STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 An Annual and a Follow Up Survey were conducted by Adult Care Licensure Section on 4/1/15.	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 observation, interviews and record review, the facility failed to notify the physician for 1 of 1 sampled resident (#1) who used oxygen and complained of increase breathing difficulties related to sanding and painting at the facility. The findings are: Review of Resident #1's current FL-2 dated 12/29/14 revealed: -Diagnoses included COPD (severe), osteoporosis and back pain. -Resident #1 was on 2 liters of oxygen continuously. -Resident #1 had an order for Brovana (a long acting bronchodilator which relaxes the muscles in the airway to improve breathing) 15 mcg/2ml nebulizer two times daily. -Resident #1 had an order for Pulmicort (a corticosteroid which reduced inflammation of the airway) 0.5ml/2ml nebulizer twice daily. -Resident #1 had an order for Proventil (a short acting bronchodilator which relaxes the airway making it easier to breathe) 2.5 mg/3ml nebulizer	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 273	Continued From page 1 four times daily. Review of the Licensed Health Professional Support (LHPS) evaluation dated 1/18/15 revealed: -Resident #1 used oxygen continuously via nasal cannula. -Resident #1 had an O2 concentrator. -Resident #1 received multiple nebulizer treatments as ordered by a physician. -Resident #1 experienced shortness of breath (SOB) on exertion. Review of a facility's letter dated 2/12/15 revealed renovations were beginning. -Planned scope of work for the renovations of common areas and resident rooms include flooring, painting, lighting and parking lot resurfacing. -The renovations are to be completed in phases. -We will do our utmost to ensure the residents' day to day comfort, and to minimize any unexpected changes. Observation of Hall 200 on 4/1/15 at 9:00 a.m. - 2:00 p.m. revealed: -The entrance door to room 207 was enclosed in a plastic protective barrier. -Sanding was being done in the protective area near room 207. -A vacuum sanding system was inside the protective barrier. (The system was a portable vacuum to capture and remove the dusk before exposure to the air.) -The sanding area was 8 ft. X 4 ft. which was enclosed by a plastic protective barrier. -The protective barrier was taped to the ceiling and the wall. Observation on 4/1/15 at 9:05 a.m. revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 273	Continued From page 2	D 273		

-Resident #1 was sitting in the wheelchair next to the air condition in room 202 on the 200 Hall.
-The air condition was set on 60 degrees Fahrenheit.
-Resident #1 was in no acute distress.

Interview with Resident #1 on 4/1/15 at 9:05 a.m. revealed:
-She had been having increase breathing problems related to renovations at the facility.
-The painting and sanding began about two weeks ago.
-At the beginning of the renovation phase, she was able to tolerate the sanding and painting.
-She put towels under her door to block out the fumes from the paint or dusk from the sanding.
-She turned up the air condition to make breathing easier for her.
-She would go outside to breathe fresh air.
-She notified the Administrator on 3/30/15 about increased breathing difficulties related to sanding and painting at the facility.
-Resident #1 told the Administrator the best thing for her to do was to go home.
-She told the Administrator she was leaving the facility on 4/1/15.
-She had not been informed about the renovation projects, prior to beginning in February 2015.
-If she had known about renovations projects at the facility, she would not have come to the facility on 12/29/14

Telephone interview with Resident #1's family member on 4/1/15 at 2:45 p.m. revealed:
-Resident #1 wanted to leave the facility because the fumes from the painting and dusk from the sanding were causing her to have increased breathing difficulties on 3/30/15.
-She did not know the exact date that Resident #1 told her about having increased breathing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 273	Continued From page 3	D 273		

difficulties related to renovations at the facility.
-Resident #1 was leaving the facility on 4/1/15.
-She had received information from the facility regarding renovations, but did not know the date.

Confidential interview with a staff member revealed:
- Resident #1 had complained of increase breathing difficulties related to sanding and painting at the facility.
-Staff member did not know the exact date.
-Information was given to oncoming shift.
-The resident's physician was not notified.

Interview with the Resident Care Coordinator (RCC) on 4/1/15 at 4:45 p.m. revealed:
-Resident #1 reported to RCC on 3/31/15 that she was having increase breathing difficulties related to the dusk and remodeling.
-Resident #1 stated she was leaving the facility on 4/1/15 because of increase breathing difficulties related to renovations.
-RCC had not notified Resident #1's physician of resident's complaints of having increase breathing problems related to the dusk and remodeling.
-She did not notify Resident #1's physician on 3/31/15 because the office was closed when she found out about Resident #1's breathing difficulties.
-She normally would have notified Resident #1's physician immediately of resident's complaints of breathing difficulties.

Interview with the Administrator on 4/1/15 at 5:15 p.m. revealed:
-She was aware Resident #1 was having increased breathing difficulties related to the sanding and re-painting at the facility on 3/30/15.
-She offered to call the resident's physician about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL082024	A. BUILDING: _____ B. WING _____	04/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING RIDGE ASSISTED LIVING	700 MOUNT OLIVE DRIVE NEWTON GROVE, NC 28366

(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 273	Continued From page 4 Resident #1 having increase breathing difficulties related to sanding and re-painting. -Resident #1 did not want the Administrator to call her physician. -Resident #1 just wanted to leave the facility . -She did not want to be moved to another location in the facility. -Resident #1's family member stated the best thing was to let resident go home. -Resident #1's family member stated Resident #1 was hypersensitive to paint smells. -She did not know Resident #1 was hypersensitive to paint smells. -The facility did not have a system in place to assess residents during the phases of sanding and painting. -Resident #1 and family member were notified by letter and word of mouth the facility would begin sanding and re-painting, prior to beginning the project on 2/12/15. -Normally the resident's physician would be contacted immediately about the resident having increase breathing difficulties related to sanding and re-painting. Attempted to reach Resident #1's physician, but he was unavailable by phone.	D 273		