Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: _____ B. WING _____	04/03/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Durham County Department of Social Services conducted an annual survey from 04/01/25 to 04/03/25.	D 000		
D 091	10A NCAC 13F .0306 (b)(5)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one chair that is comfortable as preferred by the resident, which may include a rocking or straight chair, with or without arms, that is high enough for the resident to easily rise without discomfort; (6) additional chairs available, as needed, for use by visitors; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a comfortable chair for each resident in 13 of 15 resident rooms on the 100 hall. The findings are: Observation of occupied resident rooms on 04/01/25 at 9:33am and 10:30am revealed: -Room #101 had one bed and no chair. -Room #102 had two beds and no chairs. -Room #103 had two beds and one chair.	D 091	Please see attachment	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kenneth Jones | Administrator | 5/14/25

Reviewed and Acknowledged K.M. 05/19/25

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D 091	Continued From page 1 -Room #104 had two beds and no chairs. -Room #107 had two beds and one chair. -Room #109 had two beds and no chairs. -Room #110 had two beds and one chair. -Room #111 had two beds and no chairs. -Room #112 had two beds and one chair. -Room #113 had two beds and no chairs. -Room #114 had two beds and no chairs. -Room #118 had one bed and no chair. -Room #120 had two beds and one chair. Interview with one of the residents in room #102 on 04/01/25 at 11:07am revealed: -He sat in his wheelchair all day and slept in his bed at night. -He did not have anywhere else to sit in his room. -He would like to have a chair in his room. Interview with the resident in room #118 on 04/01/25 at 10:15am revealed he did not have anywhere else to sit in his room except on his bed and he would like a chair. Interview with a personal care aide (PCA) on 04/02/25 at 9:25am revealed: -She did not know every resident should have a chair. -Some residents would wander into other residents' rooms and sit in their chair. Interview with the Maintenance Director on 04/03/25 at 8:10am revealed: -He was not aware each resident should have a chair in their room. -He thought family members would bring a chair. -He thought the resident rooms were too small to have one or two chairs in each room. Interview with the Administrator on 04/03/25 at 11:52am revealed he expected each resident to	D 091	Please see attachment	

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D 091	Continued From page 2 have a chair in their room.	D 091		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 7 sampled residents (#1 and #6) had completed tuberculosis (TB) testing upon admission. The findings are: 1. Review of Resident #1's current FL2 dated 10/02/24 revealed: -Diagnoses included dementia, history of cerebrovascular accident and hyperlipidemia. -Resident #1 was admitted to the facility on 10/11/2022. Review of Resident #1's immunization records revealed: -There was no documentation of a negative TB skin test.	D 234	Please see attachment	

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D 234	Continued From page 3 -There was no documentation of a positive TB skin test. Interview with the Resident Care Coordinator (RCC) on 04/03/25 at 10:53am revealed: -Resident #1's TB skin test was not available for review. -She thought Resident #1's files were thinned and the completed TB skin test was misplaced. -All residents must have completed TB skin testing prior to admission. -The Administrator was responsible to ensure TB skin tests were completed upon residents' admissions to the facility. Interview with the Administrator on 04/03/25 at 11:48am revealed: -Resident #1 had a completed TB skin test prior to admission. -Resident #1 did not have a completed TB skin test available for review. -He did not know why Resident #1's TB skin test was not available for review. -All residents must have a completed skin test prior to admission. -He was responsible to ensure TB skin testing was completed and documented in residents' records prior to admission. Based on observations, interviews, and record review, it was determined Resident #1 was not interviewable. 2. Review of Resident #6's current FL2 dated 07/12/24 revealed: -Diagnoses included dementia, diabetes and asthma. -Resident #6 was admitted to the facility on 07/12/2021.	D 234	Please see attachment	

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D 234	Continued From page 4 Review of Resident #6's immunization records revealed: -There was no documentation of a negative TB skin test. -There was documentation of a TB skin test dated 11/03/10. -There was documentation the TB skin test was read on 11/05/10 and had a positive result of 10 millimeters. -There was documentation a chest x-ray was scheduled for 11/09/10. -There was no documentation or results of a completed chest x-ray to rule out TB. Interview with the Resident Care Coordinator (RCC) on 04/03/25 at 10:53am revealed: -Resident #6's TB skin test result was positive which required a chest x-ray to rule out TB. -There was no documentation of Resident #6's chest x-ray results or if the chest x-ray was completed. -All residents must have completed TB skin testing prior to admission. -The Administrator was responsible to ensure TB skin tests were completed upon residents' admissions to the facility. Interview with the Administrator on 04/03/25 at 11:48am revealed: -Resident #6 had a completed TB skin test prior to admission with a positive result dated 11/05/10. -Resident #6 had a chest x-ray scheduled for 11/09/10 but there were no results available for review. -All residents must have a completed skin test prior to admission. -The Licensed Health Professional Support (LHPS) nurse was responsible to ensure the completion of the chest x-ray to rule out TB.	D 234	Please see attachment	

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D 234	Continued From page 5 Based on observations, interviews, and record review, it was determined Resident #6 was not interviewable.	D 234		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service on the 400 hall included a place setting consisting of a knife, fork, and spoon. The findings are: Observation of the lunch meal service on 04/01/25 at 11:33am revealed: -The meal consisted of chicken with rice, peas and carrots, a roll, and jello with fruit. -There were 24 place settings with a fork and a spoon; there were no knives on the tables for resident use. Interview with a resident on the 400 hall on	D 286	Please see attachment	

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D 286	Continued From page 6 04/02/25 at 3:55pm revealed she could have eaten her meal better if she had a knife to cut the chicken. Interview with an Occupational Therapy Assistant on 04/02/25 at 11:25am revealed: -He worked with one of the residents on the 400 hall on fine motor skills that would include eating. -He thought she could benefit from the use of a knife to cut her meat if needed. Observation of the breakfast meal service on 04/02/25 at 7:53am revealed: -The meal consisted of biscuits, gravy, grits, orange juice and water. -A beverage cart arrived on the 400 hall that contained a basket of silverware. -There were 28 place settings with a fork and a spoon; there were 8 knives on the tables for resident use. Interview with a personal care aide (PCA) on 04/02/25 at 9:30am revealed: -She helped set the table for meals. -She only had 8 knives to put at the place settings for the breakfast meal service on 04/02/25. -She set out what the kitchen sent. -She did not go to the kitchen and ask for additional knives. Interview with a dietary aide on 04/02/25 at 2:40pm revealed: -He sent the silverware to the 400 hall at breakfast and lunch. -He was a new employee but knew each resident should have a fork, knife, and a spoon. -He did not have any knives to send to the 400 hall for the lunch meal on 04/01/25. -He only had 8 knives to send to the 400 hall for the breakfast meal on 04/02/25.	D 286	Please see attachment	

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D 286	Continued From page 7 Interview with the Resident Care Coordinator (RCC) on 04/02/25 at 2:40pm revealed: -Each resident should have a fork, knife, and a spoon at each meal. -The silverware was sent to the 400 hall by the dietary staff. -They just purchased knives; there should be enough for all residents. -The medication aide (MA) should let the kitchen staff know if there was a need for more silverware. Interview with the Dietary Manager on 04/02/25 at 2:29pm revealed: -She did not know why knives were not sent for the lunch meal service on 04/01/25. -The breakfast meal service on 04/02/25 was probably short on knives because the dietary aide was new. -There were enough knives to send to the 400 hall at each meal. Interview with the Administrator on 04/03/25 at 11:52am revealed: -Knives were just purchased so there should have been enough for all residents at all meals. -Each resident was expected to have a fork, knife, and a spoon at each meal.	D 286	Please see attachment	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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D 310	Continued From page 8 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve therapeutic diets as ordered by the physician for 4 of 4 sampled residents (#1, #10, #11, and #12) who had an order for a pureed diet with thin liquids (#1), a mechanical soft diet with thickened liquids (#10), a pureed diet (#11), and a mechanical soft diet (#12). The findings are: 1. Review of Resident #1's current FL2 dated 10/02/24 revealed diagnoses included mixed alzheimer's and vascular dementia, history of cerebrovascular accident, hyperlipidemia, and history of deep vein thrombosis. Review of Resident #1's signed physician's order dated 03/31/25 revealed there was an order for a pureed diet with thin liquids; may have double portions upon request. Review of the facility's therapeutic diet menu for the lunch meal service dated 04/01/25 revealed the pureed diet consisted of lemon pepper chicken, pureed fluffy steamed rice, pureed peas and carrots, a pureed dinner roll, pureed fruit cocktail, and a beverage of choice. Observation of the lunch meal service on 04/01/25 between 11:43am and 12:23pm revealed: -Resident #1 was served a pureed plate of a pureed biscuit, ground chicken, rice and peas and carrots with chunky fruit medley, a glass of thickened water, a glass of thickened tea, and a mighty shake. -The chicken, rice, peas and carrots, and fruit	D 310	Please see attachment	

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D 310	Continued From page 9 medley were not pureed. -Resident #1 was served thickened liquids instead of thin liquids as ordered. -Resident #1 ate 100% of his meal. Review of the facility's therapeutic diet menu for the breakfast meal service dated 04/03/25 revealed the pureed diet consisted of pureed sausage with gravy, pureed cereal of choice, a pureed biscuit, coffee and a beverage of choice. Observation of the breakfast meal service on 04/03/25 between 7:45am and 8:03 revealed: -Resident #1 was served a pureed plate of ground sausage with a thin liquid, ground oatmeal with a thin liquid, ground french toast with a thin liquid, a glass of thickened water and thickened juice. -There was no gravy on the sausage and the sausage, oatmeal and french toast were not pureed. -Resident #1 was served thickened liquids instead of thin liquids as ordered. -Resident #1 ate 100% of his meal. Interview with the dietary aide (DA) on 04/03/25 at 9:15am revealed: -He prepared the thickened liquids for the residents who were ordered thickened liquids. -He had two residents that were on thickened liquids; he prepared thickened liquids for Resident #1. -He did not look at a list to see who was served thickened liquids; he knew because he had been told by the Dietary Manager (DM) who received thickened liquids. -After breakfast on 04/03/25, he was told by the DM that Resident #1 would no longer be served thickened liquids.	D 310	Please see attachment	

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D 310	Continued From page 10 Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/03/25 at 8:25am was unsuccessful. Refer to interview with a personal care aide (PCA) on 04/03/25 at 9:28am. Refer to interview with the Dietary Manager (DM) on 04/03/25 at 8:45am. Refer to interview with the Resident Care Coordinator (RCC) on 04/03/25 at 9:48am. Refer to interview with the Administrator on 04/03/25 at 11:52am. 2. Review of Resident #10's current FL2 dated 02/07/25 revealed diagnoses included vascular dementia, insomnia, dysphagia, and cerebral infarction. Review of Resident #10's signed physician order dated 03/26/25 revealed: -There was an order for a regular, mechanical soft diet (meat should be chopped and moist; fruits and vegetables should be soft). -There was no order for thickened liquids. Review of the facility's therapeutic diet menu for the lunch meal service dated 04/01/25 revealed the mechanical soft diet consisted of ground lemon pepper chicken, fluffy steamed rice, peas and carrots, a dinner roll, fruit cocktail, and a beverage of choice. Observation of the lunch meal service on 04/01/25 between 11:43am and 12:23pm revealed: -Resident #10 was served a plate of ground chicken, ground rice, ground dinner roll, ground	D 310	Please see attachment	

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D 310	Continued From page 11 fruit cocktail, a glass of thickened water and a glass of thickened tea. -Resident #10 ate 100% of his meal. Review of the facility's therapeutic diet menu for the breakfast meal service dated 04/03/25 revealed the mechanical soft diet consisted of ground sausage with gravy, cereal of choice, a biscuit, coffee and a beverage of choice. Observation of the breakfast meal service on 04/01/25 between 7:45am and 8:03am revealed: -Resident #10 was served a plate with ground sausage without gravy, hot cereal, french toast cut into small bite size pieces with syrup, and a glass of thickened juice and a glass of thickened water. -Resident #10 ate 100% of his meal. Interview with the Speech Therapist (ST) on 04/03/25 at 9:50am revealed: -Resident #10 was on a pureed diet with nectar thick liquids because he had difficulty chewing. -He was on thickened liquids because he choked easily. -He was very impulsive and would eat quickly. Attempted telephone interview with Resident #10's Primary Care Provider (PCP) on 04/03/25 at 8:25am was unsuccessful. Refer to interview with a personal care aide (PCA) on 04/03/25 at 9:28am. Refer to interview with the Dietary Manager (DM) on 04/03/25 at 8:45am. Refer to interview with the Resident Care Coordinator (RCC) on 04/03/25 at 9:48am.	D 310	Please see attachment	

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D 310	Continued From page 12 Refer to interview with the Administrator on 04/03/25 at 11:52am. 3. Review of Resident #11's current FL2 dated 12/04/24 revealed diagnoses included dementia, right hydrocele, and vitamin B12 deficiency. Review of Resident #11's diet order dated 03/10/25 revealed an order for a pureed diet. Review of the facility's therapeutic diet menu for the lunch meal service dated 04/01/25 revealed the pureed diet consisted of lemon pepper chicken, pureed fluffy steamed rice, pureed peas and carrots, a pureed dinner roll, pureed fruit cocktail, and a beverage of choice. Observation of the lunch meal service on 04/01/25 between 11:43am and 12:23pm revealed: -Resident #11 was served a plate with a pureed biscuit, ground chicken, rice and peas and carrots with chunky fruit medley, a glass of thickened water, a glass of juice and a glass of water. -The chicken, rice, peas and carrots, and fruit medley were not pureed. -Resident #11 ate 100% of his meal. Review of the facility's therapeutic diet menu for the breakfast meal service dated 04/03/25 revealed the pureed diet consisted of pureed sausage with gravy, pureed cereal of choice, a pureed biscuit, coffee and a beverage of choice. Observation of the breakfast meal service on 04/01/25 between 7:45am and 8:03 revealed: -Resident #11 was served a plate of ground sausage with a thin liquid, ground oatmeal with a thin liquid, ground french toast with a thin liquid, a glass of water and a glass of juice.	D 310	Please see attachment	

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D 310	Continued From page 13 -There was no gravy on the sausage and the sausage, oatmeal and french toast were not pureed. Attempted telephone interview with Resident #11's Primary Care Provider (PCP) on 04/03/25 at 8:25am was unsuccessful. Refer to interview with a personal care aide (PCA) on 04/03/25 at 9:28am. Refer to interview with the Dietary Manager (DM) on 04/03/25 at 8:45am. Refer to interview with the Resident Care Coordinator (RCC) on 04/03/25 at 9:48am. Refer to interview with the Administrator on 04/03/25 at 11:52am. 4. Review of Resident #12's current FL2 dated 01/08/25 revealed diagnoses included dementia, history of stroke, hypertension, and hyperlipidemia. Review of Resident #12's diet order dated 01/08/25 revealed there was an order for a mechanical soft diet. Observation of the lunch meal service on 04/01/25 from 12:25pm to 12:40pm revealed: -Resident #12 was served two bone-in chicken wings, peas and carrots, rice, fruit medley, and a roll. -Resident #12 ate 75% of his lunch. Interview with the Speech Therapist on 04/03/25 at 9:50am revealed: -Resident #12 was seen by speech therapy and was ordered a mechanical soft diet.	D 310	Please see attachment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: _____ B. WING _____	04/03/2025

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

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D 310	Continued From page 14 -Resident #12 did not have any teeth or dentures and had difficulty chewing foods that were not mechanically soft. -Resident #12 was ordered a mechanical soft diet in January 2025. -He could have difficulty consuming a regular diet. Attempted telephone interview with Resident #12's Primary Care Provider (PCP) on 04/03/25 at 8:25am was unsuccessful. Refer to interview with a personal care aide (PCA) on 04/03/25 at 9:28am. Refer to interview with the Dietary Manager (DM) on 04/03/25 at 8:45am. Refer to interview with the Resident Care Coordinator (RCC) on 04/03/25 at 9:48am. Refer to interview with the Administrator on 04/03/25 at 11:52am. Interview with a personal care aide (PCA) on 04/03/25 at 9:28am revealed: -The PCAs went to the kitchen door to ask for a resident's plate. -Their diet sheet was in a folder outside the kitchen door as a reference. -She knew the residents and knew what type of diet they received. -The DM knew what diet each resident was ordered. Interview with the Dietary Manager (DM) on 04/03/25 at 8:45am revealed: -She would ask a medication aide (MA) to print her a dietary list each morning so she could prepare the meals for the day.	D 310	Please see attachment	

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	HAL032091	A. BUILDING _____ B. WING _____	04/03/2025

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D 310	Continued From page 15 -She prepared enough food for each therapeutic diet as it was listed on the printed dietary list. -She did not enter new diet orders into the electronic system; she did not know who was responsible for entering the new diet orders. -When new diet orders were written the Resident Care Coordinator (RCC) or a MA would bring the new order to the kitchen. -The MAs would ask her for a specific therapeutic diet, and she would prepare it for them. -She pureed the food in the blender which had a pureed setting on it. -Sometimes the pureed food would sit too long and become too firm. -Pureed food should be smooth without lumps. Interview with the Resident Care Coordinator (RCC) on 04/03/25 at 9:48am revealed: -She or her assistant would enter the diet orders into the electronic system. -She printed a dietary list for each meal and placed it in the folder outside the kitchen door and gave a copy to the DM. -Pureed food should be smooth. Interview with the Administrator on 04/03/25 at 11:52am revealed: -The RCC should enter the diet orders into the computer. -The MA or PCA should look at the diet list posted outside the kitchen door when requesting a resident's plate. -Pureed diets should be blended, hold firm, no liquid with a smooth texture. -He expected diets to be served as ordered. -He was concerned a resident could choke if not served the correct diet as ordered.	D 310	Please see attachment	

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D 358	Continued From page 16	D 358		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 residents (#8 and #9) during the 8:00am morning medication pass including a medication for constipation and an inhaler, and for 2 of 7 sampled residents for record review including a cream (#3) and a medication for chronic obstructive pulmonary disease (COPD) (#5). The findings are: 1. The medication error rate was 5% as evidenced by the observation of 2 errors out of 37 opportunities during the 8:00am medication pass on 04/02/25. a. Review of Resident #8's current FL-2 dated 03/12/25 revealed diagnoses included dementia, hypertension, hyperlipidemia, and anemia. Review of Resident #8's signed physician order dated 03/12/25 revealed there was an order for polyethylene glycol (used to treat constipation) mix 17 grams in 8 ounces of water and drink daily.	D 358	Please see attachment	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 17 Observation of the medication pass for Resident #8 on 04/02/25 at 8:44am revealed: -The MA obtained a 5-ounce cup from the medication cart. -The MA removed a bottle of polyethylene glycol powder from the medication cart. -The MA poured a capful of powder into a 5-ounce cup. -The MA poured water into the 5-ounce cup until it was three-fourths full. -The MA mixed the powder in the water and administered the liquid to Resident #8. -The polyethylene glycol was not mixed with 8-ounces of fluid as ordered. Review of Resident #8's April 2024 electronic medication administration record (eMAR) on 04/02/25 revealed: -There was an entry for polyethylene glycol mix 17 grams of powder (one capful) into 8 ounces of fluid and drink daily with a scheduled administration time of 8:00am. -There was documentation polyethylene glycol was administered as ordered on 04/02/25. Interview with the medication aide (MA) on 04/03/25 at 11:04am revealed: -The order was to mix the medication in 8-ounces of water. -He did not know what size the cups were on the medication cart. -He did not know the cup he used to mix the medication was a 5-ounce cup. Telephone interview with a representative from the facility's contracted pharmacy on 04/02/25 at 11:51am revealed: -The pharmacy had an order for polyethylene glycol 17 grams in 8 ounces of fluid daily.	D 358	Please see attachment	

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D 358	Continued From page 18 -The medication would be easier for Resident #8 to take if it was dissolved in more liquid, so it would not be too thick to drink. Interview with Resident #8 on 04/03/25 at 11:04am revealed he had a chronic problem with constipation, but he had not had a problem recently. Interview with a second MA on 04/03/25 at 11:10am revealed: -Resident #8 did not complain of constipation. -Resident #8 had a problem with constipation about a month ago, but it was resolved. Interview with the Resident Care Coordinator (RCC) on 04/03/25 at 2:41pm revealed: -The MA should administer the medication as ordered. -There were 8-ounce cups on the medication cart specifically for administering polyethylene glycol. -The 5-ounce cups were to be used for water to take pills. -She expected MAs to use the 8-ounce cups when mixing polyethylene glycol powder. -She did not observe the MAs administer medications to the residents. -No one did a routine medication pass observation with the MAs. Interview with the Administrator on 04/03/25 at 11:52am revealed the polyethylene glycol may not be dissolved completely if it was not placed in 8-ounces of fluid as ordered. Attempted telephone interview with Resident #8's primary care provider (PCP) on 04/03/25 at 8:25am was unsuccessful. Refer to the interview with the Resident Care	D 358	Please see attachment	

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	HAL032091	A. BUILDING: _____ B. WING _____	04/03/2025

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D 358	Continued From page 19 Coordinator (RCC) on 04/02/25 at 2:41pm. Refer to the interview with the Administrator on 04/03/25 at 11:52am. b. Review of Resident #9's current FL-2 dated 11/08/24 revealed diagnoses of dementia, hypertension, cancer, depression, and schizophrenia. Review of Resident #9 signed physician order dated 02/10/25 revealed there was an order for Breo Ellipta 100-25 mcg inhaler (used to treat COPD) one inhalation daily and rinse mouth after each use. Observation of the medication pass for Resident #9 on 04/02/25 at 8:56am revealed: -The medication aide (MA) removed the inhaler from the medication cart. -The MA gave Resident #9 the inhaler to administer to himself. -After the medication was administered the resident did not rinse his mouth and the MA did not instruct Resident #9 to rinse his mouth. Review of Resident #9's April 2024 electronic medication administration record (eMAR) on 04/02/25 revealed: -There was an entry for Breo Ellipta 100-25mcg inhaler one inhalation daily and rinse mouth after each use with a scheduled administration time of 8:00am. -There was documentation the Breo Ellipta inhaler was administered as ordered on 04/02/25 at 8:00am. Interview with the MA on 04/03/25 at 1:51pm revealed: -He knew Resident #9 was to rinse his mouth out	D 358	Please see attachment	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 20 after using the inhaler. -Resident #9 rinsed his mouth out this morning after the inhaler was administered. -Resident #9 would go to his room and rinse his mouth out. -He did not see Resident #9 rinse his mouth out this morning after he administered the inhaler. Interview with Resident #9 on 04/03/25 at 11:07am revealed: -He rinsed his mouth out this morning after he used his inhalers because the MA told him to rinse his mouth. -He did not rinse his mouth each time after using the inhaler. Telephone interview with a representative from the facility's contracted pharmacy on 04/02/25 at 11:51am revealed: -The pharmacy had an order for Resident #9 for Breo Ellipta 100-25mcg inhaler one inhalation daily and rinse mouth after each use. -The pharmacy dispensed Breo Ellipta 100-25mcg one inhaler on 01/02/25, 02/03/25 and 03/04/25; each inhaler would last 30 days. -It was important to rinse the mouth after inhaling a medication with a steroid to prevent the medication from building up in the resident's mouth and causing thrush. Interview with the Resident Care Coordinator (RCC) on 04/03/25 at 2:41pm revealed: -The MAs were to follow the directions on the medication order. -The MA should have made sure Resident #9 rinsed his mouth out after inhaling the medication. -She did not observe the MAs administer medications to the residents. -No one did a routine medication pass observation with the MAs.	D 358	Please see attachment	

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

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D 358	Continued From page 21 Interview with the Administrator on 04/03/25 at 11:52am revealed Resident #9 should rinse his mouth after using an inhaler to ensure all the medication was removed from his mouth. Attempted telephone interview with Resident #9's Primary Care Provider (PCP) on 04/03/25 at 8:25am was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 04/02/25 at 2:41pm. Refer to the interview with the Administrator on 04/03/25 at 11:52am. 2. Review of Resident #5's current FL2 dated 12/14/24 revealed: -Diagnosis included COPD. -There was an order for ipratropium-albuterol 2.5ml/3ml (used to treat COPD) one vial by nebulizer twice daily. Review of Resident #5's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for ipratropium-albuterol 2.5mg/3ml one vial by nebulizer twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that ipratropium-albuterol was administered twice daily from 02/01/25 to 02/28/25. Review of Resident #5's March 2025 eMAR revealed: -There was an entry for ipratropium-albuterol 2.5mg/3ml one vial by nebulizer twice daily with a scheduled administration time of 8:00am and 8:00pm.	D 358	Please see attachment	

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	HAL032091	A. BUILDING: _____ B. WING _____	04/03/2025

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

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D 358	Continued From page 22 -There was documentation that ipratropium-albuterol was administered twice daily from 03/01/25 to 03/31/25. Review of Resident #5's April 2025 eMAR on 04/01/25 revealed: -There was an entry for ipratropium-albuterol 2.5mg/3ml one vial by nebulizer twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that ipratropium-albuterol was administered on 04/01/25 at 8:00am. Observation of Resident #5's medications on hand on 04/01/25 at 2:14pm revealed: -There was a box with 45 of 60 ipratropium-albuterol 2.5mg/3ml vials dispensed on 01/21/25 available for administration. -There was a second box with 53 of 60 ipratropium-albuterol 2.5mg/3ml vials dispensed on 03/18/25 available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 04/01/25 at 3:25pm revealed: -The pharmacy had an order for ipratropium-albuterol 2.5mg/3ml one vial by nebulizer twice daily. -The pharmacy dispensed 60 vials of ipratropium-albuterol 2.5mg/3ml on 01/21/25, 02/17/25, and 03/18/25. -The facility should have 48 of the 60 vials remaining that were dispensed on 03/18/25. Based on observations, interviews, record review and medications on hand it was determined that there were 98 of 180 vials of ipratropium-albuterol 2.5mg/3ml available for administration for Resident #5 when there should have been 32	D 358	Please see attachment	

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	HAL032091	A. BUILDING: _____ B. WING _____	04/03/2025

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

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D 358	Continued From page 23 vials remaining for administration. Interview with a personal care aide (PCA) on 04/03/25 at 11:15am revealed: -Resident #5 would become short of breath with exertion, such as transferring from bed to chair and when personal care was provided. -There was an order for oxygen as needed and she would place the oxygen on when Resident #5 became short of breath. Interview with the MA on 04/02/25 at 1:32pm revealed: -She administered Resident #5's nebulizer treatment as ordered. -Resident #5 did not refuse her nebulizer treatments. -She did not know why there were extra vials of medication available for Resident #5's nebulizer. Interview with another MA on 04/02/25 at 2:25pm revealed: -She administered nebulizer treatments to Resident #5 when she worked on the medication cart. -Resident #5 took the nebulizer treatments without problem. -There should not be any extra vials of medication if the nebulizer treatment was administered as ordered. Interview with the Resident Care Coordinator (RCC) on 04/03/25 at 2:41pm revealed: -The medication was delivered every 30-days on cycle fill. -There was enough medication sent each month to last 30 days with no extra. -There should not be any extra vials of medications.	D 358	Please see attachment	

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	HAL032091	A. BUILDING: _____ B. WING _____	04/03/2025

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

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D 358	Continued From page 24 Interview with the Administrator on 04/03/25 at 11:52am revealed: -The MAs should document on the eMAR if Resident #5 refused her medications. -Resident #5 needed the medication. Attempted telephone interview with Resident #5's Primary Care Provider (PCP) on 04/03/25 at 8:25am was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 04/02/25 at 2:41pm. Refer to the interview with the Administrator on 04/03/25 at 11:52am. 3. Review of Resident #3's current FL-2 dated 07/08/24 revealed: -Diagnoses included dementia, encephalopathy and hypertension. -There was an order for minerin creme (used to treat dry skin) 16 ounces (oz) apply topically to legs every morning for dry skin. Review of Resident #3's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for minerin creme 16 oz apply topically to legs every morning for dry skin scheduled for administration at 10:00am. -There was documentation minerin creme was not administered on 02/18/25, 02/24/25 and 02/28/25 due to resident refusals. Review of Resident #3's March 2025 eMAR revealed: -There was an entry for minerin creme 16 oz apply topically to legs every morning for dry skin scheduled for administration at 10:00am. -There was documentation minerin creme was	D 358	Please see attachment	

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D 358	Continued From page 25 not administered on 03/01/25, 03/02/25 and 03/06/25 due to resident refusals. Observation of Resident #3's medications on hand on 04/02/25 at 11:12am revealed there was a half-full container of minerin creme dated 07/12/24 available for administration. Telephone interview with the facility's contracted pharmacy on 04/02/25 at 11:41am revealed: -There was an active order on file for minerin creme 16 oz apply topically to legs every morning for dry skin for Resident #3. -The most recent and only dispense date for Resident #3's minerin creme was 07/12/24. Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable. Interview with a medication aide (MA) on 04/02/25 at 11:25am revealed she administered Resident #3's minerin creme and Resident #3 never refused the minerin creme. Interview with a second MA on 04/03/25 at 11:05am revealed she thought Resident #3's minerin creme would have lasted for approximately four months at most if it was administered as ordered. Interview with the Resident Care Coordinator (RCC) on 04/03/25 at 10:30am revealed: -She did not know Resident #3's minerin creme on the medication cart was dated and dispensed on 07/12/24 and the container was half-full. -She did not know how long Resident #3's 16 oz container of minerin creme would last if it were applied daily as ordered. -The MAs were responsible for administering	D 358	Please see attachment	

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D 358	Continued From page 26 medications as ordered. Interview with the Administrator on 04/03/25 at 12:20pm revealed: -He did not know Resident #3's minerin creme on the medication cart was dispensed on 07/12/24. -He would expect the 16 oz container of minerin creme to be gone by now if it was administered as ordered by the provider. -MAs were responsible to administer medications as ordered. Attempted telephone interview with Resident #3's primary care provider (PCP) on 04/03/25 at 8:28am was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 04/02/25 at 2:41pm. Refer to the interview with the Administrator on 04/03/25 at 11:52am. _____ Interview with the Resident Care Coordinator (RCC) on 04/02/25 at 2:41pm revealed: -She supervised the MAs. -The MAs were expected to audit the medication carts weekly on first and second shift. -She would randomly audit the medication carts. -When auditing the medication carts, they looked for expired and discontinued medications and made sure that all medications on the eMAR were in the medication cart. Interview with the Administrator on 04/03/25 at 11:52am revealed he expected medications to be administered as ordered.	D 358	Please see attachment	
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032091	A. BUILDING: _____ B. WING _____	04/03/2025

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

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D 366	Continued From page 27 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed a resident take their medication. The findings are: Observation of a resident on 04/02/25 at 10:12am revealed: -The resident was asleep in his bed. -There was an almost full clear plastic cup that contained a thick orange substance on his nightstand. -There was not a medication aide (MA) present observing the resident take his medication. Attempted interview with the resident on 04/02/25 at 10:15am was unsuccessful. Interview with the MA on 04/02/25 at 10:20am revealed: -She handed the resident the cup of medication and he started to drink it. -The medication was metamucil. -She did not stay with the resident while he finished taking the medication. -She did not have to stay with the resident until he	D 366	Please see attachment	

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D 366	Continued From page 28 finished the medication because it was not a narcotic or a pill. A second observation on 04/02/25 at 10:46am revealed the almost full plastic cup of medication was still at the resident's bedside. Interview with the Resident Care Coordinator (RCC) on 04/02/25 at 2:59pm revealed: -MAs were expected to stay with the residents until the resident took or refused their medication. -She was concerned another resident could go into the room and take the medication if it was left in a room. Interview with the Administrator on 04/03/25 at 11:52am revealed: -He expected MAs to remain with residents until they finished taking their medications. -The resident's medication should not have been left at his bedside. -It was a memory care facility; he was concerned another resident could take the medication that was left in the room.	D 366	Please see attachment	
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 371		

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D 371	Continued From page 29 failed to ensure infection control measures were implemented during the morning medication pass. The findings are: Review of the facility's undated hand hygiene policy revealed: -Gloves were to be worn to prevent the healthcare worker's hands from becoming contaminated with blood or body substances. -The MA should wear gloves when it could be reasonably anticipated that contact with mucous membranes may occur. -Gloves were not a substitute for hand hygiene. -If the task required gloves, the MA should perform hand hygiene prior to donning gloves and immediately after removing gloves. Observation of the morning medication pass on 04/02/25 between 7:38am and 7:48am revealed: -At 7:38am, the MA donned gloves and checked a resident's FSBS. -She obtained the insulin pen from the resident's zippered bag of insulin supplies and administered 22 units to the resident. -She removed her gloves and did not wash or sanitize her hands. -At 7:43am, the same MA donned gloves and checked a second resident's FSBS. -She obtained the insulin pen from the resident's zippered bag of insulin supplies and administered 5 units of insulin to the second resident. -She opened the top drawer of the medication cart and retrieved the second resident's inhaler and administered 2 puffs to the second resident. -She returned the inhaler, reached into another drawer on the medication cart and retrieved a bottle of liquid medication. -She poured 10mls of medication into the	D 371	Please see attachment	

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D 371	Continued From page 30 graduated medication cup and administered the medication to the second resident. -She removed her gloves and did not wash or sanitize her hands. Interview with the MA on 04/02/25 at 1:32pm revealed: -She should have sanitized her hands between residents but she was busy and in a. -She should have removed her gloves and sanitized her hands after each FSBS check. -She should sanitize her hands whenever she removed her gloves . -She knew she should sanitize her hands before donning and doffing gloves but she was busy and there was "a lot going on." Observation of a morning medication pass with a second MA on 04/02/25 between 8:29am and 8:56am revealed: -At 8:29am, the MA administered two inhalers to a resident; he was not wearing gloves and did not wash or sanitize his hands before or after administration of the inhalers. -At 8:32am, the MA returned to the medication cart, prepared 11 pills and a liquid medication to administer to a resident; the MA did not wash or sanitize his hands before or after the administration of these medications. -At 8:48am, the MA administered an inhaler to a resident; the MA did not wash or sanitize his hands before or after the administration of the inhaler or don gloves. -At 8:56am, the MA retrieved a pair of gloves from the housekeeping cart, donned the gloves, entered a resident's room and administered eye drops; the MA did not wash or sanitize his hands before or after the administration of the eye drops and before or after donning and doffing gloves.	D 371	Please see attachment	

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D 371	Continued From page 31 Interview with the second medication aide on 04/03/25 at 11:04am revealed: -He wore gloves when he administered all medications, including pills, inhalers, and eye drops. -He would change his gloves between each resident. -He would wash or sanitize his hands after he removed his gloves. -He administered two inhalers in the dining room and did not wear gloves. -There were no gloves on his medication cart. -He used gloves when he administered a resident's eye drops, but failed to sanitize his hands. -He had gotten busy and was behind in his medication administration and he forgot to get a box of gloves and use the gloves when administering the inhalers. -He should have washed or sanitized his hands after administering medications to the residents. Interview with the Resident Care Coordinator (RCC) on 04/03/25 at 2:41pm revealed: -The MAs should wash or sanitize their hands before and after donning and doffing gloves. -Gloves should be worn when administering inhalers. -She expected the MA to wash or sanitize their hands and wear gloves to decrease the chance of infection. Interview with the Administrator on 04/03/25 at 11:52am revealed: -The MAs should wash or sanitize their hands with proper technique before and after donning and doffing gloves. -He was concerned about transmitting germs or bacteria and blood-borne pathogens from resident to resident or from resident to employee.	D 371	Please see attachment	

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DURHAM RIDGE
ASSISTED LIVING &
ALZHEIMER'S CARE

Durham Ridge Assisted Living – Durham, NC
HAL-032-091
Durham County
It is Durham Ridge Assisted Living's policy and standard practice to comply with all North Carolina Adult Care Home rules and state regulations.

10A NCAC 13F .0306 (b)(5)(6) Housekeeping and Furnishings

Plan of Correction and Prevention of Reoccurrence:

It is Durham Ridge Assisted Living's policy to ensure that each resident room has enough chairs for each resident. Immediately following the state survey, housekeeping and maintenance surveyed rooms on 100 halls to ensure compliance. All rooms that did not have sufficient chairs were given chairs at that time 4/7/25. A room inspection worksheet was created to include checking for furniture in rooms 5/5/25. All new employees will be educated on the importance of 10A NCAC 13F .0306 (b)(5)(6) Housekeeping and Furnishings as it pertains to chairs in the resident rooms prior to them taking assignment.

Monitoring and Responsibility and Frequency:

Enviromental Specialist and or designee to monitor with room inspection worksheet weekly for one month and then monthly for 6 months for one year thereafter.

Administrator and or designee to monitor monthly with room inspection worksheet for 3 months and then every 6 months for one year thereafter.

Competition Date: May 18, 2025

10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunization

Plan of Correction and Prevention of Reoccurrence:

It is Durham Ridge Assisted Living's policy to ensure that each resident has a negative tb skin test, chest x-ray, or QuantiFERON test prior to admission. A Negative chest x-ray was given to survey team for resident number 2 prior to exit and a mobile x-ray was arranged for resident 1 prior to the survey team leaving on 4/3/24. A Tb clinic was held by community LHPS nurse on 4/29/25 to ensure all residents were brought up to compliance. A new tickler was created to keep track of tb skin test from admission and forward. Form must be completed with results prior to move-in and then a copy will be given to LHPS nurse for any follow-up. All new managers will be trained on the importance of 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunization prior to them taking assignment.

Monitoring and Responsibility and Frequency:

Resident Care Coordinator and or designee to review new admissions for tb test weekly for one month and then monthly for a year thereafter

Administrator and or designee to review new admissions for tb test monthly for 3 months and then every 6 months for a year thereafter.

Competition Date: May 18, 2025

10A NCAC 13F .0904(b)(1) Nutrition and Food Service

Plan of Correction and Prevention of Reoccurrence:

It is Durham Ridge's policy to ensure that each resident has a sufficient place setting which includes a knife. Community purchased knives on 4/2/25 to ensure there were enough in the building. Food Service Director ordered more knives on 4/9/25 from contracted food service group. Team members from the kitchen were enrolled on online trainings through contracted Pharmacy to be completed no later than 5/11/25. Training included proper food service procedures in memory cares. The administrator and Food Service Director held a meeting on 4/30/25 to discuss the importance of knives as it pertains to a resident's place setting and what to do in the event there are not enough for each resident. Knife inventory log was enacted by the community to ensure there is enough supply for each resident. The Food Service Director to keep this up to date and at any time the supply of knives gets too low, an order should be made. All new staff to be trained on the importance of 10A NCAC 13F .0904(b)(1) Nutrition and Food Service prior to them taking an assignment.

Monitoring and Responsibility and Frequency:

FSD and or designee will monitor communities supply of table knives on a weekly basis using the knife inventory log for one month and then monthly for 6 months.

Administrator and or designee will monitor the community's supply of table knives monthly using the knife inventory log for 3 months.

Competition Date: May 18, 2025

10A NCAC 13F .0904(e)(4) Nutrition and Food Service

Plan of Correction and Prevention of Reoccurrence:

It is Durham Ridge's policy to ensure that all residents receive their meals and snacks in accordance with their diet order as prescribed by their PCP. An in-service began during the survey and has continue until all employees have completed- to go over the importance of residents receiving the correct diet. Dietary Team members were in-serviced following survey, 5/5/25, to go over the proper consistency of each therapeutic diet. Inservice included benefits and need for all therapeutic diet orders offered by community and how each diet should present before being served to resident. Each food service employee was enrolled in training through the online training provided by contracted Pharmacy on training that pertains to therapeutic diets and proper serving of them. New forms stating

therapeutic diets have been made and will be placed in areas accessible to cooks and care team. New or changed diet orders will go to FSD and will be added to the new diet order form that has been implemented. Meal observance forms will be utilized by FSD to ensure consistency of therapeutic diets is proper and how they are intended to be. All new Dietary aides to be educated on the importance of 10A NCAC 13F .0904(e)(4) Nutrition and Food Service prior to them taking assignment moving forward.

Monitoring and Responsibility and Frequency:

FSD and or designee will monitor the preparation of meals and accuracy of diets served daily for a week, weekly for a month, and then monthly for 6 months thereafter.

The administrator and or designee will monitor the preparation of meals and accuracy of diets served weekly for one month and then monthly for 3 months thereafter.

Competition Date: May 18, 2025

10A NCAC 13F .1004 (a) Medication Administration

Plan of Correction and Prevention of Reoccurrence:

It is the policy of Durham Ridge to ensure all medications are prepared and administered appropriately. In-services began on 4-4-25 to address the use of proper cups when administering Polyethylene glycol and the proper administering of inhalers. Additional training has been assigned to Med Aides on topics that include inhalers and medication administration in memory care units to be completed no later than 5/18/25. All new med aides will be trained in the importance of following doctor's orders as prescribed prior to them taking assignment.

Monitoring and Responsibility and Frequency:

Resident Care Coordinator and or designee to observe a med pass and complete a full cart audit weekly for one month and then monthly thereafter.

Administrator and or designee to observe a med pass and will review full cart audits every two weeks for a month and then monthly for three months thereafter.

Competition Date: May 18, 2025

10A NCAC 13F .1004 Medication Administration (i)

Plan of Correction and Prevention of Reoccurrence:

It is the policy of Durham Ridge to ensure all medications are prepared and administered appropriately. An in-service began immediately after the state exited the building, 5/3/25, to go over the importance of 10A NCAC 13F .1004 Medication Administration (i) and all med aide to be trained by 5/18/25. Additional training has been assigned to Med Aides on topics medication administration in memory care units specifically to ensuring that residents are administered each medication as it is written to be completed no later than 5/18/25. All new Med Aides will be trained on the importance of 10A NCAC 13F .1004 Medication Administration (i) prior to them taking assignment.

Monitoring and Responsibility and Frequency:

Resident Care Coordinator and or designee to observe a med pass weekly for one month and then monthly thereafter.

Administrator and or designee to observe a med pass every two weeks for a month and then monthly for three months thereafter.

Competition Date: May 18, 2025

10A NCAC 13F .1004 (n) Medication Administration

Plan of Correction and Prevention of Reoccurrence:

It is the policy of Durham Ridge to ensure all rules and regulations are followed as it pertains to 10A NCAC 13F .1004 (n) Medication Administration. An in-service was conducted by LHPS nurse following the state survey, 4/4/25, which included but not limited to infection control as it pertains to medication administration. State approved infection control training was assigned to all med aide with a due date of 5/18/25. All new Med Aides will be assigned the state approved infection control and must complete it prior to taking assignment.

Monitoring and Responsibility and Frequency:

Resident Care Coordinator and or designee to observe a med pass o ensure proper infection control procedures are being followed weekly for one month and then monthly thereafter.

Administrator and or designee to observe a med pass to ensure proper infection control procedures are being followed every two weeks for a month and then monthly for three months thereafter.

Competition Date: May 18, 2025