Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation with onsite visits on February 16, 2021 and February 23, 2021 and desk review survey on February 17-19, 2021 and February 22-24, 2021 with a telephone exit on February 25, 2021.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 1 sampled resident (Resident #1) with orders for finger stick blood sugar (FSBS) checks. The findings are: Review of Resident #1's current FL-2 dated	D 276	It is the policy of Durham Ridge Assisted Living to assure the documentation of the following in resident records: written procedures, treatments or orders from a physician or other licensed health professional and implementation of those procedures, treatments, or orders. All resident hospital discharge summaries from the last three months were pulled and re-evaluated to ensure that no orders were missed when they were processed. An in-service was held with Medication Technicians on February 24, 2021 by the Resident Care Coordinator, on topics including but limited to, documenation and implementation of procedures, treatments and orders from a licensed health professional. An in-service was held on March 26, 2021with a representative from Duke Hopsital, to include but not be limited to, the information included in and where it is located in a discharge summary. Another in-service was held with Medication Technicians on March 30, 2021, on topics including but limited to, documentation and implementation of procedures, treatments and orders from a licensed health professional.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peggy Cox
TITLE: Administrator
(X6) DATE: 4/6/21

Reviewed and accepted-SS-5/3/21

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D 276	Continued From page 1 11/03/2020 revealed diagnoses included dementia, schizophrenia, intellectual development disorder, hypertension, and asthma. Review of Resident #1's hospital discharge summary dated 02/01/21 revealed: -Discharge diagnoses included severe sepsis, diabetic ketoacidosis (DKA) with coma-associated type 2 diabetes mellitus (DM), and uncontrolled DM with complication. -There was an order to start Lantus (a long acting insulin used to treat diabetes mellitus), inject 3 units subcutaneously nightly. -There was an order for a blood glucose meter kit (a glucometer is used to check finger stick blood sugars (FSBS)). -There was an order for blood glucose diagnostic test strips (used with the glucometer) three times daily. -There was an order for lancets (used to check FSBS) use one each two times daily. Review of Resident #1's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus insulin with the directions to inject 3 units subcutaneously at bedtime with a start date of 02/02/21 and an end date of 02/15/21. -There was a block to initial the administration of the Lantus and a second block to document the site of the injection. -There was documentation 3 units of Lantus were administered at 9:00pm on 02/02/21-02/06/21 and 02/08/21-02/14/21 with an exception on 02/07/21 as Resident #1 refused. -There was a second entry for Lantus insulin with the directions to check Resident #1's FSBS before administering, inject 3 units subcutaneously at bedtime with a start date of	D 276	Additional training will be scheduled as needed. The Administrator will review all admissions and re-admissions weekly to ensure that all orders are processed and being followed as prescribed.	April 11, 2021 and Ongoing

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D 276	Continued From page 8 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 11, 2021.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to ensure two nutritional supplements were served as ordered for 1 of 1 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 11/03/2020 revealed diagnoses included dementia, schizophrenia, intellectual development disorder, hypertension, and asthma. Review of Resident #1's hospital discharge summary dated 12/15/20 revealed: -Admitting diagnosis was diabetic ketoacidosis (DKA). -Resident #1's glucose was greater than 1600 upon arrival to the emergency department. -There was an order for a glucose-controlled nutritional supplement with meals. -There was a second order for a nutritional frozen	D 310	It is the policy of Durham Ridge Assisted Living to assure all therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. All resident diet orders were evaluated and diet lists were updated to show all residents with therapeutic diets and those with orders for nutritional supplements. An inservice was held with Medication Technicians on Feburary 24, 2021. on topics including but not limited to diet orders, modified diets, and nutritional supplements. An inservice was held with Dietary staff on April 5, 2021 on topics including but not limited to diet order modified diets, and nutritional supplements. The Resident Care Coordinator and Dietary Manager will coordinate with each other weekly to ensure that the diet list is up to date and staff is aware of the diets of the residents and who is to recieve nutritional supplements.	April 11, 2021 and Ongoing

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D 358	Continued From page 12 (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 9 sampled residents (Resident #1 and #5) related to two antibiotics and two oral diabetic medications (#1) and a monthly injectable anti-psychotic medication (#5). The findings are: 1. Review of Resident #1's current FL-2 dated 11/03/2020 revealed diagnoses included dementia, schizophrenia, intellectual development disorder, hypertension, and asthma. Review of an Emergency Medical Service responders (EMS) report dated 12/09/20 revealed: -EMS responded to the facility due to Resident #1 being found on the floor and was noted to be lethargic and sluggish. -Resident #1 was found to be tachycardic and hyperglycemic with no history of diabetes. -Oxygen level was not obtained due to Resident #1's very cold extremities. -Intravenous vein (IV) access was attempted but unable to obtain due to poor vascular access. -Resident #1 was transported to the local emergency department for evaluation. Review of Resident #1's hospital discharge	D 358	It is the policy of Durham Ridge Assisted Living to assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practitioner with are maintained in the resident's record. The Resident Care Coordinators pulled all discharge summaries from the last three months to ensure that all orders within them have been processed. An in-service was held on February 24, 2021 for all Medication Technicians, on topics including but not limite administration of medications, including but not limited to, oral diabetic and injectable anti-psychotic medications. An in-service was held on March 19, 2021 with Medication Technicians by a Pharmacist from the long-term care pharmacy. An in-service was held on March 26, 2021 with a representative from Duke Hospital regarding but not limited to what information is included in and where to find it in a discharge summary. An in-service was held on March 30, 2021 with Medication Technicians on topics including but not limited to oral diabetic and injectable anti-psychotic medications. The RCC or Designee will follow up with new orders daily. The Administrator or Compliance Officer will review weekly for continued compliance.	March 21, 2021 and Ongoing

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D 367	Continued From page 37	D 367		

(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 2 of 9 sampled residents (#8, #9) for a sleep medication (#8) and a skin protectant ointment (#9).

The findings are:

1. Review of Resident #8's current FL-2 dated 03/26/20 revealed:
-Diagnoses included dementia, fracture of the right femur, muscle weakness and dysphagia.
-Melatonin (a supplement used to treat insomnia) 5mg at bedtime as needed for sleep.

Observation of Resident #8's medication on hand on 02/16/21 at 1:15pm revealed there was 1 tablet remaining out of 30 tablets on a blister pack labeled melatonin 5mg take at bedtime as needed for sleep dispensed on 01/04/21.

Observation of Resident #8's medication on hand on 02/23/21 at 2:04pm revealed:
-There was no melatonin remaining on the medication cart.
-The medication aide (MA) reordered the melatonin from the facility's contracted pharmacy through the electronic medication administration

Provider's Plan of Correction (D 367):

It is the policy of Durham Ridge Assisted Living to assure that each resident's medication administration record (MAR) is accurate and includes the resident's name, the name of the medication or treatment, the strength and dosage or quantity of the medication, instructions for administration, the reason or justification for the administration of PRN medications or treatments and the resulting effect on the resident, the date and time of administration, documentation of any omission of medications or treatments and the reason for the omission, including refusals, and the name or initials of the person administering the medication or treatment.

An in-service was held on February 24, 2021 with Medication Technicians, on topic including but not limited to MAR documenation and medication administration.

An in-service was held on March 19, 2021 by the Pharmacist from the long-term care pharmacy, on medication administration and MAR documentation.

An in-service was held on March 30, 2021 on a variety of topics about documentation and medication administration.

The RCC will monitor weekly for continued compliance.

Complete date: April 11, 2021 and Ongoing

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D 367	Continued From page 45 -The MAs should document the use of zinc oxide on the eMARs. -She was responsible for auditing the eMARs monthly, and Resident #9's eMAR had not been audited for February 2021. Telephone interview with the Administrator on 02/24/21 at 2:32pm revealed: -She did not know Resident #9 had an order for an ointment to be applied after incontinent episodes. -The Administrator's expectation was the MAs should be using zinc oxide after Resident #9 had an incontinent episode. -The MAs should document the use of zinc oxide on the eMARs. -The RCC was responsible for auditing the eMARs monthly. Based on observations, interviews, and record reviews it was determined Resident #9 was not interviewable.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure residents received care and services necessary to maintain the residents health, safety, and welfare as related to health care.	D912	It is the policy of Durham Ridge Assisted Living to assure that every resident has the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws, rules, and regulations. In-services were held with Durham Ridge staff on February 24th and March 19th, 29th, and 30th, 2021 on a variety of topics to approve the overall level of care of the residents and their rights.	April 11, 2021 and Ongoing

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation with onsite visits on February 16, 2021 and February 23, 2021 and desk review survey on February 17-19, 2021 and February 22-24, 2021 with a telephone exit on February 25, 2021.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 1 sampled resident (Resident #1) with orders for finger stick blood sugar (FSBS) checks. The findings are: Review of Resident #1's current FL-2 dated	D 276		

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D 276	Continued From page 2	D 276		

02/15/21.
-There was a block to initial the administration of the Lantus and a second block to document the site of the injection.
-There was documentation three units of Lantus were administered at 9:00pm on 02/15/21 and the site was right arm.
-There was no documentation of a FSBS reading on 02/15/21.
-There was no entry for FSBS on the eMAR.

Interview with a medication aide (MA) on 02/16/21 at 1:45pm revealed:
-Resident #1's eMAR did not have anywhere to document a FSBS.
-She would call the 2nd shift MA to ask where the MA documented Resident #1's FSBS.

Second interview with the MA on 02/16/21 at 1:57pm revealed the 2nd shift MA reported there was no order to check Resident #1's FSBS before administering insulin.

Interview with Resident #1 on 02/16/21 at 2:00pm revealed:
-He did not get his FSBS checked daily.
-No one checked his FSBS at the facility.

Telephone interview with a MA on 02/17/21 at 7:11pm revealed:
-She had not taken Resident #1's FSBS.
-She had not noticed the order to check Resident #1's FSBS because there had not been anywhere to record the FSBS.
-She reviewed the eMAR on 02/17/21 and did see a box where a FSBS would be recorded; "this was new" because there had not been anywhere to record a FSBS for Resident #1 on the eMAR.
-She did not see any directions related to the FSBS like most residents had on their eMAR.

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D 276	Continued From page 3	D 276		

-She would not give Resident #1's insulin if Resident #1's FSBS was low.
-She called Resident #1's primary care provider (PCP) when Resident #1's FSBS was low or high.

Telephone interview with the pharmacy's technician on 02/18/21 at 8:40am revealed:
-The order for Resident #1's FSBS was added to the eMAR on 02/15/21.
-There usually would be a place to document the FSBS, but it had been missed, and she would add it in now.
-She reviewed the discharge papers during the telephone interview on 02/18/21 for Resident #1 and acknowledged seeing the order for the FSBS three times a day.
-The order for the FSBS three times a day was overlooked.

Telephone interview with the pharmacy's supervisor on 02/18/21 at 9:00am revealed:
-The pharmacy's technician who entered Resident #1's order missed the entry three times a day.
-They were supposed to put in a literal order, meaning exactly how the order read.
-Typically, when they sent out a glucometer to be used for FSBS someone at the facility would call and ask for FSBS orders if there were no orders.
-No one had called to clarify FSBS orders for Resident #1.
-Today, 02/18/21, was the first time she had heard about Resident #1's FSBS being overlooked.

Telephone interview with a medication aide (MA) on 02/18/21 at 9:35am revealed:
-Resident #1 did not have an order for FSBS.
-She told the Clinical Resident Care Coordinator (RCC) and the Administrator Resident #1 needed

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D 276	Continued From page 4	D 276		

an order to check his FSBS. (She did not recall a date).
-When Resident #1 was in the hospital she had heard his FSBS was 1300.
-Resident #1 had a new glucometer.
-Normally she would try to read a resident's discharge papers, but she had not seen Resident #1's discharge papers.
-She had never taken Resident #1's FSBS because he did not have an order to check his FSBS.

Telephone interview with the Clinical RCC on 02/18/21 at 9:48am revealed:
-Whoever was working when Resident #1 came back to the facility should have reviewed the discharge papers and sent the discharge papers to the pharmacy.
-The MA would slide the discharge papers under her door.
-The Clinical RCC, the Administrative RCC, or the MA could accept the orders from the pharmacy.
-She did not know who accepted the orders from the discharge summary dated 02/01/21.

Second telephone interview with the Clinical RCC on 02/18/21 at 9:48am revealed:
-She had approved Resident #1's 02/01/21 discharge orders after the pharmacy had entered the orders in the eMAR.
-She had not seen the order for Resident #1's FSBS.
-She did not recall a MA telling her an order was needed to check Resident #1's FSBS.
-She put the discharge orders in the primary care provider's (PCP's) box so the PCP could check as well.
-She should have double-checked the discharge orders.

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D 276	Continued From page 5	D 276		

Review of Resident #1's PCP visit summary dated 02/04/21 revealed:
-She reviewed limited medical records from Resident #1's hospitalization.
-She was going to order baseline labs to include an glycolated hemoglobin test (HgbA1C- a test to determine the three month average blood sugar).
-There was documentation to continue to monitor Resident #1's blood sugars.
-The plan was to monitor and make adjustments as needed.

Telephone interview with Resident #1's PCP on 02/18/21 at 8:20am revealed:
-The Administrator had told her Resident #1 was in DKA.
-Resident #1 had no history of diabetes.
-Resident #1 experienced elevated blood sugars and electrolytes, he was dehydrated and experienced kidney issues.
-Resident #1 was placed on Lantus insulin.
-Normally FSBS was not done with Lantus, but she wanted to have a baseline for Resident #1 because he went into "crisis so fast."
-She told the RCC to do FSBS, even if they only did it for a week.
-She did not see anything in Resident #1's hospital discharge papers about checking FSBS three times daily.
-On 02/15/21 she ordered the FSBS to be done prior to administering Resident #1's Lantus.
-The FSBS should be seen on Resident #1's eMAR, but she was reviewing Resident #1's eMAR during the telephone interview and did not see any FSBS recorded.
-She would expect the order for FSBS to be done.

Telephone interview with a hospitalist at the local hospital on 02/18/21 at 4:10pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 6	D 276		

-Review of Resident #1's hospital record showed Resident #1 was discharged with orders to check FSBS in the morning and evening.
-Resident #1 was at risk of having FSBS that were too high or too low.

Telephone with a local hospital Nurse Practitioner (NP) on 02/18/21 at 4:26pm revealed:
-She worked with the diabetic management team at the hospital.
-Resident #1 was discharged on low-dose long-acting insulin, Lantus 3 units.
-At a minimum Resident #1's FSBS should be checked twice daily at variable times.
-Usually, the FSBS would be checked in the morning to get a picture of how well the medication was working.
-Resident #1's FSBS should have been checked every morning.
-If Resident #1's FSBS readings were changing, the insulin could be adjusted as needed.
-Her number one concern was Resident #1 could have had low blood sugar and was administered insulin without knowing the insulin should have been held.
-Resident #1's FSBS should have been checked before administering the Lantus because "you cannot take insulin if you do not know what the FSBS was."
-"You definitely would not administer insulin without knowing the FSBS."
-Low blood sugar could cause complications, including significant neurological problems, and even a stroke.

Second review of Resident #1 February 2021 eMAR on 02/19/21 revealed a FSBS of 164 documented on 02/18/21.

Observation of Resident #1's glucometer on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 7	D 276		

Continued From page 7

02/23/21 revealed:
-The dates and times did not match the current date and time.
-There was a FSBS reading of 153 on 04/04/21.
-There was a FSBS reading of 164 on 04/05/21.
-There was a FSBS reading of 154 on 04/07/21.
-There was a FSBS reading of 191 on 04/08/21.
-There was a FSBS reading of 231 on 04/09/21.

Telephone interview with the Administrator on 02/19/21 at 3:14pm revealed:
-She did not know all the orders were not transcribed from the discharge summary into Resident #1's eMAR.
-She did not know Resident #1 had orders to get FSBS daily when he was discharged from the hospital on 12/15/20.
-She expected Resident #1's discharge orders to have been followed.

____

The facility failed to ensure physician orders were implemented for Resident #1 who was recently diagnosed with DKA and uncontrolled type 2 DM with complications who had FSBS ordered twice daily. The facility had not checked Resident #1's FSBS before administering insulin from 02/01/21-02/15/21. Administering insulin to Resident #1 without knowing what the current FSBS readings were, could have lowered his FSBS further, and low blood sugar could cause complications, including significant neurological problems, and even a stroke. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/19/21 for this violation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 8 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 11, 2021.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to ensure two nutritional supplements were served as ordered for 1 of 1 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 11/03/2020 revealed diagnoses included dementia, schizophrenia, intellectual development disorder, hypertension, and asthma. Review of Resident #1's hospital discharge summary dated 12/15/20 revealed: -Admitting diagnosis was diabetic ketoacidosis (DKA). -Resident #1's glucose was greater than 1600 upon arrival to the emergency department. -There was an order for a glucose-controlled nutritional supplement with meals. -There was a second order for a nutritional frozen	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 9	D 310		

supplement with meals.

Review of Resident #1's December 2020 electronic medication administration record (eMAR) revealed there was no entry or documentation Resident #1 received a nutritional supplement.

Review of Resident #1's January 2021 eMAR revealed there was no entry or documentation Resident #1 received a nutritional supplement.

Telephone with the hospital Nurse Practitioner (NP) on 02/23/21 at 8:53am revealed:
-She worked with the diabetic management team at the hospital.
-She had seen Resident #1 during his hospitalization in December 2020.
-The liquid nutritional supplement was ordered for Resident #1 during his hospitalization (12/11/20) because he was not eating well.
-Resident #1 was still not eating well and she thought he might enjoy the frozen nutritional supplement so on 12/15/20 she ordered the frozen nutritional supplement.
-The nutritional supplements were ordered so Resident #1 would get some calories and carbohydrate intake.
-She would have expected the nutritional supplements to have been administered to Resident #1.
-Someone could have starvation ketosis, where they become ketonic from not eating.

Interview with a MA on 02/23/21 at 2:15pm revealed:
-Resident #1 had been refusing medication and was not eating for maybe about a week or so before going to the hospital on 01/01/21.
-She remembered talking to one of the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 10	D 310		

providers about Resident #1 refusing to take his medications and eat, but she did not recall who.
-She talked to the Clinical RCC about Resident #1 refusing to take his medications and eat.

Interview with Resident #1 on 02/23/21 at 2:20pm revealed:
-He did not eat what the facility provided because he did not like the food.
-He liked to order food from outside the facility.
-He did not drink a liquid nutritional supplement.
-No one had offered him a liquid or a frozen nutritional supplement.
-He did not know if he would like a nutritional supplement or not, but he would try it.

Interview with the cook on 02/23/21 at 3:53pm revealed:
-Dietary did not provide liquid nutritional supplements with meals.
-If a resident had an order for a supplement, the MAs provided the supplement.

Interview with a medication aide (MA) on 02/23/21 at 4:00pm revealed:
-Resident #1 did not get a nutritional supplement.
-Resident #1 did not have an order for a nutritional supplement.

Interview with a second MA on 02/23/21 at 4:07pm revealed:
-She recalled Resident #1 being provided a liquid nutritional supplement.
-If Resident #1 did not eat his meals she would offer him a liquid nutritional supplement.
-Sometimes Resident #1 would say yes to the liquid nutritional supplement and sometimes he would say no.
-Sometimes Resident #1 would accept the liquid nutritional supplement, but would not drink it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ___ B. WING ___	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 11	D 310		

-She did not document when Resident #1 had a liquid nutritional supplement.
-The Clinical RCC knew Resident #1 was not eating because it was discussed at the change of shift.

Telephone interview with the Clinical RCC on 02/24/21 at 11:20am revealed:
-Nutritional supplements required a physician's order.
-If a nutritional supplement was ordered and provided it would have been documented on the resident's eMAR.
-She was not aware of an order for a nutritional supplement for Resident #1.

Interview with the Administrator on 02/23/21 at 3:05pm revealed:
-She did not know Resident #1 had been ordered two nutritional supplements when he was discharged from the hospital on 12/15/20.
-Resident #1 was refusing his medications and meals and may have refused the nutritional supplement but we "should have tried."
-She was concerned Resident #1 was accepted back into the facility without discharge orders and the discharge orders were not obtained.
-She expected orders to be followed but was concerned Resident #1 returned to the facility without orders.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

10A NCAC 13F .1004 Medication Administration
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12	D 358		

Continued From page 12

(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 9 sampled residents (Resident #1 and #5) related to two antibiotics and two oral diabetic medications (#1) and a monthly injectable anti-psychotic medication (#5).

The findings are:

1. Review of Resident #1's current FL-2 dated 11/03/2020 revealed diagnoses included dementia, schizophrenia, intellectual development disorder, hypertension, and asthma.

Review of an Emergency Medical Service responders (EMS) report dated 12/09/20 revealed:
-EMS responded to the facility due to Resident #1 being found on the floor and was noted to be lethargic and sluggish.
-Resident #1 was found to be tachycardic and hyperglycemic with no history of diabetes.
-Oxygen level was not obtained due to Resident #1's very cold extremities.
-Intravenous vein (IV) access was attempted but unable to obtain due to poor vascular access.
-Resident #1 was transported to the local emergency department for evaluation.

Review of Resident #1's hospital discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ____ B. WING ____	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13	D 358		

Continued From page 13

summary dated 12/15/20 revealed:
-Admitting diagnosis was diabetic ketoacidosis (DKA).
-Resident #1's glucose was greater than 1600 upon arrival to the emergency department.
-Resident #1's A1C was 14.8 (An A1C test is a blood test that reflects your average blood glucose levels over the past 3 months. An A1C level below 5.7 percent is considered normal).
-Resident #1 presented with a fever with severe sepsis on admission.
-Resident #1 was treated with IV antibiotics for proctocolitis (inflammation of the colon) and once improved was placed on oral antibiotics.
-There was an order for Cipro 500mg twice a day for 9 days. (Cipro is an antibiotic used to treat infections).
-There was an order for Flagyl 500mg three times a day for 9 days.(Flagyl is an antibiotic used to treat infections).
-There was an order for Actos 15mg once a day. (Actos is used to treat diabetes mellitus).
-There was an order for Januvia 50mg once a day. (Januvia is used to treat diabetes mellitus).

According to the American Diabetes Association a Hemoglobin A1C target result of less than 7% is recommended for adults with a diagnosis of diabetes. The higher the level of A1C increases the risk of developing diabetes complications. Complications include neuropathy (nerve damage), kidney disease, and diabetic ketoacidosis. (Diabetic ketoacidosis is a serious complication which can lead to coma and death).

Review of Resident #1's 24-hour acute monitoring report dated 12/15/20-12/18/20 revealed:
-Resident #1 returned to the facility from the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358		D 358		

Continued From page 14

-Resident slept through the night and had no complaints.
-Resident ate breakfast and lunch on 12/16/20 and 60 percent of his dinner.
-Resident had a good day on 12/17/20.
-There was no other documentation.

Review of Resident #1's December 2020 electronic medication administration record (eMAR) revealed:
-There was no entry for Cipro 500mg twice a day for 9 days.
-There was no entry for Flagyl 500mg three times a day for 9 days.
-There was no entry for Actos 15mg once a day.
-There was no entry for Januvia 50mg once a day.
-There was documentation Resident #1 was refusing a lot of his scheduled medications.

Review of Resident #1's January 2021 eMAR revealed:
-There was no entry for Cipro 500mg twice a day for 9 days.
-There was no entry for Flagyl 500mg three times a day for 9 days.
-There was no entry for Actos 15mg once a day.
-There was no entry for Januvia 50mg once a day.

Review of Resident #1's pharmacy dispensing records for 12/06/20-12/31/20 revealed:
-Cipro 500mg twice a day for 9 days was not dispensed.
-Flagyl 500mg three times a day for 9 days was not dispensed.
-Actos 15mg once a day was not dispensed.
-Januvia 50mg once a day was not dispensed.

Review of Resident #1's PCP visit summary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 15	D 358		

dated 12/21/20 revealed:
-This was an initial visit for Resident #1.
-Staff reported Resident #1 was fairly cooperative, eating well and sleeping well and the staff had no concerns.
-Resident #1 was apparently hospitalized recently with elevated FSBS, had no history of diabetes, and was not taking any medications at this time.
-Resident #1 was discharged back to the facility without any medications.
-The treatment plan was to order baseline labs.
-There was documentation to continue to monitor Resident #1's blood sugars and she would monitor and make adjustments as needed.

Telephone interview with Resident #1's PCP on 02/23/21 at 11:02am revealed:
-She did not see Resident #1 when he returned from the hospital until a week later.
-Typically, residents return to the facility with general orders.
-The Clinical Resident Care Coordinator (RCC) did not have Resident #1's discharge papers so she "set things in motion" to obtain the papers herself.
-When she reviewed the discharge papers, she had assumed the antibiotics had been completed.
-It was an oversight she did not see the oral diabetic medication.
-The providers were not consistently getting information from the hospital, and nobody knew if anything had changed or not.
-She was aware Resident #1 was refusing medications.

Review of Resident #1's PCP's visit summary dated 12/23/20 revealed:
-Resident #1 was seen at the request of the facility staff due to complaints of abdominal pain and decreased appetite.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 16	D 358		

-Resident #1 requested to go to the hospital.
-Resident #1 had asked the staff if he quit eating could he go to the hospital because he had made a friend at the hospital and wanted to visit his friend.
-Resident #1 reported he had abdominal pain, vomiting, diarrhea, hematochezia, and hematemesis.
-Staff reported Resident #1 had not vomited or had diarrhea.
-Resident #1's exam and vitals were reassuring.
-Resident #1 was encouraged to eat.
-Transfer to the hospital was not recommended.

Telephone interview with another PCP on 02/24/21 at 12:35pm revealed:
-She did not know why Resident #1 was not seen until 12/21/20, six days after his hospitalization.
-They typically would have seen a resident within three days of discharge.
-Residents were put on their schedule by their office at the request of the facility staff.
-She had seen Resident #1 on 12/23/20 at the request of staff.
-She had not seen Resident #1's discharge summary dated 12/15/20 prior to her visit.
-She was not aware Resident #1 had been discharged with 2 antibiotics and 2 oral diabetic medications.
-She had read the other provider's note dated 12/21/20, and the provider had documented Resident #1 returned with no diabetic medications and was, "going on that."
-If she had she known Resident #1 had not received the antibiotics that were ordered at discharge she would have started him on antibiotics.
-When she completed Resident #1's physical exam everything was benign, and nothing presented of concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C **02/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY** **DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 17	D 358		

-If she had known Resident #1 was ordered the antibiotics and diabetic medication she would have checked to see why it had not been administered.
-If Resident #1 received his medication as ordered it definitely would have made a difference in his FSBS.
-If Resident #1 received his medications as ordered it could have possibly prevented the incident where he was hospitalized on 01/01/21 with high FSBS but she could not say for sure.

Review of Resident #1's care note dated 01/01/21 revealed the resident was found unresponsive and attempts to wake him up did not work.

Review of an EMS report dated 01/01/21 revealed:
-EMS responded to the facility due to Resident #1 being found unresponsive.
-Resident #1 was unconscious, responsive to pain, laying in his bed with labored respirations and a ketone like odor (fruity) to his breath.
-They were unable to palpate a radial pulse.
-Oxygen was applied 10 liters per minute with a non-rebreather mask.
-The cardiac monitor was unable to get a pulse oximetry reading.
-Resident #1 was transported to the local emergency department.

Review of Resident #1's incident report dated 01/01/21 revealed:
-Resident #1 was found in the bed unresponsive at 9:40am.
-Resident #1's finger stick blood sugar (FSBS) was taken and was registered as high.
-Resident #1 was transported to the emergency department.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C **02/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 18	D 358		

Review of Resident #1's hospital discharge summary dated 02/01/21 revealed:
-Resident #1 presented at the ED with altered mental status.
-Resident #1's labs were impressive with a glucose level of 1362.
-On admission Resident #1 met severe sepsis criteria with tachycardia (rapid heartbeat), tachypnea (rapid breathing), hypothermia (significant and potentially dangerous drop in body temperature), and lactic acidosis (lactic acid build up in the bloodstream noted when oxygen levels, become low in cells).
-Resident #1 was identified as being in acute hypoxemic respiratory failure and required a non-rebreather mask at admission and was weaned to 4 liters via nasal cannula.
-Resident #1's active problems included altered mental status, severe sepsis (infection), lactic acidosis, DKA (a serious diabetes complication where the body produces excess blood acids (ketones)), intravascular depletion (deficit in extracellular fluid volume), hypothermia, uncontrolled type 2 diabetes with complications, acute kidney injury, dehydration with hypernatremia (too much sodium in the blood), and sudden severe confusion due to brain dysfunction caused by illness.
-Resident #1 required critical care services due to the threat of imminent deterioration of his condition.
-Resident improved and was moved from intensive care unit to the medical care unit.
-Resident had an A1C of 14.8.
-Resident was hospitalized on 01/01/21 and discharged back to the facility on 02/01/21.

Telephone interview with a hospitalist at the local hospital on 02/23/21 at 8:10am revealed:
-Resident #1 was prescribed Flagyl and Cipro to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C **02/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 19	D 358		

treat colitis in December 2020.
-If Resident #1 was not administered the antibiotics there was a chance the infection would worsen, and he would become septic again.
-In December 2020 Resident #1's infection was related to colitis and in January 2021 the infection was a wound.
-Resident #1 not receiving his oral diabetic medication could have contributed to the resident going back into DKA.
-It was very concerning Resident #1 did not receive the medications as ordered.
-She expected Resident #1's medications to be administered as ordered unless Resident #1's PCP made changes once the resident was evaluated at the facility.

Telephone with the hospital Nurse Practitioner (NP) on 02/23/21 at 8:53am revealed:
-She worked with the diabetic management team at the hospital.
-She had seen Resident #1 during his hospitalization.
-Resident #1 not receiving his antibiotics and having an ongoing infection could have contributed to "throwing his sugars out of whack."
-Resident #1's A1C was 6.3 in 2004.
-Resident #1 has been on an insulin drip in the hospital in December 2020 and it was decreased daily.
-Resident #1 did well, and oral medication was ordered versus insulin because his FSBS went from 233 to 118 and was "well controlled."
-Resident #1 was a new diabetic and it was a lot of work to get his diabetes under control.

Telephone interview with the Administrative RCC on 02/23/21 at 10:34am revealed:
-Resident #1's discharge summary dated 12/15/20 was never received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C **02/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358		D 358		

Continued From page 20

-The RCC had faxed a request to the hospital to obtain the discharge papers.
-Resident #1's PCP requested the discharge papers and did not receive them until 5-days later and did not "think" to give them to us.
-The NP had printed Resident #1's discharge papers today, 02/23/21 and this was the first time they had seen the discharge papers from 12/15/20.

Telephone interview with Resident #1's PCP on 02/23/21 at 11:02am revealed:
-She did not always receive hospital discharge summaries when the resident returned.
-There had to be a better system to make sure the facility received hospital discharge orders.
-If paperwork came back after hours, it was put in the Clinical RCC's office and that could delay orders.
-It was an imperfect system.
-They typically see residents within a day or two when they return from the hospital.
-She was not sure what happened on their end that Resident #1 was not scheduled to be seen until one week after returning from hospital admission.
-Communication was important and making sure the information was available.

Interview with a MA on 02/23/21 at 2:15pm revealed:
-Resident #1 had been refusing medication and was not eating for maybe about a week or so before going to the hospital on 01/01/21.
-She remembered talking to one of the facility's providers about Resident #1 refusing to take his medications and eat, but she did not recall who.
-She talked to the Clinical RCC about Resident #1 refusing to take his medications and eat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 21	D 358		

Interview with Resident #1 on 02/23/21 at 2:20pm revealed:
-He had been to the hospital a couple of times recently but did not recall the dates.
-He did not know what happened on 01/01/21, he just knew he went to the hospital for a long time.
-He had not been eating because he did not like the food.
-He had not been feeling good, but he did not remember if he had told anyone about it.

Interview with the Clinical RCC on 02/23/21 at 2:23pm revealed:
-When a resident returned from the hospital the MA was responsible for reviewing the discharge papers, faxing the papers to the pharmacy, and sliding the original under her door.
-She would make sure the discharge papers were faxed to the pharmacy, refax the papers if it did not go through, see what needed to be changed with the resident's orders, and placed the discharge orders in the PCP's office to be reviewed and signed.
-The pharmacy entered orders into the eMAR and she or the MA approved the orders.
-She did not know what happened to Resident #1's discharge papers when he returned on 12/15/20.
-She did not recall if anyone told her Resident #1 was refusing his medications and not eating prior to going to the hospital on 01/01/21.

Interview with a MA on 02/23/21 at 3:42pm revealed:
-She was working when Resident #1 returned from the hospital on 12/15/20.
-Resident #1 did not have discharge papers with him when he returned.
-She did not recall if she told anyone Resident #1 did not have discharge papers with him when he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C **02/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 22	D 358		

returned.
-She most likely told the Clinical RCC, but she could not be sure.

Telephone interview with the facility's transport driver on 02/25/21 at 9:00am revealed:
-He always asked the "lady at the hospital" for paperwork, and she told me it was in the resident's bag.
-He pulled the paperwork out and laid it on the seat in the car, so he would remember to give it to the MA when they got back to the facility.
-He did not recall if he had picked up Resident #1 on 12/15/20.
-He felt confident if he was the one who picked Resident #1 up at the hospital, he would have given the discharge papers to the MA or Clinical RCC.

Telephone interview with the Clinical RCC on 02/24/21 at 11:20am revealed:
-She had looked everywhere for Resident #1's discharge papers dated 12/15/20.
-Resident #1's discharge papers for 12/15/20 were located in the resident's room on 02/23/21.

Interview with the Administrator on 02/23/21 at 3:05pm revealed:
-She did not know Resident #1 had returned from the hospital on 12/15/20 without discharge papers.
-If a resident returned from the hospital without discharge papers, she would expect the MA to tell the EMS to go back to the hospital to obtain the discharge papers.
-The facility should not take a resident back without discharge papers because you would not know what care the resident needed.
-The facility should have had more safety nets in place to make sure physician's orders were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 23	D 358		

missed.
-She did not know there were medications ordered for Resident #1 that he did not receive.
-She was concerned Resident #1 was accepted back into the facility without discharge orders and the discharge orders were not obtained.
-Resident #1 was very sick when he went back to the hospital on 01/01/21.

Refer to the telephone interview with the Quality Assurance Specialist with the facility's contracted pharmacy on 02/24/21 at 10:10am.

2. Review of Resident #5's current FL-2 dated 09/07/20 revealed:
-Diagnoses included dementia and schizophrenia.
-There was a medication order for Invega Sustenna 117 mg (used to treat certain mental/mood disorders) intramuscular due after 28 days.

Review of Resident #5's prescriptions revealed there was a prescription dated 09/11/20 with Invega Sustenna 117 mg intramuscular due on 10/09/20.

Review of Resident #5's six-month physician orders dated 11/03/20 revealed there was a medication order for Invega Sustenna 117 mg intramuscular every 28 days.

Review of Resident #5's December 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for Invega Sustenna 117 mg intramuscularly every 28 days, scheduled for 9:00am.
-There was documentation of Resident #5 refusing administration on 12/19/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 24	D 358		

Review of Resident #5's January and February 2021 eMARs revealed there were no entries for Invega Sustenna.

Review of Resident #5's pharmacy dispensing record revealed:
-Invega Sustenna 117 mg was dispensed 09/11/20, and 10/23/20.
-There was no dispense dates for December 2020, January 2021, and February 2021.

Review of the facility injection log book revealed Resident #5 did not have an injection log for Invega Sustenna.

Observation of the Resident Care Coordinator (RCC) on 02/23/21 at 3:45pm revealed she looked in the facility injection book and was not able to locate Resident #5's injection log for Invega Sustenna.

Observation of Resident #5's medications on hand revealed there was no Invega Sustenna available for administration.

Review of Resident #5's former PCP visit notes revealed:
-There was a noted dated 09/16/20 indicating Resident #5 refused provider visit.
-There was a note dated 09/23/20 indicating Resident #5 refused her new patient visit and was referred to mental health for evaluation.
-There was a note dated 10/01/20 indicating Resident #5 was refusing all medications and staff were to continue encouraging Resident #5 to take her medications.
-There was a note dated 10/08/20 indicating Resident #5 was refusing all scheduled medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 25 -There was a noted dated 10/19/20 indicating Resident #5 was refusing all scheduled medications. -There was a note dated 10/26/20 indicating Resident #5 refused all medications and vital signs. Review of Resident #5's Psychiatrist visit notes revealed: -There was a note dated 11/19/20 that Resident #5 had previously refused psychiatric services but was cooperative. -The note dated 11/19/20 that indicated Resident #5 had Invega Sustenna ordered to treat schizophrenia and cognitive impairment. -The note also indicated Resident #5 had a history of refusing medications because she did not believe she needed medications. -There was a note dated 12/09/20 that indicated Resident #5 was on Invega Sustenna to treat schizophrenia and cognitive impairment and to continue current treatment plan. -There was a note dated 01/27/21 that indicated Resident #5 was "still resisting injections". Based on observations, record reviews and interviews, on 02/16/21 Resident #5 was out of the facility at the local hospital. Telephone interview with Resident #5's responsible person on 02/19/21 at 9:14am revealed: -Resident #5 was in the hospital for mental health treatment because she was refusing her medications. -Resident #5 had a history of refusing medications because she stated that she did not need them. -She was told by the physician at the hospital that Resident #5 had not received her Invega	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ___ B. WING ___	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 26 Sustenna injection since her admission to the facility in September 2020. -She was contacted by a new contracted medical staff at the end of November 2020 or beginning of December 2020 to provide consent for administering the injection to Resident #5, but she did not recall the name of the company. -She did provide consent for the new staff to administer the injection to Resident #5. -She told the current Administrator in November 2020 that the only medication that kept Resident #5 stable was Invega Sustenna. -Staff contacted her to tell her Resident #5 was refusing all medications and she told staff at the facility that was Resident #5's normal response. -She did not recall the name of the staff or the date of the call. -She received a bill recently from the facility contracted pharmacy and she did not see Invega Sustenna listed on the bill. -She did not call the pharmacy or the facility when she did not see the Invega Sustenna was not listed on the pharmacy bill. Telephone interview with a representative of Resident #5's former Primary Care Provider (PCP) on 02/22/21 at 2:14pm revealed: -Resident #5 was seen frequently by the PCP prior to 11/30/20 when their company was no longer the facility contracted provider. -Resident #5 was offered the Invega Sustenna injection by the PCP but she did not know the exact dates. -The former PCP and her staff were at the facility daily on the weekdays and the former PCP did not write a discontinue order for Resident #5's Invega Sustenna. Telephone interview with Resident #5's facility contracted Psychiatrist on 02/18/21 at 3:13pm	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27	D 358		

Continued From page 27

revealed:
-Resident #5 refused to participate in the examination and he continued to try to see her.
-Her appearance was kempt, and she ate enough to sustain herself.
-The resident was supposed to receive Invega Sustenna monthly, but she was not compliant with medications.

Telephone interview with Resident #5's facility contracted Psychiatrist on 02/19/21 at 2:15pm revealed:
-He visited Resident #5 on 11/19/20, 12/09/20, and 01/27/21 and he went to the facility weekly.
-Resident #5 had Invega Sustenna ordered to treat schizophrenia and the medication was an antipsychotic medication.
-Staff informed him that Resident #5 refused all of her medications in November 2020, December 2020 and January 2021.
-He did not know Resident #5's Invega Sustenna was not entered on the January and February 2021 eMARs.
-He had not discontinued Resident #5's Invega Sustenna and thought she was actively offered the Invega Sustenna injection as ordered.
-He did not know she had missed the Invega Sustenna injections for January and February 2021.
-He thought Resident #5's Invega Sustenna injection was still an active order and that she was offered the injection.
-When he saw Resident #5 on 01/27/21, she had no hallucinations, but she was suspicious of him.
-He described her behavior on 01/27/21 as loosely suspicious and paranoid.

Telephone interview with the facility contracted Pharmacist on 02/18/21 at 3:43pm revealed:
-There was an order dated 09/11/20 for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C **02/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 28 #5's Invega Sustenna 117 mg every 28 days. -There was no discontinue order for Resident #5's Invega Sustenna. -Resident #5's Invega Sustenna was dispensed on 09/11/20 and 10/23/20. -There was no Invega Sustenna dispensed for Resident #5 in December 2020, January and February 2021 Telephone interview with the facility contracted pharmacy medical records/order entry Supervisor on 02/19/21 at 12:03pm revealed: -Resident #5's FL-2 was received on 09/11/20. -Resident #5 had an order in the computer system dated 09/11/20 for Invega Sustenna 117 mg every 28 days. -On 10/23/20, the Clinical Resident Care Coordinator (RCC) called and requested Resident #5's Invega Sustenna 117 mg for delivery to the facility. -There was an original end date of 10/24/20 in the computer system for Resident #5's Invega Sustenna. -Resident #5's Invega Sustenna was added back to her profile and the end date changed to 12/31/20. -Resident #5 was added back because she was removed on 10/24/20. -Resident #5's Invega Sustenna order was approved on 10/30/20. -The facility could override the end dates of medications. -A request was sent to the facility asking for Resident #5's six-month physician orders on 01/26/21 but Resident #5's FL-2 was sent to the facility pharmacy. -The pharmacy could not use her FL-2 for continued orders because FL-2 orders could only be used for 30 days of medications. -A FL-2 could not be used as a refill order.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 29	D 358		

-If Resident #5's six-month physician orders were received the Invega Sustenna would have appeared on her January and February 2021 eMARs.

Telephone interview with a second shift medication aide (MA) on 02/19/21 at 1:50pm revealed:
-When a resident had an injection due for administration the LHPS nurse administered the injection.
-The Clinical RCC processed all the medication orders.

Telephone interview with a first shift MA on 02/22/21 at 10:47am revealed:
-The Administrator, a licensed nurse, used to do the injections, but by December 2020 the injections were administered by the current facility contracted PCP.
-If a resident was due for an injection, it popped up on the eMAR computer screen.
-She would tell the Clinical RCC or the PCP that the medication was due.
-If she observed the PCP administering the injection, she documented in the eMAR system that the injection was administered.
-Sometimes the PCP went to the Clinical RCC's office and documented the administration of the injection.
-The MA were not responsible for sending six-month physician orders to the pharmacy.
-The Clinical RCC was responsible for sending six-month physician orders to the pharmacy.

Telephone interview with another first shift MA on 02/23/21 at 9:57am revealed:
-She verified that her initials were the initials documented on Resident #5's December 2020 eMAR on 12/19/20 at 9:00am for the refusal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 30 -MAs did not administer injections and she notified the PCP or the Administrator if a resident was due for an injection. -The person who administered the injection signed off the injection. -She signed off only if she observed the injection given by the PCP. -When an injection was due, it popped up on the eMAR computer screen. -She thought she approached Resident #5 to offer medications to her, but she refused. -She did not recall documenting Resident #5's refusal of the injection, and it might have been the Administrator who approached her for the injection. -The current PCP attempted to approach Resident #5, but she did not recall when they approached Resident #5. -She thought she would notice if a medication was not on the eMAR if it appeared on the previous month eMAR. -She would report any missing medications on the eMAR system to the Clinical RCC. -She did not recall if Resident #5's Invega Sustenna was discontinued. -The eMAR system also has a notification when a medication was near the end date and it had a different color. -She did not recall Resident #5's Invega Sustenna appearing on the screen to notify staff that the medication was about to end. -She would tell the Clinical RCC when a notification occurred on the eMAR concerning the end date of a medication. -She did not recall notifying the Clinical RCC about a medication notification, but she did tell the Clinical RCC about Resident #5 refusing medications in January 2021. -The Clinical RCC was responsible for obtaining new orders for medications and for refilling	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 31	D 358		

Continued From page 31

medications such as insulin, narcotics, and monthly injectable medications.

Telephone interview with the Clinical RCC on 02/22/21 at 11:23am revealed:
-The MA were not able to administer intramuscular injections.
-The current and former facility contracted PCP administered injections to the residents.
-The facility had an injection book that was used by the PCP to know when residents were due for injections and which residents had injections.
-The PCP told her when the next injection was due so she could order the medication and have the medication on hand to administer.
-The PCP knew who had injections because upon admission, all the paperwork that was sent with a resident was sent to the PCP for review.
-Residents' six-month physician orders were completed every six months and she was responsible for knowing which resident needed six-month physician orders.
-She was responsible for faxing residents' six-month physician orders to the pharmacy.
-The pharmacy contacted her when they needed an order or ran out of refills for a medication.
-She saw that Resident #5's Invega Sustenna was listed on her six-month physician orders dated 11/03/20.

Telephone interview with the facility contracted Licensed Health Professional Support (LHPS) Registered Nurse (RN) on 02/22/21 at 12:26pm revealed:
-She did administer injections for the facility when a request was made to her by the Owner, Administrator or Clinical RCC.
-She only administered injections when a resident was new to the facility and there was not ample time to arrange home health or the PCP was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C **02/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 32	D 358		

in the facility.
-She administered injections when a provider ordered medication such as Lovenox without the knowledge that MAs were not allowed to give this medication.
-She administered injections during the pandemic when the provider did not come to the facility.
-The facility had an injection book that contained the residents who were supposed to receive injections.
-She remembered Resident #5 but never offered her an injection.
-If Resident #5 was supposed to receive injections when the former facility contracted PCP cared for residents, that was who probably administered or offered the injection to Resident #5.

Telephone interview with the Clinical RCC on 02/22/21 at 12:44pm revealed:
-She was mistaken Resident #5 did not have a discontinue order for Invega Sustenna.
-She saw in the eMAR computer system that Resident #5's Invega Sustenna had an end date of 12/31/20.
-She telephoned the former PCP and the pharmacy to find out what happened with Resident #5's Invega Sustenna in November 2020, December 2020, January 2021, and February 2021.

Interview with the Clinical RCC on 02/23/21 at 3:50pm revealed:
-The pharmacy never entered Resident #5's Invega Sustenna on the January and February 2021 eMAR.
-She was told by a representative at the pharmacy that she entered the end date of 12/31/20.
-The pharmacist reported that the pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 33	D 358		

technician removed it from Resident #5's profile and never entered it back.
-She did not recall providing the end date of 12/31/20 to the pharmacy.
-She thought she would have caught Resident #5's missing Invega Sustenna on a chart review.
-She did chart reviews by reviewing residents' new orders, FL-2 and comparing them to the eMAR.
-She did not remember the last time she did a chart review for residents.
-When she did a chart review, she compared the resident's PCP orders to what was documented on the resident's eMAR.
-Medications that were near the end date would appear on the eMAR screen in yellow.
-If she was aware that Resident #5's Invega Sustenna was about to end she would have contacted the pharmacy to ask questions about why the medication was ending.
-She would have contacted the pharmacy because some providers send prescriptions electronically or telephone the pharmacy.
-She was told by the pharmacist that there was no discontinue order for Resident #5's Invega Sustenna.
-She did not recall any contact from the pharmacy to let her know Resident #5's six-month orders were not received.
-She did not know FL-2 orders were only good for 30 days of medications.
-She requested injectable medications only when the PCP told her to request it.
-She did not know Resident #5 did not have an injection log in the injection log book so that the PCP was aware of Resident #5's injections and was able to document the administration of the injections.
-The lack of the injection sheet in the injection book was an oversight on her part.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 34	D 358		

-She always made an injection sheet for residents upon admission or when there was a new order for an injection.
-She did not check the injection book to ensure each resident with an order for an injection had an injection sheet.
-She was responsible for ensuring the six-month physician orders were signed by the physician and faxed; she was responsible for ensuring an injection sheet was made and placed in the injection book; and she was responsible for notifying the pharmacy when an injectable medication was required for a resident.

Telephone interview with the Administrator on 02/24/21 at 9:55am revealed:
-The Clinical RCC was responsible for reviewing orders and sending orders to the pharmacy.
-The Clinical RCC was also responsible for the completion of six-month physician orders and sending them to the pharmacy.
-She expected an injection sheet completed for residents who have an injection ordered.
-The injection book was accessible in the PCP office and the injection sheet allowed for a location for the PCP to sign for administration of the injection.
-The Clinical RCC and herself tried to check the injection book at the end of the week to ensure residents who had injection sheets in the book did not miss their injections.
-She expected MAs to document in the eMAR system that the injection was given by the PCP.
-She knew Resident #5 refused medications.
-She was told on 02/23/21 that Resident #5 did not have an injection sheet in the injection book.
-She recalled telling the Psychiatrist Resident #5 was refusing her injection.
-The Clinical RCC was responsible for the process to ensure residents obtained their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

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D 358	Continued From page 35	D 358		

monthly injections.

Refer to the telephone interview with the Quality Assurance Specialist with the facility's contracted pharmacy on 02/24/21 at 10:10am.

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Telephone interview with the Quality Assurance Specialist with the facility's contracted pharmacy on 02/24/21 at 10:10am revealed:
-Physician orders were received by fax or escript into the pharmacy.
-The entry technician was responsible for inputting the orders into the eMAR system.
-Discontinued orders were instantaneous.
-New orders or orders that were changed were double-checked by the pharmacist after the entry technician had put the orders into the eMAR system before releasing the orders for the facility.
-The time frame was about 3-4 hours from the time the order was received until the facility could approve the order on their end.
-Medications were delivered at night, so the medication could be administered the next day.
-If the medication was needed sooner, the facility would use a back-up pharmacy.
-The pharmacy would expect a discharge summary to be faxed to them when a resident returned to the facility from the hospital.
-The discharge orders would be compared to the current profile and if there were any omissions, they would complete an omission form and have the facility obtain clarification.
-The facility was responsible for getting orders from the provider to the pharmacy.

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The facility failed to ensure medications were administered as ordered including two oral diabetic medication and two antibiotics for a resident who was diagnosed with diabetic ketoacidosis (DKA) and severe sepsis during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

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D 358 Continued From page 36 D 358

hospitalization from 12/09/20-12/1520 and 16 days later the resident who was not administered the antibiotics and diabetic medications was found unresponsive, had a blood glucose of 1362 and was hospitalized from 01/01/21-01/31/21 with a diagnosis of severe sepsis and DKA, and ensure an injectable anti-psychotic medication was offered to a resident diagnosed with schizophrenia after the six-month physician orders were not sent to the pharmacy and the medication was missed on the January and February 2021 (#5) . The facility's failure placed the residents at substantial risk of physical harm and constitutes a Type A2 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/24/21 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 27, 2021

D 367 10A NCAC 13F .1004(j) Medication Administration D 367

10A NCAC 13F .1004 Medication Administration
(j) The resident's medication administration record (MAR) shall be accurate and include the following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367		D 367		

Continued From page 37

(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 2 of 9 sampled residents (#8, #9) for a sleep medication (#8) and a skin protectant ointment (#9).

The findings are:

1. Review of Resident #8's current FL-2 dated 03/26/20 revealed:
-Diagnoses included dementia, fracture of the right femur, muscle weakness and dysphagia.
-Melatonin (a supplement used to treat insomnia) 5mg at bedtime as needed for sleep.

Observation of Resident #8's medication on hand on 02/16/21 at 1:15pm revealed there was 1 tablet remaining out of 30 tablets on a blister pack labeled melatonin 5mg take at bedtime as needed for sleep dispensed on 01/04/21.

Observation of Resident #8's medication on hand on 02/23/21 at 2:04pm revealed:
-There was no melatonin remaining on the medication cart.
-The medication aide (MA) reordered the melatonin from the facility's contracted pharmacy through the electronic medication administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

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D 367	Continued From page 38	D 367		

record (eMAR) system.

Review of Resident #8's pharmacy dispensing records revealed:
-There was a current order for Resident #8 melatonin 5mg take one tablet at bedtime as needed for sleep.
-There were 30 melatonin 5mg tablets dispensed on 01/01/21.
-There were 28 melatonin 3mg tablets dispensed on 12/13/2019.
-There were no other dispense dates for Resident #8's melatonin 5mg.

Review of Resident #8's January 2021 eMAR revealed:
-There was an entry for melatonin 5mg take one tablet as needed at bedtime for sleep; there was a note at the end of the entry in parentheses that stated family provides.
-Melatonin 5mg was documented as administered on 01/27/21.
-There were no other entries documenting administration of melatonin 5mg for the month of January 2021.

Review of Resident #8's February 2021 eMAR revealed:
-There was an entry for melatonin 5mg take one tablet as needed at bedtime for sleep; there was a note at the end of the entry in parentheses that stated family provides.
-There were no entries documenting melatonin 5mg was administered from 02/01/21 to 02/23/21.

Telephone interview with Resident #8's family member on 02/23/21 at 9:37am revealed:
-She had provided Resident #8's melatonin until March 2020, but she stopped due to the pandemic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C **02/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY** **DURHAM, NC 27703**

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D 367	Continued From page 39 -She could not remember who at the facility had asked her to stop providing the melatonin for Resident #8, but they had asked her to allow the pharmacy to provide the melatonin to limit contact and contamination. -Resident #8 had a physician's order for the melatonin to help her sleep at night because she would wake up in the middle of the night and want to walk. -Resident #8 had taken melatonin prior to her admission to the facility. Telephone interview with a medication aide (MA) on 02/19/21 at 11:01am revealed: -She worked second shift. -She was familiar with Resident #8 and her medication. -Resident #8 only had one scheduled medication in the evenings and the melatonin that was PRN (as needed). -She had not administered Resident #8 her melatonin during January 2021 or February 2021. -She always documented on the eMAR when she administered any PRN medications. Interview with a MA on 02/23/21 at 2:04pm revealed: -He was very familiar with Resident #8 and her medication because he always worked on the hall she resided on. -He had never administered Resident #8 her melatonin because she slept well and did not need it. -Resident #8 did not the cognitive ability to ask for her melatonin. -He documented on the eMAR whenever he administered a medication that was PRN; he documented why he had to administer the mediation and if the medication worked.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

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D 367	Continued From page 40	D 367		

Telephone interview with a second MA on 02/23/21 at 3:58am revealed:
-She worked on second shift and sometimes worked on the hall Resident #8 resided on.
-She was familiar with Resident #8 and her medications.
-Resident #8 did not have any problems falling asleep but would wake up about once every couple of weeks and get out of bed.
-Resident #8 could be redirected back to bed and would fall back asleep without having to take any medication.
-She had administered Resident #8's melatonin on 01/27/21 because the resident got up about two hours after going to sleep that night and did not fall back to sleep on her own.
-She documented on the eMAR that she had administered the melatonin to Resident #8 when she gave it to her on 01/27/21.
-She always documented on the eMAR when she administered any PRN medications.

Telephone interview with a MA on 02/24/21 at 9:52am revealed:
-She worked on second shift and was familiar with Resident #8 because she regularly worked on the hall Resident #8 resided on.
-Resident #8 only had one medication that was scheduled for administration in the evening and it was not melatonin.
-She had never administered Resident #8 her melatonin because Resident #8 slept well and did not need it.
-She documented on the eMAR whenever she administered any PRN medications for any of the residents.

Telephone interview with the Resident Care Coordinator (RCC) on 02/24/21 at 11:25am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 41	D 367		

-The MAs used a code to sign in that was linked to their initials.
-On the eMAR screen the MAs were required to tap on the resident's name, and then tap on the medication.
-MAs are supposed to check the medication card against the eMAR three times before each administration; they were to look for the medication name, dosage, time and the residents name on the card.
-After administering the medication, the MA then tapped on the medication on the screen and it shaded the medication as gray to indicate the medication had been administered and placed their initials on the eMAR.
-The MA was required to enter the reason for administration and the effectiveness of any PRN medication in the notes section on the eMAR.
-She conducted weekly medication audits buy randomly selecting residents and looking at their medications on hand and the eMAR.
-She looked at the eMAR and then the medication to see what tablets were still in the card when she conducted an audit.
-When she recognized a concern, she would meet with the MAs immediately and discuss the concern and what happened and then notify the physician.
-She could not recall the last time she had audited Resident #8's medication.
-If she had found a medication card with only one tablet and no administration documentation on the eMAR she would discuss with the MAs.
-She could not explain why Resident #8's melatonin had been administered and not documented.

Telephone with the Administrator on 02/24/21 at 12:05pm revealed:
-The RCC was responsible for the auditing of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 42 medication and the eMAR. -She was not familiar with the process but only knew there was a schedule to conduct the audits. -Audits were safety nets and caught mistakes; medication that was administered and not documented should be found during a medication audit. -She did not have an explanation for why Resident #8's melatonin had been administered and not documented. Attempt to interview the second shift supervisor by telephone on 02/24/21 at 10:17am was unsuccessful. Based on interviews and record reviews it was determined Resident #8 was not interviewable. 2. Review of Resident #9's current FL-2 dated 07/07/20 revealed: -Diagnoses included unspecified dementia, arthritis, and schizophrenia paranoid type. -Resident #9 was incontinent of bowel and bladder. Review of Resident #9's New Prescription Form dated 02/09/21 revealed there was an order for zinc oxide cream 22% to be applied to the groin and the scrotum twice daily and after incontinent episodes. (zinc oxide is a skin protectant that is used to treat and prevent diaper rash and minor skin irritations.) Observation of Resident #9's medication on hand on 02/16/21 at 1:15pm revealed: -There was one-half of a tube of zinc oxide ointment 20%. -The label read to apply to the groin and the scrotum area twice a day and after each incontinent episode.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

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D 367	Continued From page 43 Telephone interview with Resident #9's primary care physician (PCP) on 02/24/21 at 10:25am revealed based on her assessment on 02/24/21 the resident was getting zinc oxide after each incontinent episode. Review of Resident #9's February 2021 electronic medication administration records (eMARs) revealed: -There was an entry for zinc oxide ointment 20% to be applied to the groin and the scrotum area twice daily, scheduled at 8:00am and 8:00pm. -Zinc oxide ointment 20% was documented as administered at 8:00am and 8:00pm from 02/10/21-02/22/21 and at 8:30am on 02/23/21. -There was an entry for zinc oxide ointment 20% to be applied to the groin and the scrotum area after incontinent episodes. - Zinc oxide ointment 20% was documented as administered on 02/17/21 at 3:34pm. Interview with a medication aide (MA) on 02/23/21 at 2:15pm revealed: -She knew Resident #9 had an order for an ointment to be applied after incontinent episodes. -Resident #9 was incontinent between 4-5 times on first shift between the hours of 7:00am to 3:00pm. -The personal care aide (PCA) notified her when Resident #9 had an incontinent episode, and she would apply zinc oxide ointment to the groin and the scrotum area after incontinent episodes. -She only documented zinc oxide at 8:00am, but she did not document when she applied zinc oxide after Resident #9's incontinent episodes. -She gave no response to why she did not document zinc oxide on the eMARs. -The MAs were responsible for the accuracy of the eMARs.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 44	D 367		

-The Resident Care Coordinator (RCC) was responsible for auditing the eMARs for accuracy.

Interview with a second MA on 02/23/21 at 3:10pm revealed:
-She knew Resident #9 had an order for an ointment to be applied after incontinent episodes.
-Resident #9 was incontinent about 2 times on second shift between the hours of 3:00pm to 11:00pm.
-The PCA notified her when Resident #9 had an incontinent episode, and she would apply zinc oxide to the groin and the scrotum area after incontinent episodes.
-She documented zinc oxide at 8:00pm, but she did not document when she applied zinc oxide after Resident #9's incontinent episodes.
-She gave no response to why she did not document zinc oxide on the eMARs.
-The MAs were responsible for the accuracy of the eMARs.
-The RCC was responsible for auditing the eMARs for accuracy.

Telephone interview with a third MA on 02/24/21 at 1:07pm revealed:
-She did not know Resident #9 had an order for an ointment to be applied after incontinent episodes.
-Resident #9 was incontinent about three times on third shift between the hours of 11:00pm to 7:00am.

Telephone interview with the RCC on 02/24/21 at 9:34am and 3:50pm revealed:
-She knew Resident #9 had an order for an ointment to be applied after incontinent episodes.
-The RCC's expectation was the MAs should be using zinc oxide after Resident #9 had an incontinent episode.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C 02/25/2021

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D 367	Continued From page 45 -The MAs should document the use of zinc oxide on the eMARs. -She was responsible for auditing the eMARs monthly, and Resident #9's eMAR had not been audited for February 2021. Telephone interview with the Administrator on 02/24/21 at 2:32pm revealed: -She did not know Resident #9 had an order for an ointment to be applied after incontinent episodes. -The Administrator's expectation was the MAs should be using zinc oxide after Resident #9 had an incontinent episode. -The MAs should document the use of zinc oxide on the eMARs. -The RCC was responsible for auditing the eMARs monthly. Based on observations, interviews, and record reviews it was determined Resident #9 was not interviewable.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure residents received care and services necessary to maintain the residents health, safety, and welfare as related to health care.	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: ______ B. WING ______	R-C **02/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM RIDGE ASSISTED LIVING	**3420 WAKE FOREST HWY DURHAM, NC 27703**

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D912	Continued From page 46 The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 1 sampled resident (Resident #1) with orders for finger stick blood sugar (FSBS) checks. [Refer to Tag D0276, 10A NCAC 13F .0902 (c)(3-4) Health Care (Type B Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to assure each resident was free of neglect related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 9 sampled residents (Resident #1 and #5) related to two antibiotics and two oral diabetic medications (#1) and a monthly injectable anti-psychotic medication (#5). [Refer to Tag D0358, 10A NCAC 13F .1004 (a) Medication Administration (Type A2 Violation)]	D914		