STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 a complaint investigation on 08/04/21-08/06/21. The Wake County Department of Social Service initiated the complaint on 08/02/21.	D 000		
D 087	10A NCAC 13F .0306(b)(1) 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: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following: (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to maintain a bariatric hospital bed designed to accommodate large individuls in good repair for 1 of 5 sampled resident (#4) related to the bed being inoperable and the facility failed to provide top or bottom	D 087		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 087	Continued From page 1 sheets for the bariatric hospital bed. The findings are: a. Observation of Resident #4's room on 08/04/21 at 9:30am revealed: -She was lying on her back in a bariatric hospital bed which is an extra heavy duty and extra wide bed with a higher weight capacity designed to accomodate larger individuals. -There was a trapeze over the bed for self-positioning. -The head of the bed was fixed at a 30-degree angle and could not be adjusted because the bed was inoperable. Review of Resident #4's current FL-2 dated 09/16/20 revealed: -Diagnosis included osteoarthritis of the hips and knees and history of depressive episodes. -She was admitted to the facility on 10/01/2019. Review of a clinical consultation report dated 03/22/21 revealed: -Resident #4 had become more inactive over the past few months, was more bed bound, and morbidly obese. -She had a history of osteoarthritis of the hips and knees which exacerbated her mobility and plan of care. Interview with Resident #4 on 08/06/21 at 9:00 am and 2:00pm revealed. -She remained in bed all the time. -The motor to the bed was inoperable and the head of the bed could not be adjusted. -She could not remember how long the bed had been inoperable -It would be nice to be able to adjust the head of the bed.	D 087		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 087	Continued From page 2 -The bed was the property of the facility. Interview with a personal care aide (PCA) on 08/06/21 at 3:00pm revealed: -Resident #4 remained in bed all the time. -The PCA was not aware that the head of Resident #4's bed could not be adjusted. Interview with the Clinical Operations Specialist on 08/06/21 at 3:30pm revealed it was the responsibility of the facility to repair Resident #4's bed if the facility owned the bed. Interview with the Administrator on 08/06/21 at 3:00pm revealed he was not aware the head of Resident #4's hospital bed could not be adjusted or the motor which adujsuted the head of the bed was inoperable. Interview with the Executive Director (ED) on 08/06/21 at 3:20pm revealed she was not aware the head of Resident #4's hospital bed could not be adjusted or the motor was inoperable. b. Observation of Resident #4's room on 08/05/21 at 9:45am revealed: -There were no top or bottom sheets provided for the bariatric hospital bed. -A white blanket was used as a bottom sheet to cover the bed with another white blanket used as a covering for the resident. -The white blanket used as a bottom sheet did not completely cover the bed and the foam mattress was seen at the top and at the bottom, about six inches each. Interview with Resident #4 on 08/06/21 at 9:00am and 2:00pm revealed. -She remained in bed all the time. -It would be nice to have sheets for her bed.	D 087		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 087	Continued From page 3 Interview with a personal care aide (PCA) on 08/06/21 at 3:00pm revealed: -There were no sheets available for Resident #4's bariatric hospital bed. -The PCA thought that the fcility had some sheets to fit the bed but they were badly soiled by Resident #4 and were discarded. Interview with the Administrator on 08/06/21 at 3:00pm revealed he was not aware there were no sheets available for Resident #4's hospital bed. Interview with the Executive Director (ED) on 08/06/21 at 3:20pm revealed she was not aware there were no sheets available for Resident #4's hospital bed.	D 087		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance to the residents assessed needs for 1 of 5 sampled residents (#3) left unsupervised in the television room of the special care unit. The findings are:	D 270		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 4 Interview with the Administrator on 08/04/21 at 5:00pm revealed the facility did not have a supervision policy. Review of Resident #3's current FL-2 dated 08/21/20 revealed: -Diagnoses included dementia. -The resident was intermittently disoriented and semi-ambulatory; there was no documentation of a specified ambulatory assistive device. Review of Resident #3's Resident Register revealed: -The resident had significant memory loss requiring direction. -The resident required a walker and wheelchair. Review of Resident #3's current care plan dated 03/05/21 revealed: -The resident wandered, was always disoriented, confused, had significant memory loss requiring direction, and used a wheelchair for ambulation. -The resident required extensive assistance with ambulation, bathing, dressing, and transfers. Interview with a personal care aide (PCA) on 08/04/21 at 9:29am revealed Resident #3 was dependent upon 2 staff for activities of daily living (ADL's) and a wheelchair for ambulation. Review of Resident #3's current Licensed Health Professional Support (LHPS) review dated 05/07/21 revealed the resident resided in the Special Care Unit (SCU) due to dementia and safety concerns. a. Observations of the SCU on 08/04/21 from 3:58pm - 4:04pm revealed: -There were 10 residents in the television room.	D 270		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 270	Continued From page 5 -There was a nurses' station across from the television room which allowed full view of the television room. -There was a door leading from the television room to the courtyard. -On the wall to the left of the door was a Keyhole lock. -There was one resident standing just to the left of the door to the courtyard touching the keyhole lock. -Resident #3 was sitting in a wheelchair in front of the door to the courtyard. -Resident #3 had a key on a green lanyard in his hand. -Resident #3 was trying to open the door with his hands and insert the key in the door handle. -The door handle did not have a keyhole. -The resident standing to the left of the door was taping at the keyhole lock with his hand and mumbling. -Resident #3 wrapped the lanyard with the key attached around the door handle. -Resident #3 yelled out, "my (explicit) hurts". -Resident #3 pulled on the lanyard wrapped around the door handle elevating himself from the wheelchair. -Resident #3's arms began shaking and was yelling. "Get it ..., get it." -Resident #3 fell to the floor on his buttocks between the door and the wheelchair. -Resident #3 yelled for help. -A visitor walked up and down the hall between the nurses' station and television room, there was no staff. -The visitor looked down the main hall at the entrance of the SCU by the SCU Coordinators office, there was no staff. -The visitor knocked on the door to the SCU Coordinators office and turned the door handle, the door was locked.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 270	Continued From page 6	D 270		

-The SCU Coordinator opened the door to her office.
-In the SCU Coordinators' office was the SCU Coordinator, a medication aide/supervisor (MA/S) and a PCA.
-The visitor informed the SCU Coordinator Resident #3 was on the floor, there were residents in the television room, and there was no staff available.
-The SCU Coordinator, MA/S, and PCA approached Resident #3 at 4:04pm.
-The PCA took the key from Resident #3.
-The PCA and SCU Coordinator lifted Resident #3 from the floor and placed the resident in the wheelchair.

Observation of the SCU Courtyard on 08/04/21 at 4:11pm revealed:
-The courtyard was surrounded by a tall wooden fence with a wooden gate the same height.
-The gate had a magnetic lock and a keypad.
-The gate was not locked and was open approximately 1 foot to the outside of the facility.
-The gate opened easily when pushed.

Interview with the PCA on 08/04/21 at 4:10pm revealed:
-Resident #3 had a key that opened the door from the television room to the courtyard.
-The key was supposed to have been secured at the nurses' station.
-The key was placed in the keyhole lock on the wall to the left of the door to the courtyard earlier by another staff.
-The staff unlocked the door for 2 other residents to enter the courtyard earlier.
-Those 2 residents were in the courtyard unsupervised at that time.
-The staff left the key in the keyhole lock so the 2 other residents could enter back in the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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

when they wanted.
-She did not remember who the staff was who left the key in the keyhole lock.
-The gate to the courtyard was always closed and locked.

Interview with the SCU Coordinator on 08/04/21 at 4:15pm revealed:
-The key to the courtyard door was to be secured at the nurses' station because residents could "elope" if they had the key.
-It was the responsibility of the Maintenance Director to ensure the SCU courtyard gate was closed and locked.
-It was ultimately her responsibility to ensure the key was secured at the nurses' station.

Interview with the Administrator on 08/04/21 at 4:28pm revealed:
-The key to the SCU courtyard should not be left in the lock because residents could access the key and elope.
-The key to the SCU courtyard unlocked every door with a magnetic lock in the facility .
-The key to the SCU courtyard unlocked the courtyard gate.
-The key to the SCU courtyard unlocked the stoves accessible by the residents in the SCU and assisted living side.
-The key to the SCU courtyard door was to be secured behind the nurses' station to keep the residents safe.
-All SCU staff were responsible to ensure the key to the SCU courtyard door was secured behind the nurses' desk.
-The SCU Coordinator was ultimately responsible to ensure the key to the courtyard door was secured behind the nurses' desk.
-The SCU courtyard gate was to always be closed and locked by a magnetic lock with a

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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		

keypad to prevent residents from eloping.
-It was the responsibility of every staff in the facility to ensure the courtyard gate was closed and locked.
-He did not know the key to the courtyard was not secured behind the nurses' station.
-He did not know the SCU courtyard gate was unlocked and opened.
-Residents were to always be supervised by staff when in the SCU courtyard because they were at risk for falls.
-It was unacceptable for staff to be congregated in the SCU Coordinator's office because residents needed to be supervised to keep them safe.

Interview with the Maintenance Director on 08/05/21 at 8:20am revealed:
-The SCU Courtyard gate was always to be locked because the SCU residents had access to the courtyard.
-He unlocked and opened the gate to the SCU Courtyard on 08/03/21 to allow landscapers inside the gate.
-He told the SCU Coordinator on 08/03/21 he had opened the SCU Courtyard gate because he left early.
-It was the responsibility of the SCU Coordinator to ensure the SCU Courtyard gate was closed and locked every day.

Interview with a second PCA on 08/05/21 at 9:12am revealed Resident #3 required constant supervision because he would slip out of his wheelchair.

Interview with the SCU Coordinator on 08/05/21 at 1:00pm revealed:
-Resident #3 was at risk for falls and experienced agitation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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		

-A MA and PCA were in the office with her.
-The other PCA was in the dining room putting a trash bag in the trash can.
-She did not know where the third PCA was.
-She did not know why residents were not supervised in the SCU television room on 08/04/21.
-She was not told on 08/03/21 by the Maintenance Director he left the SCU courtyard gate unlocked and opened.
-She was just told today, 08/05/21, by the Maintenance Director he left the SCU courtyard gate unlocked and opened on 08/03/21.
-She had no process in place to ensure the SCU courtyard gate was closed and locked.

Telephone interview with Resident #3's family member on 08/06/21 at 8:30am revealed:
-She visited the resident about once weekly.
-The resident would not curse.
-The resident would slip out of the wheelchair because he did not like being still.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

Refer to interview with the Administrator on 08/04/21 at 4:28pm.

Refer to interview with a second PCA on 08/05/21 at 9:12am revealed:

Refer to interview with the SCU Coordinator on 08/05/21 at 1:00pm.

Refer to interview with the Administrator on 08/06/12 at 11:15am.

b. Observation of Resident #3 on 08/06/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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	D 270		

10:15am revealed:
-The resident was sitting in his wheelchair in the doorway of his room.
-A PCA was holding a gauze pad to the back of the resident's head.
-There was blood on the gauze pad.
-The gauze pad was removed to reveal a laceration to the back of the resident's head.
-There was a blood trail on several areas of the back of Resident #3's head.
-The resident was alert and confused.

Observation of a wooden box on 08/06/21 at 10:30am identified as used to hit Resident #3's head revealed:
-The box was on a table in the craft room of the SCU.
-The box was wooden, 12 in long x 6 in wide, and one of the doors was broken in half.
-On the end of the box was a metal hinge and a metal lock that could open and close.

Review of Resident #3's hospital emergency department discharge instructions dated 08/06/21 revealed:
-There was a diagnosis of a scalp laceration.
-The resident had 4 staples to the scalp to repair the laceration.

Interview with a PCA on 08/06/21 at 10:32am revealed:
-She witnessed the assault on Resident #3.
-She was wiping tables in the kitchen when she heard screams in the SCU television room.
-She looked up through the glass window from the dining room to the SCU television room.
-Resident #3 was sitting in his wheelchair in the television room with his back to the assaulting resident.
-A resident was hitting Resident #3 in the back of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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	D 270		

the head with a wooden box.
-She ran from the dining to the SCU television room to stop the assault.
-Resident #3 was struck in the head with a wooden box 3 times by the other resident.
-The other resident was still hitting Resident #3 in the head when she approached the residents.
-The wooden box broke while Resident #3 was hit in the head.
-There was no staff in the SCU television room.
-She was told by another PCA today, 08/06/21, staff always needed to physically be in the SCU television room to supervise residents because the residents needed constant supervision.
-She had never been told before today, 08/06/21, residents in the SCU television room needed constant supervision.
-There was no specific staff assigned to supervise the residents in the SCU television room.
-She was told by the SCU Coordinator to perform PCA duties and assist in the kitchen.
-She felt it was important to receive resident report when starting the shift so she would know the supervision and care needs for the residents to keep residents and herself safe.

Interview with the Administrator on 08/06/21 at 10:10am revealed:
-He was recently informed of a resident to resident altercation that had just occurred this morning, 08/06/21.
-Resident #3 was in the television room of the SCU.
-Another resident walked up to Resident #3 and began hitting him in the head with a wooden toolbox.
-Emergency Medical Services (EMS) had been notified.
-Resident #3 was being transferred to the hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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	D 270		

for evaluation.
-The other resident was being transferred to the hospital for a psychological evaluation.

Interview with EMS personnel on 08/06/21 at 10:20am revealed:
-Resident #3 had a 1.5 in - 2 in laceration to the back of the head.
-Resident #3 was being transported to the hospital for evaluation.

Interview with a second PCA on 08/06/20 at 10:40am revealed:
-She had been informed by the SCU Coordinator this morning, 08/06/21, resident in the SCU television room needed constant staff supervision to ensure resident safety.
-She had never been told before today, 08/06/21, residents in the SCU television room needed constant supervision.
-There was no specific staff assigned to supervise the residents in the SCU television room.

Interview with the SCU Coordinator on 08/06/21 at 10:42am revealed:
-This morning, 08/06/21, she told a staff the residents in the television room needed constant supervision to ensure resident safety. She could not remember who she told.
-Residents in the SCU were at risk for falls and some exhibited behavior concerns because of the level of cognition.
-She had not assigned a specific staff to supervise residents in the television room.
-It was every staff's responsibility to supervise residents in the television room.
-Before today's (08/06/21) incident, she talked to the staff on 08/05/21 to let other staff know if they had to leave an area which left residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 13 unsupervised. Telephone interview with Resident #3's Primary Care Provider (PCP) on 08/06/21 at 10:50am revealed: -SCU residents had decreased cognition levels which placed them at increased risk for falls and adverse behaviors. -She expected staff to constantly supervise the SCU residents who were gathered to ensure resident safety. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to interview with the Administrator on 08/04/21 at 4:28pm. Refer to interview with a second PCA on 08/05/21 at 9:12am revealed: Refer to interview with the SCU Coordinator on 08/05/21 at 1:00pm. Refer to interview with the Administrator on 08/06/12 at 11:15am. _____ Interview with the Administrator on 08/04/21 at 4:28pm revealed: -He knew Residents in the SCU were supervised 24 hours a day 7 days a week by staff. -Staff were to check on residents every 2 hours. -There was no way staff could "have eyes" on the residents at all times. -It was unacceptable there was no staff on the SCU floor to supervise the residents. -Unsupervised, the residents could fall, elope, or ingest things they should not which could cause injury, harm, abuse, and/or neglect.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 270	Continued From page 14 Interview with a second PCA on 08/05/21 at 9:12am revealed: -Residents while in the television room were always supposed to be within sight of staff . -Staff did not have to be in the television room to supervise the residents. Interview with the SCU Coordinator on 08/05/21 at 1:00pm revealed: -SCU residents congregated in the television room were to always be in eyesight of staff because there were residents who were at risk for falls, had wandering and/or aggressive behaviors. -Staff should not have left residents in the SCU television room unattended. -If staff were unable to supervise the residents while in the SCU television room, they were to notify other staff or the Executive Director (ED) if relief was needed. -The MA/S and SCU Coordinator were both responsible to ensure residents were not left unsupervised. -The PCAs knew the facility policy was to never leave SCU residents unsupervised. -She depended upon SCU staff to always supervise the residents. -She had no process in place to ensure residents were always supervised by staff. Interview with the Administrator on 08/06/12 at 11:15am revealed: -SCU residents in the television room required constant staff supervision. -He expected staff to constantly supervise residents who were congregated together to ensure resident safety. -He did not expect a specific staff to be assigned to constantly supervise the residents who were congregated together in the SCU.	D 270		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 270	Continued From page 15 -Staff were assigned residents at the beginning of their shifts. -Each PCA was assigned 8 residents. -He expected each PCA to supervise their assigned residents. -If that PCA was assisting another resident with care, he expected the PCA to report to the MA or SCU Coordinator. -The MA or SCU Coordinator was expected to supervise that PCA's assigned residents while the PCA did other tasks. _____ The facility failed to supervise residents who resided in the Special Care Unit including Resident #3 who had a diagnosis of dementia and who was at risk for falls which resulted in Resident #3 on 08/05/21 obtaining a key to the Special Care Unit and attempting to unlock the doors to the SCU which resulted in the resident falling out of the wheelchair and only receiving staff assistance due to prompting by a visitor; On 08/06/21, Resident #3 being struck in the head with a wooden box with a metal lock by another resident resulting in Resident #3 being transported to the emergency department for medical assessment of a head injury and received 4 staples. The facility's failure resulted in substantial risk of serious physical injury and neglect of the resident and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 08/04/21. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 05, 2021.	D 270		

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D 273	Continued From page 16	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the acute healthcare needs for 1 of 5 sampled residents (#3) related to a choking episode requiring the Heimlich maneuver, and wounds to the left knee and leg and right first toe. The findings are: Review of Resident #3's current FL-2 dated 08/21/20 revealed: -Diagnoses included dementia. -The resident was intermittently disoriented. Review of Resident #3's current care plan dated 03/05/21 revealed: -The resident wandered, was always disoriented, confused, and had significant memory loss requiring direction. -The resident required staff supervision when eating. a. Review of the Special Care Unit (SCU) 24-hour communication report dated 08/01/21 revealed: -Resident #3 choked in the dining room at 1:00pm. -The SCU Coordinator performed the Heimlich maneuver on Resident #3. -Resident #3 was choking on phlegm; nothing came up.	D 273		

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D 273	Continued From page 17 -It was signed by the medication aide (MA) for first, second, and third shift. Review of Resident #3's facility provider communication, physician notes, and charting notes on 08/05/21 revealed: -There was no documentation Resident #3's hospice provider had been informed of Resident #3 choking and required the Heimlich maneuver. -There was no documentation Resident #3's Primary Care Provider (PCP) had been notified of Resident #3 choking and required the Heimlich maneuver. -There was no documentation Emergency Medical Services (EMS) had been notified of Resident #3's choking, requiring the Heimlich maneuver. Interview with a personal care aide (PCA) on 08/05/21 at 9:55am revealed: -She was working in the SCU dining room on 08/01/21 when she heard Resident #3 trying to cough. -She turned to see Resident #3 pointing to his throat. -She asked Resident #3 if he was choking and he nodded yes. -The SCU Coordinator performed the Heimlich maneuver on Resident #3. -Nothing came up with the Heimlich maneuver. -Resident #3 stopped choking and trying to cough. -Resident #3 was given water to drink upon his request. -Resident #3 self-propelled in the wheelchair out of the SCU dining room and began interacting with other residents. -EMS was not notified. -She did not know if Resident #3's PCP was notified.	D 273		

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D 273	Continued From page 18	D 273		

-She thought it was the responsibility of the medication aide (MA) or SCU Coordinator to notify Resident #3's PCP.

Telephone interview with Resident #3's hospice Registered Nurse (RN) on 08/05/21 at 10:21am revealed:
-She expected facility staff to have notified hospice Resident #3 had a choking episode and required the Heimlich maneuver immediately.
-The resident may have needed a modified diet and/or speech evaluation to ensure the resident was not holding food in his cheek which could contribute to choking.
-Had she been notified she would have recommended a soft mechanical diet and evaluated the resident.
-Not informing hospice the resident was choking placed the resident at increased risk for another choking episode which could lead to aspiration, aspiration pneumonia, hospitalization, or death.
-The goal of hospice was to provide comfort care to the resident, but the family and PCP could initiate the need for a higher level of treatment.
-Hospice was available to the facility for notifications of resident needs 24 hours a day 7 days a week.

Interview with a medication aide/supervisor (MA/S) on 08/05/21 at 11:41am revealed:
-EMS should have been notified when Resident #3 was choking after the Heimlich performed on 08/01/21.
-Hospice should have been notified when Resident #3 choked.

Interview with the SCU Coordinator on 08/05/21 at 1:00pm revealed:
-She walked in the dining room on 08/01/21 to talk with staff.

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D 273	Continued From page 19 -On 08/01/21, she heard staff ask Resident #3 if he was choking. -Resident #3's face was red, he was in "distress", and he could not speak. -Resident #3 was choking on food. -She performed 2 abdominal thrusts of the Heimlich maneuver on Resident #3. -Nothing came up but Resident #3 coughed, tried to speak, and sounded like he had mucus in his throat. -Resident #3 then asked for water and was given water by the PCA. -Resident #3 stopped choking and coughing. -She did not notify EMS Resident #3 was choking and required the Heimlich maneuver. -She did not notify Resident #3's hospice provider the resident was choking and required the Heimlich maneuver. -There was no reason EMS or hospice was not notified Resident #3 choked on 08/01/21 -She told the Executive Director (ED) on 08/01/21 Resident #3 had a choking episode and required the Heimlich maneuver because she wanted all staff cardiopulmonary resuscitation [(CPR) a lifesaving technique used during a cardiac or breathing emergency] certified. -The facility did not have a policy requiring EMS or a PCP to be notified when a resident choked and/or required the Heimlich maneuver. -She should have notified Resident #3's hospice nurse. -Hospice was to be notified for any concerns regarding hospice residents. Interview with the ED on 08/05/21 at 2:30pm revealed: -She was a Licensed Practical Nurse (LPN). -She was told on 08/01/21 a resident in the SCU required the Heimlich maneuver because of choking.	D 273		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 273	Continued From page 20	D 273		

-She was to be informed if the Heimlich maneuver had to be performed on any resident.
-When told, she would assess the resident, fax the PCP, and call the family.
-EMS was to be notified only in her absence.
-She did not assess Resident #3 when told of the 08/01/21 incident.
-She expected Resident #3's hospice nurse to be notified the resident was choking and requiring the Heimlich maneuver immediately after the resident was safe.
-She also expected Resident #3's PCP to be notified the resident was choking and requiring the Heimlich maneuver immediately after the resident was safe.

Second interview with the ED on 08/05/21 at 4:00pm revealed:
-The SCU Coordinator told her during the 08/03/21 morning meeting Resident #3 had choked and required the Heimlich maneuver.
-The SCU Coordinator called and left a message for Resident #3's PCP on 08/02/21.

Telephone interview with Resident #3's PCP on 08/06/21 at 10:50am revealed:
-She had not been notified Resident #3 had a choking episode on 08/01/21.
-She had not been notified Resident #3 required the Heimlich maneuver on 08/01/21.
-She expected hospice or herself to be notified of Resident #'3's choking incident on 08/01/21 after the Heimlich was performed.
-Resident #3 would have needed to be evaluated for a diet change.
-Not notifying her or hospice placed Resident #3 at increased risk for another choking episode, aspiration pneumonia, and death.
-Resident #3 had a diagnosis of dementia which increased the risk for aspiration.

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 273	Continued From page 21 Interview with the Administrator on 08/06/12 at 11:15am revealed: -The ED, family, then PCP should have been notified of Resident #3's choking incident and need for Heimlich maneuver once resident safety had been ensured; in that order. -EMS should have been notified to evaluate Resident #3. b. Observation of Resident #3 on 08/04/21 at 2:30pm revealed: -The resident was transferred from the wheelchair to the bed by a personal care aide (PCA) and the Special Care Unit (SCU) Coordinator. -The resident's socks were removed. -The resident had approximately a 1-centimeter (cm) x 1 cm blood blister to the top of the right 1st toe. -There was an open wound approximately 1-millimeter (mm) x 1 mm in the blood blister. -The blood blister perimeter was red. -There was a wound approximately 3 cm in diameter to the left knee. -The perimeter was red. -There were scattered wounds to the left lower leg. -There was no drainage to the left knee wound or scattered wounds to the lower leg. -There was no drainage to the right 1st toe. Interview with the PCA on 08/04/21 at 2:38pm revealed: -She did not bathe Resident #3. -She did not dress Resident #3. -She knew Resident #3 had wounds to his left leg. -She did not know Resident #3 had a wound to his right 1st toe.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 22 -Resident #3 received hospice services. Interview with the PCA on 08/06/21 at 3:57pm revealed: -She removed Resident #3's socks on 08/03/21 during 2nd shift. -She did not remember if Resident #3 had wounds to his left knee and/or lower leg. -She did not remember if Resident #3 had a wound or blood blister to his right 1st toe. -She would report any wounds observed during personal care to the MA. -The PCAs did not document personal care performed. -The PCAs did not document when notifying the MA of resident wounds. Interview with the SCU Coordinator on 08/04/21 at 2:40pm revealed: -Resident #3's baths were provided by hospice 2 times a week on Tuesdays and Thursdays. -Resident #3 was seen by the hospice nurse for wound care 1 time a week. Review of Resident #3's current Licensed Health Professional Support (LHPS) review dated 05/07/21 revealed there was no documentation of wounds. Interview with the medication aide/supervisor (MA/S) on 08/04/21 at 9:43am revealed: -Resident #3 had "old" wounds to both legs. -The wounds to Resident #3's legs were "scratches". -Resident #3's left leg had more scratches than the right leg. -Resident #3 would scratch at his legs causing the wounds. -Resident #3 had been examined by his Primary Care Provider (PCP) for the leg scratches.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 23 -She did not know when the PCP had examined Resident #3's leg wounds. Telephone interview with Resident #3's hospice Registered Nurse (RN) on 08/05/21 at 10:21am revealed: -Resident #3 was admitted to hospice for end stage dementia. She did not know the date. -Resident #3 was seen by hospice nursing once weekly. -Resident #3 was being treated for a wound to his left 2nd toe that was currently healed. -She had not been notified of a wound to Resident #3's left knee. -She had not been notified of scattered wounds to Resident #3's left lower leg. -She had not been notified of a wound or blood blister on the top of Resident #3's right first toe. -She last examined Resident #3's feet and lower legs on 08/02/21. -On 08/02/21, Resident #3 did not have wounds to his left lower leg or left knee. -On 08/02/21, Resident #3 did not have a blood blister to his right great toe. -On 08/02/21, Resident #3 had a red, blanchable area to the top of his right first toe. -It was the responsibility of the MA or the SCU Coordinator to notify hospice of the resident's wounds. -She expected facility staff to notify hospice immediately upon discovery of any wounds. -Had she been notified by the facility the resident had wounds, she would have evaluated the resident the same day, spoken with staff, consulted with the Primary Care Provider (PCP) for orders, and informed the family. -Resident #3's wounds could possibly lead to infection, the need for antibiotics, hospitalization, and/or amputation. -The goal of hospice was to provide comfort care	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 273	Continued From page 24	D 273		

to the resident, but the family and PCP could initiate the need for a higher level of treatment.
-Hospice was available to the facility for notifications of resident needs 24 hours a day 7 days a week.

A second interview with Resident #3's hospice RN on 08/05/21 at 11:05am revealed:
-She had made a visit to evaluate the resident on 08/05/21.
-The resident had a "blood blister" to the right 1st toe which measured 1-centimeter (cm) x 2 cm.
-It was possible the blood blister developed due to friction from the resident's shoe.

Interview with the MA on 08/05/21 at 11:38am revealed:
-Some PCAs could determine if a wound was serious or not.
-A wound that was not serious was a skin tear or a scratch.
-A serious wound would "gush blood".
-The process for reporting resident wounds was: The PCA would report to the MA and the MA would report to the Executive Director (ED).
-MAs would perform resident skin assessments if the PCA reported wounds.
-It was the responsibility of the MA to notify hospice if Resident #3 had wounds.
-Hospice would be notified the same day wounds were discovered because the facility had unlicensed staff and Resident #3 would need to be evaluated.
-Hospice was available for contact 24 hours a day 7 days a week.
-The MAs or the medication aide/supervisor (MA/S) would document Resident #3's wounds in the 24-hour shift report book.
-She saw Resident #3 had "scratches" on his legs and was picking at them on 08/03/21 or 08/04/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 25	D 273		

-She documented Resident #3's leg wounds in the 24-hour shift report for the day she observed the resident's wounds.

Observation of the MA/S on 08/05/21 at 11:40am revealed she reviewed the 24-hour shift report book for 08/02/21 - 08/05/21.

A second interview with the MA/S on 08/05/21 at 11:42am revealed:
-She reviewed the 24-hour shift report book for 08/02/21 - 08/05/21.
-She did not document Resident #3's wounds in the 24-hour shift report for the days 08/02/21 - 08/05/21.
-She cleaned wounds she felt was not serious with skin wound cleanser.
-She thought she could care for Resident #3's wounds to his legs because they were not serious.
-She did not clean Resident #3's wounds.
-She did not notify hospice of Resident #3's wounds.
-She did not notify other facility staff of Resident #3's leg wounds.
-Resident #3's leg wounds were skin tears.
-She should have notified hospice of Resident #3's leg wounds because they were skin tears.

A third interview with Resident #3's hospice RN on 08/05/21 at 12:17pm revealed:
-The wounds to the left knee and right 1st toe were infected.
-Keflex (an antibiotic used to treat a bacterial infection) was ordered on 08/05/21 for Resident #3's left knee wound and right 1st toe.

Interview with the SCU Coordinator on 08/05/21 at 1:00pm revealed:
-She first saw the blood blister to Resident #3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 26	D 273		

right 1st toe on 08/04/21.
-She did not report Resident #3's wound to the right 1st toe to hospice because she knew hospice would be back to the facility to see other residents that same week.
-She was going to report Resident #3's wound to the right 1st toe when she saw the hospice RN.
-The process for reporting wounds was the PCA to report to the MA and the MA report to the SCU Coordinator or the Executive Director (ED).
-The MA, SCU Coordinator, or the ED would notify the residents PCP or hospice provider.
-The MA or SCU Coordinator would document the wound in the 24-hour shift report.
-Staff were expected to look for wounds and skin changes when performing personal care to include donning and doffing clothing.

Telephone interview with a representative for Resident #3's podiatrist on 08/05/21 at 3:45pm revealed:
-Resident #3 was last seen by podiatry on 07/23/21.
-Resident #3's podiatry diagnoses were claudication (pain in the legs or arms when walking due to decreased blood flow), peripheral vascular disease, numbness, hyperkeratotic (thickening of the outer layer of skin) lesions and onychomycosis (a nail fungus causing thick, brittle, crumbly, or ragged nails).

Telephone interview with Resident #3's PCP on 08/06/21 at 10:50am revealed:
-She did not know about Resident #3's wounds.
-Resident #3's wounds should be managed by hospice.

Interview with the Administrator on 08/06/12 at 11:15am revealed:
-He expected staff to have "immediately" notified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 27 the ED when Resident #3's wounds were discovered. -The ED was also an LPN. -The ED was to evaluate Resident #3's wound to ensure it was covered with a dressing, call the residents family member, then notify hospice or the residents PCP. In that order. Attempted telephone interview with Resident #3's podiatrist on 08/05/21 at 3:45pm was unsuccessful. _____ The failure of the facility to notify Resident #3's Primary Care Provider the resident choked on 08/01/21 during lunch requiring abdominal thrusts of the Heimlich Maneuver placed the resident at increased risk for choking episodes, aspiration pneumonia, and death and failed to notify the hospice nurse of wounds to Resident #3's left knee and toe which resulted in an infection requiring antibiotics placed the resident at risk for hospitalization and amputation. The facility's failure placed the resident at risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/04/21 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 5, 2021.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 310	Continued From page 28 (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to serve nectar thickened liquids for 1 of 2 sampled residents with orders for thickened liquids (Resident #8) and failed to ensure the nectar thickened liquids were measured accurately before serving the residents for 2 of 2 residents (Resident #2 and #8). The findings are: 1. a. Review of Resident #8's current FL-2 dated 06/08/21 revealed diagnosis included dementia. Observation of Resident #8 during breakfast in the special care unit (SCU) dining room on 08/05/21 between 8:23am- 8:25am revealed: -Resident #8 was holding her hand to her mouth and salivating. -Resident #8 was assisted out of the dining room into the SCU by staff. -Resident #8 stated that she felt as if something was stuck in her throat and was coughing. -The medication aide (MA) provided Resident #8 a trashcan and the resident continued to cough until she vomited two times. -The MA provided Resident #8 with a cup of	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 310	Continued From page 29	D 310		

water from the medication cart.
-Resident #8 drank the non-thickened water and stated that she felt better.
-Resident #8 was served all thin liquids at breakfast and consumed less than 25% of milk, less than 25% of water and 50% of orange juice.

Review of a signed diet communication order for Resident #8 dated 07/19/21 revealed nectar thickened liquids.

Interview with a dietary aide (DA) on 08/05/21 at 7:44am revealed Resident #8 did not have a diet order for thickened liquids.

Interview with the dietary manager (DM) on 08/05/21 at 7:47am revealed:
-The dietary staff prepared thickened orange juice, apple juice and milk.
-The water and tea were purchased already thickened.
-Resident #8 did not have a diet order for thickened liquids.

Interview with the Special Care Unit (SCU) Coordinator on 08/05/21 at 10:15am revealed:
-The dietary staff labeled thickened liquids with the resident's name and the consistency of the liquid.
-The speech therapist (ST) observed Resident #8 drinking regular, thin liquids and informed the SCU Coordinator Resident #8 needed thickened liquids (not sure of date).

Observation of the MA on 08/06/21 at 8:00am revealed the MA placed beverages labeled "N" on the table next to the table setting where Resident #8 was seated.

Interview with the MA on 08/06/21 at 8:10am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 310	Continued From page 30	D 310		

revealed she was told by the dietary staff and the MA in the SCU the nectar thickened liquids belonged to another resident, not Resident #8.

Observation of Resident #8 on 08/06/21 at 8:21am in the SCU dining room revealed:
-There was a glass of regular, thin water sitting in front of Resident #8.
-Resident #8 took a sip of the non-thickened water.
-The MA was prompted by the state surveyor to remove the water from Resident #8's reach and go to dietary to get nectar thickened liquids for Resident #8.

Interview with the Executive Director (ED) on 08/06/21 at 9:06am revealed:
-She received an email from the speech therapist (ST) regarding Resident #8 not receiving her nectar thickened liquids and another resident was receiving it instead.
-Resident #8's diet order for nectar thickened liquids was rewritten by the ST on 07/08/21 and the ST had the Primary Care Provider (PCP) sign the order.
-Resident #8 was placed on nectar thickened liquids due to aspiration (not sure of date).
-She expected the dietary staff to follow proper diet instructions.
-She was concerned about Resident #8 receiving the wrong diet order because she aspirated on 08/05/21 in the dining room.

Interview with the Administrator on 08/06/21 at 10:23am revealed:
-The facility staff and the dietary staff were expected to follow the diet order to ensure residents were receiving their diets as ordered.
-The DM was responsible for ensuring the dietary staff served thickened liquids.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 310	Continued From page 31	D 310		

-Resident #8 was at risk for aspiration if she received regular, thin liquids.

Interview with the ST on 08/06/21 at 9:32am revealed:
-She rewrote the diet order for Resident #8 to receive nectar thickened liquids on 07/19/21 and the PCP signed the order.
-The diet order for nectar thickened liquid was written for Resident #8 because she was silently aspirating. (Silent aspiration is when a person inhales food or liquid into the lungs without the body reflex to cough).
-She observed Resident #8 last week (not sure of date) and she did not receive her nectar thickened liquids.
-She informed the ED Resident #8 did not receive her nectar thickened liquids.
-Resident #8 was at risk for aspiration pneumonia if she consumed regular beverages instead of nectar thickened liquids.

Interview with the PCP on 08/06/21 at 11:49am revealed she was concerned Resident #8 was at risk for aspiration/choking if she did not receive her nectar thickened liquids.

Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable.

b. Interview with a medication aide (MA) on 08/06/21 at 8:37am revealed:
-The dietary aide (DA) measured the scoops for the thickened liquids for Resident #8 and placed them in the foam cup.
-The MA poured the orange juice and the water in the cups without measuring the number of ounces.
-She was instructed from the DA to pour the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 310	Continued From page 32	D 310		

orange juice half full of the foam cup and fill the other foam cup with water.
-The MA was prompted by the state surveyor to return to the kitchen and have the nectar thickened liquids remade by dietary.

Review of the mixing instructions for the nectar/honey thickened liquids revealed:
-Pour 4 ounces of cold or hot liquid into a glass.
-Slowly add level measured thickener to liquid.
-Stirring with fork of whisk as you pour.
-Stir briskly until thickener has dissolved and before serving.
-Let water and juices stand for at least 1 minute.
-Let milk and supplements stand for 5-10 minutes.
-Stir and serve.

Observation of the DA and the Dietary Manager (DM) on 08/06/21 at 8:40am revealed the orange juice and water were remade following the instructions from the original container of thickened powder.

Interview with the speech therapist (ST) on 08/06/21 at 9:32am revealed the nectar thickened liquids needed to be measured out accurately, if not Resident #8 was at risk of aspiration pneumonia.

Interview with the Primary Care Provider (PCP) on 08/06/21 at 11:49am revealed she was concerned Resident #8 was at risk for aspiration/choking if the nectar thickened liquids were not prepared following accurate instructions.

Based on observations, interviews and record reviews, it was determined Resident #8 was not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 310	Continued From page 33 Refer to interview with a dietary aide (DA) on 08/05/21 at 7:44am. Refer to interview with the Dietary Manager (DM) on 08/05/21 at 7:47am. Refer to interview with the Executive Director (ED) on 08/06/21 at 9:06am. Refer to interview with the Administrator on 08/06/21 at 10:23am. 2. Review of Resident #2's current FL-2 dated 06/15/21 revealed: -Diagnoses included dementia, cerebrovascular accident (CVA), atrial fibrillation, anemia and hypertension. -Resident #2's diet order was puree with honey thickened liquid. Observation of the Dietary Manager (DM) on 08/05/21 at 7:54am revealed: -The DM prepared nectar thickened orange juice in a plastic cup for Resident #2 without measuring the number of ounces. -The state surveyor requested the DM pour the orange juice into a liquid measuring cup to determine the number of ounces that were poured into the plastic cup. -After measuring it was determined, she poured 6 ounces of orange juice to prepare the nectar thickened liquid instead of 4 ounces. Attempted telephone interview on 08/06/21 at 11:30am with the Primary Care Provider (PCP) was unsuccessful. Refer to interview with a dietary aide (DA) on 08/05/21 at 7:44am.	D 310		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 310	Continued From page 34 Refer to interview with the Dietary Manager (DM) on 08/05/21 at 7:47am. Refer to interview with the Executive Director (ED) on 08/06/21 at 9:06am. Refer to interview with the Administrator on 08/06/21 at 10:23am. _____ Interview with a dietary aide (DA) on 08/05/21 at 7:44am revealed: -She did not know how much juice should be poured into the plastic cups when preparing the thickened liquids. -She did not measure the juice nor the water before she mixed the thickener with the beverage. -She was told to make the thickened liquids but was not told how much of the beverages to measure in the cups. She was told to estimate. -She poured 2 teaspoons and "a little over and stirred it until it got thick." -"The residents can drink it and they do not get choked." -She did not know how many ounces the plastic cups she used to prepare thickened liquids where. Interview with the Dietary Manager (DM) on 08/05/21 at 7:47am revealed: -The dietary staff had to prepare thickened orange juice, apple juice and milk. -The water and tea were purchased already thickened. -The dietary staff poured the orange juice to the top of the last line when using plastic cups. -She did not know how many ounces of orange juice was poured into the cup.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 310	Continued From page 35 Interview with the Executive Director (ED) on 08/06/21 at 9:06am revealed: -She expected the dietary staff to measure the beverages before adding the thickened powder to a cup. -She expected the dietary staff to follow the instructions on the back of the thickened powder container. -She expected the dietary staff to take their time to avoid mistakes. Interview with the Administrator on 08/06/21 at 10:23am revealed the dietary staff were expected to use the instructions on the back of the thickened powder container to prepare thickened liquids. _____ The facility failed to ensure thickened liquids were served as ordered for Resident #8 who was ordered nectar thickened liquids and received liquids without a thickening agent added and failed to follow the instructions when making a nectar thickened beverage for Resident #2; the nectar and honey thickened liquids were prepared accurately for Resident #2 and #8 which increased the risk for aspiration/choking. These failures were detrimental to the residents, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/06/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 20, 2021.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 312	Continued From page 36 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 1 resident (#2) sampled was treated with respect, consideration and dignity as evidence by staff standing while providing feeding assistance to the resident. The findings are: Review of Resident #2's current FL-2 dated 06/15/21 revealed: -Diagnoses included dementia, cerebrovascular accident (CVA), atrial fibrillation, anemia and hypertension. -Resident #2 was constantly disoriented and had wandering behaviors. Review of Resident #2's current care plan dated 06/28/21 revealed Resident #2 required extensive assistance eating. Observations during the breakfast meal on 08/05/21 from 8:10am until 8:35am revealed: -At 8:10am, the personal care aide (PCA) brought Resident #2 to the dining room. -The PCA stood next to Resident #2 at the table and began assisting Resident #2 to eat breakfast. -From 8:16am until 8:30am the PCA stood over Resident #2 while assisting the resident to eat.	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 312	Continued From page 37 Interview with the PCA on 08/05/21 at 8:30am revealed: -She stood while assisting Resident #2 to eat because she did not know if the chairs were cleaned and disinfected. -She had not considered it disrespectful to stand over Resident #2 while assisting her to eat breakfast. Interview with the Special Care Unit (SCU) Coordinator on 08/05/21 at 10:00am revealed: -Staff were expected to assist residents with their meal face to face and not stand while providing feeding assistance. -Staff were expected to sit and not stand while assisting residents with meals due to dignity concerns and being more personable with the residents. Interview with the Executive Director (ED) on 08/05/21 at 2:12pm revealed she expected staff to sit with residents while assisting the residents with a meal and to make the residents feel comfortable while they were eating their meal. Interview with the Administrator on 08/05/21 at 2:52pm revealed: -He expected staff to treat the residents with respect and dignity while assisting them to eat a meal. -He expected the staff to be eye level with the resident and not to rush the resident while assisting them to eat a meal. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 315	Continued From page 38	D 315		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure activities were provided to promote active involvement by all residents. The findings are: Review of the Special Care Unit (SCU) activity calendar for 08/04/21 revealed: -Musical bingo was scheduled for 11:00am. -Hallway bowing was scheduled for 1:00pm. -Nature walk was scheduled for 2:00pm. Observation of the special care unit (SCU) on 08/04/21 at 11:00am revealed: -Residents were gathered in the television room. -The television was on. -There were no activities offered. Observation of the SCU on 08/04/21 at 1:00pm revealed: -There were 8 residents in the television room. -The television was on.	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 315	Continued From page 39 -There were no activities offered. Observation of the SCU on 08/04/21 at 2:00pm revealed: -Residents were gathered in the television room. -The television was on. -There were no activities offered. Review of the SCU activity calendar for 08/05/21 revealed: -Devotions was scheduled for 10:00am. -Bakers Club was scheduled for 11:00am. -Basketball was scheduled for 1:00pm. -Finish the phrase was scheduled for 4:00pm. Observation of the SCU on 08/05/21 at 10:00am revealed: -Residents were gathered in the television room. -The television was on. -There were 3 staff at the nurses' station. -Activities were not offered. Observation of the SCU on 08/05/21 at 10:00am revealed no activities were offered. Observation of the SCU on 08/05/21 at 11:00am revealed no activities were offered. Observation of the SCU on 08/05/21 at 1:00pm revealed no activities were offered. Observation of the SCU on 08/05/21 at 4:00pm revealed no activities were offered. Interview with a residents' family member on 08/04/21 at 9:58am revealed: -On 08/03/21 there was a visitor who provided religious worship for the residents in the SCU. -The activity on 08/03/21 was the only activity provided in the SCU since 05/27/21.	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 315	Continued From page 40 Interview with the Administrator on 08/05/21 at 10:25am revealed: -The Activities Director (AD) was responsible for the activities in assisted living (AL) unit. -The AD completed the activities calendar for the Special Care Unit (SCU) Coordinator. -The SCU Coordinator was responsible for conducting activities in the SCU. Interview with a medication aide/supervisor (MA/S) on 08/05/21 at 11:41am revealed: -There had not been activities in the SCU since the COVID-19 pandemic. -There was no staff available to provide activities in the SCU. -There was no AD for the SCU. -The assisted living (AL) side AD did not provide activities for residents in the SCU. -The only activity provided for residents in the SCU was television. Interview with the SCU Coordinator on 08/05/21 at 1:00pm revealed: -She was responsible for providing activities for residents in the SCU. -There were no activities provided for residents in the SCU because she had other tasks to perform such as a personal care aide (PCA) or MA when short staffed. -The facility AD did not provide activities for residents in the SCU. -The last activity provided for SCU residents was 06/19/21. -The SCU residents built bird houses and painted them on 06/19/21. -The SCU residents enjoyed activities provided on 06/19/21. Interview with the Executive Director (ED) on	D 315		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 315	Continued From page 41 08/05/21 at 2:30pm revealed: -She expected the SCU Coordinator to provide activities or the SCU residents. -She expected the SCU Coordinator to delegate to other staff the responsibility of providing activities to the SCU residents if she was unable to provide. -The facility AD would inform the SCU Coordinator of activities being offered on the AL side. -She expected the SCU residents to be brought to the AL side to participate in activities when notified by the AD. -The SCU Coordinator was to bring SCU residents to the AL side on 08/04/21 to participate in activities but did not. -The SCU Coordinator told her on 07/28/21 activities were not being provided to SCU residents. -She told the SCU Coordinator on 07/28/21 the expectation of her to perform activities for the SCU residents. -Activities for the SCU residents were necessary to increase their cognitive status and give them purpose. -She had not followed up with the SCU Coordinator to ensure activities were being provided. Telephone interview with the facility's PCP on 08/06/21 at 10:50am revealed: -Residents in the SCU had deceased cognition levels. -Residents in the SCU required "serious" stimulation to help promote and maintain cognition levels. -She expected activities to be offered and provided to the residents in the SCU. Interview with the Administrator on 08/06/12 at	D 315		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 315	Continued From page 42 11:15am revealed: -Residents in the SCU needed mental exercise due to having decreased cognition levels. -He did not know activities were not being provided for residents in the SCU until today. -He observed today, 08/06/21, there were no activities being provided for the residents in the SCU. -He expected activities to be provided to the residents in the SCU to maintain their cognition levels.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure residents were treated with respect and dignity for 2 of 5 sampled (#2, #3) residents as evidenced by staff speaking rudely to a resident (#2); and a resident who resided in the Special Care Unit (SCU) being teased and laughed at by two staff (#3). The findings are: Review of the facility's Abuse and Neglect Reporting Policy including suspected/confirmed Resident to Resident Abuse Policy on 08/05/21 revealed: -All reporting of abuse and neglect was handled	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 43	D 338		

in accordance with state rules and regulations.
-Psychological abuse was deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress.

Review of the facility's census report dated 08/04/21 revealed:
-The SCU in-house census was 26 residents.
-The assisted living (AL) census was 43.

1. Review of Resident #3's current FL-2 dated 08/21/20 revealed:
-Diagnoses included dementia.
-The resident was intermittently disoriented and semi-ambulatory;

Review of Resident #3's Resident Register revealed:
-The resident had significant memory loss requiring direction.
-The resident required a walker and wheelchair for ambulation.

Review of Resident #3's current care plan dated 03/05/21 revealed:
-The resident wandered, was always disoriented, confused, had significant memory loss requiring direction, and used a wheelchair for ambulation.
-The resident required extensive assistance with ambulation, bathing, dressing, and transfers.
-The resident was dependent upon staff for toileting.

Observation of the Special Care Unit (SCU) on 08/04/21 at 1:15pm revealed:
-There was a medication aide/supervisor (MA/S) sitting behind the nurses' station.
-Staff E and a personal care aide (PCA) were

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 44	D 338		

standing against the front of the nurses' station.
-Resident #3 self-propelled in the wheelchair to the nurses' station.
-Resident #3 was holding his shoe in his hands.
-The MA, Staff E, or the PCA did not attempt to assist Resident #3 with donning his shoe.
-Resident #3 yelled as he reached for an object behind the nurses' station.
-Staff E pushed the object away and stated, "that's not yours. It's not a hat".
-The PCA walked between the nurses' desk and Resident #3.
-The PCA flicked her fingers under Resident #3's nose as she walked by.
-Resident #3 yelled, "Did ya'll see that, Ya'll saw that".
-The MA/S and Staff E laughed.
-The PCA continued to walk away.
-Resident #3 continued to yell and curse.
-Staff E flicked her fingers at the brim of Resident #3's hat twice.
-Resident #3 continued to yell and curse and self-propelled down the hall between the nurses' station and television room.

Interview with Staff E on 08/04/21 at 2:04pm revealed:
-It was normal for Resident #3 to have screaming outbursts and agitation.
-Resident #3 would yell out and curse if touched.
-Resident #3 approached the nurses' station and tried to grab her jacket.
-She pushed the jacket away from Resident #3.
-She reached for and touched Resident #3's hat once.
-Resident #3 began cursing and yelling.
-She knew Resident #3 would begin cursing and yelling if she reached for and touched his hat.
-There was no reason why she reached for and touched Resident #3's hat.

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 338	Continued From page 45	D 338		

-She did not intend to "agitate" Resident #3.
-The PCA reached for Resident #3's hat as she walked away.
-Resident #3 yelled out "yall saw what happened".
-She and the MA laughed at Resident #3 when he began yelling.
-She and the MA thought Resident #3 yelling was funny because they did not expect Resident #3 to yell.
-She and the MA were not "picking" at Resident #3 when they laughed at him.
-She was not "picking" at Resident #3 when she reached for his hat.
-Resident #3 was in the SCU because he had dementia, memory loss, and could not process things the way someone without mental impairments could.
-She did not think it was wrong to reach for Resident #3's hat.
-She did not think it was wrong to laugh at Resident #3.
-She had received online facility education regarding SCU residents about 3 weeks ago.
-She had received online facility education regarding resident rights and respect and dignity about 3 weeks ago.

Interview with the PCA on 08/04/21 at 2:17pm revealed:
-Resident #3 would curse and fuss when he was "messed" with such as telling Resident #3 she liked his hat.
-She would "pick" at and "talk junk" to Resident #3 because his responses were funny.
-Resident #3 would curse and get loud when picked at and talked junk to.
-Resident #3 was sometimes confused.
-She pushed Resident #3 out of her way when she walked away from the nurses' station.
-She did not flick her fingers under Resident #3's

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 338	Continued From page 46	D 338		

nose when she walked away from the nurses' station.
-She told Resident #3 she liked his hat and to be nice while using hand gestures as she walked away from the nurses' station.
-Resident #3 yelled when she told him she liked his hat and to be nice.
-The MA and Staff E laughed at Resident #3 because he yelled out.
-Resident #3 had dementia and she would not do anything to disrespect the resident.

Interview with the MA/S on 08/04/21 at 2:25pm revealed:
-The PCA touched Resident #3's hat.
-Resident #3 yelled, "Don't touch my hat, stop. Did yall see that?"
-She and Staff E laughed at Resident #3's response to the PCA touching his hat.
-She did not think it was wrong to laugh at Resident #3's response.
-She did not see Staff E reach for Resident #3's hat.

Telephone interview with Resident #3's hospice provider on 08/05/21 at 10:21am revealed:
-The resident had decreased cognition levels related to end stage dementia.
-Staff were expected to not "ridicule" the resident because of the decreased cognition levels.
-Ridiculing the resident could cause an increase in agitation and it was uncertain how the resident would respond.
-Hospice was available to the facility for notifications of resident needs 24 hours a day 7 days a week.

Interview with the SCU Coordinator on 08/05/21 at 1:00pm revealed:
-Resident #3 did not like anyone to touch his hat,

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D 338	Continued From page 47	D 338		

ears, or back of head.
-Staff E had previously "agitated" Resident #3 about 2 months ago by bothering his hat.
-Staff E would also bother Resident #3's ears and back of head.
-Two months ago, Resident #3 told the Staff E he did not like her.
-She told the Staff E 2 months ago she was "agitating" Resident #3.
-Two months ago, Staff E did not have an explanation as to why she agitated Resident #3.
-She told Staff E 2 months ago to leave Resident #3 alone.
-Staff E was transferred to the assisted living (AL) side 2 months ago because of bothering Resident #3's hat, ears and back of head.
-Staff E was transferred from AL back to SCU about 1 month ago due to speaking disrespectful to another resident on the AL side.
-Staff were expected to not laugh at Resident #3 because it caused increased agitation for the resident.
-Staff knew Resident #3 did not like to be laughed at because of previous encounters with the resident.
-She did not know if the facility had a resident abuse policy.

Interview with the ED on 08/05/21 at 2:30pm revealed:
-She did not know of any staff in the facility who had spoken negatively to a resident.
-Staff were expected to not speak negatively to a resident because it was considered a form of resident abuse.
-Residents residing in the SCU had cognitive deficits.
-Staff were expected to not "flip" at or touch a resident's hat because it was an invasion of the resident's personal space.

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D 338	Continued From page 48 -Staff E had previous allegations of talking harshly to another resident on the AL side. -Staff E had worked a few shifts in SCU but was not her normal assignment. -She did not know when Staff E was scheduled to work in the SCU. -Staff were expected to not laugh at residents because it was disrespectful and not dignified. -Staff laughing at residents was considered making fun of the resident. -SCU staff knew Resident #3 did not like his hat, ears, or back of head touched by providing personal care to the resident. -Staff E was pulled from the SCU to the AL because of work performance issues. -She thought separating Staff E from specific co-workers in the SCU would improve Staff E's work performance. -Staff E was transferred back to the SCU from the AL because of the allegations of speaking harshly to an AL resident. -Staff E was investigated when accused of speaking harshly to the AL resident and the accusations were unsubstantiated. -She had never been informed of any incident that occurred between the Staff E and Resident #3. -She expected to be informed by any staff when there was an allegation of resident rights. Interview with the Administrator on 08/05/21 at 4:30pm revealed: -Residents in the SCU had cognitive impairments and could not comprehend as well as a person without cognitive impairments. -Staff were not to speak disrespectful to residents. -Staff were not to ridicule residents. -He did not know Resident #3 had been spoken to disrespectfully by staff.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 49 -He did not know Resident #3 had been ridiculed by staff. 2. Review of Resident # 5's current FL2 dated 06/30/21 revealed diagnoses included hypertension, osteoarthritis, polyneuropathy, and atrial fibrillation. Review of Resident #5's current assessment and care plan dated 07/12/21 revealed: -Resident #5 ambulated with devices, had limited range of motion and limited strength in her upper extremities. -Resident #5 had limited vision and used hearing aids. -Resident #5 required supervision with eating, grooming and personal hygiene and required limited assistance with toileting, bathing, dressing and transferring and extensive assistance with ambulation. Review of a Health Care Personnel Registry 24-Hour Initial Report dated 07/08/21 revealed: -The incident happened on 07/06/21 at 8:00pm. -The incident was resident abuse to Resident #5. -Staff E was heard yelling at Resident #5 and speaking inappropriately to her. Review of a facility interview form dated 07/07/21 completed by the ED revealed: -The interviewee was the medication aide (MA) that overheard the incident with Resident #5 and Staff E. -Resident #5 needed help getting ready for bed, she did not want to get her night clothes on yet, she wanted to brush her teeth. -Resident #5 was told by Staff E, personal care aide (PCA), "she would have to put her night clothes on now or one else would come help her."	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 50 -Staff E was overheard yelling at Resident #5 saying Resident #5 "was lucky that Staff E went down to answer her page because she didn't have to help her, and Resident #5 was getting on her nerves and pissing her off." Review of a facility Interview Form for Subject of Investigation dated 07/07/21 completed by the ED revealed: -The interviewee was the PCA that had the incident with Resident #5. -Staff E's statement was she went to tell Resident #5 to "let's get your pajamas on." Resident #5 told her "it was still light outside." Staff E told Resident #5 she would be upset if she came back late to put her pajamas on. Resident #5 told her she" would have her daughter come put her pajamas on." She had to shout for Resident #5 to hear her without her hearing aids. Interview with the ED on 08/05/21 at 10:46am revealed: -She received a complaint from a MA that she heard Staff E yelling at Resident #5 and talking in a brash tone to her. -This incident happened on 07/06/21 and it was reported to her on 07/07/21. -She did not know why it was reported on the next day. -Staff E had not come to work on 07/07/21 and the ED called her and informed her she was suspended. -The policy was for any incident to be reported immediately. -Her concerns would be it could upset the resident. -She expected all residents to be treated respectfully. Interview with a MA on 08/05/21 at 4:23pm	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 51 revealed: -She was passing medications at 8:00pm and her cart was parked outside Resident #5's door. -Resident #5's door was opened about 3 inches and she was standing outside the door. -She heard Staff E talk to Resident #5 very negatively saying Resident #5 was lucky Staff E had come to help her get her pajamas on. -As Staff E came out of Resident #5's room she commented loudly Resident #5 was pissing her off because "she can do this stuff on her own that she is asking for help for." -Resident #5 was upset when the MA went into her room. -She does not know why she did not report it on that day. She knew she should have. -The policy was to report it immediately. Interview with Resident #5 on 08/06/21 at 9:52 am revealed: -She could not recall the incident where Staff E was yelling at her. -She had to have help dressing. -She was not supposed to go the bathroom by herself because of previous falls. Attempted telephone interview with Resident #5's family on 08/06/21 at 11:00am was unsuccessful. Attempted telephone interview with Resident #5's primary care provider on 08/06/21 at 12:00pm was unsuccessful. Attempted telephone interview with Staff E on 08/06/21 at 12:20pm was unsuccessful. _____ The facility failed to ensure residents were treated with respect and dignity as evidenced by a resident diagnosed with dementia in the special care unit who was picked on, ridiculed, laughed	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 338	Continued From page 52 at, and waved fingers in his face by staff which resulted in mental anguish and agitation (#3). This failure was detrimental to the welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 08/04/21. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 20, 2021.	D 338		
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 and in accordance with the facility's policies for 2 of 5 residents (#9, #10) observed during the medication pass including errors with an antidepressant, an antifungal powder and eye drops (#9) and nasal spray, an oral pain reliever and a topical pain reliever (#10). The findings are: The medication error rate was 14% as evidenced by the observation of 6 errors out of 41	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 358	Continued From page 53	D 358		

opportunities during the 8:00am/9:00am medication pass on 08/05/21.

1a. Review of Resident #9's current FL-2 dated 06/15/21 revealed diagnoses included right femur fracture, osteoarthritis, spinal stenosis, chronic obstructive pulmonary disease (COPD), depression, anxiety, dysphagia, hypertension (HTN), atrial fibrillation (A-Fib) and gastroesophageal reflux disease (GERD).

Review of Resident #9's physician's orders dated 01/27/21 revealed there was an order for Voltaren Gel 1% apply 2 grams (gm) topically to neck and knees twice a day. (Voltaren Gel is a topical nonsteroidal anti-inflammatory gel used to treat arthritis.)

Observation of the 8:00am/9:00am medication pass on 08/05/21 at 7:36am revealed the medication aide (MA) did not administer or offer the Voltaren Gel for Resident #9.

Observation of Resident #9's medications on hand on 08/05/21 at 12:09pm revealed:
-There was ½ tube of Voltaren Gel on hand.
-Resident #9's name was hand written on the Voltaren Gel and there was no pharmacy label present.

Review of Resident #9's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Voltaren Gel 1% apply 2gm topically to the neck and knees twice a day scheduled at 8:00am and 8:00pm.
-Voltaren Gel was documented as administered on 08/05/21 at 8:00am.

Interview with the MA on 08/05/21 at 12:08pm

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 358	Continued From page 54	D 358		

revealed:
-She had not administered the Voltaren Gel.
-Resident #9 sometimes refused the Voltaren Gel and she forgot to ask if he wanted it.
-She accidentally documented on Resident #9's eMAR on 08/05/21 at 8:00am that she administered the Voltaren Gel.

Interview with Resident #9 on 08/05/21 at 2:58pm revealed:
-The MA had not administered the Voltaren Gel on 08/05/21 during the 8:00am medication pass and he had not requested it.
-He had generalized pain all of the time.

Refer to interview with the Executive Director on 08/05/21 at 12:23pm.

Refer to interview with the Administrator on 08/05/21 at 2:45pm.

Telephone interview with Resident #9's PCP on 08/06/21 at 11:55am revealed Voltaren Gel should be administered as ordered for adequate pain control.

b. Review of a subsequent physician's order for Resident #9 dated 07/14/21 revealed there was an order for Tylenol 500mg administer 2 tablets (1000mg total) every 8 hours as needed for pain. (Tylenol is used to treat minor aches, pains and reduce fevers.)

Observation of the 8:00am/9:00am medication pass on 08/05/21 at 7:36am revealed:
-Resident #9 voiced complaints of generalized pain and requested Tylenol.
-The MA reviewed Resident 9's electronic medication administration record (eMAR) and administered 2 tablets of Tylenol 325mg.

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 358	Continued From page 55 Observation of Resident #9's medications on hand on 08/05/21 at 12:09pm revealed there were 58 of 60 tablets of Tylenol 500mg remaining from the supply dispensed on 07/31/21. Review of Resident #9's August 2021 eMAR revealed: -There was an entry for Tylenol 500mg administer 2 tablets every 8 hours as needed for pain. -Tylenol was documented as administered on 08/05/21 at 7:36am. Interview with the MA on 08/05/21 at 12:08pm revealed: -She was not aware that she administered Resident #9 Tylenol 325mg 2 tablets instead of the ordered Tylenol 500mg 2 tablets. -The administration of the incorrect Tylenol dosage was an "oversight." Interview with Resident #9 on 08/05/21 at 2:58pm revealed he had generalized pain daily. Telephone interview with Resident #9's PCP on 08/06/21 at 11:55am revealed Tylenol should be administered as ordered for adequate pain control. Refer to interview with the Executive Director on 08/05/21 at 12:23pm. Refer to interview with the Administrator on 08/05/21 at 2:45pm. c. Review of a subsequent order for Resident #9 dated 07/14/21 revealed there was an order for Flonase 1 spray to each nostril twice a day as needed. (Flonase is used to relieve allergic and non-allergic nasal symptoms such as stuffy/runny	D 358		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 358	Continued From page 56 nose, itching and sneezing.) Observation of the 8:00am/9:00am medication pass on 08/05/21 at 7:36am revealed: -The medication aide (MA) administered Resident #9 Flonase 50mcg 1 spray to each nostril. -Resident #9 had not requested the Flonase. Observation of Resident #9's medications on hand on 08/05/21 at 12:09pm revealed: -There was 1 bottle of Flonase 50mcg dispensed on 02/14/21, opened on 05/15/21 and was ½ full. -There was a "directions changed refer to chart" sticker on the Flonase box. Review of Resident #9's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Flonase 50mcg administer 1 spray in each nostril twice a day as needed. -There was no documentation for the administration of Flonase on 08/05/21. Interview with the MA on 08/05/21 at 12:08pm revealed: -She was not aware that the directions for Resident #9's Flonase had changed. -She saw the "directions changed refer to chart" sticker on the Resident #9's Flonase box but had not reviewed the orders for instructions. -Resident #9's Flonase used to be administered routinely and she was used to administering the Flonase with the morning medication pass. Telephone interview with Resident #9's PCP on 08/06/21 at 11:55am revealed medications should be administered as ordered. Refer to interview with the Executive Director on	D 358		

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D 358	Continued From page 57 08/05/21 at 12:23pm. Refer to interview with the Administrator on 08/05/21 at 2:45pm. 2a. Review of Resident #7's current FL-2 dated 02/04/21 revealed diagnoses included intellectual disability, hyperlipidemia, anxiety, major depressive disorder, allergic rhinitis, hypertension (HTN), age related osteoporosis and gastroesophageal reflux disorder (GERD). Review of Resident #7's physician's orders dated 02/04/21 revealed there was an order for Azelastine 0.05% eye drops administer 1 drop into each eye twice a day. (Azelastine is an antihistamine used to treat itching of the eyes.) Observation of the 8:00am/9:00am medication pass on 08/05/21 at 7:23am revealed the MA did not administer Resident #7's Azelastine eye drops. Observation of Resident #7's medications on hand on 08/05/21 at 12:09pm revealed there was a ¼ bottle of Azelastine eye drops dispensed on 07/14/21 that remained. Review of Resident #7's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Azelastine eye drops 1 drop to each eye twice a day scheduled at 8:00am and 8:00pm. -Azelastine eye drops were documented as administered on 08/05/21 at 8:00am. Interview with the MA on 08/05/21 at 12:17pm revealed: -She did not administer Resident #7's Azelastine	D 358		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 358	Continued From page 58	D 358		

eye drops with the 8:00am medication pass because the resident received multiple eye drops and she had to wait about 5 minutes in between the different eye drops.
-She administered Resident #7's Azelastine eye drops after breakfast.

Interview with Resident #7 on 08/05/21 at 12:55pm revealed the MA did not administer her Azelastine eye drops after breakfast.

Refer to interview with the Executive Director on 08/05/21 at 12:23pm.

Refer to interview with the Administrator on 08/05/21 at 2:45pm.

Attempted telephone interview with Resident #7's PCP on 08/06/21 at 10:46am was unsuccessful.

b. Review of Resident #7's physician's orders dated 02/04/21 revealed there was an order for Buspar 30mg twice a day. (Buspar is a medication used to treat anxiety.)

Observation of the 8:00am/9:00am medication pass on 08/05/21 at 7:23am revealed the medication aide (MA) did not administer Resident #7's Buspar.

Observation of Resident #7's medications on hand on 08/05/21 at 12:09pm revealed there was a card with 58 of 60 Buspar 30mg tablets dispensed on 07/31/21 that remained.

Review of Resident #7's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Buspar 30mg twice a day scheduled at 8:00am and 8:00pm.

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D 358	Continued From page 59	D 358		

-Buspar was documented as administered on 08/05/21 at 8:00am.

Interview with the MA on 08/05/21 at 12:17pm revealed:
-She usually administered Resident #7's Buspar with the rest of her 8:00am medications but she administered it after breakfast on 08/05/21.
-Resident #7 had a supply of Buspar that was dispensed in a bottle and there was none left; she had to find the supply dispensed in the bubble cards by the pharmacy.

Interview with Resident #7 on 08/05/21 at 12:55pm revealed the MA did not Buspar after breakfast.

Refer to interview with the Executive Director on 08/05/21 at 12:23pm.

Refer to interview with the Administrator on 08/05/21 at 2:45pm.

Attempted telephone interview with Resident #7's PCP on 08/06/21 at 10:46am was unsuccessful.

c. Review of Resident #7's physician's orders dated 02/04/21 revealed there was an order for Nystatin Powder 100,000 unit (u)/gram (gm) apply to affected area twice a day. (Nystatin Powder is a topical antifungal used to treat fungal or yeast infections of the skin.)

Observation of the 8:00am/9:00am medication pass on 08/05/21 at 7:23am revealed the medication aide (MA) did not administer Resident #7's Nystatin Powder.

Observation of Resident #7's medications on hand on 08/05/21 at 12:09pm revealed there was

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D 358	Continued From page 60 ¼ bottle of Nystatin Powder remaining from the supply dispensed on 07/03/21. Interview with the MA on 08/05/21 at 12:17pm revealed she did not administer Resident #7's Nystatin Powder with her 8:00am medications because Resident #7 would notify the MA when she wanted the Nystatin Powder applied. Review of Resident #7's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Nystatin Powder 100,000 u/gm topically to affected areas twice a day scheduled at 8:00am and 8:00pm. -Nystatin Powder was documented as administered on 08/05/21 at 8:00am. Interview with Resident #7 on 08/05/21 at 12:55pm revealed: -She had not received her Nystatin Powder on 08/05/21. -She would tell the MA when she wanted her Nystatin Powder, but she had not requested it yet. -The Nystatin Powder was applied to her groin and abdominal folds for redness and itchiness and had been helpful. Refer to interview with the Executive Director on 08/05/21 at 12:23pm. Refer to interview with the Administrator on 08/05/21 at 2:45pm. Attempted telephone interview with Resident #7's PCP on 08/06/21 at 10:46am was unsuccessful. _____ Interview with the Executive Director on 08/05/21 at 12:23pm revealed: -It was the responsibility of the medication aide	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 61 (MA) to administer medications as ordered by the primary care provider (PCP). -It was the responsibility of the MA to document on the resident's electronic medication administration record (eMAR) after medications were administered. Interview with the Administrator on 08/05/21 at 2:45pm revealed: -It was the responsibility of the MA to administer medications as ordered by the PCP. -It was the responsibility of the MA to document on the resident's eMAR after medications were administered.	D 358		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were always present to meet the needs of residents residing in the Special Care Unit (SCU) for 3 of 9 shifts sampled from 07/03/21-07/05/21. The findings are: Review of the facility's current license effective	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 465	Continued From page 62 01/01/21 revealed the facility was licensed as a special care unit (SCU) with 36 beds and an assisted living (AL) facility with a capacity of 60 beds. Review of the facility's resident census report dated 07/04/21 revealed there was a SCU census of 27 residents which required 27 staff hours on first and second shift and 21.6 staff hours on third shift. Review of the punch detail records for staff dated 07/04/21 revealed there were 11.72 staff hours provided on the second shift, a shortage of 15.28 hours. Review of the facility's resident census report dated 07/05/21 revealed there was a SCU census of 27 residents which required 27 staff hours on first and second shift and 21.6 staff hours on third shift. Review of the punch detail records for staff dated 07/05/21revealed: -There were 25.11 staff hours provided on the first shift, a shortage of 1.89 hours. -There were 16.29 staff hours provided on the third shift, a shortage of 5.31hours. Interview with the Special Care Unit Coordinator (SCUC) on 08/04/21 at 11:00am revealed: -The SCU was short staffed. -On 08/02/21 for 2nd shift there was 1 medication aide (MA) and 1 personal care aide (PCA) staffing the SCU. -The SCU had three residents that required staff assistance for feeding. -Sometimes when short staffed she would help serve meals, and staff as a PCA or MA when short staffed.	D 465		

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D 465	Continued From page 63 Interview with a SCU MA on 08/04/21 at 2:40pm revealed: -The MAs and PCA worked 8hr shifts in the SCU. -The first shift worked 7:00am - 3:00pm, the second shift worked 3:00pm - 11:00pm and the third shift worked 11:00pm - 7:00am. Interview with a 1st shift PCA on 08/04/21 at 9:56am revealed: -Last week the SCU was short staffed but could not recall the days. -There was only 2 PCAs and 1 MA working SCU. Interview with another 1st shift PCA on 08/04/21 at 10:00am revealed: -Last week the SCU worked short staffed 2 days but she could not recall which days. -Second and Third shift work short staffed more that first shift. Interview with the Administrator on 08/06/21 at 3:25pm revealed: -It was the responsibility of the SCC to complete the staff schedule and find coverage for vacant shifts for the SCU. -The Executive Director would work as a PCA in the evenings and on weekends when needed. -They had contracted with a staffing company for help but there were times when they had staffing needs the staffing company did not have anyone to send. A second interview with the SCUC on 08/06/21 at 3:30pm revealed: -There was 2-3 times a week the SCU was short staffed. -The facility had a contract with a staffing agency about 2 months ago but some days the agency would not be able to provide the staffing that was	D 465		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 465	Continued From page 64 needed. -They were trying to recruit staff online and offering increased pay to recruit staff to the facility. -She worked as a PCA when needed.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 468	Continued From page 65 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 6 staff sampled (Staff A, C and E) who were responsible for personal care and supervision in the special care unit (SCU) completed 6 hours of orientation within the first week of employment and 20 hours of training specific to the SCU population within 6 months of employment. The findings are: 1. Review of Staff A's personnel record on 08/06/21 revealed: -Staff A was hired 10/26/20 as a medication aide (MA). -There was no documentation Staff A completed an additional 20 hours (hrs) of Special Care Unit (SCU) training within the first 6 months (mths) of hire. Review of Staff A's electronic training record on 08/06/21 revealed: -Staff A completed 1 hr of additional SCU training on 11/03/20. -Staff A completed 0.75 hr of additional SCU training on 01/26/21. -There was no documentation Staff A completed an additional 20 hrs of SCU training within the first 6 mths of hire. Attempted interview with Staff A on 08/06/21 at 4:05pm was unsuccessful. Refer to interview with the Administrator on 08/05/21 at 3:26pm. Refer to interview with the Executive Director (ED) on 08/06/21 at 3:30pm.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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 468	Continued From page 66 Refer to interview with the Business Office Manager (BOM) on 08/06/21 at 4:00pm. 2. Review of Staff C's personnel record on 08/06/21 revealed: -Staff C was hired on 01/01/20 as a medication aide (MA). -There was no documentation Staff C completed 6 hours of Special Care Unit (SCU) training within the first week of hire. -There was no documentation Staff C completed an additional 20 hrs of SCU training within the first 6 months of hire. Review of Staff C's electronic training record revealed there was no documentation of SCU training between the hire date of 01/01/20 - 11/03/20. Interview with the Executive Director on 08/06/21 at 3:30pm revealed: -Staff C was originally hired in 2012. -Staff C "left the facility for a short time" and was rehired in 2020. -She did not know staff C's facility severance date. -She did not know Staff C's exact hire date of 2020. -She thought Staff C's SCU training from the hire date of 2012 would count towards the requirements of her new hire date for 2020. Attempted interview with Staff C on 08/06/21 at 4:00pm was unsuccessful. Refer to interview with the Administrator on 08/05/21 at 3:26pm. Refer to interview with the Executive Director	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 468	Continued From page 67 (ED) on 08/06/21 at 3:30pm. Refer to interview with the Business Office Manager (BOM) on 08/06/21 at 4:00pm. 3. Review of Staff E's personnel record revealed: -Staff E was hired on 06/29/20 as a personal care aide (PCA). -There was a certificate in Staff E's record documenting completion of six hours of orientation that was not dated or signed. -There was no documentation Staff E completed her 20 hours of training within six months of employment related to personal care and supervision in the SCU. Attempted telephone interview with Staff E was unsuccessful. Refer to interview with the Administrator on 08/05/21 at 3:26pm. Refer to interview with the Executive Director (ED) on 08/06/21 at 3:30pm. Refer to interview with the Business Office Manager (BOM) on 08/06/21 at 4:00pm. _____ Interview with the Administrator on 08/05/21 at 3:26pm revealed: -The Business Office Manager (BOM) was responsible for collecting trainings and filing in personnel records. -The 20-hour trainings for the SCU and the infection control trainings were completed electronically. Interview with the Executive Director (ED) on 08/06/21 at 3:30pm revealed she did not know who was responsible to ensure the required 20 hr	D 468		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 468	Continued From page 68 SCU training was performed. Interview with the Business Office Manager on 08/06/21 at 4:00 revealed: -She was responsible for maintaining and auditing personnel records at the facility. -She was aware that staff completed their required training online or electronically. -She was working on a process to ensure personnel training records were available in the facility for review.	D 468		
D 611	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal	D 611		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 611	Continued From page 69 protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak; (7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and	D 611		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 611	Continued From page 70 (8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to follow outlined infection control policies and procedures related to a resident on contact isolation (#10). The findings are: Review of the facility's Community Infection Control Policy dated 02/11/21 revealed: -The Community will utilize Transmission-Based Precautions per CDC recommendations. -Contact Precautions are used for known or suspected infections that represent an increased risk for contact transmission and staff shall: clean hands prior to entry and upon exit of resident room, use personal protective equipment (PPE) including gloves and gown for all interactions that may involve contact with the resident or the resident's environment, use dedicated equipment and clean and disinfect reusable equipment before use on another person. Review of Resident #10's current FL-2 dated 02/20/21 revealed diagnoses included hypertension (HTN), depression, transient ischemic attack (TIA), chronic constipation, dysphagia and gastroesophageal reflux disease	D 611		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 611	Continued From page 71 (GERD). Observation of Resident #10's room on 08/04/21 revealed: -There was a box of isolation gowns beside Resident #10's room door. -There was no isolation sign posted and no isolation station at Resident #10's door. Observation of the breakfast meal on 08/06/21 at 8:39am revealed: -The personal care aide (PCA) was passing out resident's breakfast trays on the hallway. -The PCA took Resident #10's breakfast tray from the meal cart and placed it on Resident #10's bedside table. -The PCA wore a mask only while in Resident #10's room and did not perform hand hygiene when she exited. -The PCA went back to the meal cart, got a cup of milk and reentered Resident #10's room wearing a mask only. -The PCA did not perform hand hygiene when she exited Resident #10's room. -The PCA went back to the dietary cart and continued to serve other resident's breakfast trays in their rooms. -The PCA did not perform hand hygiene in between passing trays to other residents. Review of Resident #10's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Valacyclovir 1 gram (gm) three times a day for 7 days scheduled at 7:00am, 1:00pm and 7:00pm. (Valacyclovir is an antiviral medication used to treat shingles.) -Valacyclovir was documented as administered from 08/04/21 - 08/06/21.	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 611	Continued From page 72 Interview with the PCA on 08/06/21 at 9:48am revealed: -She was made aware that Resident #10 was on isolation for shingles during change of shift report on 08/05/21. -Residents who were on isolation usually had an isolation sign posted on their door and an isolation station with clean PPE supplies and hand sanitizer outside of their room. -She was aware of the PPE needed because of a computer training that she completed on infection control with the facility about 6 months ago. -The staff were to wear a gown, mask and gloves while in the room and perform hand hygiene when they exited Resident #10's room. -She was not sure why she did not wear PPE while in Resident #10's room. -She was not sure why she did not perform hand hygiene after she exited Resident #10's room. -She was not sure why she did not perform hand hygiene in between serving resident's their breakfast trays in their rooms. Interview with a medication aide (MA) on 08/06/21 at 8:46am revealed: -Resident #10 was on isolation because of a recent diagnosis of shingles. -Resident #10 went to the emergency room (ER) approximately 2 days ago for complaints of chest pain and was diagnosed with shingles. -The staff were to wear gown, gloves and mask while in Resident #10's room and perform hand hygiene upon exit. -She was not sure why there was not a PPE station set up outside of her room that consisted clean PPE supplies, hand sanitizer and a trash bin. -She was unsure why there was no an isolation sign on Resident #10's door to inform staff of the PPE required to care for the resident.	D 611		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D 611	Continued From page 73	D 611		

-Residents that were on isolation would usually have an isolation cart outside of their door and an isolation sign posted on their doors.
-She was not sure whose responsibility it was to set up the PPE stations and put the isolation signs on the doors.

Interview with the Executive Director on 08/06/21 at 11:10am revealed:
-Residents on isolation should have an isolation sign posted on the outside of their room to show the PPE required to care for that resident.
-Residents on isolation should also have an isolation station with clean PPE supplies, hand sanitizer and trash bins outside of their room for easy access.
-Resident #10 went to the ER for complaints of chest pain and was diagnosed with shingles on 08/03/21.
-She did not have the ER discharge notes from the 08/03/21 visit because Resident #10's daughter went to the ER with her and had not brought the paperwork to the facility.
-Resident #10 should have been on isolation precautions for shingles and the isolation sign and trash bin should have been present at her room.
-It was the responsibility of the Resident Care Coordinator (RCC) or the ED to ensure that the isolation stations and the isolation signs were in place.
-It was the responsibility of the staff to perform hand hygiene between residents and as needed.

Telephone interview with Resident #10's primary care provider (PCP) on 08/06/21 at 11:55am revealed:
-The staff should follow the facility's infection control policy.
-The staff should perform hand hygiene prior to

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 611	Continued From page 74 entering and exiting a resident's room for infection control.	D 611		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure the acute healthcare needs for 1 of 5 sampled residents (#3) related to a choking episode requiring the Heimlich maneuver, and wounds to the left knee and leg and right first toe. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

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D914	Continued From page 75	D914		

This Rule is not met as evidenced by:
Based on observation, interview and record reviews, the facility failed to assure residents were free of abuse and neglect related to resident rights, nutrition and food service and supervision.

The findings are:

1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance to the residents assessed needs for 1 of 5 sampled residents (#3) left unsupervised in the television room of the special care unit. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].

2 .Based on observations, record reviews and interviews, the facility failed to serve nectar thickened liquids for 1 of 2 sampled residents with orders for thickened liquids (Resident #8) and failed to ensure the nectar thickened liquids were measured accurately before serving the residents for 2 of 2 residents (Resident #2 and #8). [Refer to Tag 310, 10A NCAC 13F ..0904(e) (4) Nutrition and Food Service (Type B Violation)].

3 .Based on observations, interviews, and record reviews the facility failed to ensure residents were treated with respect and dignity for 2 of 5 sampled (#2, #3) residents as evidenced by staff speaking rudely to a resident (#2); and a resident who resided in the Special Care Unit (SCU) being teased and laughed at by two staff (#3). [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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
D935	Continued From page 76	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

(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
D935	Continued From page 77 exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 4 sampled staff (A) who administered medications had completed the 5, 10, or 15-hour medication administration training course or had documentation of the medication aide verification form. The findings are: Review of Staff C's personnel record on 08/06/21 revealed: -Staff C was hired on 01/29/20. -There was documentation Staff C passed the written medication aide (MA) exam on 09/19/18. -There was documentation of a Medication Clinical Skills Competency Evaluation form dated 02/07/20. -There was no documentation Staff C completed the 5, 10, or 15-hour (hr) medication administration training course. -There was no documentation of the facility MA Verification form prior to employment as a MA. Interview with the Executive Director (ED) on 08/06/21 at 3:30pm revealed: -The Business Office Manager (BOM) was responsible to ensure the 5, 10, or 15 hr medication administration training course was in Staff C's staff folder. -It was ultimately the ED's responsibility to ensure the BOM maintained accurate staff folders. -She had no process to ensure the BOM was maintaining accurate staff folders.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	C 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FUQUAY VARNIA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D935	Continued From page 78 Interview with the Business Office Manager on 08/06/21 at 4:00 revealed: -She was responsible for maintaining and auditing personnel records at the facility. -She was aware that staff completed their required training online or electronically. Attempted interview with Staff C on 08/06/21 at 4:00pm was unsuccessful.	D935		