STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	R-C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted Follow-Up Survey on 04/27/21-04/28/21.	{D 000}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to notify the primary care provider (PCP) for 2 of 3 sampled residents (#2 and #5) regarding a resident's thromboembolic deterrent (TED) hose (#5) and notifying the PCP of daily blood pressures (#2). The findings are: 1. Review of Resident #5's current FL2 dated 01/06/21 revealed: -Diagnoses included essential hypertension, atrial fibrillation, and chronic kidney disease. -There was an order for compression stockings (used for swelling in the feet and ankles). Observation of Resident #5 on 04/28/21 at 3:04pm and 3:40pm revealed: -Resident #5 was in her room, sitting on the side of the bed. -Resident #5 did not have compression stockings on. -There was one compression stocking laying on the shower chair in the resident's bathroom. Interview with Resident #5 on 04/28/21 at 3:34pm revealed:	D 273		

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-She was supposed to wear compression stockings because her legs were swelling, but they had not been swelling and "looked fine."
-She did not wear compression stockings because the stockings were too tight and hurt her legs.
-The compression stockings hurt her legs "so bad that [she] cried."
-She could not put the compression stockings on herself; the staff had to put the compression stockings on for her.
-No one had tried to put the compression stockings on her in the last 3-4 weeks, but she would not wear the compression stockings "even if they tried."
-She did not know if her primary care provider (PCP) knew she was not wearing the compression stockings, but she had not talked to the PCP about it.
-The last time she saw her compression stockings, they were in her bathroom.

Observation of Resident #5's bathroom on 04/28/21 at 3:47pm revealed there was one compression stocking laying on the shower chair.

Second interview with Resident #5 on 04/28/21 at 3:38pm revealed she did not know where the second compression stocking was, but it was "around here somewhere."

Observation of Resident #5 on 04/29/21 at 7:19am revealed:
-She was sitting at the dining room table.
-She had on a pair of white ankle-length socks and bedroom slippers.
-She did not have compression stockings on her legs.

Review of Resident #5's 04/15/21-04/29/21

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medication administration record (MAR) revealed:
-There was an order to apply compression stockings every morning and remove them at bedtime with a scheduled administration time of 6:00am and between 8:00pm-10:00pm.
-There was documentation Resident #5's compression stockings were not available to be applied on 04/15/21, 04/17/21, 04/19/21-04/21/21, and 04/23/21-04/24/21.
-There was documentation Resident #5 refused on 04/27/21-04/29/21.
-There was documentation Resident #5's compression stockings were applied on 04/16/21, 04/18/21, 04/22/21, and 04/25/21-04/26/21.

Review of Resident #5's care notes revealed:
-On 04/22/21, a medication aide (MA) documented Resident #5 refused to wear her compression stockings; the compression stockings had been put on twice and the resident took them off complaining the stockings hurt.
-On 04/28/2, a MA documented Resident #5 refused to wear her compression stockings.
-There was no documentation Resident #5's PCP had been notified of refusals and/or missing compression stockings.

Telephone interview with Resident #5's PCP on 04/29/21 at 9:05am revealed:
-Resident #5's compression stockings were ordered for swelling.
-He was not aware Resident #5 was not wearing her compression stockings as ordered; there was another provider who may have been notified.
-Resident #5's swelling in her legs could worsen if she did not wear her compression stockings as ordered.
-He would have expected to be notified if Resident #5 was not wearing her compression stockings.

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D 273	Continued From page 3 Telephone interview with Resident #5's PCP's home health assistant on 04/29/21 at 10:08am revealed: -Usually when the facility staff wanted to notify the PCP of something regarding a resident, the call would come through her department. -Her department was responsible for inputting the information into the resident's record for the provider. -There were no notes in Resident #5's record; the provider had not been notified Resident #5 was not wearing her compression stockings as ordered. Interview with a personal care aide (PCA) on 04/29/21 at 9:42am revealed: -Resident #5 "used to wear compression stockings" but did not now because Resident #5 complained the stockings were painful. -She could not recall the last time she had seen Resident #5 wear compression stockings. -She had not applied Resident #5's compression stockings. -No one had asked her to apply Resident #5's compression stockings. Telephone interview with a MA on 04/29/21 at 11:48am revealed: -Resident #5 had worn her compression stockings. -He could not recall a time when Resident #5 did not wear her compression stockings. -He saw Resident #5 with her compression stockings on yesterday, 04/28/21. -He had not notified Resident #5's PCP she was not wearing her compression stockings. Telephone interview with a second MA on 04/29/21 at 12:00pm revealed:	D 273		

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-Resident #5 would not wear her compression stockings because they hurt her.
-She documented in the MAR when Resident #5 refused to wear the compression stockings.
-No one had told her to notify Resident #3's PCP if she was not wearing the compression stockings.

Telephone interview with another MA on 04/29/21 at 2:30pm revealed:
-Resident #5's compression stockings were scheduled to be applied at 6:00am.
-There were times she had not been able to find Resident #5's compression stockings.
-She did not notify Resident #5's PCP because she did not know Resident #5's compression stockings had been missing for multiple days because other staff had documented Resident #5 had worn her compression stockings.
-She ordered Resident #5 a new pair of compression stockings last week because she had not been able to locate the compression stockings.
-She attempted to put Resident #5's compression stockings on "one day last week" and the resident refused because the stockings hurt her legs. (She did not recall the date.)
-She documented in the MAR when Resident #5's compression stockings were not available or if the resident refused to wear the compression stockings; she did not notify anyone of this.

Interview with the interim Wellness Director (WD) on 04/29/21 at 1:35pm revealed:
-The MA was responsible for applying and removing Resident #5's compression stockings.
-If the resident refused to wear the compression stockings, the PCP should be notified.
-There was not a set number of times for refusals before notifying the PCP, but "like three in a row."

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-The MA could either fax or call the PCP for notification.
-Resident #5 had refused to wear her compression stockings "a few times."
-If the MA could not locate Resident #5's compression stockings, a new pair should be ordered from the pharmacy.
-If Resident #5's compression stockings could not be located, even after "several" staff had looked for them, she would expect a new pair to be ordered the same day.
-The PCP should have been notified and the MA should have documented the contact with the PCP in a chart note.

Telephone interview with a pharmacy technician with the facility's contracted pharmacy on 04/29/21 at 1:59pm revealed the pharmacy had dispensed a pair of compression stockings for Resident #5 on 03/21/21 and 04/21/21.

Telephone interview with the Executive Director (ED) on 04/29/21 at 2:09pm revealed:
-Resident #5's compression stockings were scheduled to be applied in the am and removed in the pm.
-Applying Resident #5's compression stockings was part of the medication pass and was the responsibility of the MA.
-If Resident #5's compression stockings could not be located, she expected the MA to notify the interim WD or the ED.
-If the compression stockings could not be located, after multiple people looked, she would expect a new pair to be ordered.
-Resident #5 had the right to refuse to wear her compression stockings, but if there were "frequent refusals" the PCP should be notified.
-She would expect the PCP to be notified if Resident #5 missed wearing her compression

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stockings; there was no definitive number, but "like if three days in a row."
-She was concerned Resident #5 went without her compression stockings for an extended length of time before a new pair was ordered.

2. Review of Resident #2's current FL-2 dated 08/10/20 revealed diagnoses included acute respiratory failure with hypoxia (low levels of oxygen in the blood) and compression fracture of the third lumbar vertebra.

Review of Resident #2's six-month physician's orders dated 03/25/21 revealed there was an order for daily blood pressure (BP) checks and send the results to the primary care physician (PCP).

Review of Resident #2's April 2021 MAR revealed:
-There was an entry for check BP daily and send results to PCP scheduled during first shift (7:00am-3:00pm).
-There was documentation indicating Resident #2's BP had been checked from 04/01/21-04/28/21.
-Resident #2's BP was 167/79 on 04/16/21, was 156/78 on 04/17/21, was 153/67 on 04/18/21, and was 167/74 on 04/22/21.

Review of Resident #2's record revealed there was no documentation Resident #2's BP checks for 04/16/21-04/18/21 and 04/22/21 had been sent to Resident #2's PCP.

Interview with a medication aide (MA) on 04/28/21 at 12:15pm revealed:
-The MAs were responsible for checking Resident #2's BP and sending the results to Resident #2's PCP.

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-She routinely faxed the results to Resident #2's PCP each day and filed the documentation in Resident #2's record.
-She did not know if the other MAs followed the same process.

Interview with a second MA on 04/28/21 at 12:20pm revealed:
-The MAs were responsible for faxing Resident #2's BP results to Resident #2's PCP.
-Once verification of successful fax delivery was received, the document was filed in Resident #2's record.
-If the document was not in Resident #2's record, the results had not been faxed to the PCP.
-Resident #2's PCP's staff called the facility for the BP results if facility staff did not fax the information to Resident #2's PCP.

Interview with Resident #2 on 04/28/21 at 2:48pm revealed:
-Staff took her BP every morning.
-Her BP was supposed to be sent to her PCP because her PCP would adjust her medication based on the results.

Interview on 04/28/21 at 4:33pm with the MA responsible for checking Resident #2's BP and sending the results to Resident #2's PCP from 04/16/21-04/18/21 and 04/22/21 revealed:
-She faxed Resident #2's BP results to Resident #2's PCP from 04/16/21-04/18/21 and on 04/22/21.
-She placed the documentation in the filing bin at the nursing station.
-The document should have been in Resident #2's record.
-The documentation could have been misfiled and in another resident's record.

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D 273	Continued From page 8 Interview with the interim Wellness Director (WD) on 04/29/21 at 11:50am revealed: -The MAs were responsible for faxing Resident #2's daily BP to Resident #2's PCP. -Resident #2's daily BP results should have been faxed to the PCP as ordered. -No one monitored whether or not the BP results were provided to Resident #2's PCP. Interview with the Executive Director (ED) on 04/29/21 at 1:48pm revealed: -The MAs were responsible for providing Resident #2's daily BP results to Resident #2's PCP. -Resident #2's daily BP results should have been faxed to the PCP as ordered. -The BP results were provided to the PCP either by fax or phone. -She did not know if anyone monitored whether or not the daily BP results were provided to the PCP. Interview with the WD on 04/28/21 at 3:00pm revealed she called the PCP and was informed Resident #2's BP results for 04/16/21-04/18/21 and 04/22/21 were not provided to the PCP. Attempted interviews with Resident #2's PCP on 04/28/21 at 2:45pm, 3:16pm, and 4:40pm were unsuccessful.	D 273		