STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068025	A. BUILDING: _____ B. WING _____	R 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE STRATFORD	405 SMITH LEVEL ROAD CHAPEL HILL, NC 27516

(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 on 07/16/24 through 07/17/24.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up to meet the healthcare needs for 1 of 5 sampled residents (#3) who had an order for Thromboembolic deterrent (TED) compression hose. The findings are: Review of Resident #3's current FL2 dated 05/23/24 revealed diagnoses included Alzheimer's disease, anemia, essential hypertension, and depression. Review of Resident #3's physician's orders dated 05/03/23 and 05/16/24 revealed orders to apply TED hose in the morning, and remove in the evening. Review of Resident #3's physician's visit note dated 05/02/24 revealed: -Resident #3 had a diagnoses of peripheral vascular disease and peripheral edema. -She had trace edema to her legs. Review of Resident #3's June 2024 electronic medication administration record (eMAR) revealed:	D 273		

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D 273	Continued From page 1 -There was an entry for TED hose, apply every morning and remove at bedtime scheduled at 8:00am and removal at 8:00pm. -There was documentation TED hose were not applied for 5 days from 06/01/24 through 06/30/24. -The documented reasons for not applying TED hose were that the TED hose were reordered and awaiting delivery from the pharmacy, or not administered due to needing to measure Resident #3's feet. -There was documentation TED hose were not removed at 8:00pm for 12 days from 06/01/24 through 06/30/24. -The documented reason for not removing TED hose was that removal was not applicable. Review of Resident #3's July 2024 eMAR from 07/01/24 through 07/16/24 revealed: -There was an entry for TED hose, apply every morning and remove at bedtime scheduled at 8:00am and removal at 8:00pm. -There was documentation TED hose were not applied for 2 days from 07/01/24 through 07/16/24. -The documented reason for not applying TED hose was that the facility was awaiting the TED hose to be delivered from the pharmacy. -There was documentation TED hose were not removed at 8:00pm for 7 days from 07/01/24 through 07/15/24. -The documented reason for not removing the TED hose was that Resident #3 did not have TED hose on to remove. Review of Resident #3's progress notes for June and July 2024 revealed there was no documentation that Resident #3's primary care provider (PCP) was notified that she did not wear TED hose daily as ordered.	D 273		

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D 273	Continued From page 2 Observation of Resident #3 on 07/16/24 at 3:00pm and on 07/17/24 at 9:40am revealed she was sitting in her wheelchair in the common living area with black TED hose on. Observation of Resident #3's room on 07/17/24 at 10:23am revealed there was a second pair of back TED hose in her top dresser drawer. Interview with a medication aide (MA) on 07/16/24 at 2:55pm revealed: -She had documented Resident #3's TED hose as not applied that morning because Resident #3 did not have TED hose on when she checked her during the morning medication pass. -The night shift personal care aides (PCA) applied Resident #3's TED hose when staff got her out of bed in the morning. -She documented whether or not the TED hose were on Resident #3 when she was giving Resident #3 her morning medications. -Resident #3's TED hose were ordered from the pharmacy and had not come in yet. -She was not aware of Resident #3 having a second pair of TED hose in her room until the Memory Care Coordinator (MCC) told her that morning on 07/16/24. Telephone interview with a representative from the facility's contracted pharmacy on 07/16/24 at 3:15pm revealed: -The pharmacy had an order for TED hose for Resident #3 on 08/08/22, but the order was to add the TED hose to Resident #3's profile only, so none had been dispensed. -The pharmacy had received a refill request for TED hose for Resident #3 on 05/15/24, but the pharmacy had responded that a new order was needed.	D 273		

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-The pharmacy did not receive the order dated 05/16/24 for TED hose for Resident #3.
-The pharmacy had never dispensed TED hose for Resident #3.

Interview with the MCC on 07/17/24 at 10:20am revealed:
-He thought Resident #3's TED hose came from her family since they did not come from the pharmacy.
-Resident #3 had two pairs of black TED hose that she rotated wearing during the previous year.
-He was not aware that Resident #3 did not wear TED hose daily as ordered.
-He audited the eMARs every Monday and Friday, but had not noticed the documentation that Resident #3's TED hose were not applied and removed daily as ordered.
-The MA was responsible for checking that the PCA had applied Resident #3's TED hose every morning.
-If Resident #3 did not have TED hose on, the MA was responsible to find the TED hose and apply them, then document that they were applied.
-Resident #3's TED hose were ordered to prevent swelling, and he had not observed any swelling to Resident #3's legs in the previous few months.
-He had not notified Resident #3's PCP about her not wearing TED hose daily as ordered because he thought the MAs had been applying them every morning.
-There was no documentation to indicate the MAs had notified Resident #3's PCP that they had not applied her TED hose or that she needed a new pair.

Second interview with a MA on 07/17/24 at 10:30am revealed:
-She was working on 05/16/24 when Resident #3 did not have TED hose on.

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-The PCP was at the facility that day, so she notified him that Resident #3 needed a new order for TED hose.
-The PCP told her he would fax a new order to the pharmacy.
-The PCP did not give her the signed order for TED hose.
-The PCP would have left the written order with the MCC or the Resident Care Manager (RCM).
-She did not know if the TED hose had been delivered.
-Each morning that she worked, she either documented that Resident #3's TED hose were on or that they were not on.
-If Resident #3 did not have TED hose on, she would tell the PCA to find the TED hose and apply them to Resident #3.
-She had not observed any swelling to Resident #3's legs.

Interview with a PCA on 07/17/24 at 10:45am revealed:
-She was responsible for applying Resident #3's TED hose in the morning and letting the MA know they were applied so the MA could document in the eMAR.
-Sometimes she could not find Resident #3's TED hose, so the MA documented the TED hose as not applied.
-Resident #3 had black TED hose, but she was only aware of her having one pair.
-She did not think that Resident #3 would be able to remove TED hose by herself because of her mobility and because the TED hose were tight.
-She had not observed any swelling to Resident #3's legs.

Interview with the Licensed Health Professional Support (LHPS) nurse on 07/17/24 at 11:00am revealed:

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-Resident #3 had an order for TED hose for as long as she could remember doing her LHPS assessments.
-She was at the facility every week, and sometimes she saw Resident #3 with her TED hose on, and sometimes Resident #3 did not have her TED hose on.
-Last week when she was at the facility, Resident #3 was not wearing her TED hose.
-When Resident #3 did not have her TED hose on, she did not observe any swelling to her legs.
-She told the MA that Resident #3 did not have her TED hose on, and the MA told her that Resident #3 did not have any TED hose available to apply.

Interview with a second MA on 07/17/24 at 11:05am revealed:
-He usually worked on the afternoon shift (3:00pm to 11:00pm) and sometimes on the night shift (11:00pm to 7:00am).
-He had never observed Resident #3 remove TED hose by herself, so he did not know why there were documented as TED hose having been applied more than they were documented as being on to remove in the evening.
-The PCAs removed Resident #3's TED hose in the evening then reported to him so he could document that her TED hose were either removed, or that she did not have any TED hose on that evening to remove.
-He had never seen Resident #3's TED hose; she either did not have them on or the PCA had already removed them by the time he checked to document the removal.
-He had never observed swelling to Resident #3's legs.
-If Resident #3 had swelling in her legs, the PCAs would have reported it to him to follow up on.

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D 273	Continued From page 6 Interview with the RCM on 07/17/24 at 11:50am revealed: -Resident #3 had an order to wear TED hose since her admission to the facility in July of 2022. -Resident #3's TED hose were applied by the PCAs, but the MAs were responsible for ensuring she was wearing them every day. -She was aware that Resident #3 did not wear TED hose every day as ordered. -She had documented Resident #3's TED hose as not applied on 06/05/24 due to being on order at the pharmacy. -She spoke with the MCC on 06/05/24 about Resident #3 not having TED hose on, and he told her that they had been reordered from the pharmacy, so that was what she documented. -Whenever she saw Resident #3 without her TED hose on, she would tell the MA on shift that day that staff needed to apply the TED hose. -She had not seen Resident #3's new order for TED hose dated 05/16/24. -Resident #3's PCP would have given the written order for TED hose to either her or the MCC, and whoever was given the order would have been responsible for faxing the order to the pharmacy. -She or the MCC would be responsible for notifying the PCP about Resident #3 not wearing TED hose daily as ordered, but she had not contacted the PCP. -She had not observed any swelling to Resident #3's legs. Interview with the Administrator on 07/17/24 at 12:30pm revealed: -He was not aware that Resident #3 was not having her TED hose applied daily as ordered. -Either the MA, the MCC, or the RCM would be responsible for notifying the PCP that Resident #3 did not have her TED hose applied daily as ordered.	D 273		

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D 273	Continued From page 7 -If TED hose were not available in Resident #3's room to put on her, the MA was responsible for communicating with the MCC to either try and locate the TED hose, or contact the family or pharmacy to obtain a replacement pair. -If Resident #3's PCP ordered a new pair of TED hose on 05/16/24, the MCC or RCM would have been responsible for ensuring the order was received at the pharmacy and then delivered to the facility. Based on observation, record review and attempted interview, it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's guardian on 07/17/24 at 9:54pm was unsuccessful. Attempted telephone interview with Resident #3's PCP on 07/17/24 at 10:00am was unsuccessful.	D 273		