Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on March 1, 2022 to March 3, 2022 with an exit via telephone on March 4, 2022.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (Resident #1) related to failure to contact emergency medical services (EMS) timely as requested by the resident who reported pain following an unwitnessed fall. The findings are: Review of Resident #1's current FL-2 dated 02/14/22 revealed diagnoses included fracture of the right inferior pubic ramus (pelvic fracture), acute kidney injury, and Alzheimer's dementia. Review of an incident report for Resident #1 revealed: -The report was completed by the day shift medication aide (MA) on 02/13/22. -The incident occurred on 02/12/22 at 9:00am. -The resident experienced a witnessed fall. -Resident #1 stated she was "hurting really bad." -The resident stated she fell and got up by herself. -The resident had a bruise in an unidentified	{D 273}	HWD and/or designee immediately re-educated all staff on emergency protocols. New hires and new agency staff assignment will be educated prior to first independent shift on the floor. HWD and/or designee and Administrator or designee will have clinical stand-up meeting daily to include discussion of incidents and follow-up. HWD and/or designee will place reference binder including emergency response policies, incident reporting process and procedures and phone tree in area readily available to all staff. All staff including agency staff will be educated on the contents and location of this binder. Administrator and/or designee will notify all agency partners of emergency procedures, communication and community phone tree. HWD, BOM and/or designee will review staff training grid at least monthly to ensure all staff currently working in the community have received documented training on emergency procedures, reporting of incidents and location of reference binder in the community. Any discrepancies will be reported immediately to the Administrator. HWD or designee will provide education to any team member without documented training prior to the beginning of the team member's next scheduled shift.	4.3.22 4.3.22 4.3.22 4.3.22 4.3.22

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Bell, Administrator — TITLE — (X6) DATE 4/3/22

RECEIVED
APR 08 2022
ADULT CARE LICENSURE SECTION
RALEIGH

Reviewed and Acknowledged. P.D 04/11/22

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{D 273}	Continued From page 1 location. -EMS was called and transported Resident #1 to the emergency department (ED). Review of Resident #1's progress notes dated 02/13/22 revealed: -The day shift MA entered a note at 7:33am indicating the resident was sent to the hospital because of an abnormal gait. -The resident stated she fell and told a personal care aide (PCA) she needed to go to the hospital, but no one listened to her. -The same MA entered a second note at 7:57am indicating the resident was sent to the ED after a fall on another shift. -The resident was complaining of pain on her whole right side. -The same MA entered a third note at 1:42pm indicating the hospital physician called and reported the resident had a fracture to the right side (no further information indicated) and an infection. Review of Resident #1's hospital discharge summary dated 02/14/22 revealed: -Resident #1 was admitted to the hospital on 02/13/22 because she had a pelvic fracture due to a fall. -Surgery to fix the fracture was not in Resident #1's best interest. -Facility staff reported the resident had an unwitnessed fall during third shift. -The resident was found out of her bed on the floor and was assisted back into bed. -First shift staff noted Resident #1's abnormal gait and the resident reported right-sided pain. -First shift staff called EMS to transport the resident to the hospital. -Resident #1 was discharged from the hospital on 02/14/22 with orders to use a wheelchair pending	{D 273}		

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{D 273}	Continued From page 2 follow-up with an orthopedist. -Resident #1 had an order for physical therapy (PT) evaluation and treatment. Review of a written statement submitted by an agency PCA revealed: -The statement was signed and dated 02/13/22. -The PCA worked third shift on 02/12/22. -At 6:15am, Resident #1 walked up to the PCA and stated she was hurting and had fallen. -The other third shift PCA reported Resident #1's complaint to the MA. -The MA said it was "old," but she would "check it out." Review of a written statement submitted by another agency PCA revealed: -The statement was signed and dated 02/13/22. -The resident stated she was hurting as the PCA walked her to the bathroom. -The resident could not walk any further so the PCA sat her down on her rolling walker and pushed her. -The PCA asked the resident if she fell and the resident said yes. -The resident said she told "them" (unknown) she wanted to go to the emergency room, but they were doing something else and put her back in the bed and said she would be okay. Review of a written statement submitted by a day shift MA revealed: -The statement was signed. -Resident #1 was fine when she completed her shift on 02/12/22 at 7:10 (no am or pm documented). -The resident was walking and everything. -On 02/13/22, the resident was sitting in the chair by the nursing station saying she was hurting.	{D 273}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 273}	Continued From page 3	{D 273}		

Review of a written statement submitted by a former MA revealed:
-The statement was signed and dated 02/14/22 at 11:44am.
-Resident #1 was in the common area watching television before the MA's shift ended on 02/12/22.
-When the MA clocked out at 11:35pm, Resident #1 was "safe and well."

Review of a written statement by unknown staff revealed:
-The statement was unsigned and undated.
-Staff walked into Resident #1's room at approximately 6:30 (no am or pm documented).
-Resident #1 was on the floor sitting against the side of the bed with her legs out in front of her.
-Staff checked Resident #1 for injuries and asked if she hit her head.
-Resident #1 said no and asked to be helped up to the bathroom.
-Staff assisted Resident #1 up and Resident #1 used her walker to ambulate to the bathroom.
-Staff walked with Resident #1 back to her bed.
-Resident #1 sat on the edge of the bed and pulled up her adult briefs.
-Staff asked if the resident was getting up and Resident #1 replied, "In a minute," and then lay down in bed.

Review of a written statement submitted by a first shift PCA revealed:
-The statement was undated.
-The resident said she did not want breakfast.
-The resident was not hungry at lunch time.
-Resident #1 got up to use the bathroom by herself and got back in her bed.
-She took her medicine and got back in bed.
-She did not try to eat dinner; she wanted to rest.

Division of Health Service Regulation

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{D 273}	Continued From page 4 Review of a text message from an agency MA revealed: -The MA sent the text to the Memory Care Coordinator (MCC) on 02/16/21 at 1:51pm. -On 02/11/22 at 11:00pm, she received the keys from the MA who had been working on the Memory Care Unit (MCU). (Review of timecard data revealed the MA worked on 02/12/22, not 02/11/22.) -The outgoing MA reported the residents were fine and in bed. -At 4:00am or 5:00am while she was on the assisted living (AL) side, a PCA reported Resident #1 said she had fallen and was in pain. -She immediately went to the MCU and asked Resident #1 what had happened. -The resident said she did not know what happened but reported pain. -The MA administered acetaminophen (used to treat pain). -When the MA returned to the MCU later, the resident was still sitting up. -The MA asked the PCA if the resident was still complaining of pain and was told no. -The MA asked the resident if she was experiencing pain and the resident said no. -The MA documented the acetaminophen was effective in Resident #1's electronic medication administration record (eMAR). Review of a text message from an agency PCA revealed: -Resident #1 was sitting by the nursing station in the MCU on 02/12/22. -She noticed a small bruise on the resident's forehead. -The other PCA told her to let the MA know the resident was having hip pain. -She went and told the MA, and the MA gave medicine to the resident.	{D 273}		

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{D 273}	Continued From page 5	{D 273}		

Review of Resident #1's eMAR for February 2022 revealed:
-There was an entry for acetaminophen 325mg take two tablets every eight hours as needed for pain/fever.
-There was documentation acetaminophen was administered at 5:07am on 02/13/22 and was effective.

Telephone interviews with Resident #1's primary care provider (PCP) on 03/02/22 at 9:27am and 03/04/22 at 10:57am revealed:
-He expected staff to assess the resident and contact the family after a resident experienced a fall.
-It would not have made a difference in Resident #1's outcome if she had been transported to the ED sooner.
-He would have preferred Resident #1 been transported to the ED sooner to alleviate any pain she had experienced.
-He had not spoken with the physical therapist about Resident #1's progress.
-He thought Resident #1 would not need to permanently use a wheelchair.

Interview with the first shift MA on 03/03/22 at 10:00am revealed:
-She could not remember the exact date of the incident involving Resident #1 but she had arrived to her shift at 6:45am.
-Resident #1 was limping while she was using her walker.
-The resident said she had to use the bathroom.
-The MA asked what was wrong and the resident said her back hurt.
-The resident said she fell the night before and told "the girl" she had to go to the hospital.
-The resident said the girls picked her up from the

Division of Health Service Regulation

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{D 273}	Continued From page 6 floor, put her back into her bed, and told her she would be all right. -On 02/13/22, she had Resident #1 sit at the nursing station while she called the Health and Wellness Director (HWD) to let her know she was calling EMS for Resident #1. -The HWD instructed her to notify the family and the PCP, write a progress note, and complete an incident report. -She lifted up Resident #1's shirt to examine her back. -She palpated the resident's back and the resident reported pain on the right side of her lower back. -She saw a bruise on the resident's right hip when she assisted her with toileting before EMS arrived. -She thought Resident #1 may have fallen on "some third shift." -She had not received report of anyone helping Resident #1 into bed after she was found on the ground. -The MA from the previous shift said Resident #1 was fine. -She did not remember the PCAs who were scheduled to work the day of the incident involving Resident #1. -She did not remember when the resident told her she fell and got herself up. -She may have entered that language into the report while she was rushing to complete the report. -Resident #1 would be able to get up by herself. -The information in her progress notes was accurate. Interview with a first shift PCA on 03/03/22 at 1:26pm revealed: -Before the incident in mid-February 2021, Resident #1 used a walker and would ambulate	{D 273}		

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{D 273}	Continued From page 7	{D 273}		

to the bathroom by herself.
-He did not think the resident would be able to get herself up from the floor.

Interview with the MCC on 03/03/22 at 1:33pm revealed:
-Staff was expected to notify the MA when a resident had a fall.
-The MA was expected to contact him or the HWD for guidance when a resident had a fall.
-The family and PCP were always notified.
-EMS would be called as needed.
-When he reported to work on 02/14/22, he talked with the first shift MA.
-The first shift MA reported to him that Resident #1 said the PCA did not listen to her when she stated she needed to go to the hospital.
-The MA called the HWD on 02/13/22.
-He would have expected the PCA to report the incident to the MA to follow-up and examine the resident.
-He obtained written statements from the MAs who had worked the two previous shifts but did not recall the contents of their statements.
-He did not know if they ever found out who the PCAs were who helped Resident #1 back into bed.
-Before the incident in mid-February 2022, Resident #1 used a walker.
-Resident #1 was now using a wheelchair.
-He did not think she would have been able to get herself off the ground.
-She may have been able to get herself up if her walker was locked and she used it for stability.
-He was upset that Resident #1 had to wait to receive medical care.
-Staff from the second and third shifts before the resident was sent out for care said she had been fine.

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{D 273}	Continued From page 8	{D 273}		

Interview with the Resident Care Coordinator (RCC) on 03/03/22 at 2:31pm revealed:
-Staff were expected to call EMS and notify the HWD, the resident's responsible party, and the PCP when a resident had a fall.
-Staff were supposed to complete an incident report after a resident had a fall.
-The PCA was expected to report to the MA if a resident asked to go to the hospital.
-She would have called EMS after Resident #1 asked to go to the hospital.
-EMS would not have to transport the resident to the hospital; they could complete an assessment of the resident.
-The situation involving Resident #1 "doesn't make sense."
-She had not read Resident #1's progress notes dated 02/13/22.
-She did not know which staff were involved.
-The PCA should have gone straight to the MA when Resident #1 was found on the floor.
-She educated staff to report incidents to the MA.

Interview with the HWD on 03/03/22 at 3:05pm revealed:
-She assessed residents after a fall if she was on the premises at the time of the fall.
-When a resident had an unwitnessed fall or hit his or her head, the resident was sent to the hospital.
-Staff were expected to write notes, notify the responsible party and the PCP, and follow the orders of the PCP.
-An incident report was supposed to be completed; any staff could complete an incident report.
-Management would obtain statements from all staff in the building no matter where a fall occurred.
-She did not work in the facility from

Division of Health Service Regulation

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{D 273}	Continued From page 9 02/06/22-02/17/22 but was available by telephone. -She received a call on 02/13/22 from the first shift MA reporting Resident #1's complaint of pain. -The MA said the resident reported she had fallen. -The resident was limping and hurting. -No one had previously reported an incident involving Resident #1. -She instructed the MA to call EMS. -It was "hard to pinpoint" information received from a resident of the MCU. -Staff needed to "read between the lines" when working with residents in the MCU. -If she asked Resident #1 if she fell, Resident #1 would deny it. -She did not think the resident would be able to get herself off the floor. -She had not read the 02/13/22 progress notes. -She would have asked the MA to clarify what the resident said. -She did not think Resident #1 could put the thoughts together as documented in the progress note. -The same MA had worked the previous day. -The MA told her Resident #1 was in bed and did not want to get up. -The resident stayed in bed all day. -The resident came out to the dining room to eat. -The MA said nothing happened to Resident #1 during the shift. -Resident #1 did not complain of pain while being assisted with toileting. -All staff were interviewed. -She intended to terminate staff, but no one knew anything. -There were no staff changes or terminations in the MCU as a result of this incident. -She told the MA to get statements from the staff	{D 273}		

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{D 273}	Continued From page 10 who were at the facility. -Not all of the staff statements were written down; most statements were verbal. -She could not provide access to the statements because they were not in one folder. -Permanent staff worked the MCU because they were familiar with the residents. -She narrowed down the time of Resident #1's incident to Friday, 02/11/22, because the resident stayed in bed all day on 02/12/22. Interview with the Administrator on 03/03/22 at 4:08pm revealed: -Resident #1 did not tell anyone she had fallen. -She expected staff to call the HWD when a resident had a fall. -At the very least, she expected the PCA to let someone know what was going on with a resident. -The residents in the MCU needed to be assessed at face value. -She did not know when Resident #1's injury occurred. -She had not read Resident #1's progress notes dated 02/13/22. -The HWD had a folder containing the written statements from staff. -A MA saw Resident #1 in the common area watching television. -There was an unsigned statement. -There was a statement from agency staff. -There was another statement from agency staff. -It was difficult to follow-up with the agency staff; they did not always return calls. -At the very least, she would have expected staff to call the HWD when something occurred. -She did not know what happened with this situation. Second interview with the day shift MA on	{D 273}		

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{D 273}		{D 273}		

Continued From page 11

03/03/22 at 6:23pm revealed:
-Saturday, 02/12/22, was a good day for Resident #1.
-The resident was not in bed on Saturday; she was up all day on Saturday.
-The resident was walking around, smiling, and talking on the phone with a friend.
-When she completed her shift in the evening, the resident was watching television with several other residents.
-She did not remember the MA who gave her report when she came to work on 02/13/22.

Telephone interview with an agency PCA on 03/03/22 at 8:12pm revealed:
-She was never assigned Resident #1's hall.
-She was working on the AL side on third shift.
-She was re-assigned to the MCU at 1:00am or 2:00am on 02/13/22 after staff left because of illness.
-When she went into the MCU, Resident #1 was sitting in a chair near the nursing station.
-She noticed Resident #1 had a bruise no larger than the size of a quarter on her forehead above one of her eyes.
-The other PCA told her Resident #1 had pain in her hip.
-The other PCA did not tell her that Resident #1 fell.
-She went to the AL side to report the bruise and pain to the MA.
-The MA came to the MCU right away.
-The MA said she already knew about the bruise and it was old.
-Once the MA came to the MCU, the PCA continued rounds on her assigned residents and did not know what happened with Resident #1.
-Resident #1 did not fall in her care or during her shift.
-She was asked by an agency MA to write a

Division of Health Service Regulation

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{D 273}	Continued From page 12	{D 273}		

statement regarding if Resident #1 had fallen.
-She sent her statement via text message to the MA on 02/15/22 at 3:09pm.

Telephone interview with a former MA on 03/04/22 at 8:28am revealed:
-She worked second shift on 02/12/22.
-She worked the AL side and the MCU.
-There were no reports of any incidents involving Resident #1 during second shift on 02/12/22.
-Resident #1 was in the common area watching television most of the day during second shift on 02/12/22.
-One of the first shift PCAs had talked with Resident #1, but the incident had occurred during third shift on an unknown date.

Telephone interview with an agency MA on 03/04/22 at 8:47am revealed:
-On 02/12/22 between 1:00am-2:00am while she was working the AL side, a PCA from the MCU told her a resident reported she had fallen.
-She went to the MCU and examined Resident #1.
-The resident was sitting near the medication cart.
-She asked Resident #1 if she fell and the resident said she did not know.
-The resident said her head hurt.
-There were no visible marks on the resident's face, head, or hands.
-She did not observe the resident's gait.
-She administered acetaminophen to the resident.
-At 6:30am she went to follow-up on the resident.
-The resident was sitting near the nursing station; the PCA said the resident was no longer complaining of pain.
-All the residents were in bed when the second shift MA left.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 273}	Continued From page 13	{D 273}		

-Resident #1 never told her she fell; the PCA said the resident said she fell.
-On 02/13/22 she told the oncoming first shift MA, "I gave her a Tylenol. They said she fell."
-She spoke with the HWD at around 10:00am on 02/13/22.
-The HWD asked her why she did not complete an incident report and told her Resident #1 had a broken hip.
-She did not know what had happened to the resident.
-She provided a written statement to the HWD that included she gave the resident medication for pain.

Telephone interview with the HWD on 03/04/22 at 10:05am revealed the RCC and MCC were not able to pinpoint when the incident occurred or who was involved, so she focused on the care that was needed for the resident as a result of her injury.

Telephone interview with an agency PCA on 03/04/22 at 10:30 revealed:
-She saw Resident #1 sitting in a chair by the nursing station on 02/13/22.
-Resident #1 got up and was not walking right while she was pushing her walker.
-She was walking slowly and limping and said, "I can't walk."
-The resident said she fell and told staff she wanted to go to the ER, but staff were "up there doing their own thing."
-The resident had a knot below her hip line on the right side.
-The resident said she felt like she wanted to fall down.
-She reported Resident #1's condition to the MA.
-Resident #1 was not in this condition the last time she had worked first shift on 02/11/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 273}	Continued From page 14	{D 273}		

-She provided a signed and dated written statement.
-No one followed-up with her about her statement.

Telephone interview with another agency PCA on 03/04/22 at 12:07pm revealed:
-She saw Resident #1 ambulating with her walker during third shift on 02/13/22; she did not remember the time.
-Resident #1 said she was in pain and that she had fallen.
-She asked the MA to check on Resident #1.
-The MA said it was an old fall and Resident #1 was fine.
-She did not hear about anyone finding Resident #1 on the floor.
-Resident #1 was normally up and active; she routinely watched television late at night.
-Resident #1 was fine during the previous shifts she had worked; she did not know the dates.
-She provided a written statement to the RCC.

Telephone interview with Resident #1's physical therapist on 03/04/22 at 2:54pm revealed:
-Resident #1 was diagnosed with a right-sided pelvic fracture.
-Resident #1 was receiving therapy twice a week.
-The resident was limited by her cognition but was actively participating in her therapy.
-She was doing okay with transferring.
-His goals for Resident #1's therapy were to improve her transfer ability and safety to prevent future falls.
-He did not discuss any falls with Resident #1.
-He expected Resident #1 to be out of her wheelchair and able to use her walker after her pelvic fracture had healed.

Attempted interview with Resident #1's family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 273}	Continued From page 15 member on 03/02/22 at 4:49pm was unsuccessful. Interview with Resident #1 on 03/03/22 at 1:27pm revealed: -She did not remember experiencing a fall in mid-February 2022. -She did not remember staff helping her up from the floor in her room and putting her in bed. ____________________ The facility failed to refer the resident for medical care in response to the resident's report of a fall and complaint of pain on 02/13/22 resulting in the resident going without medical treatment for at least five hours and sent to the emergency room resulting in a diagnosis of a pelvic fracture. This failure placed the resident at a substantial risk for serious physical harm and neglect which constitutes a Type A2 Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/03/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 2, 2022.	{D 273}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	{D 276}	HWD and/or designee will review all PRN diuretic orders to determine if there are weight parameters for administration. Daily weight checks will be added to eMAR of all residents with weight parameter for administration. HWD or designee will provide med aides with an exceptions list for daily and weekly weights. HWD or designee will educate med aides on use of list to ensure weights are taken appropriately.	3.28.22 3.28.22

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{D 276}	Continued From page 16 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to obtain daily weights for 1 of 2 sampled residents (#4) in order to administer an as needed medication to help reduce fluid overload in relation to weight gain. Review of Resident #4's current FL2 dated 01/24/22 revealed diagnoses included paroxysmal atrial fibrillation, chronic kidney disease, heart failure with reduced ejection fraction, hypertension, acute UTI and acute kidney injury. Review of Resident #4's physician's orders dated 01/04/22 revealed there was an order for furosemide (used to treat fluid retention) 40mg ½ tablet daily as needed for weight gain greater than 3 pounds in 24 hours. Review of Resident #4's progress note dated 01/11/22 revealed: -Resident #4's current weight was 191 pounds; there was no date documented. -Resident #4 weighed 200 pounds on 12/01/22. Review of Resident #4's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for furosemide 40mg ½ tablet daily as needed for weight gain greater than 3 pounds in 24 hours. -There was no documentation that an extra dose of furosemide had been administered from 01/04/22 to 01/31/22. -There was no entry for or documentation of daily weights. Review of Resident #4's February 2022 eMAR	{D 276}	HWD or designee will review eMAR of residents on exceptions list at least weekly to ensure weights are taken and recorded and appropriate follow-up occurred.	3.28.22 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

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THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 276}	Continued From page 17 revealed: -There was an entry for furosemide 40mg ½ tablet daily as needed for weight gain greater than 3 pounds in 24 hours. -There was no documentation that an extra dose of furosemide had been administered from 02/01/22 to 02/28/22. There was no entry for or documentation of daily weights. Interview with Resident #4 on 03/01/22 at 4:31pm revealed: -The facility staff weighed her once a week. -She was weighted today; her weight was 183. -The doctor wanted her to weight every morning before breakfast. -She did not know why the facility staff did not weight her each morning. -She took furosemide because she retained fluid and had swelling in her feet. -She took furosemide one tablet each day. -She had not received any extra doses of furosemide. Interview with a personal care aide (PCA) on 03/03/22 at 8:25am revealed: -The PCA would obtain the resident's weights when asked by the medication aide (MA). -The PCA would give the reading to the MA. Interview with a MA on 03/02/22 at 3:10pm revealed: -The MAs weighed the residents and documented the readings on the eMAR. -The order to weigh the residents would pop up on the day the weight was scheduled. -The MA had not administered additional furosemide to Resident #4 based on weight readings. -Resident #4 would need to have daily weights	{D 276}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 276}	Continued From page 18	{D 276}		

obtained to administer an additional dose of furosemide in relation to weight.
-Resident #4 was not weighed daily.

Interview with the Primary Care Provider (PCP) on 03/03/22 at 2:28pm revealed:
-The order for furosemide 40mg ½ tablet daily as needed for weight gain greater than 3 pounds in 24 hours should have been discontinued.
-He thought the order had been discontinued.
-He did not expect weights to be obtained daily unless Resident #4 was having an acute episode of fluid retention.

Interview with the Resident Care Coordinator (RCC) on 03/02/22 at 3:23pm revealed:
-The orders for obtaining the weights were entered on the eMAR.
-The MA was responsible for seeing that the resident's weights were obtained as ordered.
-The MA or the PCA would obtain resident's weights.
-Resident #4's weights would be documented on the eMAR.
-She did not know how often Resident #4's weight should be obtained.
-Resident #4's weight should be obtained daily in order to know if the extra dose of furosemide was needed.
-Resident #4 would need an extra dose of furosemide if her weight increased by 3 pounds in 24 hours.
-The staff would have to weigh Resident #4 daily to know if she needed an extra dose of furosemide.
-She did not know what complications could occur with fluid overload.
-She did not know why Resident #4's weight was not obtained daily.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ____ B. WING ____	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 20	{D 358}		

reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#1, #6) observed during the morning medication pass including errors with the administration of an anti-depressant and vitamin supplement (#1); administration of a stool softener (#6); and for 5 of 5 residents sampled (#1, #2, #3, #4, #5) for record review including errors with a diuretic, an anti-depressant, and a laxative (#1); two pain relievers and a laxative (#2); an arthritis relief gel (#3); an anti-convulsant (#4); and a medication used to treat Parkinson's disease, an anti-diabetic medication, a sleep aide, and a medication used to increase the flow of urine (#5).

1. The medication error rate was 11% as evidenced by the observation of 3 errors out of 27 opportunities during the 8:00am medication passes on 03/02/22.

a. Review of Resident #1's current FL2 dated 2/14/2022 revealed diagnoses included acute kidney injury, fracture of right inferior pubic ramus, urinary urgency, generalized weakness, traumatic rhabdomyolysis, fall, acute encephalopathy, subacromial bursitis, osteoarthritis of left shoulder and depression.

1. Review of Resident #1's hospital discharge summary dated 02/14/22 revealed:
-Resident #1 was hospitalized from 02/13/22 to 02/14/22.
-The hospital discharge summary was electronically signed by a Medical Doctor (MD) at the hospital.
-There were medications changes noted on the hospital discharge summary.
-There was an order for duloxetine (used to treat depression) 20mg daily.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ________ B. WING ________	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 21 Observation of the morning medication pass on 03/02/22 at 8:02am revealed: -The medication aide (MA) prepared duloxetine 40mg for administration to Resident #1. -The MA administered duloxetine 40mg to Resident #1. Observation of Resident #1's medication on hand on 03/02/22 at 8:02am revealed: -There was a bubble pack with duloxetine 40mg available for administration. -There were 30 tablets of duloxetine 40 mg dispensed on 02/24/22. -There was no duloxetine 20mg available for administration. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/02/22 at 11:50am revealed: -The pharmacy had an order for duloxetine 40mg daily. -The pharmacy did not have an order for duloxetine 20mg daily. Interview with the MA on 03/02/22 at 2:53pm revealed: -She administered the medication as it was entered on the eMAR. -She did not know Resident #1 had an order for duloxetine 20mg daily. -She knew Resident #1 had been in the hospital. -She had not looked at Resident #1's discharge summary. -The hospital discharge summaries were reviewed by the Health Wellness Director (HWD) upon the resident's return from the hospital. -The RCC (Resident Care Coordinator) or the HWD would be called when the resident returned from the hospital to the facility after hours. -The hospital discharge orders would be faxed to	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 22	{D 358}		

Continued From page 22

the pharmacy by the MA, RCC, MCC or the HWD.
-A confirmation fax would be received, confirming the orders were received by the pharmacy.
-The pharmacy should be called to make sure they received the faxed orders.
-The pharmacy entered all the orders into the eMAR.

Interview with the Memory Care Coordinator (MCC) on 03/02/22 at 2:21pm revealed:
-He did not know Resident #1's duloxetine order had been changed on the discharge summary.
-He did not review Resident #1's discharge summary.
-The hospital discharge summary would be reviewed by the MA, RCC, MCC or the HWD.
-The discharge orders would be faxed to the pharmacy when there were new orders written.
-The pharmacy would call or fax a notification when they could not fill the order because there was no physician's signature.
-The hospital discharge orders should be followed when a resident returned from the hospital, until the Primary Care Provider (PCP) saw the resident and reviewed the discharge summary.

Interview with the RCC on 03/02/22 at 3:23pm revealed:
-She did not know Resident #1's duloxetine order had been changed on the discharge summary.
-The discharge summaries were reviewed by the MCC or the HWD.
-The MA would be responsible for reviewing the discharge summary on the weekends.
-The discharge summaries were reviewed for new orders.
-The new hospital discharge orders would be faxed to the pharmacy.
-The PCP would be called and informed of new

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 23 hospital discharge orders. -The RCC did not know why the order for duloxetine 20mg daily was not faxed to the pharmacy. Interview with the PCP on 03/04/22 at 2:28pm revealed: -He did not recall reviewing Resident #1's discharge summary. -He would have noticed the change in the dosage of duloxetine had he reviewed the discharge summary. -The order should have been caught by the staff and reported to me. -Duloxetine was used as an anti-depressant. Interview with the HWD on 03/02/22 at 3:34pm revealed: -The RCC, MCC or HWD would review the hospital discharge summary for new orders. -The PCP would follow the hospital discharge summary on the electronic chart. -The facility would fax new hospital discharge orders to the pharmacy. -The pharmacy would send the new hospital discharge orders back to the facility for the PCP to review. -The pharmacy would not take electronically signed physician's orders. -The HWD did not know if the PCP was notified of the new orders on the hospital discharge summary. Interview with the Administrator on 03/02/22 at 4:08pm revealed: -The hospital discharge summary was given to the MA or the MCC/RCC when the resident returned from the hospital. -The MA/MCC/RCC would review the hospital discharge summary for new orders.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 24	{D 358}		

-The MA/MCC/RCC would notify the HWD.
-The HWD would review the hospital discharge summary within 24 hours.
-The MA/MCC/RCC would fax the new hospital discharge orders to the pharmacy.
-The pharmacy would fill the new orders if they were electronically signed.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

2. Review of Resident #1's current FL2 dated 2/14/2022 revealed there was an order for vitamin B-12 (used as a supplement) 2500 mcg sublingual daily.

Observation of the morning medication pass on 03/02/22 at 8:02am revealed:
-The medication aide (MA) prepared vitamin B-12 2500 mcg sublingual
for administration to Resident #1 with 8 other pills.
-The MA administered vitamin B-12 to Resident #1 by mouth.

Observation of Resident #1's medications on hand on 03/02/22 at 7:55am revealed:
-Resident #1 had a bubble pack of vitamin B-12 2500mcg on hand for administration.
-The direction on the bubble pack was take one tablet under the tongue daily.

Interview with a MA on 03/02/22 at 3:03pm revealed:
-The MA knew that sublingually meant to administer the medication under the tongue.
-The MA administered the vitamin B-12 by mouth with Resident #1's other by mouth medications.
-Resident #1 could not take a sublingual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 25 medication. -The MA did not know why the vitamin B-12 was ordered sublingually. -The MA had not reported to the Memory Care Coordinator (MCC) that Resident #1 could not take the sublingual medication. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/02/22 at 11:50am revealed the pharmacy had an order for vitamin B-12 2500mcg one tablet sublingually daily. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/02/22 at 12:00pm revealed vitamin B-12 was used as a supplement. Interview with the Memory Care Coordinator (MCC) on 03/02/22 at 2:21pm revealed: -He did not know the medication was ordered sublingually. -The MA should follow the orders as written. Interview with the Primary Care Provider (PCP) on 03/04/22 at 2:28pm revealed: -He did not know why vitamin B-12 was ordered sublingual. -The route of the administration of vitamin B-12 should not affect the absorption rate of the medication. Interview with the Health Wellness Director (HWD) on 03/02/22 at 3:48pm revealed: -Resident #1 was a high functioning dementia resident in the Special Care Unit. -Resident #1 should be able to take a sublingual medication. -The HWD was aware that Resident had an order for a sublingual medication.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 26	{D 358}		

Interview with the Administrator on 03/02/22 at 4:08pm revealed:
-Resident #1 would be able to have a medication administered sublingually.
-The MAs should follow the PCP orders as written.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

b. Review of Resident #6's current FL2 dated 08/16/21 revealed diagnoses included acute kidney injury, diarrhea, non-intractable vomiting with nausea, ileitis and dementia without behavioral disturbances - Lewy body verses vascular.

Review of Resident #6's physician's orders dated 11/29/21 revealed there was an order for polyethylene glycol 3350 (used to treat constipation) 17gms in 8 ounces of water, juice or coffee daily.

Review of Resident #6's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for polyethylene glycol 3350 17gms in 8 ounces of water, juice or coffee daily with a scheduled administration time of 8:00am.
-There was documentation polyethylene glycol 3350 17gms was administered on 03/02/22 at 8:00am.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/02/22 at 11:50am revealed the pharmacy had an order for polyethylene glycol 3340 17gms in 8 ounces of water, juice or coffee daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 27	{D 358}		

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/02/22 at 11:57am revealed polyethylene glycol 3350 was used to prevent constipation.

Interview with the Memory Care Coordinator (MCC) on 03/02/22 at 2:21pm revealed:
-The MA was expected to place the polyethylene glycol 17gms in 8 ounces of water, juice or coffee as ordered.
-The MA should follow orders as written.
-He did not know that the cups on the medication cart were 5-ounce cups.
-The cups on the medication cart were not large enough to mix polyethylene glycol as ordered.
-There were no larger cups in house to be placed on the medication cart.
-He would order larger cups for the medication carts.

Interview with the Primary Care Provider (PCP) on 03/04/22 at 2:28pm revealed Resident #6 could have problems with constipation or diarrhea if the medication was not administered as ordered.

Interview with the Health Wellness Director (HWD) on 03/02/22 at 3:48pm revealed:
-The HWD did not know there were 5-ounce cups on the medication cart until today.
-The HWD did not know there were no 8-ounce cups in the facility to administer a liquid medication as ordered.
-The MAs need to have cups large enough to dissolve the medication in the liquid.

Interview with the Administrator on 03/02/22 at 4:08pm revealed:
-The Administrator was not aware that there were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 28 no 8-ounce cups on the medication cart to use for medications that were ordered to be mixed in 8-ounces of liquid. -The Administrator had not been notified that there was a need for 8-ounce cups for the medication cart. -The MAs should be following the PCP orders as written. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted interview with Resident #6's PCP on 03/04/22 at 3:00pm was unsuccessful. c. Review of Resident #4's current FL2 dated 01/24/22 revealed diagnoses included tonic clonic seizures, paroxysmal atrial fibrillation, acquired hypothyroidism, chronic kidney disease, generalized anxiety disorder, gastroesophageal reflux disease, heart failure with reduced ejection fraction, hypertension, type 2 diabetes mellitus, diabetic neuropathy, Wernicke's encephalopathy, acute UTI and acute kidney injury. Review of Resident #4's hospital discharge summary dated 01/24/22 revealed: -Resident #4 was hospitalized from 01/19/22 to 01/24/22. -The hospital discharge summary was electronically signed by a Medical Doctor (MD) at the hospital on 01/24/22. -There were medications changes noted on the hospital discharge summary. -There was an order topiramate 100mg two tablets by mouth every night. Review of Resident #4's January 2022 electronic medication administration record (eMAR)	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 29	{D 358}		

revealed there was no entry for topiramate to be administered.

Review of Resident #4's February 2022 eMAR revealed there was no entry for topiramate to be administered.

Review of Resident #4's medication on hand revealed there was no topiramate medication on hand to be administered.

Interview with Resident #4 on 03/02/22 at 3:20pm revealed:
-She had a seizure in the hospital last month.
-She saw a neurologist while she was in the hospital.
-This was Resident #4's first seizure; she has not had any additional seizures.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/02/22 at 11:50am revealed:
-The pharmacy did not have an order for topiramate.
-The facility faxed 2 pages with medication changes to the pharmacy a few weeks ago; there was no physician's signature attached.
-The pharmacy returned the 2 pages of medications to the facility with notification that the physician's signature was needed.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/02/22 at 12:00pm revealed:
-Topiramate was used for seizures.
-Topiramate was classified as an anti-convulsant.

Interview with the medication aide (MA) on 03/02/22 at 2:53pm revealed:
-The hospital discharge summaries are reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ____ B. WING ____	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 30	{D 358}		

by the Health Wellness Director (HWD) upon the resident's return from the hospital.
-The HWD or the RCC would be called when the resident returned from the hospital to the facility after hours.
-The hospital discharge orders would be faxed to the pharmacy.
-She received a confirmation fax, confirming the orders were received by the pharmacy.
-She would call the pharmacy to make sure they received the faxed orders.
-The pharmacy entered all the orders into the eMAR.

Interview with the Memory Care Coordinator on 03/02/22 at 2:21pm revealed:
-The hospital discharge summary would be reviewed by the MA, RCC, MCC or the HWD.
-The discharge orders would be faxed to the pharmacy when there were new orders written.
-The pharmacy would call or fax a notification when they could not fill the order because there was no physician's signature.
-The hospital discharge orders should be followed, after a resident returned for a hospitalization, until the PCP could review them.

Interview with the RCC on 03/02/22 at 3:23pm revealed:
-The discharge summaries were reviewed by the MCC or the HWD.
-The MA would be responsible for reviewing the discharge summary on the weekends.
-The discharge summaries are reviewed for new orders.
-The new hospital discharge orders would be faxed to the pharmacy.
-The PCP would be called and informed of new hospital discharge orders.
-The RCC did not know why the order for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 31	{D 358}		

topiramate 100mg was not faxed to the pharmacy.
-The RCC did not review Resident #4's discharge summary.

Interview with the PCP on 03/04/22 at 2:28pm revealed:
-He received the discharge summaries when he visited the facility on Mondays and Thursdays.
-He had not been notified about the new order for topiramate 100mg 2 tablets at night.
-He did not see the new order on the discharge summary for topiramate.
-He should have caught the order for topiramate on the discharge summary.
-He would expect the facility to review the hospital discharge summary and notify him of changes to medications.

Interview with the HWD on 03/02/22 at 3:34pm revealed:
-The RCC, MCC or HWD would review the hospital discharge summary for new orders.
-The PCP would follow the hospital discharge summary on the electronic chart.
-The facility would fax new hospital discharge orders to the pharmacy.
-The pharmacy would send the new hospital discharge orders back to the facility for the PCP to review.
-The pharmacy would not take electronically signed physician's orders.
-The HWD did not know if the PCP was notified of the new medication, topiramate.

Interview with the Administrator on 03/02/22 at 4:08pm revealed:
-The hospital discharge summary was given to the MA or the MCC/RCC when the resident returned from the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 32	{D 358}		

-The MA/MCC/RCC would review the hospital discharge summary for new orders.
-The MA/MCC/RCC would notify the HWD.
-The HWD would review the hospital discharge summary within 24 hours.
-The MA/MCC/RCC would fax the new hospital discharge orders to the pharmacy.
-The pharmacy would fill the new orders if they were electronically signed.

d. Review of Resident #1's current FL-2 dated 02/14/22 revealed diagnoses included fracture of the right inferior pubic ramus (pelvis), acute kidney injury, and Alzheimer's dementia.

1. Review of Resident #1's current FL-2 dated 02/14/22 revealed:
-There was an order for triamterene-hydrochlorothiazide 37.5-25mg (Maxzide-25) (a diuretic used to treat high blood pressure) take one tablet daily.
-There was an order to hold the Maxzide-25 pending a repeat basic metabolic panel (BMP) with creatinine (a blood test providing information on kidney function).

Review of Resident #1's laboratory results revealed Resident #1 had blood drawn for a complete metabolic panel on 02/21/22.

Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Maxzide-25 scheduled for administration at 8:00am.
-Maxzide-25 was documented as administered from 02/01/22-02/12/22, 02/15/22-02/23/22, and 02/25/22-02/28/22.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 33	{D 358}		

Continued From page 33

-Maxzide-25 was not held as ordered before Resident #1's blood was drawn on 02/21/22.

Observation of Resident #1's medication available for administration on 03/02/22 at 2:10pm revealed:
-There was one blister pack containing 16 Maxzide-25 tablets.
-The label indicated the pharmacy dispensed 30 Maxzide-25 tablets on 02/04/22.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/02/22 at 4:13pm revealed:
-The pharmacy processed orders on hospital discharge summaries if they were signed by a physician.
-The discharge summary dated 02/14/22 was not signed by a physician.
-She sent a message to the facility on 02/14/22 at 5:09pm indicating the orders for Resident #1 were not valid and would not be processed.

Telephone interview with Resident #1's primary care provider (PCP) on 03/02/22 at 9:27am revealed:
-Facility staff preferred he review hospital discharge summaries before he made any changes to orders.
-The pharmacy would not change any orders unless he co-signed the hospital discharge summary.
-He did not think he needed to review hospital discharge summaries because a physician had electronically signed the FL-2 on the discharge summary.
-Facility staff should have changed Resident #1's medications as ordered on the FL-2 on the discharge summary.
-He expected staff to review to the FL-2,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 34 implement the changes, and let him know of the changes the next time he visited the facility. -He visited the facility two times each week. -The change to Resident #1's Maxzide-25 was overlooked by him and the Health and Wellness Director (HWD). -He would have expected Resident #1's Maxzide-25 to be held as ordered. -He intended to make changes to Resident #1's Maxzide-25 based on the results of Resident #1's bloodwork. Interview with a medication aide (MA) on 03/02/22 at 2:54pm revealed: -She routinely gave hospital discharge summaries to the HWD or to the Resident Care Coordinator (RCC). -She routinely called the HWD if she received hospital discharge summaries after hours. -She would fax new orders to the pharmacy and then call the pharmacy to make sure the fax had been received. -She called the PCP if medications were changed. Interview with an agency MA on 03/03/22 at 8:49am revealed: -She was not told what to do with hospital discharge summaries. -She routinely placed the hospital discharge summary on the desk at the nursing station and informed the oncoming MA it was there. Interview with the Memory Care Coordinator (MCC) on 03/03/22 at 1:33pm revealed: -He, the MA, HWD, and RCC were responsible for reading hospital discharge summary orders and faxing them to the pharmacy. -If orders were not in an acceptable form, the PCP would be contacted to write orders.	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 35	{D 358}		

-The hospital discharge summary was reviewed for medication changes.
-He faxed the two pages containing Resident #1's hospital discharge medication orders to the pharmacy when Resident #1 was discharged from the hospital on 02/14/22.
-He did not fax the entire hospital discharge summary to the pharmacy.
-The pharmacy returned the orders and said they were not "formal" orders.
-He notified Resident #1's PCP and the PCP wrote new orders.
-He missed the order to hold Resident #1's Maxzide-25.
-He expected Resident #1's medication orders to be followed.

Interview with the HWD on 03/03/22 at 3:05pm revealed:
-She expected staff to provide her or the RCC with hospital discharge summaries.
-She provided a copy of the hospital discharge summary to the PCP when he visited the facility.
-The pharmacy would not accept unsigned orders.
-She contacted the PCP when an order was needed.
-She expected the PCP to send her a copy of any orders he sent to the pharmacy.
-Resident #1's Maxzide-25 not being held would have had an effect on the results of her blood test.
-This was a medication error.
-She held the MCC responsible for Resident #1's Maxzide-25 not being held.
-She held herself ultimately responsible for the accurate administration of medication.

Interview with the Administrator on 03/03/22 at 4:08pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 36 -The HWD was responsible for reviewing hospital discharge summary orders. -The pharmacy would not accept orders as written on hospital discharge paperwork. -If orders were electronically signed, the pharmacy would process them. -She preferred the hospital or the PCP to provide "hard" prescriptions. -The pharmacy said the best way was to inform the hospital a hard prescription was needed; this was not always easy to get. -The pharmacy could send a copy of an electronic order to the facility if necessary. -It was important to follow orders on the discharge summary. -The HWD was working from home when Resident #1 was discharged from the hospital on 02/14/22. -The hospital orders needed to be followed prevent negative outcomes for the residents. -She expected medication to be administered as ordered by the prescribing provider. -The HWD was ultimately responsible for accurate medication administration. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's responsible person on 03/02/22 at 4:23pm was unsuccessful. 2. Review of Resident #1's current FL-2 dated 02/14/22 revealed there was an order for polyethylene glycol (a laxative) take one packet (17 grams [G]) two times daily in 4-8 ounces of fluid. Review of Resident #1's February 2022 electronic	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 37 medication administration record (eMAR) revealed: -There was an entry for polyethylene glycol 17G mix in suitable liquid and drink once daily scheduled for administration at 8:00am. -Polyethylene glycol was documented as administered once daily from 02/01/22-02/12/22, 02/15/22-02/23/22, and 02/25/22-02/28/22. -There was not an entry for polyethylene glycol 17G twice daily. Observation of Resident #1's medication available for administration on 03/02/22 at 2:10pm revealed: -There was one 8.3-ounce container of polyethylene glycol powder which was the equivalent of 14 daily doses. -The label indicated the pharmacy dispensed the medication on 04/19/21. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/02/22 at 4:13pm revealed: -The discharge summary dated 02/14/22 was not signed by a physician. -She sent a message to the facility on 02/14/22 at 5:09pm indicating the orders for Resident #1 were not valid and would not be processed. Telephone interview with another pharmacist at the facility's contracted pharmacy on 03/03/22 at 9:31am revealed: -The pharmacy last dispensed polyethylene glycol for Resident #1 on 04/19/21. -Facility staff were supposed to request refills of Resident #1's polyethylene glycol; it was not automatically dispensed by the pharmacy. -The pharmacy had not received any refill requests from the facility for Resident #1's polyethylene glycol.	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ____ B. WING ____	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 38	{D 358}		

Telephone interviews with Resident #1's primary care provider (PCP) on 03/02/22 at 9:27am and 3:14pm revealed:
-Resident #1 could have experienced constipation or pain because her polyethylene glycol was not administered as ordered.
-Resident #1 was able to express pain to staff.
-He expected Resident #1's polyethylene glycol to be administered as ordered on the hospital discharge summary.

Interviews with a medication aide (MA) on 03/02/22 at 2:14pm and on 03/03/22 at 10:00am revealed:
-She administered polyethylene to Resident #1.
-Staff were supposed to call the pharmacy to request refills of Resident #1's polyethylene glycol.
-She did not perform medication cart audits.
-The Memory Care Coordinator (MCC) and the Resident Care Coordinator (RCC) were responsible for completing medication cart audits.
-She did not know how often medication cart audits were completed.
-The MCC was responsible for ordering medication refills.

Interview with the MCC on 03/03/22 at 1:33pm revealed:
-He did not notice the change to Resident #1's polyethylene glycol on the 02/14/22 hospital discharge summary.
-Either he or the MA requested refills of medications.
-He did not remember the last time he conducted a medication cart audit.
-He did not know if Resident #1 was receiving polyethylene glycol.
-He expected medication to be administered as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 39 ordered. Interview with the RCC on 03/03/22 at 2:31pm revealed: -The MAs must not have been administering polyethylene glycol to Resident #1. -The MA needed to be retrained. Interview with the Health and Wellness Director (HWD) on 03/03/22 at 3:05pm revealed: -She expected the MCC and RCC to audit the medication carts two times a month. -The MCC and RCC were expected to verify that ordered medications were available on the medication cart, remove expired medications, and review what was and was not being used. -It would take three days to complete one full cart audit. -The MCC and RCC had been completing medication cart audits. -She had not verified the medication cart audits were occurring. -Her goal was to complete a cart audit once or twice each month. -She intended to complete a cart audit the week after it had been audited by the MCC or RCC. -She last completed an audit on the memory care unit (MCU) medication cart in January 2022. -She questioned whether Resident #1 was receiving polyethylene glycol as ordered. -Resident #1 may have experienced increased constipation if she was not receiving polyethylene glycol as ordered. -This was unacceptable because the role of the MA was to administer medications. -She had not received any reports of pain or constipation from Resident #1. -She held the MCC responsible for Resident #1's polyethylene glycol not being administered as ordered.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 40 -She held herself ultimately responsible for the accurate administration of medication. -The MAs needed more training and education on the importance of resident care. Interview with the Administrator on 03/03/22 at 4:08pm revealed: -The HWD was responsible for assigning how often medication carts were audited. -The medications carts were audited weekly. -The MAs completed the medication cart audits and were overseen by the HWD. -The MCC and RCC assisted with medication cart audits. -The pharmacy completed medication cart audits quarterly. -She expected medication to be administered as ordered. -She was concerned Resident #1 may not have been receiving polyethylene glycol as ordered. -The MAs needed to take ownership of the medication carts. -The HWD was ultimately responsible for accurate medication administration. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's responsible person on 03/02/22 at 4:23pm was unsuccessful. 3. Review of Resident #1's current FL-2 dated 02/14/22 revealed there was an order for duloxetine (an anti-depressant) take 20mg by mouth daily. Review of Resident #1's February 2022 electronic medication administration record (eMAR)	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 41 revealed: -There was an entry for duloxetine 40mg daily scheduled for administration at 8:00am. -Duloxetine 40mg was documented as administered once daily from 02/01/22-02/12/22, 02/15/22-02/23/22, and 02/25/22-02/28/22. -There was not an entry for duloxetine 20mg daily. Observation of Resident #1's medication available for administration on 03/02/22 at 2:10pm revealed: -There was one blister pack containing 17 duloxetine 40mg tablets. -The label indicated the pharmacy dispensed 30 duloxetine 40mg tabletes on 02/04/22. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/02/22 at 4:13pm revealed: -The discharge summary dated 02/14/22 was not signed by a physician. -She sent a message to the facility on 02/14/22 at 5:09pm indicating the orders for Resident #1 were not valid and would not be processed. Telephone interview with Resident #1's primary care provider (PCP) on 03/02/22 at 9:27am revealed: -He expected facility staff to clarify and/or change Resident #1's order for duloxetine as ordered on the 02/14/22 hospital discharge summary. -He expected staff to notify him of changes to the residents' medication orders. Interview with the Memory Care Coordinator (MCC) on 03/03/22 at 1:33pm revealed: -He did not notice the change to Resident #1's duloxetine on the 02/14/22 hospital discharge summary.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 42	{D 358}		

-He expected medication to be administered as ordered.

Interview with the HWD on 03/03/22 at 3:05pm revealed:
-This was a medication error.
-She held the MCC responsible for Resident #1's duloxetine not being administered as ordered.
-She held herself ultimately responsible for the accurate administration of medication.

Interview with the Administrator on 03/03/22 at 4:08pm revealed:
-She expected medication to be administered as ordered.
-The HWD was ultimately responsible for accurate medication administration.

Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.

Attempted telephone interview with Resident #1's responsible person on 03/02/22 at 4:23pm was unsuccessful.

e. Review of Resident #2's current FL-2 dated 09/21/21 revealed diagnoses included Alzheimer's Disease, chronic back pain, hearing disability, and anxiety.

1. Review of an outside provider note form dated 02/09/22 revealed:
-The form was signed by Resident #2's dentist.
-Resident #2 had a molar removed.
-Resident #2 needed to be taking 600mg ibuprofen (used to relieve mild to moderate pain) every 4-6 hours (breakfast, lunch, dinner, bedtime) for 3-4 days.
-Resident #2 could take the ibuprofen with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 43	{D 358}		

acetaminophen (used to relieve mild to moderate pain).

Review of Resident #1's February 2022 electronic medication administration record (eMAR) revealed there was no entry for ibuprofen 600mg.

Observation of Resident #2's medication available for administration on 03/02/22 at 2:28pm revealed there was no ibuprofen 600mg on hand.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/02/22 at 4:13pm revealed the pharmacy had not received an order for ibuprofen 600mg for Resident #2.

Telephone interview with Resident #2's primary care provider (PCP) on 03/02/22 at 3:14pm revealed:
-He was not aware Resident #2's dentist had ordered ibuprofen 600mg for the resident.
-He expected medication to be administered as ordered.

Telephone interview with Resident #2's dentist on 03/02/22 at 3:55pm revealed:
-Resident #2 was not necessarily in any risk from not receiving the ibuprofen 600mg as ordered.
-He ordered the ibuprofen to mitigate pain and infection following Resident #2's tooth removal.
-Elderly or dementia patients were not always able to communicate pain.

Interview with the Memory Care Coordinator (MCC) on 03/03/22 at 1:33pm revealed:
-He received the paperwork from Resident #2's dental appointment on 02/09/22.
-The order for ibuprofen 600mgwas not clear.
-He called the dental office four times but did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 44	{D 358}		

receive a return call.
-He did not document his calls to the dental office.
-Resident #2 did not complain of dental pain.
-Resident #2 did not receive ibuprofen 600mg as ordered.

Interview with the HWD on 03/03/22 at 3:05pm revealed:
-Resident #2's order for ibuprofen 600mg was not filled.
-This was a medication error.
-She needed to follow-up with the MCC about this situation.
-She held herself ultimately responsible for the accurate administration of medication.

Interview with the Administrator on 03/03/22 at 4:08pm revealed:
-She expected medication to be administered as ordered.
-She was concerned Resident #2 may have experienced pain as a result of not getting the ibuprofen as ordered.
-The HWD was ultimately responsible for accurate medication administration.

2. Review of Resident #2's primary care provider's (PCP) order dated 12/29/21 revealed there was an order for Voltaren gel 1% (a topical pain reliever) apply 4 grams (G) to lower back twice a day.

Review of Resident #2's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Voltaren gel 1% apply 4G to lower back twice a day scheduled for administration at 8:00am and 8:00pm.
-Voltaren gel was documented as administered 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ________ B. WING ________	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 45 of 3 opportunities. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for Voltaren gel 1% apply 4G to lower back twice a day scheduled for administration at 8:00am and 8:00pm. -Voltaren gel was documented as administered 62 of 62 opportunities. Review of Resident #2's February 2022 eMAR revealed: -There was an entry for Voltaren gel 1% apply 4G to lower back twice a day scheduled for administration at 8:00am and 8:00pm. -Voltaren gel was documented as administered 53 of 56 opportunities. Observation of Resident #2's medication available for administration on 03/02/22 at 2:28pm revealed: -There was one partially used 100G tube of Voltaren gel 1%. -The label on the box indicated the pharmacy dispensed the Voltaren gel on 12/29/21. -There was a measuring device in the Voltaren gel box. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/03/22 at 9:31am revealed: -The pharmacy last dispensed two 100G tubes of Voltaren gel 1% for Resident #2 on 12/29/21. -Two tubes of Voltaren gel would last for a total of 25 days. -Facility staff were supposed to request refills of Resident #2's Voltaren gel; it was not automatically dispensed by the pharmacy. -The pharmacy had not received any refill requests for Resident #2's Voltaren gel.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 46 Interview with a medication aide (MA) on 03/02/22 at 2:14pm revealed: -She did not use the measuring device when she administered the Voltaren gel to Resident #2. -She placed an unknown amount of Voltaren gel on her hand before applying it to Resident #2's lower back. -She did not know how much Voltaren gel she was applying on Resident #2. -She did not know if Voltaren gel was on cycle fill or if staff had to request refills from the pharmacy. -She did not know why Voltaren that was last dispensed in December 2021 was still on the medication cart in March 2022. Telephone interview with Resident #2's primary care provider (PCP) on 03/02/22 at 3:14pm revealed: -Resident #2's Voltaren gel should have been applied as ordered to provide relief from pain. -He was concerned Resident #2 was not getting relief from pain. -He expected medication to be administered as ordered. -He held the Health and Wellness Director (HWD) and the Memory Care Coordinator (MCC) responsible for medication administration. Interview with Resident #2 on 03/03/22 at 10:30am revealed he had pain in his back. Interview with the MCC on 03/03/22 at 1:33pm revealed: -He expected medication to be administered as ordered. -Resident #2 complained of back pain. -Resident #2 was not receiving Voltaren gel as ordered. -He did not remember the last time he conducted	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ___ B. WING ___	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 47	{D 358}		

a medication cart audit.
-Either he or the MA requested refills of medications.

Interview with the Resident Care Coordinator (RCC) on 03/03/22 at 2:31pm revealed:
-Resident #2 complained of back pain.
-The MAs must not have been administering Resident #2's Voltaren gel as ordered.
-The MAs needed to be retrained.

Interview with the HWD on 03/03/22 at 3:05pm revealed:
-She was concerned Resident #2 may not have been receiving Voltaren gel as ordered.
-This was unacceptable because the role of the MA was to administer medications.
-The MAs needed more training and education on the importance of resident care.
-She held herself ultimately responsible for the accurate administration of medication.

Interview with the Administrator on 03/03/22 at 4:08pm revealed:
-She was concerned Resident #2 may have experienced pain by not receiving the Voltaren gel as ordered.
-She did not know if the MAs were administering the Voltaren gel.
-She expected medication to be administered as ordered.
-The HWD was ultimately responsible for accurate medication administration.

3. Review of Resident #2's current FL-2 dated 09/21/21 revealed there was an order for polyethylene glycol (a laxative) take 17 grams (G) daily.

Review of Resident #2's December

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 48 2021-February 2022 electronic medication administration records (eMAR) revealed: -There was an entry for polyethylene glycol 17G mix in suitable liquid and drink once daily scheduled for administration at 8:00am. -Polyethylene glycol was documented as administered once daily for 89 of 90 opportunities. Observation of Resident #2's medication available for administration on 03/02/22 at 2:28pm revealed: -There was one 8.3-ounce container of polyethylene glycol powder which was the equivalent of 14 daily doses. -The label indicated the pharmacy dispensed the medication on 01/03/22. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/03/22 at 9:31am revealed: -The pharmacy last dispensed polyethylene glycol for Resident #2 on 01/03/22. -Facility staff were supposed to request refills of Resident #2's polyethylene glycol; it was not automatically dispensed by the pharmacy. -The pharmacy had not received any refill requests from the facility for Resident #2's polyethylene glycol. Interviews with a medication aide (MA) on 03/02/22 at 2:14pm and on 03/03/22 at 10:00am revealed: -She administered polyethylene to Resident #2. -Staff were supposed to call the pharmacy to request refills of Resident #2's polyethylene glycol. -She did not perform medication cart audits. -She did not know how often medication cart audits were completed.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 49	{D 358}		

-The Memory Care Coordinator (MCC) and the Resident Care Coordinator (RCC) were responsible for completing medication cart audits.
-The MCC was responsible for ordering medication refills.

Telephone interview with Resident #2's primary care provider (PCP) on 03/02/22 at 3:14pm revealed:
-Resident #2 could have experienced constipation or pain because his polyethylene glycol was not administered as ordered.
-Resident #2 was able to express pain to staff.
-He expected Resident #2's polyethylene glycol to be administered as ordered.
-He was concerned Resident #2 was not getting polyethylene glycol.

Interview with the MCC on 03/03/22 at 1:33pm revealed:
-Either he or the MA requested refills of medications.
-He did not remember the last time he conducted a medication cart audit.
-He did not know if Resident #2 was receiving polyethylene glycol as ordered.
-He expected medication to be administered as ordered.

Interview with the RCC on 03/03/22 at 2:31pm revealed:
-The MAs must not have been administering polyethylene glycol to Resident #2.
-The MAs needed to be retrained.

Interview with the Health and Wellness Director (HWD) on 03/03/22 at 3:05pm revealed:
-She expected the MCC and RCC to audit the medication carts two times a month.
-Resident #2 may have experienced increased

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 50	{D 358}		

constipation if he was not receiving polyethylene glycol as ordered.
-She questioned whether Resident #2 was receiving polyethylene glycol as ordered.
-This was unacceptable because the role of the MA was to administer medications.
-She had not received any reports of pain or constipation from Resident #2.
-She held the MCC responsible for Resident #2's polyethylene glycol not being administered as ordered.
-She held herself ultimately responsible for the accurate administration of medication.
-The MAs needed more training and education on the importance of resident care.

Interview with the Administrator on 03/03/22 at 4:08pm revealed:
-She was concerned Resident #2 may not have been receiving polyethylene glycol as ordered.
-She expected medication to be administered as ordered.
-The MAs needed to take ownership of the medication carts.
-The HWD was ultimately responsible for accurate medication administration.

f. Review of Resident #3's current FL-2 dated 12/07/21 revealed:
-Diagnoses included dementia, diabetes mellitus two, history of stroke, chronic pain and gait disorder.
-There was an order for diclofenac sodium external gel 1% (used to treat arthritis pain) 2gm applied to both knees twice daily.

Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for diclofenac sodium

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ________ B. WING ________	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 51	{D 358}		

external gel 1% 2gm apply topically to both knees scheduled at 8:00am and 8:00pm.
-Diclofenac sodium external gel 1% was documented as administered 10 times and refused 18 times.

Observation of Resident #3's medication available for administration on 03/02/22 at 2:51pm revealed:
-The was an empty tube of diclofenac sodium gel with a dispense date of 11/17/21.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/03/22 at 9:38am revealed:
-All medications in medication cards were on a cycle fill date.
-Creams and gels needed to be re-ordered as needed because they were not cycle filled.
-The facility notified the pharmacy for refills on medications that did not cycle fill.
-A thirty-day supply of Resident #3's diclofenac sodium external gel 1% 2mg was dispensed on 11/17/21.
-There were no more dispense dates for Resident #3's diclofenac sodium gel 1%.
-A measuring guide was included with each tube of diclofenac gel when it was dispensed.

Interview with Resident #3 on 03/03/22 at 10:19am revealed she could not recall if the diclofenac gel was applied to her knees.

Interview with a medication aide (MA) on 03/02/22 at 3:10pm revealed:
-Resident #3 would refuse the diclofenac gel and it was documented on the eMAR.
-She used a guide to measure the 2mg of diclofenac for Resident #3.
-She applied the diclofenac gel to each of

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	**4713 GARRETT ROAD DURHAM, NC 27707**

(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 358}	Continued From page 52 Resident #3's knees when she worked. -She had applied the diclofenac that morning to Resident #3's knees; she had emptied the tube. -Medications were not on an auto fill and had to be reordered by the MAs. -She was going to reorder the diclofenac gel that day. -She did not know why the tube of diclofenac gel had lasted as long as it did. -She did not know if the MA on the other shift applied the diclofenac gel. Telephone interview with Resident #3's primary care provider (PCP) on 03/02/22 at 3:30pm revealed: -Resident #3's diclofenac gel was ordered for her knee pain and should have been applied twice daily. -She had not complained of pain. -He expected the order for the diclofenac gel to be followed as ordered. -If the diclofenac gel was not applied as ordered it could cause a degrading of her quality of life; she would be less likely to participate in daily activities of life. Interview with the Memory Care Coordinator (MCC) on 03/03/22 at 10:21am revealed: -Medicated creams and gels were not cycle filled and needed to be reordered from the pharmacy by himself or a MA. -He expected all medication to be administered as ordered, including Resident #3's diclofenac gel. -The tube of diclofenac gel came with a guide to measure the 2mg. -The tube of diclofenac gel dispensed on 11/17/21 should have run out long before that day, 03/03/22. -He did cart audits once a week but Resident #3's	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 53	{D 358}		

diclofenac gel must have been overlooked.

Interviews with the Health and Wellness Director (HWD) on 03/03/22 at 1:40pm and 3:27pm revealed:
-Resident #3's diclofenac gel should have been administered as ordered.
-Resident #3's diclofenac gel should have been reordered because the amount dispensed on 11/17/21 should have been gone.
-The MAs were not administering Resident #3's diclofenac gel 1% as ordered.
-This was unacceptable because the role of the MA was to administer medications.
-The MAs needed more training and education on the importance of resident care.
-She held herself ultimately responsible for the accurate administration of medication.

Interview with the Administrator on 03/03/22 at 4:08pm revealed:
-She was concerned Resident #3 may have experienced pain by not receiving the diclofenac gel 1% as ordered.
-She did not know if the MAs were administering the diclofenac gel 1%.
-She expected medication to be administered as ordered.
-The HWD was ultimately responsible for accurate medication administration.

g. Review of Resident #5's current FL-2 dated 05/25/21 revealed diagnoses included Parkinson's disease, type two diabetes, neuromuscular dysfunctional bladder, and metabolic encephalopathy.

1. Review of Resident #5's current FL-2 dated 05/25/21 revealed there was an order for carbidopa/levodopa (used to treat Parkinson's

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ____ B. WING ____	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 54	{D 358}		

disease) 10-100mg three times daily.

Review of Resident #5's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for carbidopa/levodopa 10-100 mg scheduled three times daily at 8:00am, 2:00pm, and 9:00pm.
-There was no documentation Resident #5 refused medications.
-There was documentation Resident #5 was out of the facility for five days.
-There was documentation Resident #5 was administered the carbidopa/levodopa 10-100mg 67 times out of 67 opportunities in February 2022.

Observation of Resident #5's medication on hand on 03/02/22 at 2:26pm revealed:
-There were three medication cards with carbidopa/levodopa 10-100mg.
-There was a medication card with a dispense date of 01/05/22 and was labeled as 2 of 2 cards; 30 tablets were dispensed, and 16 tablets were available for administration.
-There was a second mediation card with a dispense date of 02/04/22 and was labeled as 1 of 2 cards; 60 tablets were dispensed, and 60 tablets were available for administration.
-There was a third medication card with a dispense date of 02/04/22 and was labeled as 2 of 2 cards; 30 tablets were dispensed, and 30 tablets were available for administration.
-Resident #5 had a total of 136 tablets of carbidopa/levodopa 10-100mg available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 03/02/22 at 9:21am revealed:
-All medications in medication cards were on a

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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{D 358}	Continued From page 55 cycle fill date. -Resident #5 had a current order for carbidopa/levodopa 10-100mg scheduled three times daily. -Ninety tablets of carbidopa/levodopa 10-100mg were dispensed from the pharmacy on 01/05/22, and 02/04/22; each dispense was for a 30-day supply. -Carbidopa/levodopa was used to treat Parkinson's disease. Interview with Resident #5's primary care provider (PCP) on 03/03/22 at 2:57pm revealed: -Resident #5 was ordered carbidopa/levodopa 10-100mg three times daily to treat his Parkinson's disease. -Possible outcomes of Resident #5's carbidopa/levodopa not administered as ordered could include increased cognitive impairment, increased rigidity, and increased risk of falls. -He expected all medications to be administered as ordered for Resident #5. Interview with a medication aide (MA) on 03/03/22 at 10:12am revealed: -She was new and did not know if medication was on a cycle fill. -Resident #5 did not refuse his medication. -She administered Resident #5 his medications as scheduled at 8:00am and 2:00pm when she worked. -She had not paid attention to the dispense dates on the medication cards. -She did a cart audit about once a week, but she did not look at the extra medications. -She thought the extra medication was from over ordering. Interview with the Resident Care Coordinator (RCC) on 03/03/22 a 1:40pm revealed:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 56	{D 358}		

-She did medication cart audits about once a week; the last cart audit was done the week before.
-All tablets were on a 30-day cycle fill schedule.
-She did not look at the drawer that contained the unused and extra medication cards when she did the last cart audit.
-She usually checked the extra medication cards to check the dates and to see if there was medication that had been on the cart longer than thirty days.
-If Resident #5 had 136 tablets of carbidopa/levodopa on the medication cart the he might not have been administered his medication as ordered.
-She was concerned Resident #5 was not administered his medication as ordered because it was ordered for a reason.
-She expected the MAs to administer medication as ordered.

Interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:02pm revealed:
-She expected the Memory Care Coordinator (MCC) and RCC to audit the medication carts two times a month.
-The MCC and RCC were expected to verify that ordered medications were available on the medication cart, remove expired medications, and review what was and was not being used.
-It would take three days to complete one full cart audit.
-The MCC and RCC had been completing medication cart audits.
-She had not verified the medication cart audits were occurring.
-Her goal was to complete a cart audit once or twice each month.
-She intended to complete a cart audit the week after it had been audited by the MCC or RCC.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 57 -There was a drawer that held the excess mediations on the medication carts, but she did not check the drawer when she did a medication cart audit. -She did not realize Resident #5 had an excess of carbidopa/levodopa available for administration. -Resident #5 would refuse his medication after 9:30pm, but she did not think he had refused any medications. -The excess medication would not be on hand if Resident #5 was administered his medication as ordered by the MAs. -She was ultimately responsible for ensuring the resident's medications were administered as ordered. Interview with the Administrator on 03/03/22 at 4:08pm revealed: -The HWD was responsible for assigning how often medication carts were audited. -The medications carts were audited weekly. -The MAs completed the medication cart audits and were overseen by the HWD. -The MCC and RCC assisted with medication cart audits. -The pharmacy completed medication cart audits quarterly. -She expected medication to be administered as ordered. -Resident #5's excess medication indicated his medication was not administered as ordered. -Excess medication was supposed to be removed from the medication cart when new cycle fill cards came to the facility. -The MAs needed to take ownership of the medication carts. -The HWD was ultimately responsible for accurate medication administration. Based on observations, interviews and record	{D 358}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 58	{D 358}		

reviews, it was determined Resident #5 was not interviewable.

2. Review of Resident #5's current FL-2 dated 05/25/21 revealed there was an order for metformin (an anti-diabetic medication) 500mg twice daily with meals.

Review of Resident #5's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for metformin 500mg scheduled twice daily with meals at 8:00am and 5:00pm.
-There was no documentation Resident #5 refused medications.
-There was documentation Resident #5 was out of the facility for five days.
-There was documentation Resident #5 was administered metformin 500mg 45 times out of 45 opportunities in February 2022.

Observation of Resident #5's medication on hand on 03/02/22 at 2:26pm revealed:
-There were three medication cards with metformin 500mg.
-There was a medication card with a dispense date of 01/05/22 and was labeled as 2 of 2 cards; 30 tablets were dispensed, and 1 tablet was available for administration.
-There was a second mediation card with a dispense date of 02/02/22 and was labeled as 1 of 2 cards; 30 tablets were dispensed, and 25 tablets were available for administration.
-There was a third medication card with a dispense date of 02/02/22 and was labeled as 2 of 2 cards; 30 tablets were dispensed, and 21 tablets were available for administration.
-Resident #5 had a total of 47 tablets of metformin 500mg available for administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 59	{D 358}		

Telephone interview with a representative from the facility's contracted pharmacy on 03/02/22 at 9:21am revealed:
-All medications in medication cards were on a cycle fill date.
-Resident #5 had a current order for metformin 500mg scheduled twice daily.
-Sixty tablets of metformin 500mg were dispensed from the pharmacy on 01/05/22, and 02/02/22; each dispense was for a 30-day supply.
-Metformin was used to treat diabetes.

Interview with Resident #5's primary care provider (PCP) on 03/03/22 at 2:57pm revealed:
-Resident #5 was ordered metformin 500mg twice daily to treat his type two diabetes.
-Possible outcomes from Resident #5's metformin not administered as ordered could include increased blood sugar levels and increase complications from diabetes including neuropathy in his extremities and kidney injuries.
-He expected all medications to be administered as ordered for Resident #5.

Interview with a medication aide (MA) on 03/03/22 at 10:12am revealed:
-She was new and did not know if medication was on a cycle fill.
-Resident #5 did not refuse his medication.
-She administered Resident #5 his medications as scheduled when she worked.
-She had not paid attention to the dispense dates on the medication cards.
-She did a cart audit about once a week, but she did not look at the extra medications.
-She thought the extra medication was from over ordering.

Interview with the Resident Care Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 60 (RCC) on 03/03/22 a 1:40pm revealed: -She did medication cart audits about once a week; the last cart audit was done the week before. -All tablets were on a 30-day cycle fill schedule. -She did not look at the drawer that contained the unused and extra medication cards when she did the last cart audit. -She usually checked the extra medication cards to check the dates and to see if there was medication that had been on the cart longer than thirty days. -If Resident #5 had 47 tablets of metformin on the medication cart the he might not have been administered his medication as ordered. -She was concerned Resident #5 was not administered his medication as ordered because it was ordered for a reason. -She expected the MAs to administer medication as ordered. Interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:02pm revealed: -She expected the Memory Care Coordinator (MCC) and RCC to audit the medication carts two times a month. -The MCC and RCC were expected to verify that ordered medications were available on the medication cart, remove expired medications, and review what was and was not being used. -It would take three days to complete one full cart audit. -The MCC and RCC had been completing medication cart audits. -She had not verified the medication cart audits were occurring. -Her goal was to complete a cart audit once or twice each month. -She intended to complete a cart audit the week after it had been audited by the MCC or RCC.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ____ B. WING ____	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 61 -There was a drawer that held the excess mediations on the medication carts, but she did not check the drawer when she did a medication cart audit. -She did not realize Resident #5 had an excess of metformin 500mg available for administration. -Resident #5 would refuse his medication after 9:30pm, but she did not think he had refused any medications. -The excess medication would not be on hand if Resident #5 was administered his medication as ordered by the MAs. -She was ultimately responsible for ensuring the resident's medications were administered as ordered. Interview with the Administrator on 03/03/22 at 4:08pm revealed: -The HWD was responsible for assigning how often medication carts were audited. -The medications carts were audited weekly. -The MAs completed the medication cart audits and were overseen by the HWD. -The MCC and RCC assisted with medication cart audits. -The pharmacy completed medication cart audits quarterly. -She expected medication to be administered as ordered. -Resident #5's excess medication indicated his medication was not administered as ordered. -Excess medication was supposed to be removed from the medication cart when new cycle fill cards came to the facility. -The MAs needed to take ownership of the medication carts. -The HWD was ultimately responsible for accurate medication administration. Based on observations, interviews and record	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 62	{D 358}		

Continued From page 62

reviews, it was determined Resident #5 was not interviewable.

3. Review of Resident #5's current FL-2 dated 05/25/21 revealed there was an order for trazadone (used as a sleep aide) 150mg at bedtime.

Review of Resident #5's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for trazadone 150mg scheduled at 9:00pm.
-There was no documentation Resident #5 refused medications.
-There was documentation Resident #5 was out of the facility from 02/16/22 to 02/23/22.
-There was documentation Resident #5 was administered trazadone 150mg 22 times out of 22 opportunities in February 2022.

Observation of Resident #5's medication on hand on 03/02/22 at 2:26pm revealed:
-There were four medication cards with trazadone 150mg.
-There was a medication card with a dispense date of 10/7/21; 30 tablets were dispensed, and 25 tablets were available for administration.
-There was a second medication card with a dispense date of 12/06/21; 30 tablets were dispensed, and 2 tablets were available for administration.
-There was a third mediation card with a dispense date of 01/05/22; 30 tablets were dispensed, and 30 tablets were available for administration.
-There was a fourth medication card with a dispense date of 02/04/22; 30 tablets were dispensed, and 30 tablets were available for administration.
-Resident #5 had a total of 87 tablets of

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 63 trazadone 150mg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 03/02/22 at 9:21am revealed: -All medications in medication cards were on a cycle fill date. -Resident #5 had a current order for trazadone 150mg scheduled at bedtime. -Thirty tablets of trazadone 150mg were dispensed from the pharmacy on 10/07/21, 11/07/21, 12/04/21, 01/05/22, and 02/02/22; each dispense was for a 30-day supply. -Trazadone could be used as a sleep aide. Interview with Resident #5's primary care provider (PCP) on 03/03/22 at 2:57pm revealed: -Resident #5 was ordered trazadone 150mg at bedtime to help him sleep. -Possible outcomes from Resident #5's trazadone not administered as ordered could be lack of sleep which could make his sleep cycles off and increase his risk of falls. -He expected all medications to be administered as ordered for Resident #5. Interview with a medication aide (MA) on 03/03/22 at 10:12am revealed: -She was new and did not know if medication was on a cycle fill. -Resident #5 did not refuse his medication. -She administered Resident #5 his medications as scheduled when she worked. -She had not paid attention to the dispense dates on the medication cards. -She did a cart audit about once a week, but she did not look at the extra medications. -She thought the extra medication was from over ordering.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

(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 358}	Continued From page 64 Interview with the Resident Care Coordinator (RCC) on 03/03/22 a 1:40pm revealed: -She did medication cart audits about once a week; the last cart audit was done the week before. -All tablets were on a 30-day cycle fill schedule. -She did not look at the drawer that contained the unused and extra medication cards when she did the last cart audit. -She usually checked the extra medication cards to check the dates and to see if there was medication that had been on the cart longer than thirty days. -If Resident #5 had 87 tablets of trazadone on the medication cart the he might not have been administered his medication as ordered. -She was concerned Resident #5 was not administered his medication as ordered because it was ordered for a reason. -She expected the MAs to administer medication as ordered. Interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:02pm revealed: -She expected the Memory Care Coordinator (MCC) and RCC to audit the medication carts two times a month. -The MCC and RCC were expected to verify that ordered medications were available on the medication cart, remove expired medications, and review what was and was not being used. -It would take three days to complete one full cart audit. -The MCC and RCC had been completing medication cart audits. -She had not verified the medication cart audits were occurring. -Her goal was to complete a cart audit once or twice each month. -She intended to complete a cart audit the week	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

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 358}	Continued From page 65	{D 358}		

after it had been audited by the MCC or RCC.
-There was a drawer that held the excess mediations on the medication carts, but she did not check the drawer when she did a medication cart audit.
-She did not realize Resident #5 had an excess of trazadone available for administration.
-Resident #5 would refuse his medication after 9:30pm, but she did not think he had refused any medications.
-The excess medication would not be on hand if Resident #5 was administered his medication as ordered by the MAs.
-She was ultimately responsible for ensuring the resident's medications were administered as ordered.

Interview with the Administrator on 03/03/22 at 4:08pm revealed:
-The HWD was responsible for assigning how often medication carts were audited.
-The medications carts were audited weekly.
-The MAs completed the medication cart audits and were overseen by the HWD.
-The MCC and RCC assisted with medication cart audits.
-The pharmacy completed medication cart audits quarterly.
-She expected medication to be administered as ordered.
-Resident #5's excess medication indicated his medication was not administered as ordered.
-Excess medication was supposed to be removed from the medication cart when new cycle fill cards came to the facility.
-The MAs needed to take ownership of the medication carts.
-The HWD was ultimately responsible for accurate medication administration.

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	HAL032133	A. BUILDING: ______ B. WING ______	R 03/04/2022

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{D 358}	Continued From page 66 Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable. 4. Review of Resident #5's current FL-2 dated 05/25/21 revealed there was an order for Flomax (used to prevent urinary retention) 0.4mg twice daily. Review of Resident #5's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Flomax 0.4mg twice daily scheduled at 8:00am and 9:00pm. -There was no documentation Resident #5 refused medications. -There was documentation Resident #5 was out of the facility from 02/16/22 to 02/23/22. -There was documentation Resident #5 was administered Flomax 0.4mg 44 times out of 44 opportunities in February 2022. Observation of Resident #5's medication on hand on 03/02/22 at 2:26pm revealed: -There were three medication cards with Flomax 0.4mg. -There was a mediation card with a dispense date of 01/05/22 and it was labeled 1 of 2 cards; 30 tablets were dispensed, and 13 tablets were available for administration. -There was a second mediation card with a dispense date of 01/05/22 and it was labeled 2 of 2 cards; 30 tablets were dispensed, and 30 tablets were available for administration. -There was a third medication card with a dispense date of 02/04/22; 600 tablets were dispensed, and 60 tablets were available for administration. -Resident #5 had a total of 103 tablets of Flomax 0.4mg available for administration.	{D 358}		

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{D 358}	Continued From page 67	{D 358}		

Telephone interview with a representative from the facility's contracted pharmacy on 03/02/22 at 9:21am revealed:
-All medications in medication cards were on a cycle fill date.
-Resident #5 had a current order for Flomax 0.4mg twice daily.
-Sixty tablets of Flomax 0.4mg were dispensed from the pharmacy on 01/05/22, and 02/02/22; each dispense was for a 30-day supply.
-Flomax was used to treat urinary retention.

Interview with Resident #5's primary care provider (PCP) on 03/03/22 at 2:57pm revealed:
-Resident #5 was ordered Flomax 0.4mg twice daily to prevent urinary retention.
-Possible outcomes from Resident #5's Flomax not administered as ordered could be failure to empty his bladder which would lead to urine retention and paralysis of his bladder due to over distention.
-He expected all medications to be administered as ordered for Resident #5.

Interview with a medication aide (MA) on 03/03/22 at 10:12am revealed:
-She was new and did not know if medication was on a cycle fill.
-Resident #5 did not refuse his medication.
-She administered Resident #5 his medications as scheduled when she worked.
-She had not paid attention to the dispense dates on the medication cards.
-She did a cart audit about once a week, but she did not look at the extra medications.
-She thought the extra medication was from over ordering.

Interview with the Resident Care Coordinator

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{D 358}	Continued From page 68 (RCC) on 03/03/22 a 1:40pm revealed: -She did medication cart audits about once a week; the last cart audit was done the week before. -All tablets were on a 30-day cycle fill schedule. -She did not look at the drawer that contained the unused and extra medication cards when she did the last cart audit. -She usually checked the extra medication cards to check the dates and to see if there was medication that had been on the cart longer than thirty days. -If Resident #5 had 103 tablets of Flomax on the medication cart the he might not have been administered his medication as ordered. -She was concerned Resident #5 was not administered his medication as ordered because it was ordered for a reason. -She expected the MAs to administer medication as ordered. Interview with the Health and Wellness Director (HWD) on 03/03/22 at 4:02pm revealed: -She expected the Memory Care Coordinator (MCC) and RCC to audit the medication carts two times a month. -The MCC and RCC were expected to verify that ordered medications were available on the medication cart, remove expired medications, and review what was and was not being used. -It would take three days to complete one full cart audit. -The MCC and RCC had been completing medication cart audits. -She had not verified the medication cart audits were occurring. -Her goal was to complete a cart audit once or twice each month. -She intended to complete a cart audit the week after it had been audited by the MCC or RCC.	{D 358}		

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{D 358}	Continued From page 69 -There was a drawer that held the excess mediations on the medication carts, but she did not check the drawer when she did a medication cart audit. -She did not realize Resident #5 had an excess of Flomax available for administration. -Resident #5 would refuse his medication after 9:30pm, but she did not think he had refused any medications. -The excess medication would not be on hand if Resident #5 was administered his medication as ordered by the MAs. -She was ultimately responsible for ensuring the resident's medications were administered as ordered. Interview with the Administrator on 03/03/22 at 4:08pm revealed: -The HWD was responsible for assigning how often medication carts were audited. -The medications carts were audited weekly. -The MAs completed the medication cart audits and were overseen by the HWD. -The MCC and RCC assisted with medication cart audits. -The pharmacy completed medication cart audits quarterly. -She expected medication to be administered as ordered. -Resident #5's excess medication indicated his medication was not administered as ordered. -Excess medication was supposed to be removed from the medication cart when new cycle fill cards came to the facility. -The MAs needed to take ownership of the medication carts. -The HWD was ultimately responsible for accurate medication administration. Based on observations, interviews and record	{D 358}		

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{D 358}	Continued From page 70 reviews, it was determined Resident #5 was not interviewable.	{D 358}		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication aides observed residents in the special care unit taking their medication for 2 of 4 residents sampled (#1, #6) including observation of both resident with liquid medication, one left at the bedside and the other left with the resident in the living room on 03/02/22. The findings are: 1. Review of Resident #1's current FL2 dated 2/14/2022 revealed: -Diagnoses included acute kidney injury, fracture of right inferior pubic ramus, urinary urgency, generalized weakness, traumatic rhabdomyolysis, fall, acute encephalopathy, subacromial bursitis, osteoarthritis of left shoulder and depression. -Resident #1 was disoriented to place and time. Review of Resident #1's physician's orders dated	D 366	HWD or designee immediately re-educated Medication Technician on cart during medication pass noted on SOD of requirement to observe all medication being taken by resident prior to leaving the area. HWD or designee will complete re-education of all med aides, including any agency staff, related to observation of resident taking all medication prior to med aide leaving the area. HWD or designee will perform random medication pass observation weekly to ensure medication aides are following policy and procedures for medication administration in the community. Immediate re-education will be provided if discrepancies are noted.	4.3.22 4.3.22 4.3.22

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D 366	Continued From page 71	D 366		

02/14/22 revealed there was an order for polyethylene glycol (used to treat constipation) 17gms in 4 to 6 ounces of fluid twice a day.

Review of Resident #1's March 2022 electronic medication administration record (eMAR) revealed there was an entry for polyethylene glycol 17gms in suitable liquid daily.

Observation of the morning medication pass on 03/02/22 at 8:02am revealed:
-The MA poured water into a 5-ounce plastic cup.
-The MA poured one capful of polyethylene glycol into the 5-ounce cup of water and mixed with a spoon.
-The MA took the cup of polyethylene glycol into the living room where Resident #1 was seated in her wheelchair with 8 other residents.
-The MA handed the cup of polyethylene glycol in water to Resident #1.
-Resident #1 drank ¾ of her medication from the plastic cup.
-The MA returned to the medication cart which was in the hallway; Resident #1 remained in the living room with a ¼ cup of polyethylene glycol medication.

Interview with a medication aide (MA) on 03/02/22 at 8:15am revealed:
-She prepared and administered medications to Resident #1 at the 8:00am medication pass on 03/02/22
-She thought the resident had drank all the liquid medication.

Interview with the Health Wellness Director (HWD) on 03/02/22 at 3:48pm revealed Resident #1 could hand her cup with the liquid medication to another resident or a resident could take the liquid medication from Resident #1.

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D 366	Continued From page 72	D 366		

Interview with Resident #1's Primary Care Provider (PCP) on 03/03/22 at 2:28pm revealed another resident could take the liquid medication that was meant for Resident #1.

Attempted interview with Resident #1 revealed she was not-interviewable.

Refer to the interview with the Memory Care Coordinator (MCC) on 03/02/22 at 2:21pm.

Refer to the interview with the Health Wellness Director (HWD) on 03/02/22 at 3:48pm.

Refer to the interview with the Administrator on 03/02/22 at 4:08pm.

2. Review of Resident #6's current FL-2 dated 08/16/21 revealed:
-Diagnoses included acute kidney injury, diarrhea, non-intractable vomiting with nausea, Ileitis, dementia without behavioral disturbances, Lewy body verses vascular.
-Resident #6 was constantly disoriented.
-Resident #6 was a wanderer.

Review of Resident #6's physician's orders dated 11/29/21 revealed there was an order for polyethylene glycol 17gms in 8-ounces of water, juice or coffee daily.

Review of Resident #12's March 2022 electronic medication administration record (eMAR) revealed there was an entry for polyethylene glycol 17gm in 8-ounces of water, juice or coffee daily.

Observation of the morning medication pass on 03/02/22 at 7:50am revealed:

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D 366	Continued From page 73	D 366		

-The MA poured water into a 5-ounce plastic cup.
-The MA poured one capful of polyethylene glycol into the 5-ounce cup of water and mixed with a spoon.
-The MA took the cup of polyethylene glycol into the bedroom Resident #6 was lying in bed.
-Resident #6 sat on side of the bed and took the 5-ounce cup of liquid medication from the MA.
-Resident #6 drank ¾ of her liquid medication from the plastic cup.
-Resident #6 placed the cup with ¼ liquid medication remaining on her nightstand.
-The MA returned to the medication cart which was in the hallway;

Interview with a medication aide (MA) on 03/202/22 at 2:59am revealed:
-Resident #6 did not drink all her liquid medication during the 8:00am medication pass.
-She drank about ¾ of her liquid medication.
-Resident #6 placed her gum in the remaining liquid medication and placed it on her nightstand.
-Resident #6 would drink the remaining of her liquid medication.
-The MA did not remove the liquid medication from the Resident #6's room because she would drink the remaining.

Interview with the HWD on 03/02/22 at 3:48pm revealed another resident could walk in Resident #6's room and drink any liquid medication that was left in the cup.

Attempted interview with Resident #1's Primary Care Provider on 03/03/22 at 3:00pm was unsuccessful.

Attempted interview with Resident #1 revealed she was not-interviewable.

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D 366	Continued From page 74 Refer to the interview with the Memory Care Coordinator (MCC) on 03/02/22 at 2:21pm. Refer to the interview with the Health Wellness Director (HWD) on 03/02/22 at 3:48pm. Refer to the interview with the Administrator on 03/02/22 at 4:08pm. ____________________ Interview with the Memory Care Coordinator (MCC) on 03/02/22 at 2:21pm revealed: -The MA should stay with the residents until all medications were taken. -The MA should watch the residents take all their medications. -He would be concerned that another resident could take the medication. Interview with the Health Wellness Director (HWD) on 03/02/22 at 3:48pm revealed the MAs should remain with the residents until all their medications had been administered. Interview with the Administrator on 03/02/22 at 4:08pm revealed: -The MA should remain with the residents until their medication has been administered. -The MA should never leave a resident with medication; another resident could take the medication. -The MA could not document the medication was administered if she did not see the resident take all the medication.	D 366	HWD and or designee will perform cart audits weekly, comparing medication orders and medications. HWD and or designee will re-educate staff on hospital discharge summary protocol. HWD and or designee will perform random medication pass audits weekly. HWD and or designee will scan all hospital discharge summaries to provider to include updated FL2's and any new orders, along with placing in provider book.	4.3.22
{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	{D912}	HWD and/or designee immediately re-educated ency protocols. This education will include new hires and new agency staff reviewing assignment prior to first independent shift on the floor.	4.3.22

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{D912}	Continued From page 75 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 ensure 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: Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (Resident #1) related to failure to contact emergency medical services (EMS) timely as requested by the resident who reported pain following an unwitnessed fall. [Refer to Tag D273, 10A NCAC 13F .0904(b) Health Care (Type A2 Violation).]	{D912}	HWD and/or designee and Administrator or designee will have clinical stand-up meeting daily to include discussion of incidents and follow-up. HWD and/or designee will place reference binder including emergency response policies, incident reporting process and procedures and phone tree in area readily available to all staff. All staff including agency staff will be educated on the contents and location of this binder. Administrator and/or designee will notify all agency partners of emergency procedures, communication and community phone tree. HWD, BOM and/or designee will review staff training grid at least monthly to ensure all staff currently working in the community have received documented training on emergency procedures, reporting of incidents and location of reference binder in the community. Any discrepancies will be reported immediately to the Administrator. HWD or designee will provide education to any team member without documented training prior to the beginning of the team member's next scheduled shift.	4.3.22 4.3.22 4.3.22