STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on January 19-20, 2017 and January 23-24, 2017.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 6 sampled staff (Staff A) had no substantiated findings on the North Carolina Health Care Personnel Registry (NCHCPR). The findings are: Review of Staff A's personnel record revealed: -He was hired as a medication aide on 12/19/16. -No documentation of a health care personnel registry (HCPR) check was found in Staff A's record. Interview with Staff A on 01/24/17 at 5:15 p.m. revealed he did not know if a HCPR check had been completed for him. Interview with the Team Member Service Director (TMSD) on 01/24/17 at 4:35 p.m. revealed: -She could not find documentation of a health care personnel registry check in Staff A's record. " I remember doing a HCPR check for Staff A". -She completed a HCPR check on 01/23/17 for	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 137	Continued From page 1 Staff A which documented no substantiated findings on the HCPR check. -The TMSD was responsible for the completion of the HCPR checks for staff, prior to hire. -The Administrator would be responsible for doing random audits of the HCPR checks for staff monthly. Interview with the Administrator on 01/24/17 at 5:00 p.m. revealed: -He could not find documentation of a health care personnel registry check in Staff A's record. - "I know the TMSD did the HCPR check for Staff A. -The TMSD was responsible for the completion of the HCPR checks for staff, prior to hire. -He would be responsible for doing random audits of the HCPR checks for staff monthly.	D 137		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure they provided adequate supervision for 4 of 4 residents (#2, #3, #4 and #6) who had falls which resulted in injuries. The findings are:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 2	D 270		

1.Review of Resident #6's current FL-2s dated 10/20/2016 revealed:
-Diagnoses of included Altered Mental Status and Dementia.
-Resident #6 was ambulatory and transferred independently.

According to the Resident Registry Resident #6 was admitted to facility on 09/28/2016

Review of "Resident Notes" for Resident #6 revealed:
-There was an entry on 11/16/2016 at 06:36 A.M. which stated Resident #6 was put to bed between 3:30 A.M. and 4:00 A.M.
-At 5:05 A.M.the Medication Aide and Personal Care Aide heard a cry out and upon arriving to Resident #6's room she was observed lying on her left side on the floor, sheets under her with blood noted to be collecting under her head.
-Emergency Medical Services (EMS) was called and resident was sent out to the hospital
-There was an entry on 11/16/2016 at 10:00 A.M. which stated Resident #6 returned from hospital to facility with laceration on the left side of head which required seven stitches
-There was an entry on 11/17/2016 at 10:50 P.M. which stated Resident #6 was found on floor next to her bed with blood coming from an unidentified area.
-EMS was called and resident was sent out to the hospital.
-There was an entry on 11/18/2016 at 06:20 A.M. which stated a call from hospital revealed that Resident #6 had small fracture to her nose but it was unclear if fracture occurred during this fall or one of her previous falls.
-There was an entry on 12/22/2016 at 11:25 P.M. which stated Resident #6 had a fall in front of the Wellness Center while walking around with no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 3	D 270		

apparent injuries.
-There was an entry on 12/27/2016 which stated Resident #6 was found in another resident's room on the floor with apparent injuries.
-There was an entry on 01/02/2017 at 02:00 A.M. which stated Resident #6 was found on "fall mat" next to bed sleeping on floor with no apparent injuries.
-There was an entry on 01/10/2017 at 10:55 which stated Resident #6 had a fall with no apparent injuries
-There was an entry on 01/10/2017 which stated Resident #6 was observed walking with a slight "hitch" in her step and upon observation her right knee was slightly swollen with bruise on right hip.
-There was an entry on 01/11/2017 at 01:00 P.M. which stated Resident #6 had large knot on her right thigh on the side about six inches wide and very bruised.
-There was an entry on 01/12/2017 at 09:00 A.M. which stated Resident #6 had X-ray done and video recording of results was placed in her chart.
-There was an entry on 01/14/2017 at 01:00 P.M.which stated that the knot on Resident #6 leg had gone down slightly.
-There was an entry on 01/14/2017 at 01:00 P.M. which stated Resident #6 was seen by Physician's Assistant, results of X-ray was read by her noting a suspicious acute impacted subcapital fracture and resident was sent out to hospital via EMS.

Review of Incident/ Accident Reports revealed:
-Resident #6 was sent out of facility on 1/17/2017 by Emergency Medical Services (EMS) due to a broken hip.
-Resident #6 had a fall on 01/10/2017 at 10:20 A.M. with no apparent injury.
-Resident #6 had a fall on 01/02/2017 at 10:10 P.M. with no apparent injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 4	D 270		

-Resident #6 had a fall on 11/14/2016 at 05:17 A.M. with bleeding to her left ear, left side of face and left eyelid swollen and was sent to Emergency Room.
-Resident #6 had a fall on 11/16/2016 at 05:05 A.M. with bleeding from upper left ear and sent to ER.
-Resident #6 had a fall on 11/17/2016 at 10:00 P.M. with bleeding from "unknown source" and was sent to ER.
-There was no actions or interventions by staff noted on any of these reports.

Review of Resident #6's hospital discharge summary dated 11/16/2016 revealed:
-Diagnoses of cut on skin on top of head and fall.
-Laceration on her head was sutured.
-Instructed to follow-up with primary care provider.

Review of Resident #6's hospital discharge summary dated 11/17/2016 revealed:
-Diagnoses of fall and fracture of face bones.
-She was found to have a small fracture of her nose.
-Instructed not to blow her nose until she was seen by primary care provider.
-ER noted that she had suffered from recurrent falls over the past week and suggested that she be evaluated for possible higher level of care.

Review of Resident #6's hospital discharge summary dated 01/17/2017 revealed:
-Diagnoses of closed displaced fracture of right femoral neck.
-Resident #6 was found to have a right hip fracture after a fall 1 week ago.
-X-ray of right hip showed interval subcapital right femoral neck fracture with valgus impaction deformity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 5	D 270		

-Resident #6 was admitted to hospital after CT scan demonstrated what appeared to be a minimally displaced and impacted femoral head fracture extended into the femoral neck.
-According to consult by Social Worker along with Resident #6's family member has strong concerns about resident and the care she had received at current facility.
-Resident #6's family member stated that resident regularly has bruises about her body with the most recent to one of her eye/ forehead from what staff stated was caused by hitting her head on the dresser.
-Resident #6's family member stressed that he was concerned staff was not appropriately monitoring and caring for the resident.

Review of Resident #6's records revealed:
-Care Plan dated 10/04/2016 stated that resident was independent with ambulation and transfers.
-Care Plan Conference Summary dated 10/27/2016, under the comments section was noted walker with and arrow pointed to falls risk.
-Summary of Care Plan Conference Discussion stopped all medications except for Trazodone as needed for agitation and Remeron for mood.
-Care Plan dated 01/10/2017 stated that resident was assisted by walker for ambulation.

Interview with the Memory Care Wellness Director (WD) on 01/23/2017 at 04:35 P.M. revealed:
-In November 2016 Resident #6 fell out of her bed a lot.
-Facility was working on getting a doctor's order for a floor mat when Resident #6 fell out of her bed on 11/17/2016 and fractured her nose.
-When Resident #6 had a lot of falls, the facility did a care plan with family and suggested different ideas such as hip protectors, floor mat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 6	D 270		

and hospital bed.
-In agreement with the Resident #6's family Physical Therapy and a Rollator was ordered.
-Facility did fall mat, moved night stand, got a hospital bed, had a sitter to sit with Resident #6 started 11/18/2016 and then did two hour safety checks.
-The interventions helped with Resident #6's falls and she did not have any falls until January 2017.
-On 01/01/2017 Resident #6 was found sitting on a floor mat in another resident's room and was written up as an incident report because the facility was not sure if she had not fallen.
-Resident #6 was walking her laps on 01/10/2017 as she normally did and she just fell.
-Resident #6 did not hit anything when she fell and did not have any apparent injuries.
-On 01/11/2017 a bruise with raised area was noted to Resident #6's left hip.
-An X-ray was ordered and done on 01/12/2017 and was read the same day by WD.
-The X-ray was then placed in the folder assigned to Resident #6's primary care physician.
-The resident was not sent to hospital because the first report did not read as a fracture of the left hip and Resident #6 was up walking around and doing physical therapy.
-When the Nurse Practitioner came in and read the X-ray report, she realized that there was a fracture of the right hip, but not on the left hip where the bruising was noted.
-Resident #6 was sent out to the Emergency Room on 0/17/2017.

Interview with the Assistant Wellness Living Director (AWLD) on 1/24/2017 at 04:08 P.M. revealed:
-She did an assessment on Resident #6 to be cleared for the Memory Care Unit on 09/24/2016.
-Resident #6 at time of assessment walked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 7	D 270		

without walker and transferred independently.
-At time of assessment Resident 6's family member stated that she needed Physical Therapy and Occupational Therapy for strength and mobility.
-The AWLD did not work in the Secure Care Unit often and was not very familiar with Resident #6 care.

Interview with the Resident Services Consultant (RSC) on 1/24/2017 at 04:25 P.M. revealed:
-Resident #6 received Physical Therapy, Occupational Therapy, used a Rollator and received 1 on 1 sitter for three days after her falls in November 2016.
-Resident #6 was on two hour safety checks by staff when she was sent out to the hospital with a fractured right hip.
-When Resident #6 returns from Rehabilitation she would be on 15 minutes safety checks.

Refer to interview with a second Personal Care Aide (PCA) on 01/24/2017 at 02:30 P.M.

Refer to interview with a third Personal Care Aide (PCA) on 01/24/2017 at 02:35 P.M.

Refer to interview with the Assistant Living Wellness Director on 01/24/2017 at 03:05 P.M.

Refer to interview with the Resident Services Consultant on 01/24/2017 at 04:25 P.M.

Refer to interview with the Memory Care Wellness Director on 01/24/2017 at 05:10 P.M.

Refer to interview with the Administrator on 01/24/2017 at 05:50 P.M.

2.Review of Resident #3's current FL-2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 8	D 270		

12/25/2016 revealed:
-Diagnoses included Thrombocytopenia, Dementia without Behavioral Disturbance, Idiopathic Cirrhosis of Liver with Ascites and Portal Hypertension

According to the Resident Registry Resident #3 was admitted to facility on 12/22/2016.

Observation of Resident #3 on 01/19/2017 at 11:35 A.M. revealed:
-Resident #3 lying on his left side in bed next to the window with eyes closed.
-Resident #3 had a laceration on his forehead with dark purple bruising under his left eye.
-Resident #3 also had a white plastic brace on covering his torso.
-There was a floor mat next to the bed.

Interview with a Personal Care Aide (PCA) in the Special Care Unit (SCU) on 01/19/2016 at 12:00 P.M. revealed:
-Resident #3 had the most falls in the SCU.
-Staff tries to keep residents in the common area most of the time so that they can better supervise.
-Resident #3 had unsteady gait and used a wheelchair.

Review of "Resident Notes" for Resident #3 revealed:
-There was an entry on 01/01/2017 at 10:15 which stated Resident #3 was found sitting on the floor after trying to move his lamp and complained of back pain.
-There was an entry on 01/01/2017 at 06:00 A.M. which stated Resident #3 was found lying on floor on top of his covers with pillow under his head.
-There was an entry on 01/02/2017 at 09:20 A.M. which stated Resident #3 was sitting in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 9	D 270		

wheelchair when the wheelchair flipped forward and resident fell face first injuring forehead and nose.
-There was an entry on 01/05/2017 at 08:40 A.M. which stated Resident #3 was found lying on floor beside bed after trying to transfer from his wheelchair to his bed when he slipped to the floor.
-There was an entry on 01/06/2017 at 04:49 which stated Resident #3 was found lying on his floor mat beside his bed.
-There was an entry on 01/07/2017 at 10:00 P.M. which stated Resident #3 was attempting to stand up from wheelchair, lost his balance and fell forward onto right shoulder.
-There was an entry on 01/16/2017 at 06:00 A.M. which stated Resident #3 was found on floor on fall mat with covers and pillow and placed the bedside lamp on the side of fall mat.
-There was an entry on 01/17/2017 which stated Resident #3 fell and was found yelling for help.
-There was an entry on 01/19/2017 at 10:48 which stated Resident #3 was found next to bed on fall mat shortly before 15 minutes safety check was due attempting to crawl back into bed.

Review of Incident/ Accident Reports for Resident #3 revealed:
- On 01/01/2017 at 01:20 A.M. resident was found lying on floor on top of his blanket with pillow under his head.
-On 01/01/2017 at 07:15 A.M. resident was found on the floor of his room, he was trying to move his lamp and complained of back pain.
-Sent out to hospital via Emergency Medical Services (EMS).
-On 01/02/2017 at 09:20 A.M. resident was sitting in wheelchair in living room and fell forward onto the floor head first with injury to forehead and nose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 10 -Sent out to hospital via Emergency Medical Services (EMS). -On 01/05/2017 at 08:40 A.M. resident was transferring from the wheelchair to the bed when he slipped down to the floor. -On 01/06/2017 at 04:49 A.M. resident was found lying on the floor mat with pillow. -On 01/07/2017 at 04:15 P.M. resident was attempting to stand from wheelchair, became unstable and fell forward. -On 01/17/2017 at 10:00 P.M. resident was found on the floor yelling help. -On 01/17/2017 at 10:55 P.M. resident was found on the floor with his head bleeding. -Resident was sent out to the hospital. -On 01/19/2017 at 10:10 P.M. resident was found on fall mat next to his bed on 15 minutes check attempting to crawl back onto bed Review of Resident #3's Care Plans revealed: -On Care Plan dated 12/27/2016 with assessment completed by the Assistant Living Wellness Director, the resident was independent with ambulation and transferring. -On Care Plan dated 01/24/2017 with assessment completed by the Memory Care Wellness Director, the resident was totally dependent with ambulation and transfers. Review of Resident #3's hospital discharge records dated 01/17/2017 revealed: -Diagnoses for hospital visit were Spine fracture and Subdural Hematoma. -Instructed to follow-up with repeat CT scan in several weeks concerning subdural hematoma. -Appointment made for imaging on 03/03/2017 at 09:15 A.M. and to see neurosurgeon after at 09:40 A.M. -Instructed to wear Thoraco-Lumbo-Sacral Orthosis (TLSO) brace to help with L1 spine	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 11 fracture healing. Review of Resident #3's hospital discharge records dated 01/21/2017 revealed: -Diagnosis was fall. -Head CT was stable. Confidential interview with a staff revealed: -There was not enough staff to monitor residents with increased falls. -The staff member needed to give a resident a medication, but did not have any staff to monitor Resident #3, who required 15 minute checks and was constantly trying to get up out of the chair. Observation on 01/23/17 at 02:25 P.M. revealed: -The staff member had rolled Resident #3 in the wheel chair to give another resident a medication. -There was one Medication Aide and three Personal Care Aides. -The other Personal Care Aides were busy tending to residents or monitor other residents for falls. Interview with the Memory Care Wellness Director on 01/19/2017 at 12:10 P.M. revealed: -Resident #3 requires heavy care. -Resident #3 has had the most falls in the Special Care Unit (SCU). -Resident fell out of bed on 01/17/2017 at 10:00 P.M. and 10:55 P.M. was sent to the hospital and kept at the hospital for observation. -Resident #3 was sent back to facility with a brace for spine fracture to be worn for 10 weeks with instructions not to remove. -Resident was on 15 minutes safety checks with call light within reach and floor mat. -There are plans to get a hospital bed. -Resident #3 yelled for help when he wanted to get up.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 12 Interview with the Resident Services Consultant on 01/24/2017 at 04:25 P.M. revealed: -Resident #3 had a fall mat, is on 15 minutes safety checks, had Physical Therapy and uses a wheelchair. -Resident #3 did not get showers due to his brace but he did get bed baths on second shift. -To help with support he was log rolled when in bed. -Resident #3 has a follow-up appointment with his primary care physician and with neurology. Interview with the Memory Care Wellness Director on 01/24/2017 at 05:10 P.M. revealed: -Resident #3 is on 15 minutes safety checks. -His 15 minutes safety checks are on paper to make sure staff is physically going in and doing checks. -Resident #3 is doing Physical Therapy. -Facility was in the process of getting orders for hospital bed and concave mattress. -He already has a fall mat which is used when he is in bed. Refer to interview with a second Personal Care Aide (PCA) on 01/24/2017 at 02:30 P.M. Refer to interview with a third Personal Care Aide (PCA) on 01/24/2017 at 02:35 P.M. Refer to interview with the Assistant Living Wellness Director on 01/24/2017 at 03:05 P.M. Refer to interview with the Resident Services Consultant on 01/24/2017 at 04:25 P.M. Refer to interview with the Memory Care Wellness Director on 01/24/2017 at 05:10 P.M.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

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D 270	Continued From page 13 Refer to interview with the Administrator on 01/24/2017 at 05:50 P.M. 3. Review of Resident #2's current FL-2 dated 11/23/2016 revealed: -Diagnoses included Dementia and Insulin Dependent Diabetes. According to the Resident Registry Resident #2 was admitted to facility on 12/01/2015. Review of "Resident Notes" for Resident #2 revealed: -There was an entry on 09/11/2016 which stated Resident #2 was found on the floor at bedside with no complaint of pain. -There was an entry on 10/18/2016 which stated Resident #2 was found lying face down in room complaining of back and neck pain. -There was an entry on 12/05/2016 at 07:12 A.M. which stated Resident #2 was observed on floor lying on his back diagonal to bed with no complaint of pain. -There was an entry on 01/09/2017 at 09:14 A.M. which stated Resident #2 was observed to have laceration to left side of face near eye with dried blood near it and area was red and swollen. -There was an entry on 01/12/2017 at 03:35 P.M. which stated Resident #2 was discovered on the hallway floor, stated "I was sitting down, but I hit my head" and was sent out to the hospital via EMS. Review of Incident/ Accident Reports for Resident #2 revealed: -On 09/11/2016 at 01:55 A.M. resident was found lying on floor at bedside with no complaint. -On 10/18/2016 at 11:25 P.M. resident was found lying face down in room complaining of back and head pain.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

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D 270	Continued From page 14 -Sent out to hospital via Emergency Medical Services (EMS). -On 12/05/2016 at 05:40 A.M. resident was observed lying on floor on his back diagonal to bed with no apparent injury. -On 01/09/2017 at 01:45 A.M. resident was observed to have laceration to left side of face near left eye with dried blood and area red and swollen. -On 01/12/2017 at 03:25 P.M. resident was discovered on the hallway floor, stated "I was sitting down, but I hit my head" and was sent out to the hospital via EMS. Interview with the Resident Services Consultant on 01/24/2017 at 04:25 P.M. revealed Resident #2 is on two hour safety checks and is receiving Physical Therapy. Interview with the Memory Care Wellness Director on 01/24/2017 at 05:10 P.M. revealed: -Resident #2 was started on Physical Therapy. -Resident #2 did not stay in his room as much as he was before and that has helped with his falls. -Resident #2 was on one hour safety checks. Interview with Resident #2's family member on 1/24/2017 at 03:25 P.M. revealed: -Resident #2 had three falls that no one can tell her what happened. -She witnessed a number of falls of other residents due to lack of attentiveness. -She had not had any feedback as to interventions to prevent Resident #2's falls. -Physical Therapy just came to see him for the first time today. Refer to interview with a second Personal Care Aide (PCA) on 01/24/2017 at 02:30 P.M.	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 15 Refer to interview with a third Personal Care Aide (PCA) on 01/24/2017 at 02:35 P.M. Refer to interview with the Assistant Living Wellness Director on 01/24/2017 at 03:05 P.M. Refer to interview with the Resident Services Consultant on 01/24/2017 at 04:25 P.M. Refer to interview with the Memory Care Wellness Director on 01/24/2017 at 05:10 P.M. Refer to interview with the Administrator on 01/24/2017 at 05:50 P.M. _____ Interview with a second Personal Care Aide on 01/24/2017 at 02:30 P.M. revealed: -When a resident falls they are placed on 15 or 30 minutes safety checks. -They sometimes get a fall mat or hip protectors. -All staff participate in doing the 15 minutes safety checks. -The main safety check would be done by the staff assigned to that resident and documented in the computer. Interview with a third Personal Care Aide on 01/24/2017 at 02:35 P.M. revealed: -I tell the MA when a resident has had a fall. -That resident was placed in the "Hot Box". -Vital signs are checked for three days. -The resident is placed on every 30 or 15 minutes safety checks. -Usually a floor mat was placed next to the resident's bed. Interview with the Assistant Living Wellness Director on 01/24/2017 at 03:05 P.M. revealed:	D 270		

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D 270	Continued From page 16 -When a resident falls, the family member, the doctor are notified and documented in the record. -The resident is sent out if they have a bleed that won't stop or if they hit their head. -When a resident comes back to the facility after a fall, staff documents in the record, vital signs and how the resident day is for three days. -If resident had injuries then staff does safety checks every 15minutes, 30 minutes or hourly for 1-2 weeks. -Resident is made a follow-up appointment to see doctor. Interview with the Resident Services Consultant on 01/24/2017 at 04:25 P.M. revealed that the facility treats each resident's fall individually. Interview with the Memory Care Wellness Director on 01/24/2017 at 05:10 P.M. revealed: -The doctor has to sign off on Incident Reports. -If resident hits their head they are sent out to the hospital. -When resident returns to the facility and different interventions are put in place such as 15 minutes, 30 minutes or hourly safety checks. Interview with the Administrator on 1/24/2017 at 05:50 P.M. revealed: -The facility does not have a written falls policy. -The interventions are individualized per resident. -"I expect that staff will do the safety checks to prevent falls." -"I was aware of the increase in falls in the Special Care Unit (SCU)." -Every morning we all get a report during "standup". -He did not know the reason for the increase in falls in the SCU.	D 270		

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D 270	Continued From page 17 4. Review of Resident #4's current FL-2 dated 11/26/16 revealed: -The resident's current diagnoses included Dementia, Anxiety Disorder, Alzheimer's Disease and Osteoarthritis. -The resident was intermittently disoriented, wandered and semi ambulatory. -The resident was incontinent with bladder and continent with bowel. -There was an order for physical therapy, occupational therapy and skill nursing home health to assess the resident. -The current level of care was Domiciliary and the recommended level of care was the Special Care Unit (SCU). Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 2/1/16. Review of Resident #4's current Care Plan dated 11/30/16 revealed: -The resident had a significant change. -The resident required limited assistance with toileting, ambulation and transferring. -The resident ambulated using a walker. -The resident was considered fall risk. -The resident received physical therapy and occupational therapy on Tuesdays and Fridays. -The resident received skilled nursing and home health on Tuesdays and Fridays. Review of Resident #4's prior Care Plan dated 3/23/16 revealed: -The resident was independent with toileting and transferring. -The resident required supervision with ambulation. -The resident ambulated using a walker.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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CHATHAM RIDGE ASSISTED LIVING	114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517

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D 270	Continued From page 18 -The resident received physical therapy and occupational therapy on Tuesdays and Fridays. -The resident moved from the special care unit to the assisted living on 3/10/16. -The resident was a falls risk. Review of Resident #4's current Licensed Health Professional Support (LHPS) review dated 11/28/16 revealed: -The LHPS tasks reviewed included physical therapy, transfers and ambulation. -Staff was to toilet resident every two hours. -The resident walked independently with the walker. -Staff were to supervise and "offer assistance on direction if necessary." -Staff was to assist the resident with transfers. -The resident had an order for physical therapy. Resident #4 had a total of 12 documented falls from 8/7/16 to 1/17/17. A fall on 1/4/17 resulted in a fractured left radius and a fall on 1/17/17 resulted in a fractured left hip. Review of Resident #4's progress notes, entry dated 8/7/16 at 4:15 a.m. by a Supervisor revealed: -The resident's roommate "came to the Wellness Center and stated Resident #4 was on the floor. -The roommate said the resident "fell against the dresser." -Resident #4 did not know what had happened. The resident said she did not hit her head. -The resident's vital signs were within normal range. -Resident #4's Primary Care Physician (PCP) and Power of Attorney (POA) were notified. -Staff would continue to monitor the resident for falls.	D 270		

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

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D 270	Continued From page 19	D 270		

Review of Resident #4's progress notes revealed:
-An entry dated 8/10/16 at 6:45 p.m. by a Supervisor revealed the resident complained of right hip pain. The resident's PCP was notified.
-An entry dated 8/10/16 at 7:00 p.m. by a Supervisor revealed a physician, who responded to the notification of Resident #4's complaint of right hip pain and who worked with Resident #4's PCP, called and said he would send a note to the resident's PCP to evaluate the resident.
-An entry dated 8/11/16 at 7:00 a.m. by a Medication Aide (MA) revealed the resident complained of right hip pain and abdomen pain. The resident's PCP was notified.

Review of Resident #4's incident report dated 9/13/16 revealed:
-At 9:00 p.m., the resident was found conscious sitting on the floor. The resident stated she hit her head.
-The resident's blood pressure was 160/90. The rest of the vital signs were within normal range.
-The resident's PCP and POA were notified.
-The resident was taken to the local hospital by the Emergency Medical Services (EMS).

Review of Resident #4's progress notes revealed:
-An entry dated 9/13/16 at 9:00 p.m. by a Supervisor revealed the resident was very confused when she hit her head.
-An entry dated 9/14/16 at 7:25 a.m. by a MA revealed the resident returned from the hospital. There was no new orders.

Review of Resident #4's local hospital discharge summary dated 9/13/16 revealed:
-The resident was seen due to a fall and nonintractable headache, unspecified chronicity pattern and headache type."
-The resident did not have any injuries.

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D 270	Continued From page 20 -Follow-up with the PCP as soon as possible. -A note was written on the discharge summary the resident has an appointment with the PCP on 9/21/16. Interview with a Medication Aide (MA) on 1/20/17 at 4:43 p.m. revealed: -She worked mainly in the Assisted Living (AL). -If a resident had a fall, she checked the resident for injuries, took the resident's vital signs, called the POA, PCP or hospice and documented in the resident's record. -If a resident had an injury and had to get sent to the hospital, she got the paperwork (MARs, insurance information) to be sent with the resident when EMS arrived at the facility to pick up the resident. -When the resident returned from the hospital, the MA would take the resident's vital signs every shift and document it in the shift notes. Staff documented and monitored the resident every 30 minutes to two hours. -If a resident had a non-injurious fall, staff followed the same procedure, but monitored the resident every hour for three days and reminded the resident to use the call bell. -Resident #4 was found sitting on the floor on 9/13/16. -The resident did not complain of hitting her head. -The resident was sent out to the hospital. -When the resident came back from the hospital, staff took the resident's vital signs, monitored the resident every one to two hours for three days. -Then staff monitored Resident #4 every two hours. -Before the fall (9/13/16), staff routinely monitored the resident every two hours. Telephone interview with a second MA on 1/21/17 at 2:24 a.m. revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 21 -He worked all shifts as a MA in the assisted living and SCU. -He mainly worked in the assisted living. -If a resident had a fall that resulted in an injury, he took the resident's vital signs, checked the resident for skin tears, notified the resident's POA and the Administrator and get the resident's paperwork prepared for EMS. -When the resident returned from the hospital, the resident's record was placed in the hot box and he monitored the resident for 3 days. During this time, the MA's took the resident vital signs every shift, documented how the resident had done during that shift, checked the resident every 15 minutes and documented the checks. -The 15 minute checks lasted until the Director ordered them to stop the checks. -When staff monitored the resident, at night staff made sure the resident was not on the floor and was in the bed. During the day, staff made sure the resident was in the chair. -The residents in SCU are routinely monitored every two hours. -Staff make sure the residents in SCU are in the bed, the floor mats are on the floor and staff checked incontinent care. -Resident #4 had a fall September 2016 on either first or second shift in her room, when she was living in the AL. -He did not know the date of the fall. -He assessed the resident and she was not hurt. -The resident's legs were weak, which could have caused the fall, and the resident was using her walker. -Before and after the fall staff monitored the resident every two hours. Review of Resident #4's record revealed: -The resident was seen by the PCP on 9/27/16. -The PCP revealed medications were reviewed	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 22	D 270		

with changes.
-The resident was seen by the PCP on 10/26/16. The resident had no signs of injury. The resident was being treated by PT for gait dysfunction. The resident had leg pain.

Review of Resident #4's record revealed:
-There was an order dated 9/16/16 for the resident to be evaluated by physical therapy (PT) for fall and gait dysfunction.
-There was an order dated 9/22/16 and 11/8/16 for the resident to be evaluated and treated by PT.
-The resident had been seen by PT from 2/12/16 to 10/23/16.
-The resident was discharged from PT on 6/1/16, but restarted PT on 9/21/16 to 10/27/16, due to falls.
-There was an order dated 12/7/16 for PT to evaluate the resident and treat.
-PT was restarted from 12/14/16 to 1/13/17. There was an attempted visit on 1/18/17, but the resident was hospitalized.
-There was an order dated 9/28/16 for the resident to be evaluated and treated by occupational therapy (OT) due to weakness and age related debility.
-The resident had been seen by OT from 2/12/16 to 2/23/16 and on 4/29/16.

Telephone interview with the PT Supervisor on 1/24/17 at 2:33 p.m. revealed:
-PT was ordered on 11/23/16 for falls prevention and gait training and there was an order on 11/28/16 for PT to evaluate the resident and treat.
-Resident #4 had received PT from the company since 11/29/16 twice a week for five weeks.
-PT was restarted on 12/27/16 for once a week for one week and twice a week for two weeks.
-She did not see any recommendations for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

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D 270	Continued From page 23	D 270		

special walker.
-The PT recommendations on 1/17/17 revealed the resident could do transfers with assistance and to keep the resident's rolling walker near her.
-The resident was evaluated by OT on 12/1/16.

Review of Resident #4's progress notes entry dated 10/29/16 (no time) by a MA revealed:
-The resident was found sitting on the floor.
-The resident said she was trying to go to the bathroom. The resident did not complain of any pain.
-The resident's vital signs were taken and was within the normal range.
-The resident's PCP and POA were notified.

Review of Resident #4's incident report dated 11/3/16 revealed:
-At 4:00 a.m., staff heard the resident calling for help. The resident was alert and oriented and stated she was trying to go to the bathroom. The resident had abrasions on the right side of head above the eye brow, an abrasion on the right shoulder and three abrasions on the right hand knuckles.
-The resident had used a walker.
-The resident's blood pressure was 154/90. The rest of the vital signs were within normal range.
-The resident's PCP and POA were notified.
-The resident was sent out to the local hospital on 11/3/16 (no time) by the local EMS.

Review of Resident #4's the progress notes revealed:
-An entry dated 11/3/16 at 4:52 a.m. by a Supervisor revealed the resident was making unclear statements. The resident requested to go to the bathroom. When EMS arrived, the resident's blood pressure was 200/90.
-An entry dated 11/5/16 at 1:00 p.m. revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 24	D 270		

resident returned back to the facility by a family member. The resident was "extremely weak and drowsy."

Review of Resident #4's local hospital discharge summary dated 11/3/16 revealed:
-The resident was admitted to the hospital on 11/3/16.
-The resident's "principal problem" was altered mental status.
-The resident was found the morning of 11/4/16 with an abrasion on her forehead and a right hand injury.
-Continue the physical therapy to assist with gait.
-The resident was discharged from the hospital on 11/5/16.

Telephone interview with a Personal Care Aide (PCA) on 1/21/17 at 2:50 a.m. revealed:
-She only worked third shift.
-She mainly worked in the AL, but she worked in the SCU when needed.
-If a resident had a fall, she would get the MA and check the resident for injuries.
-If he resident had an injury, she would stay with the resident until the MA had gotten the paperwork prepared for EMS. Then she would go to the front of the facility and watch for EMS and lead them to the resident who had fallen.
-When Resident #4 lived in the AL, the resident was independent and staff monitored her every two hours for incontinent care.
-The resident had a fall in the AL on 11/3/16 at 4:00 a.m.
-The PCA heard someone calling for help, while she was doing rounds on her assigned hall.
-She went to go and check on the resident and saw the resident was sitting on her bottom at the foot of the bed between her bed and her roommate's bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 25	D 270		

-The resident had a skin tear on her forehead and hand. She could not remember any other injuries.
-She went and got the MA and EMS was called.
-The resident had gotten up to go to the bathroom and her legs "gave out."
-When Resident #4 returned from the hospital, staff monitored her every hour to one and a half hours.
-She did not know if the resident had PT or not.
-She was not assigned to the resident when the resident had the fall.
-The PCA, who was assigned to the resident, no longer worked at the facility.
-When Resident #4 lived in the AL and SCU, the resident always had a regular bed (no low bed, no concave mattress).
-When the resident moved to the SCU the resident had a fall mat (November 2016).

Review of Resident #4's PCP's Visit Summary dated 11/17/16 revealed:
-The resident was seen by the PCP for gait instability and recent fall.
-"The patient was at high risk for falls given her dementia and multiple comorbidities."
-The PCP reordered PT.
-"Monitor her recovery now that several medications have been stopped."

Review of Resident #4's incident report dated 11/23/16 revealed:
-At 3:30 p.m., the resident was found alert and oriented sitting on the floor in the bathroom. The resident had a cut on the left side of her head.
-The resident's vital signs were not taken.
-The resident's PCP and POA were notified.
-The resident was taken to the local hospital on 11/23/16 by EMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 26	D 270		

Review of Resident #4's progress notes revealed:
-An entry dated 11/23/16 at 3:30 p.m. by a MA revealed the resident was bleeding from a cut on her head.
-An entry dated 11/26/16 at 7:27 a.m. by the Special Care Unit Coordinator (SCUC) revealed the resident moved to the SCU. There was an order for a urinalysis (UA) and a urine culture and sensitivity.

Review of Resident #4's physicians' orders revealed there was an order dated 11/24/16 for a UA, which was completed on 11/30/16 and resulted negative for a yeast infection.

Review of Resident #4's PCP's Visit Summary revealed:
-The resident was seen by the PCP on 11/24/16 and there were no changes in medications.
-The resident was seen by the PCP on 12/7/16 there were no changes in medications. The resident was to continue PT. The PCP "will review medication list and reduce risk factors for falls as able."

Observation of Resident #4's room on 1/23/17 at 11:00 a.m. revealed:
-Upon entrance to the resident's room, the bathroom was on the right side of the room.
-The door to the bathroom opened all the way to the wall by the entrance of the room.
-The resident's roommate twin size bed was on the right side of the room.
-The head of the resident's twin size bed was on the left side of the window.
-The left side of the bed was by the wall.
-There was no fall mat by the resident's bed and the resident did not have a concave mattress.

Interview with a MA on 1/20/17 at 4:43 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 27	D 270		

revealed:
-Resident #4 had a fall in either October 2016 or November 2016 on second shift before dinner.
-The MA was working at the facility the day of the fall.
-The day of the fall, the resident had a confused day.
-The resident was found in her room in front of the bathroom coming out of the bathroom.
-The fall was non injurious.
-The POA and PCP was called and staff monitored the resident every one to two hours for three days.
-Before the fall, staff monitored the resident every two hours.
-She was unsure if anything was implemented for the resident after the falls.

Review of Resident #4's progress notes an entry dated 12/12/16 by a Supervisor at 6:40 p.m. revealed:
-The resident was observed lying on the floor in her room by a PCA "around 6:00 p.m."
-The PCA helped the resident to sit on the floor and informed the MA.
-The resident was assisted to the bathroom.
-The resident stated, "her legs went from underneath her while she was getting up from bed."
-The resident complained of knee pain.
-Staff sat the resident in a chair and the resident did not complain of any more pain.
-The resident's blood pressure was 150/95 and the rest of the vital signs were within normal range.

Review of Resident #4's incident report dated 12/18/16 revealed:
-At 12:50 p.m., the resident had gotten up from the toilet, was walking out of the bathroom and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 28	D 270		

lost her balance. The resident fell against the wall and fell to the floor. She complained of left side lower back pain. The resident had used her walker.
-The resident's vital signs were within normal range.
-The resident's PCP and POA were notified.
-The Resident was taken to the local hospital by EMS on 12/18/16 at 1:07 p.m.

Review of Resident #4's progress notes entry dated 12/18/16 at 12:42 p.m. by a MA revealed:
-The resident was found on the right side of the commode by an aide, who was doing rounds.
-The resident stated "she was getting up from the toilet, walking out of the bathroom when the front wheels on her walker hit her cabinet and it threw her balance off."
-The resident complained the left back side of her head was hurting from hitting the metal rail and her back was hurting from hitting the floor.

Review of Resident #4's progress notes entry dated 12/18/16 at 11:30 p.m. revealed the resident returned back to the facility from the hospital.

Review of the local hospital discharge summary dated 12/18/16 revealed:
-The resident was seen at the Emergency Room (ER) due to a fall.
-The "CT" scan was negative for bleeding or fractures.
-Follow-up with the primary care physician in the next week for re-evaluation.

Review of Resident #4's incident report dated 12/22/16 revealed:
-At 5:15 a.m., staff heard a loud noise in the resident's room. The resident was found alert

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 29	D 270		

and conscious sitting in a corner near the first closet door. The resident's walker laying in front of her on the floor.
-The resident's vital signs were within normal range.
-The resident's PCP and POA were notified.
-The resident was taken to the local hospital on 12/22/16 at 6:00 a.m. by EMS.

Review of Resident #4's progress notes entry dated 12/22/16 at 7:08 a.m. by a Supervisor revealed:
-The MA and PCA was standing in the hallway near the clean linen room and hear a loud noise.
-At 5:15 a.m., the MA and PCA observed the resident sitting on the floor with her head and back against the wall and the walker laid in front of her legs.
-"It is unclear what happened."
-The resident stated, "I thought I left the light on in the kitchen."

Review of Resident #4's progress notes entry dated 12/22/16 at 11:00 a.m. by a MA revealed:
-The resident returned back to the facility.
-The resident ate lunch, was toileted and laid down to rest.

Review of Resident #4's local hospital discharge summary dated 12/22/16 revealed:
-The resident did not have any injuries.
-There were no follow-up recommendation appointments.

Interview with a second PCA on 1/21/17 at 1:55 a.m. revealed:
-She worked second and third shifts at the facility as a PCA.
-If a resident had a fall, she would get the MA, take the resident's vital signs and stay with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 30	D 270		

resident until the MA evaluated the resident.
-If the resident was bleeding, the blood pressure dropped or the resident hit the head, the resident would get sent out to the local hospital.
-If a resident was sent out to the hospital when the resident came back from the hospital, staff monitored the resident every 15 minutes for 3 days to make sure the resident was safe in the bed or chair. Staff documented the monitoring on a log
-After monitoring the resident every 15 minutes for 3 days, the resident was re-evaluated to determine if the resident can be evaluated every hour.
-Resident #4's room was located close to the nurse's station.
-Sometimes Resident #4 went to the bathroom independently and sometimes she would use the call bell and request for staff to assist her to the bathroom.
-On 12/22/16, she and other staff (PCA, MA) heard a loud noise, which sounded like a fall, coming from the resident's room.
-The resident was found in front of her bathroom door and the bedroom door in her room.
-The MA had taken the resident's vital signs and the resident was sent out to the local hospital.
-Resident #4 had not returned from the local hospital by the end of her shift.
-Before the fall, she had last seen Resident #4 between 3:00 a.m. and 3:30 a.m., while she was doing rounds and the resident was sleep.
-Before and after the fall, staff had been monitoring the resident every two hours.

Review of Resident #4's PCP's Visit Summary dated 12/26/16 revealed:
-The resident was seen by the PCP due to a recent fall and gait dysfunction.
-The resident "had no signs of new skin tears or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 31	D 270		

orthopedic injuries."
-The PCP reviewed the hospital records and will continue working on reducing falls risks, "which include poor vision, medications, heart rhythm abnormalities and providing a safe living environment."
-The resident was seen with no changes in therapy, medications or new medication orders, even though the POA had a concern about the resident's increased tiredness.

Review of Resident #4's PCP's Visit Summary dated 1/1/17 revealed:
-The resident was seen by the PCP due to a recent fall and gait dysfunction.
-The resident showed no signs of new skin tears or orthopedic injuries.
-The PCP will continue working on falls reductions.
-There was no changes in the resident's current therapy, medications or new medication orders.
-There was an order for a concave mattress and falls mat.

Review of Resident #4's incident report dated 1/4/17 revealed:
-At 4:29 a.m., the resident was observed lying on her back in the middle of the floor. The rollator had overturned. The resident complained of pain in her back and left wrist. The left wrist was swollen.
-The resident's temperature and pulse were within normal range. The respirations were 21. A blood pressure reading was unable to be taken, because of how the resident was lying on the floor.
-The resident's PCP and POA were notified.
-The resident was sent out to the local hospital on 1/4/17 at 5:00 a.m. by EMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 32	D 270		

Review of Resident #4's progress notes revealed:
-An entry dated 1/4/17 at 6:28 a.m. by a Supervisor revealed the resident remained on her left side until EMS came to get the resident.
-An entry dated 1/4/17 at 10:40 a.m. by a MA revealed the local hospital called and stated the resident would return back to the facility with a cast on the left arm. "The resident is going to need extensive care and constant checks for safety."
-An entry dated 1/5/17 at 10:20 p.m. by a Supervisor revealed the resident returned back to the facility at 4:30 p.m. by the POA.

Review of Resident #4's local hospital discharge summary dated 1/5/17 revealed:
-The resident was admitted to the hospital on 1/4/17.
-There was a new thoracic vertebrae 10 (T10) compression fracture and a left distal radius fracture.
-The Radiologist findings revealed the thoracic spine had diffused osteopenia.
-The resident did not have any bleeding to the head.
-The resident's medications were reviewed and there was no indication the medications contributed to the fall.
-The resident was discharged from the hospital on 1/5/17.

Telephone interview with a MA on 1/21/17 at 2:24 a.m. revealed:
-Resident #4 had a fractured wrist. He was not scheduled to work at the facility when the resident had the fractured wrist nor could he remember when the resident had broken her wrist.
-When Resident #4 came from the hospital from the broken wrist, she was wearing an ace bandage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 33 -Staff continued to monitor her every hour. Interview with a third MA/PCA on 1/23/17 at 4:46 p.m. revealed: -She worked second shift, but "every now and then" she worked third shift. -Resident #4 had a lot of unwitnessed falls. -After the resident had broken her wrist, staff monitored the resident every thirty minutes for two weeks, when she was in her room they clipped her call bell on her so that it could alarm if she walked so many feet from her bed. -Staff never had to do 30 minute checks on the resident until she had broken her wrist. -The resident wore a call bell in the bed. Sometimes the resident took the call bell off. -Before the resident had gone in the hospital, staff monitored the resident every two hours. -When the resident laid down in her bed, staff pulled out the fall mat for the resident. Telephone interview with a fourth MA on 1/24/17 at 11:28 a.m. revealed: -When Resident #4 had the fall on 1/4/17 at 4:29 a.m., she worked as the MA in the SCU during that shift. -About six weeks ago, she and other staff heard the resident's roommate yelling for help. -Resident #4 was trying to help the roommate and Resident #4 fell. -Resident #4 was found lying on her back in front of her dresser. -She assessed the resident and the resident had swelling and pain in her left wrist. -She contacted the residents POA and Manager. -EMS came to the facility to take the resident to a local hospital. -When the resident came back from the hospital, the resident had a fractured wrist and staff continued to monitor the resident every hour for	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 34	D 270		

toileting.
-The resident's wrist was wrapped with two pieces of plastic and an ace bandage.
-Sometimes the resident removed the wrap from her wrist.

Telephone interview with a third PCA on 1/24/17 fat 12:27 p.m. revealed:
-He worked third shift in the SCU.
-When he was doing rounds on 1/4/17 at 3:40 a.m., he found Resident #4 lying in the middle of the floor, near her dresser, between her closet door and away from the floor mat.
-He had last seen her around 2:00 a.m.
-The resident's walker was in front of her.
-They encouraged the resident to stay on the floor until the MA came to evaluate the resident.
-After the MA evaluated the resident, the resident had a swollen wrist and was sent to the hospital.
-Before the fall, the resident was on two hour checks.
-When the resident came back from the hospital, the resident was placed on 15 minute checks by the MA for a couple of weeks, hourly checks for one week and then two hour checks.

Review of Resident #4's incident report dated 1/6/17 revealed:
-At 2:20 a.m., the resident was found conscious on the floor on the floor mat. The resident had tried to go to the bathroom alone.
-The resident did not have any "apparent" injuries.
-The resident's blood pressure was 138/88. The rest of the vital signs were within normal range.
-The resident's PCP and POA were notified.
-There was not documentation of the resident going to the hospital.

Review of Resident #4's progress notes entry

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 35	D 270		

dated 1/6/17 at 2:30 (a.m. or p.m. not documented) revealed:
-At 2:30 a.m., the resident was found on the floor by a PCA.
-The resident "had taken the call light off her shirt and tried to go to the bathroom."
-The resident slid and had laid on the floor mat.
-There were no injuries.

Review of Resident #4's incident Report dated 1/16/17 revealed:
-At 6:00 a.m., the resident was found laid on her back on a floor mat, which was by her bed.
-The resident did not have any "apparent" injuries.
-The resident's blood pressure was 138/78. The rest of the vital signs was within normal range.
-The resident's PCP and family member were notified.
-There was no documentation of the resident going to the hospital.

Telephone interview with a PCA on 1/21/17 at 1:55 a.m. revealed:
-On 1/16/17 at 6:00 a.m., while she was doing her rounds, she found Resident #4 on the fall mat by her roommate's bed. Staff thought the resident's roommate was trying to help her. She had last seen the resident 1 to 2 hours prior to finding the resident on the floor and the resident was sleep in bed.
-After Resident #4's fall, she could not remember if the monitoring had changed with the resident.

Review of Resident #4's Incident Report dated 1/17/17 revealed:
-At 7:45 p.m., the Resident was coming from the bathroom and fell going to bed after trying to close the door.
-The resident was conscious.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 36	D 270		

-The resident did not have any "apparent" injuries.
-The resident's temperature, pulse and respirations was within the normal range. Not applicable was written beside the resident's blood pressure, pulse and respirations.
-The resident's PCP and POA were notified.
-At 8:00 p.m., the resident was taken to the hospital by EMS.

Interview with a Supervisor/MA on 1/23/17 at 4:20 p.m. revealed:
-She worked second shift in the AL.
-On 1/17/17 at 7:00 p.m., she was passing out medications to residents when staff told her Resident #4 had fallen.
-She went to go and check on the resident for injuries.
-While assessing the resident, she did not want anyone to touch her left hip. The resident yelled and had looked like she was in a lot of pain.
-The resident was found in her room between the bathroom door and the entrance door.
-The resident was lying on her back.
-The Supervisor tried to take the resident's vital signs, but she could not because the resident was moving a lot.
-She contacted the resident's POA, PCP and called EMS.
-She did not know how often the aids monitored the resident.

Interview with a MA/PCA on 1/23/17 at 4:46 p.m. revealed:
-On 1/17/17 between 9:30 p.m. and 9:45 p.m., she was at the nurses' station and she heard a loud "bang" coming from the Resident #4's room.
-She went to go and check on the resident. The resident was lying on her back by the bathroom door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019021	A. BUILDING: _____ B. WING _____	C 01/24/2017

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

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D 270	Continued From page 37 -The resident complained her back was hurting and she was rubbing her left hip. -The POA, PCP and EMS were called and the resident went to the hospital and had not returned as of 1/23/17. -She worked as a MA the day of the fall and she did not know who was assigned to the resident the day of the fall. Review of Resident #4's local hospital summary dated 1/17/17 revealed: -The resident will be admitted to the hospital on 1/17/17. -The final diagnoses revealed the resident had a closed left hip fracture. -The left leg was "notably shortened and externally rotated." -The resident was ambulatory with a walker at baseline, but was "unable to bear weight or ambulate since fall." -The Radiologist findings of the X-ray dated 1/17/17 revealed the resident had osteopenia, with "left transcervical femoral neck fracture with mild proximal and posterior displacement." There was no dislocation. -The assessment and plan section revealed the resident would have an operation to fix the left hip. -The resident had a closed reduction percutaneous pinning (CRPP) on 1/18/17. -The splint will be replaced on the resident's left wrist, because the resident removed the splint. -Review of the clinical impression from the X-ray dated 1/18/17 revealed there was an X-ray of the left distal radius on 1/4/17. The "left distal radius fracture was "unchanged." There was "mild subchondral sclerosis around the carpal bones." The bones are "osteopenic." -The resident was discharged from the hospital on 1/20/17 to a local rehabilitation center.	D 270		

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D 270	Continued From page 38 Review of Resident #4's progress notes revealed: -An entry dated 1/18/17 at 2:15 p.m. by a MA revealed the local hospital's nurse, stated the resident was admitted to the hospital and the resident had a fractured left wrist and left hip. The left wrist was in a splint and the resident was currently in surgery. -An entry dated 1/21/17 at 10:15 a.m. by the facility's nurse revealed the residents POA came to the facility to get the resident's belongings. The POA revealed the resident's surgery "went well" and the hip was repaired with "plates and screws only with a small incision.." The resident had gone to a local rehabilitation center on 1/20/17. Telephone interview with Resident #4's POA on 1/24/17 at 9:20 a.m. revealed: -She was the resident's POA. -When the resident was first admitted to the facility, she was in the SCU. One month later she was evaluated and moved to the AL. Two months (November 2016) ago, she was transferred back to the SCU for safety reasons. -The resident had broken her wrist 1/4/17, due to a fall. -When the resident had broken her wrist the local hospital physician revealed the resident also had a fractured spine, but they could not determine if it was a new fracture or an old fracture. -Before the resident had broken her wrist, she walked independently to and from the bathroom. -The resident had received the new walker to help the resident ambulate, because of the fall on 1/4/17 when the resident had broken her wrist. -The POA had spoken with the SCUC around 12/17/16 to request a hospital bed, but the resident did not have the bed. -The resident had a fall on 1/17/17, which	D 270		

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D 270	Continued From page 39	D 270		

resulted in a hip fracture.
-When the resident was in the hospital from the fall on 1/17/17, she had a cast on her left arm even though she had taken it off and had taken the splint off.
-The resident did not reinjure the wrist from the fall on 1/17/17.
-Staff checked the resident every two hours at night and was supposed to make sure the resident had an alarm attached to her.
-The resident had been seen by PT.
-Before the fall on 1/17/17, the POA had last seen the resident on 1/10/17.
-When she saw the resident on 1/10/17, the resident was walking with a shuffle, because the resident was using a new walker.
-The resident had an order for a concave mattress and a fall mat, but she did not want the resident to use it, because the resident had slipped on the mat either going or coming from the bathroom.
-The resident had not fell out of bed. She mainly fell as she is ambulating to and from the bathroom.
-The resident had not had any other fractures since she had been living at the facility.
-She had been in constant communication with the resident's PCP since the resident had been at the facility, which included ways of trying to prevent the resident's falls.
-Many of the resident's medications had been adjusted.
-The resident was currently at a local rehabilitation center recovering from the surgery.

Interview with a fifth MA on 1/24/17 at 11:04 a.m. revealed:
-Staff checked on the residents in the AL every two hours.
-When they checked on the resident, they looked

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D 270	Continued From page 40	D 270		

to make sure the resident did not need anything and was doing fine.

Interview with the Wellness Director on 1/24/17 at 3:04 p.m. revealed:
-When Resident #4 was first admitted to the facility, the resident first live in the SCU, transferred to the AL and then back to SCU.
-She did not know how long Resident #4 had initially lived in the SCU before transferring to the AL.
-When the resident lived in the AL, at night the resident's legs would hurt. So staff would give her Gabapentin to help with the pain. The Gabapentin did not help with the leg pain.
-The staff did safety checks on Resident #4, but she was not sure how often.
-The resident received PT/OT while living in the AL. She did not know when the PT/OT started.
-The resident started declining the end of October 2016 or the beginning of November 2016.
-When a resident had a fall staff contacted the POA and PCP, complete incident report and document in the resident's record.
-If the resident had an injury, was bleeding uncontrollably, had a skin tear on the face and was in pain from a fall, the resident would get sent out to a local hospital.
-When the resident returned from hospital, the resident was assessed by a Supervisor and the Supervisor documented in the record.
-If the resident had an injurious fall, the resident was placed on 15 min to two hour checks depending on the status of the resident.

Interview with the SCUC on 1/24/17 at 5:07 p.m. revealed:
-If a resident fell and hit their head, the resident was sent out to the hospital. When the resident came back from the hospital, interventions may

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D 270	Continued From page 41 have been put in place such as a fall mat and talking with the family to see what could be done to decrease the falls to the resident. -Resident #4 had gotten up out of bed and sometimes pressed the call bell. -Resident #4 received a fall mat December 2016, due to falls. -The resident had a fall on 1/4/17, during third shift and fractured her wrist. She was unsure, the time of the fall. -When Resident #4 had returned from the hospital to the facility, The SCUC had planned to set up a meeting with the POA to see what could be done to prevent the falls, but the meeting had never taken place. -After the fall on 1/4/17, Staff did hourly checks with the resident instead of two hour checks until 1/17/17. -Resident #4 received PT after the fall, but she did not know what else was put in place for the resident. -Since 1/4/17, the resident had a call light attached to her, which she pulled out of the wall during the last two falls. -The POA did not want the resident to have a concave mattress or a hospital bed. The resident never received a concave mattress. -The last fall the resident had the SCUC was working at the facility. -The fall happened at 7:00 p.m. -She assessed the resident and the MA got the insurance information and face sheet. -The resident was sent out to the local hospital. Interview with the Resident Services Consultant on 1/24/17 at 4:40 p.m. revealed: -She was responsible for the clinical care in the AL and the SCU. -She worked at the facility two to three days weekly.	D 270		

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D 270	Continued From page 42 -If a resident had a fall, the resident's fall history, medications, and therapy would be evaluated. -When Resident #4 had a fall, she received a fall mat, therapy services and safety checks. -The resident was receiving PT and OT when the resident had fractured her wrist. After the resident fractured her wrist she was wearing a cast and the resident received a modified walker for her cast. -The falls in the SCU have increased with the past month. She cannot identify why the falls have increased. -They have enough staff to meet the needs of the residents. -If a resident was on 15 minute safety checks, more staff was added to the schedule to assist with supervision for the resident. Interview with the Administrator on 1/24/17 at 5:50 p.m. revealed: -His expectation was for staff to do whatever they had to do to take care of the residents. -The Wellness Director was responsible for monitoring falls and putting preventive measures in place. -Some residents require more frequent monitoring than others. -He was aware of the increased falls for residents in the SCU, because he received a report from the clinical staff every morning in "stand up." Telephone interview with Resident #4's PCP on 1/25/17 at 12:01 p.m. revealed: -Resident #4 has advanced dementia. -He was aware of Resident #4's falls at the facility. -He was aware of the resident's fractured wrist and hip. -The resident received PT. -He was unsure if the resident had a hospital bed	D 270		

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D 270	Continued From page 43 or fall mat. -He had been constantly reviewing and adjusting Resident #4's medications. -Resident #4 did not require any special monitoring. -He did not have a problem with staff monitoring the resident every 30 minutes to every two hours. -The resident went to the bathroom independently. -He does not know if the resident had a chair alarm. -The Resident #4 mainly fell when she was going to the bathroom. -He does not know of anything else he could have done to prevent the resident's fall. -If the resident had a sitter, she would need a "round the clock sitter." -A "round the clock sitter" was something he had not recommended. -The facility met Resident #4's need. -If the resident returned from the hospital and could not bear weight on her hip, the facility could not meet the resident's needs and the resident would need to go to a higher level of care. -If the resident was wheel chair bound, the facility could meet the Resident #4's needs. _____ The facilities failure to increase supervision for 4 out of 4 residents (#2, #3, #4, and #6) who were identified as high falls risk and resided on the Special Care Unit resulted in Resident #4 and #6 sustaining hip fractures and Resident #3 and #2 sustaining physical injuries. This failure to provide supervision was in accordance to the residents' current symptoms and assessed needs. This failure of the facility to provide supervision for the safety and well-being of the resident resulted in substantial risk of serious physical harm and neglect which constitutes a	D 270		

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D 270	Continued From page 44 Type A2 Violation. The facility submitted a Plan of Protection dated 1/24/17, as follows: -The residents in the Special Care Unit (SCU) identified as potential fall risk will be identified. -The facility's nurse will train staff on residents who are falls risks in SCU. -The training will start on 1/25/17 and will continue until all staff are trained. -The training will be completed within 30 days. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 23, 2017	D 270		
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 observations, interviews and record reviews, the facility failed to assure all residents were free from neglect related to supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to assure they provided adequate supervision for 4 of 4 residents (#2, #3, #4 and #6) who had falls which resulted in injuries. [Refer to Tag D 270 10A NCAC 13F .0901(b) Personal Care and Supervision. (Type A2 Violation)]	D914		

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