGE ASSISTED LIVING	0.400 \\				
DOMINA	MDOL ASSISTED LIVING		, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
D 601	Continued From page	163	D 601			
	-Infection control train and 11/10/20.	ing was provided 11/09/20				
	11/17/20 at 8:08am re -Staff should wear ma noses at all times and shieldsThe LHD representat wearing gowns unless for COVID-19.	vith the Administrator on vealed: sks over their mouths and they should wear a face ive said staff could stop a resident tested positive				
	-Staff were currently regowns, and gloves on there were no resident COVID-19 on the hallFace shields were op tested positive for COVID-19, staff should including face shieldsStaff should change gresident and each task-Staff should not be profood without glovesStaff should wear face the mask should cover-The face mask somet but staff should make staff should mak	tional if no residents who VID-19 were on the hall. s who tested positive for d be wearing full PPE sloves between each c. oviding care or touching e masks at all times and the nose and mouth. imes moved when working				
	4:41pm revealed: -Staff should not have residents who tested p then entering the room	th the BOM on 11/12/20 at been entering the rooms of ositive for COVID-19 and of a resident who tested without changing PPE.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE \$URVEY COMPLETED			
		HAL032091	B. WING		C 11/17/2020			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE	1111112020			
DURHAM RIDGE ASSISTED LIVING 3420 WAKE FOREST HWY								
DOTATION	KIDOL ASSISTED LIVING	DURHAM,	NC 27703					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE			
D 601	Continued From page	164	D 601					
	every medication cart had tested positive for residents had negative -He did not remember provided as a resource	when the lists were first e for staff. was responsible for placing						
	9:48am revealed: -The Administrator wa staff using PPEHe expected staff to defect an area where son before going to an are-From the beginning of managers were instructional staff to wear P	f the pandemic, all cted to watch staff and to PE. to re-educate, redirect, and						
	the coronavirus (COVI care (LTC) facilities rev-Facilities should enfor apart) with residents a -Facilities should cance. Review of the North Carlealth and Human Seguidelines for the prevention.	ne prevention and spread of D-19) disease in long term vealed: vealed: veace social distancing (6 feet and staff. el all communal dining. erolina Department of rvices (NC DHHS) ention and spread of care (LTC) facilities dated						
	-While adhering to the COVID-19 infection pre activities and dining manual control of the contro	evention, communal						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	((X3) DATE :	
			A. BUILDING:	-			
		HAL032091	B. WING				C 1 7/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	FATE, ZIP CODE			
DURHAM	RIDGE ASSISTED LIVING	3420 WA	KE FOREST H	NY			
		DURHAN	I, NC 27703				
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA	Ē ΤΕ	(X5) COMPLETE DATE
D 601	Continued From page	165	D 601				
	-These activities may who are not in isolatio COVID-19Mealtimes should be -There should be six findividual and each ta Interview with the forr 11/03/20 at 3:10pm re -There were 25 of 26 ron the 200-hall who had for COVID-19There was 1 of 26 resthe 200-hall who teste -All 25 of the residents 200-hall who had teste were past their quarant	be facilitated for residents in or quaratine for staggered. Seet of space between each ble. mer Administrator on vealed: residents currently residing and previously tested positive sidents currently residing on dinegative for COVID-19. Securrently residing on the ed positive for COVID-19 time time.					
	residents revealed: -The 25 of 26 residents 200-hall who previousl COVID-19 were beyon quarantine timeThe last established re time for the 25 resident postive for COVID-19 v -The 1 of 26 residents 200-hall who was nega 11/01/20. Observations of the 20 revealed: -There were 2 white repushed end to end in the room at the end of the inAt 11:07am, there were side of the table, side be 2 feet apart.	elease date for quarantine ts who previously tested was 10/30/20. currently residing on the ative last tested negative on 0-hall on 11/03/20 ctangular plastic tables ne middle of the living					

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL032091 C B. WING 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DURHAM RIDGE ASSISTED LIVING** 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 601 Continued From page 166 D 601 other side of the table directly across from another resident. -At 11:07am, there was 1 resident walking around the table and another resident sitting at a bedside table in the left corner of the room near the piano. -At 11:07am, a personal care aide (PCA) was passing out drinks in the dining room. No residents were wearing masks. -No staff attempted to have the residents to social distance or wear masks. -At 11:10am and 11:12am, a PCA brought two other residents into the dining room and seated them at the table -At 11:13am, a resident walked into the dining room with a mask on over her mouth but under her nose and the resident pulled the mask below her chin when she sat down at the table beside other residents. -From 11:14am - 11:19am 3 other residents came into the dining room and sat down at the table beside other residents with only 1 to 2 feet of distance between them. -At 11:41am, the PCA sat on the piano stool and pulled down her mask to talk and sing to the -The PCA was sitting approximately 2 to 3 feet from the resident beside the piano and the residents sitting near the end of the table. -At 12:00pm, the PCA started passing plates to 16 residents in the small dining room with the mask under her nose. -There were 14 residents seated at the table with 7 residents on each side sitting side by side within 1 to 2 feet of each other and they were sitting directly across from each other, not staggered. -There was 1 of the residents sitting near the window and another resident sitting beside the piano. No staff attempted to social distance the residents or encourage them to wear masks while Division of Health Service Regulation

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL032091 C B. WNG 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DURHAM RIDGE ASSISTED LIVING** 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 601 Continued From page 167 D 601 waiting for their food. Telephone interview with a personal care aide (PCA) on 11/09/20 at 5:50pm revealed: -Prior to positive COVID-19 cases, residents on the 200 hall used the living room to eat their meals. -When the number of positive COVID-19 cases increased in the facility, residents were not allowed to eat in the living room. -After the 200-hall residents completed quarantine, she began placing 12 to 14 residents in the television room again for meals. Telephone interview with the local health department (LHD) COVID-19 task force lead on 11/04/20 at 9:51 am revealed: -The facility was sent guidance concerning communal dining in May 2020 via email. -The task force encouraged for the facility to discontinue communal dining when the guidance was released by the CDC early in the pandemic. Interview with a medication aide (MA) on 11/03/20 at 10:46am revealed: -The residents on the 200-hall usually ate lunch between 11:30am - 12:00pm. -They used the common area/living room at the end of the 200-hall as a dining room. -Some residents stayed in their rooms to eat (whoever wanted to). -Other residents went to the small dining room at the end of the hall to eat. Interview with a PCA assigned to the 200-hall on 11/03/20 at 2:43pm revealed: -Staff usually stayed on their hall during their shift. -About 2 weeks ago, residents on the 200-hall started eating in the living room, prior to that all residents ate in their rooms. Division of Health Service Regulation

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL032091 B. WNG 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DURHAM RIDGE ASSISTED LIVING** 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 601 Continued From page 168 D 601 Interview with the MA assigned to the 200-hall on 11/03/20 at 12:25pm revealed: -The residents on the 200-hall had been eating in the living room since she returned to the facility around the last week of October 2020. -The residents could not social distance while eating in the living room because there was not enough room. Interview with the Business Office Manager (BOM) on 11/04/20 at 11:00am revealed: -In April or May 2020, instead of feeding all residents in the main dining room, they split residents up into groups. -They set up the living room/activity room on each hall as dining rooms so residents could still eat in small groups and social distance. -The LHD suggested the facility feed residents in shifts (3 seatings) in the main dining room. -Once the facility had a couple of residents test positive for COVID-19 (no date specified), the LHD wanted the residents back on their specific hall to eat. -The residents who tested negative for COVID-19 ate in shifts in the small dining rooms at the end of their halls and the residents who tested positive for COVID-19 ate in their rooms. -Currently, all residents were eating in their rooms except for the residents who lived on the 200-hall. -The residents on the 200-hall ate in the small dining room set up at the end of the hall because those residents were out of their 10 day quarantine. -The residents on the 200-hall were not able to eat at the same time in the small dining room because they were supposed to be at least 6 feet apart and spaced diagonally so residents were not sitting directly across from each other. -Some of the residents on the 200-hall also still Division of Health Service Regulation

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED \mathbf{C} HAL032091 B. WING 11/17/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DURHAM RIDGE ASSISTED LIVING** 3420 WAKE FOREST HWY DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 601 Continued From page 169 D 601 ate in their rooms. -Management staff were at the facility daily and watched and observed meal services and corrected anything that was not done correctly. -Management staff educated staff and monitored to make sure dining was occurring the way it was supposed to. -The residents on the 200-hall should have been social distanced when dining together for lunch on 11/03/20. Interview with the former Administrator on 11/04/20 at 11:00am revealed: -He could not recall the last time he observed dining on the 200-hall. -It "seems" like there were some residents sitting at the tables in the small dining room on the 200-hall when he was on the 200-hall at lunchtime yesterday, 11/03/20, but he did not pay any attention to it. -It was concerning to him that the residents on the 200-hall were communal dining without social distancing during the lunch meal on 11/03/20. -He observed the residents in the small dining room on the 200-hall during lunch today, 11/04/20, and they were "setting too close for sure". -He instructed staff to take the residents on the 200-hall who could eat safely to their rooms and to spread out the other residents in the small dining room. Observations of the living room at the end of the 200-hall on 11/10/20 at 5:07pm revealed: -There were 5 residents sitting at the tables in the area set up for dining. -There were 4 residents on one side of the table . siting side by side within 1 to 2 feet from each other. -There was 1 resident on the other side of the Division of Health Service Regulation

PRINTED: 12/10/2020 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL032091 C B. WING NAME OF PROVIDER OR SUPPLIER 11/17/2020 STREET ADDRESS, CITY, STATE, ZIP CODE **DURHAM RIDGE ASSISTED LIVING** 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 601 Continued From page 170 D 601 table sitting directly across from one of the other residents. -There was a dining cart with 12 disposable cups with an orange liquid, uncovered sitting on top of the drink cart. -There was a metal container with silverware uncovered on top of the cart. Telephone interview with the Administrator on 11/17/20 at 8:08am revealed: -Staff should change gloves between each resident and they should be gloved when passing out food. -It was her understanding that as long as residents were 6 feet apart, they could participate in communal dining. Telephone interview with the BOM on 11/17/20 at 9:48am revealed: -For communal dining, residents should have been appropriately social distanced with at least 6 feet apart or more and there should have not been so many residents in there at one time. -For 11/10/20, the resident in the dining room on the 200-hall should still have been social distancing. -The former Administrator was supposed to be checking on meals and dining on a daily basis. The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), the local health department (LHD), and the North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic in which staff did not know which residents tested positive or negative for COVID-19; staff did not wear face masks within the facility consistently; staff did not change gloves between tasks and resident care; Division of Health Service Regulation

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL032091 C B. WING NAME OF PROVIDER OR SUPPLIER 11/17/2020 STREET ADDRESS, CITY, STATE, ZIP CODE **DURHAM RIDGE ASSISTED LIVING** 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE TAG DATE DEFICIENCY D 601 Continued From page 171 D 601 and conducted communal dining without proper social distancing the residents 6 feet apart from one another. In October 2020, 91 residents tested positive for COVID-19, at least 18 residents were hospitalized, and 3 residents died with COVID-19 as the cause of death; a newly admitted resident was placed in a room with a resident who tested positive for COVID-19 and was not quarantined. These failures placed the residents at increased risk for transmission and infection from COVID-19, resulting in substantial risk of serious physical harm, and serious neglect, and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 17, 2020. D914 G.S. 131D-21(4) Declaration of Residents' Rights D914 It is the policy of Durham Ridge Assisted Living G.S. 131D-21 Declaration of Residents' Rights to ensure that every resident has the right to be Every resident shall have the following rights: free from mental and physical abuse, neglect 4. To be free of mental and physical abuse, and exploitation. neglect, and exploitation. Staff was in-serviced on November 4th, 9th and 10th and December 3rd and 14th, on topics, including but not limited to, Incident/Accident This Rule is not met as evidenced by: Based on record reviews, interviews and and Change of Condition Reporting, Notification observations, the facility failed to assure each in the case of an Incident/Accident, Infection resident was free of neglect related to health Control, Resident Rights and Medication care, residents rights infection prevention and Administration. control program, and special care unit staffing. The findings are: Division of Health Service Regulation STATE FORM

STATEMEN	of Health Service Report of Deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	1		FUR	M APPR
, and I Dalk	TOP CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE	CHERT
			A. BUILDING	3:	COMP	LETED
		1	- 1			
		HAL032091	B. WING		1	С
NAME OF F	PROVIDER OR SUPPLIER	STREET	4000	_	11/	17/2020
DURHAM	PIDCE ADDISON	SIREE	ADDRESS, CITY, S	TATE, ZIP CODE		
	RIDGE ASSISTED LIVI		AKE FOREST H	WY		
(X4) ID	SIMMADY	DURHA	M, NC 27703			
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	RRECTION	(X5)
			TAG	ONUSS-REPERENCED TO THE	APPROPRIATE	COMPLE
D914	Continued From	470		DEFICIENCY)	10.100	DATE
	Continued From page		D914	Durham Ridge Assistanti :		
	1. Based on observat	ions, interviews, and record	1	Durham Ridge Assisted Living	was forced to	
	reviews, the facility fa	iled to ensure coordination		Changed Primary Care Provide	ers on November	
	of health care for 5 of	5 residents sampled (#2,		30, 2020, due to lack of answe	ring calls favor	
	#4, #8, #12. #13) rela	ted to failing to notify the		and response in general to req	Uests from the	
	primary care provider	(PCP) for a resident with a	1	facility. The previous provider	Failed to a!	
	broken hip (#2): to no	tify the PCP concerning a	1	at Durham Ridge multiple	alled to snow up	
1	resident with discolore	ed and long toenails who		at Durham Ridge multiple days	in which they	
	Was not added to the	acilty podiatrist visit list		were scheduled. The change w	as made in order	
[,	(#12): to notify the DC	P and seek immediate		to provide for a more seamless	and organized	
1/4	medical evaluation for	and seek immediate	1	approach to resident care and a	Illow for easier	
	of COVID-19 who was	a resident with symptoms	1	contacting and reporting to the	rimary care	
	of COVID-19 who was	rater nospitalized,	1	group. The MD is in the facility	throo time-	
l t	O notify the PCD of an	-19 and passed away (#4);	1	week. There is also at least one	unee unes a	
r	esident with a history	attempted elopement by a	1.	facility Monday through E	PA in the	
6	#8): and failing to not	of eloping at other facilities	1 1,	facility Monday through Friday.	There are days	
r	esident with a history	y the PCP of a fall for a	1 1	with multiple providers in the fac	ility for Primary	
ir	esident with a history of	or falls with injuries	1	Care.		
D	including a fractured arm (#13). [Refer to Tag D0273, 10A NCAC 13F .0902 (b) Health Care	m (#13). [Refer to Tag	A	Additional in-services are being o	Conducted	
(Type A1 Violation)].	.0902 (b) Health Care		December 20, 2020	conducted of	
	rype A r violation)j.		tı	December 29, 2020 with by a col	nsultant from	
2.	2. Based on observations, record reviews and interviews, the facility failed to cohort staff and esidents, quarantine staff as indicated by the local health department (LHD) once they tested		ir	he long-term care pharmacy on,	topics	
1 "				noluding but not limited to, medic	ation handling	
101			P	olicies and procedures, on Dece	mber 30, 2020	
100		Inditation to man in		rith an Outside Consultant from t		
10.	sidents on two hallway	'S With over the had	P	rofessional Assisted Living Asso	ciation on	
co	mmunal dining, as rec	ommonded by the	to	pics including but not limited to,		
Ce	enters for Disease Con	trol (CDC)			1	
Ca	rolina Department of H	dealth and the	1	edication Administration, Reside	nt Rights,	
Se	rvices (NC DHHS), an	d directives from "	ini	fection Control and Incident/Acci	dent Report.	
LH	D.[Refer to Tan Dogge	, 10A NCAC 13F .0909	an	d January 7, 2021 with a pharm	noist.	
Res	sident Rights (Type A2	Wightian 13F .0909	Fun	m the law t	aust	
		. violation)].	Iro	m the long-term care pharmacy,	on topics	
3. E	Based on observations	record roviews	inc	cluding but not limited to medicat	ion	
inte	rviews, the facility faile	d to annual	adr	ministration and a series and	IOI I	
reco	Ommendations and gu	eu to ensure	au	ministration and controlled subst	ances.	
the	Centers for Disease of	control (ODO)				
Car	olina Denartment et 1	ontrol (CDC), the North				
Sen	olina Department of Hovices (NC DHHS) and	eaith and Human	1			- 1
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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL032091 C B. WING NAME OF PROVIDER OR SUPPLIER 11/17/2020 STREET ADDRESS, CITY, STATE, ZIP CODE **DURHAM RIDGE ASSISTED LIVING** 3420 WAKE FOREST HWY DURHAM, NC 27703 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL In PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5)COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY** D914 Continued From page 173 D914 Issues with the Administrator and the Assistant Local Health Department (LHD) were Resident Care Coordinator, that oversaw implemented and maintained to provide incident reporting, had been identified prior to protection of the residents during the global the survey and changes were scheduled to be coronavirus (COVID-19) pandemic as related to made on November 3, 2020. The ARCC was staff being unaware of which residents tested removed on 11/10/20. The Administrator was positive for COVID-19 thereby failing to use replaced on November 13, 2020 by the Assistant personal protective equipment (PPE) as directed Administrator. The owner of Durham Ridge, by CDC guidelines; gloves not changed who is also a licensed Administrator, returned to appropriately by staff to reduce the risk of Durham to take a more active role in the facility transmission and infection; a resident admitted on operations and plan of correction. Floor 10/23/20 and placed in the room of a resident Managers were hired and began working on who tested positive for COVID-19; and communal each shift on December 1, 2020 to oversee each . dining without social distancing 6 feet on one hallway of the facility. [Refer to Tag D0601, 10A shift and assist with communication at shift change. On 12/9/20, Durham Ridge hired an NCAC 13F .1801 Infection Prevention and Control Program (Type A2 Violation)]. Infection Control Specialist/Compliance Officer, with an extensive background, knowledge, and 4. Based on record reviews and interviews, the experience in Infection Control/Prevention and facility failed to ensure the required staffing hours Assisted Living Compliance, to implement and for the Special Care Unit (SCU) with a census of oversee policies and supervise Infection Control 106 to 118 were met for 25 of 57 shifts sampled practices. for 10/05/20, from 10/11/20 to 10/25/20, and from On 12/8/2020, Durham Ridge hired an Assistant 11/06/20 to 11/08/20 after assistance with staffing Administrator. The assistant admin will coordinate staff was offered to the facility by the local county onboarding and training, and will be responsible for health department task force and another local but not limited to educating new staff. county government agency [Refer to Tag D0465, There will be an on-call rotation, including the 10A NCAC 13F .1308 (a) Special Care Unit Staff Administrator, Assistant Administrator, Resident Care (Type B Violation)]. Coordinator, and Compliance Officer. The on-call person will be notified for every incident/accident. The Administrator will be responsible for assuring continued compliance in all rule areas weekly and that all parties above complete their duties as assigned. December 17, 2020 and ongoing