PRINTED: 05/28/2024 FORM APPROVED

Division of Health Service Regulation

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|------------------------------|---|-------------------------------|
| ANDIEAN | or dortheories | IDENTIFICATION NOMBER. | A. BUILDING: _ | | |
| | | HAL092219 | B. WING | | R 05/08/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | | DRESS, CITY, STA | | |
| THE ADDI | SON OF FUQUAY VARIN | IA . | NSON POND R YARINA, NC 27 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE |
| {D 000} | Initial Comments | | {D 000} | | |
| | The Adult Care Licen follow-up survey on N | sure Section conducted a May 7-8, 2024. | | | |
| {D 358} | 10A NCAC 13F .1004 Administration | 1(a) Medication | {D 358} | | |
| | (a) An adult care hor preparation and admiprescription and non-by staff are in accord.(1) orders by a licens which are maintained | Medication Administration me shall assure that the inistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies | | | |
| | This Rule is not met TYPE A2 VIOLATION | _ | | | |
| | reviews, the facility fa were administered as (#3, #6) observed dur- related to a medication retention, medication potassium deficiency fungal infections, medical | used to treat or prevent , medication used to treat dication used to treat or (#6) and medication used to | | | |
| | The findings are: | | | | |
| | | rate was 16% as evidenced opportunities during the ass on 05/08/24. | | | |
| | 10/19/23 revealed dia | t #6's current FL2 dated agnoses included heart ion, hyperlipidemia, thyroid | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|--------------------------------|-------------------------------|--|
| | HAL092219 | B. WING | | 05 | R 5/ 08/2024 | |
| NAME OF PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | , ZIP CODE | • | | |
| THE ADDISON OF FUOLIAY VARINA | 6516 JOI | HNSON POND ROA | AD | | | |
| THE ADDISON OF FUQUAY VARINA | FUQUAY | VARINA, NC 2752 | 6 | | | |
| PREFIX (EACH DEFICIENCY MU | MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | |
| heart failure is a condition of pump blood as well a fluid build-up in the lungs a. Review of Resident #6 10/19/23 revealed there Furosemide 40mg one to a medication used to treat by congestive heart failured by congest | as it should, resulting in s, legs, and feet). 6's current FL2 dated was an order for ablet daily (Furosemide is at fluid retention caused ire). ted living (AL) medication dam revealed: ctor (MCD) was working A). sident #6's medications, rosemide 40mg. If medications to Resident March 2024 electronic or record (eMAR) Furosemide 40mg, one documented as from 03/25/24 to April 2024 eMAR Furosemide 40mg, one documented as on 28 of 30 days in April 224, Furosemide 40mg gnot given (DNG). | {D 358} | | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 2 of 30

| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|------------------------------|---|---|---------------------|---|-------------------------------|
| , LAN | 552511011 | | A. BUILDING: _ | | |
| | | HAL092219 | B. WING | | R 05/08/2024 |
| | | | | | 05/06/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, STA | TE, ZIP CODE | |
| THE ADDISON OF FUQUAY VARINA | | | INSON POND R | | |
| | | FUQUAY | VARINA, NC 27 | 7526 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE |
| {D 358} | Continued From page | 2 | {D 358} | | |
| | Resident #6's eMAR. | | | | |
| | Review of Resident # revealed: -There was an entry f tablet dailyFurosemide 40mg w administered at 8:00a 2024On 05/08/24, Furose documented as drug -On 05/08/24, there w pharmacy on medical notes section of Resident on 05/08/24 at 2 no Furosemide 40mg | for Furosemide 40mg, one as documented as am on 7 of 8 days in May mide 40mg was not given (DNG). vas an entry "will call tion" documented in the dent #6's eMAR. ent #6's medications on 12:51pm revealed there was on the medication cart. mory Care Director (MCD) | | | |
| | -She did not usually v | vork on the B hall assisted ne was helping staff this | | | |
| | morning, 05/08/24. | IG on Resident #'6 eMAR | | | |
| | - | because she did not see | | | |
| | the medication on the | medication cart. alth and Wellness Director | | | |
| | | aith and wellness Director 05/08/24, that Resident #6 | | | |
| | , | nide 40mg on the medication | | | |
| | cart. | • | | | |
| | | e Resident Care Coordinator | | | |
| | |) if a residents' medications | | | |
| | were not on the medical | cation cart. HWD notified the pharmacy | | | |
| | | eeded or the residents' | | | |
| | primary care provider | | | | |
| | medication was need | , , | | | |
| | -The RCC and MCD | were responsible for auditing | | | |

Division of Health Service Regulation

the medication carts.

STATE FORM 6899 OLFH12 If continuation sheet 3 of 30

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | CONSTRUCTION | (X3) DATE S | |
|--|---------------------------------|---|---------------------|---|-------------|--------------------------|
| | | | A. BUILDING: _ | A. BUILDING: | | |
| | | | B. WING | | R | |
| | | HAL092219 | D. WC | | 05/0 | 8/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| THE ADDI | SON OF FUQUAY VARIN | 6516 JOH | NSON POND R | OAD | | |
| | | FUQUAY \ | /ARINA, NC 27 | 526 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {D 358} | Continued From page | e 3 | {D 358} | | | |
| | -The medication audi | ts were not scheduled for a | | | | |
| | | sually audited the carts at | | | | |
| | _ | , usually on Thursday or | | | | |
| | Friday. | | | | | |
| | _ | Resident #6's Furosemide | | | | |
| | • | ble this morning, 05/08/24. | | | | |
| | -She was unsure how | is not on the medication cart | | | | |
| | | usually work as a MA on that | | | | |
| | cart. | • • • • • • • • • • • • • • • • • • • | | | | |
| | -If there was an order | from a PCP, the medication | | | | |
| | should be available for | or administration. | | | | |
| | Interview with the RC revealed: | C on 05/08/24 at 2:35pm | | | | |
| | -Resident #6's medic | ations were sent to the | | | | |
| | facility in a monthly cy | | | | | |
| | • | narmacy, so the staff did not | | | | |
| | have to reorder the m | | | | | |
| | delivered to the facilit | ations on cycle fill were | | | | |
| | | ted pharmacy did not notify | | | | |
| | | needed a refill on their | | | | |
| | medications. | | | | | |
| | - | to contact the pharmacy to | | | | |
| | inquire if a resident no | eeded refills on their | | | | |
| | medications. | -i | | | | |
| | | eing any faxes or receiving he pharmacy informing the | | | | |
| | | eeded a new order for refills | | | | |
| | of Furosemide 40mg. | | | | | |
| | • | Resident #6 did not have | | | | |
| | Furosemide 40mg on | | | | | |
| | -She was unsure how | long Resident #6 did not | | | | |
| | | ng on the medication cart | | | | |
| | but did not think it had | 3 | | | | |
| | | ave fluid retention if he did | | | | |
| | not take Furosemide | 40mg daily. | | | | |

Division of Health Service Regulation

cart audits to make sure residents' medications

STATE FORM 6899 OLFH12 If continuation sheet 4 of 30

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---------------------|---|---------------------------------|--------------------------|
| | | | | B. WING | | R |
| | | HAL092219 | B. WING | | 05 | /08/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, STATE | , ZIP CODE | | |
| THE ADD | ISON OF FUQUAY VARIN | 1Δ 6516 JOH | INSON POND ROA | ND | | |
| IIIL ADD | OON OF TOQUAL VAININ | FUQUAY | VARINA, NC 2752 | 6 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| {D 358} | Continued From page | e 4 | {D 358} | | | |
| | by the MAs, RCC, Mo -She knew Resident were not in the cart d | ts were performed randomly CD, and HWD. #6 had medications that luring some of the audits but y current medications that | | | | |
| | contracted pharmacy revealed: -Resident #6's Furoson 11/22/23 and 30 to facility, which was a 3-Furosemide 40mg was Resident #6 but could because he was out -The pharmacy attern #6's PCP several time Furosemide 40mg but order for the medicat -The pharmacy sent facility when a new reneeded so the facility | vas a cycle fill medication for d not be sent to the facility of refills. Inpted to contact Resident es to request a new order for ut had not received a new | | | | |
| | 11:27am revealed: -Furosemide 40mg wand should be taken -Resident #6 had a dfailure and was taking reasonIf Resident #6 did nowould be at risk of wold medications order | iagnosis of congestive heart g Furosemide 40mg for that of take Furosemide 40mg, he orsening heart failure. Fired had a reason to be sident #6 should not miss | | | | |
| | b. Review of Resider | nt #6's current FL2 dated | | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 5 of 30

| DIVISION | or riealin Service Regu | ilalion | | | | |
|-------------------|-------------------------|--|------------------|--|-------------|------------------|
| | FOF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPL | ETED |
| | | | | | - | , |
| | | | B. WING | | F | |
| | | HAL092219 | B. WING | | 05/0 | 08/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, STA | ATE, ZIP CODE | | |
| | | 6516 JOH | NSON POND R | OAD | | |
| THE ADDI | SON OF FUQUAY VARIN | IA . | ARINA, NC 27 | | | |
| | OLIMANA DV OT | | 1 | | | 1 |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | , | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROP | | DATE |
| | | | | DEFICIENCY) | | |
| {D 358} | Continued From page | 5 | {D 358} | | | |
| (5 000) | Continued From page | 5 0 | (12 000) | | | |
| | 10/19/23 revealed the | | | | | |
| | | ER 20mEq, take one by | | | | |
| | mouth once daily (Po | tassium Chloride ER is an | | | | |
| | | dication used to treat or | | | | |
| | prevent potassium de | eficiency). | | | | |
| | | | | | | |
| | | ssisted living (AL) medication | | | | |
| | pass on 05/08/24 fror | n 8:10am to 8:30am | | | | |
| | revealed: | | | | | |
| | _ | irector (MCD) was working | | | | |
| | as a medication aide | | | | | |
| | -The MCD prepared f | Resident #6's medications. | | | | |
| | -The MCD looked for | Potassium Chloride ER | | | | |
| | 20mEq but was not a | ble to locate the medication | | | | |
| | on the medication car | rt. | | | | |
| | -The MCD administer | red medications to Resident | | | | |
| | #6 at 8:25am. | | | | | |
| | Review of Resident # | 6's March 2024 electronic | | | | |
| | medication administra | | | | | |
| | revealed: | , | | | | |
| | | for Potassium Chloride ER | | | | |
| | 20mEq, one tablet on | | | | | |
| | • | ER 20mEq was documented | | | | |
| | | 00am from 03/25/24 to | | | | |
| | 03/31/24. | 004 | | | | |
| | | | | | | |
| | Review of Resident # | 6's April 2024 eMAR | | | | |
| | revealed: | | | | | |
| | -There was an entry f | for Potassium Chloride ER | | | | |
| | 20mEq, one tablet on | ice daily. | | | | |
| | - Potassium Chloride | | | | | |
| | | nistered at 8:00am on 28 of | | | | |
| | 30 days in April 2024 | <u>.</u> | | | | |
| | | /04/24, Potassium Chloride | | | | |
| | | mented as drug not given | | | | |
| | (DNG). | 5 5 | | | | |
| | , , | /04/24, there was an entry | | | | |
| | | locumented in the notes | | | | |

Division of Health Service Regulation

section of Resident #6's eMAR.

STATE FORM 6899 OLFH12 If continuation sheet 6 of 30

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|---|-------------------------------|------------------------|
| | | | A. BOILDING | A. BUILDING: | | |
| | | HAL092219 | B. WING | | R 05/08/20 3 | 24 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | - | |
| THE ADD | 100N 05 5U0UAYAA | 6516 JOHN | ISON POND R | OAD | | |
| THE ADDISON OF FUQUAY VARINA FUQUAY | | | ARINA, NC 27 | 526 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE CO | (X5) MPLETE DATE |
| {D 358} | Continued From page | e 6 | {D 358} | | | |
| | 20mEq, take one table -Potassium Chloride as administered at 8:12024Potassium Chloride as drug not given (DN on 05/08/24There was an entry medication" documer Resident #6's eMAR Observation of Residhand on 05/08/24 at 100 Potassium Chlorid medication cart. Interview with the Me on 05/08/024 at 12:18 -She did not usually viving (AL) cart, but shorning, 05/08/24She documented DN for Potassium Chlorid did not see the medication cart. HWD) this morning, did not have Potassiuthe medication cartMAs should notify the (RCC), MCD, or HWD were not in the medication. | for Potassium Chloride ER et once daily. ER 20mEq was documented 00am on 7 of 8 days in May ER 20mEq was documented NG) at 8:00am will call pharmacy on the in the notes section of on 05/08/24. ent #6's medications on 12:51pm revealed there was the ER 20mEq on the mory Care Director (MCD) Spm revealed: work on the B hall assisted the was helping staff this IG on Resident #6's eMAR the ER 20mEq because she thation on the medication cart. thath and Wellness Director 105/08/24, that Resident #6 the Chloride ER 20mEq, on the Resident Care Coordinator of if a residents' medications that is a resident to the pharmacy the eded or the residents' the (PCP) if a refill on | | | | |

Division of Health Service Regulation

-The RCC and MCD were responsible for auditing

STATE FORM 6899 OLFH12 If continuation sheet 7 of 30

| Division of | <u>of Health Service Regu</u> | lation | | | | |
|-------------------|-------------------------------|-------------------------------|------------------|--|-------------|------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | URVEY |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLI | ETED |
| | | | | | _ | |
| | | | B. WING | | R | |
| | | HAL092219 | B. WING | | 05/0 | 8/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| | | 6516 JOH | NSON POND R | OAD | | |
| THE ADDI | SON OF FUQUAY VARIN | Α | ARINA, NC 27 | | | |
| | CUMMA DV CT | ATEMENT OF DEFICIENCIES | 1 | T | | |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | • | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPE | | DATE |
| | | | | DEFICIENCY) | | |
| {D 358} | Continued From page | 7 | {D 358} | | | |
| (D 000) | Continued From page | . 1 | [[D 000] | | | |
| | the medication carts. | | | | | |
| | -The medication audi | ts were not scheduled for a | | | | |
| | certain day, but she u | isually audited the carts at | | | | |
| | the end of each week | i, usually on Thursday or | | | | |
| | Friday. | | | | | |
| | -She was unsure why | Resident #6's Potassium | | | | |
| | Chloride 20mEq was | not available this morning, | | | | |
| | 05/08/24. | | | | | |
| | -She was unsure how | • | | | | |
| | | 0mEq was not on the | | | | |
| | medication cart becar | use she did not usually work | | | | |
| | as a MA on that cart. | | | | | |
| | | from a PCP, the medication | | | | |
| | should be available for | or administration. | | | | |
| | | 0 05/00/04 1 0 05 | | | | |
| | | C on 05/08/24 at 2:35pm | | | | |
| | revealed: | -#: | | | | |
| | | ations were sent to the | | | | |
| | facility in a monthly cy | | | | | |
| | • | harmacy, so the staff did not | | | | |
| | have to reorder the m | ations on cycle fill were | | | | |
| | | • | | | | |
| | delivered to the facilit | ted pharmacy did not notify | | | | |
| | | needed a refill on their | | | | |
| | medications. | rieeded a reilli on theil | | | | |
| | | to contact the pharmacy to | | | | |
| | inquire if a resident no | | | | | |
| | medications. | eeded reiliis on their | | | | |
| | | eing any faxes or receiving | | | | |
| | | the pharmacy informing the | | | ĺ | |
| | | eeded a new order for refills | | | ĺ | |
| | of Potassium Chloride | | | | ĺ | |
| | | Resident #6 did not have | | | ĺ | |
| | _ | ER 20mEq on the medication | | | ľ | |
| | cart. | | | | ĺ | |
| | | / long Resident #6 was out | | | ĺ | |
| | | e ER 20mEq but did not | | | ĺ | |
| | think it had been long | | | | ĺ | |
| | | Resident #6 was taking | | | ľ | |
| | | ··· | 1 | | | 1 |

STATE FORM 6899 OLFH12 If continuation sheet 8 of 30

| DIVISION | n nealth Service Negu | lation | | | | |
|--------------------------|--|--|----------------------------|---|-------------|--------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE S | |
| ANDILAN | OF CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING: _ | | COMILE | -120 |
| | | | | | R | |
| | | HAL092219 | B. WING | | 05/0 | 8/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, STA | TE, ZIP CODE | | |
| THE ADDI | CON OF FUOLIAY VARIN | 6516 JOH | NSON POND R | OAD | | |
| I HE ADDI | SON OF FUQUAY VARIN | FUQUAY V | ARINA, NC 27 | 7526 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {D 358} | Continued From page | e 8 | {D 358} | | | |
| | Potassium Chloride E ordered it, he needed -The MAs, RCC, MCI cart audits to make su were availableMedication cart audit by the MAs, RCC, MCI -She knew Resident were not in the cart di was not aware of any were not available. Interview with a pharm contracted pharmacy revealed: -Resident #6's Potass was last filled on 12/2 sent to the facility, when the pharmacy attem dication for Reside to the facility because -The pharmacy attem #6's PCP several time Potassium Chloride E received a new order -The pharmacy sent a facility when a new reneeded so the facility was needed and coul Interview with Reside 11:27am revealed: -Potassium Chloride I medication and shoul -Resident #6 had a difailure and was prescent | ER 20mEq, but if his PCP I the medication. D, and HWD did medication are residents' medications Its were performed randomly CD, and HWD. If had medications that aring some of the audits but acurrent medications that I current medications that I current medications that I macist at the facility's I con 05/08/24 at 1:00pm I sium Chloride ER 20mEq I 1/23 and 30 tablets were I 1/24 and 30 tablets were I 1/25 and 30 tablets were I 1/25 and 30 tablets were I 1/26 and 30 tablets were I 1/27 and 30 tablets were I 1/28 and 30 tablets were I 1/29 and 30 tablets were I 1/29 and 30 tablets were I 1/20 and 30 tablets wer | | | | |
| | -If Resident #6 did no | t take Potassium Chloride | | | | |

Division of Health Service Regulation

ER 20mEq, he would be at risk for low potassium

STATE FORM 6899 OLFH12 If continuation sheet 9 of 30

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|------------------------------|---|-------------------------------|--------------------------|
| | | HAL092219 | B. WING | B. WING | | 8/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | • | |
| THE ADD | SON OF FUQUAY VARIN | Α | NSON POND R VARINA, NC 27 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {D 358} | administered and Resany doses of any medical constitution and many many doses of any medical constitution and constitution an | red had a reason to be sident #6 should not miss dications. It #6's current FL2 dated ere was an order for Miralax in suitable liquid and drink a medication used to treat en). Isisted living (AL) medication 8:30am revealed: irrector (MCD) was working (MA). Resident #6's medications. Miralax but was not able to on the medication cart. red medications to Resident 6's March 2024 electronic ention record (eMAR) For Miralax 17gm, mix 17gm d drink once daily. Occumented as administered end of drink once daily. Or Miralax 17gm, mix 17gm d drink once daily. Occumented as administered of drink once daily. Occumented as administered of days in April 2024. End Togm was documented as administered of days in April 2024. | {D 358} | | | |

Division of Health Service Regulation

Resident #6's eMAR.

STATE FORM 6899 OLFH12 If continuation sheet 10 of 30

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|---|---------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED |
| | | | D 11/11/0 | | R |
| | | HAL092219 | B. WING | | 05/08/2024 |
| NAME OF F | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STAT | TE, ZIP CODE | |
| THE ADD | ISON OF FUQUAY VARIN | 1Δ 6516 JOH | NSON POND RO | DAD | |
| | | FUQUAY | VARINA, NC 27 | 526 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETE |
| {D 358} | Continued From page | e 10 | {D 358} | | |
| | with suitable liquid ar Miralax 17gm was do at 8:00am on 7 of 8 of -Miralax 17gm was do given (DNG) at 8:00ar -There was an entry medication" document Resident #6's eMAR Observation of Resid hand on 05/08/24 at no Miralax on the medication was need to the medication was need to the medication carts. -The medication auditation auditation and several medication auditation and several medication auditation and several medication and several medication auditation and several medication and se | for Miralax 17gm, mix 17gm and drink once daily. Documented as administered days in May 2024. Documented as drug not am on 05/08/24. It will call pharmacy on the in the notes section of on 05/08/24. It will call pharmacy on the medications on 12:51pm revealed there was adication cart. It work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping staff this work on the B hall assisted the was helping the work on the B hall assisted the was helping the work on the B hall assisted the was helping the work on the B hall assisted the was helping the work on the B hall assisted the was helping the work on the B hall assisted the was helping the work on the B hall assisted the was helping the work on the B hall assisted the was helping the work on the B hall assisted the work on the B hall assisted the was helping the work on the B hall assisted the was helping the work on the B hall assisted the was helping the work on the B hall assisted the was helping the work on t | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 11 of 30

| | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
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| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED |
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| | | HAL092219 | B. WING | | R 05/08/2024 |
| | | HALU92219 | | | 1 05/06/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | |
| THE APPROON OF ELIQUAY VARINA 6516 JOH | | | NSON POND R | OAD | |
| THE ADDI | SON OF FUQUAY VARIN | FUQUAY ' | /ARINA, NC 27 | 7526 | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | N (X5) |
| PREFIX | , | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | BE COMPLETE |
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| | | | | DETIGIENCY) | |
| {D 358} | Continued From page | e 11 | {D 358} | | |
| | | | | | |
| | Friday. | D : 1 (//OL M: 1 | | | |
| | | Resident #6's Miralax | | | |
| | | ole this morning, 05/08/24. | | | |
| | | v long Resident #6's Miralax | | | |
| | | cation cart because she did | | | |
| | not usually work as a | | | | |
| | | from a PCP, the medication | | | |
| | should be available for | or administration. | | | |
| | Intervious with the DC | C on 05/09/24 at 2:25nm | | | |
| | | C on 05/08/24 at 2:35pm | | | |
| | revealed: | ations were sent to the | | | |
| | ** * | | | | |
| | | ycle fill order from the | | | |
| | have to reorder the m | harmacy, so the staff did not | | | |
| | | ations on cycle fill were | | | |
| | delivered to the facilit | | | | |
| | | ted pharmacy did not notify | | | |
| | | s needed a refill on their | | | |
| | medications. | | | | |
| | | to contact the pharmacy to | | | |
| | inquire if a resident n | | | | |
| | medications. | | | | |
| | | / Resident #6 did not have | | | |
| | Miralax on the medical | | | | |
| | -She was unsure how | v long Resident #6 did not | | | |
| | | nedication cart but did not | | | |
| | think it had been long | 1. | | | |
| | _ | ecome constipated if he did | | | |
| | not take Miralax 17gr | | | | |
| | _ | D, and HWD did medication | | | |
| | | ure residents' medications | | | |
| | were available. | | | | |
| | -Medication cart audi | ts were performed randomly | | | |
| | by the MAs, RCC, M | · · · · · · · · · · · · · · · · · · · | | | |
| | -She knew Resident | #6 had medications that | | | |
| | were not on the cart of | during some of the audits but | | | |
| | was not aware of any | current medications that | | | |
| | were not available. | | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 12 of 30

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | (X2) MULTIPLE CONSTRUCTION (| | |
|---|---|---|------------------------------|---|-------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | BUILDING: | |
| | | | | | R |
| | | HAL092219 | B. WING | | 05/08/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | |
| | | 6516 JOH | NSON POND R | OAD | |
| THE ADD | SON OF FUQUAY VARIN | IA . | VARINA, NC 27 | | |
| | CHMMADV CT | | 1 | | N O(E) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE |
| {D 358} | Continued From page | e 12 | {D 358} | | |
| | Interview with a pharmacy revealed: -Resident #6's Mirala and a 510 gm contain which was a 30-day sometime -Miralax was not sent and must be reordered productResident #6 had refino refills had been resulted in the revealed: -Miralax was important was ordered dailyAll medications ordered administered and Resant doses of any medications. | macist at the facility's on 05/08/24 at 1:00pm x was last filled on 08/16/23 her was sent to the facility, supply. In the cycle fill each month ad since it was a bulk Ills remaining on Miralax, but quested since August 2023. Int #6's PCP on 05/08/24 at the because the medication ared had a reason to be sident #6 should not miss dications. Init was a bulk | | | |
| | 10/19/23 revealed the Powder 100,000 units daily at 8:00am and 8 medication used to the Observation of the aspass from 8:10am to -The Memory Care D as a medication aide -The MCD prepared I -She entered Resider cup containing tablets administered Resider 8:25am. | ssisted living (AL) medication 8:30am revealed: irector (MCD) was working (MA). Resident #6's medications. nt #6's room with a medicine | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 13 of 30

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|--|------------------------|
| AND FLAN | OF CORRECTION | IDENTIFICATION NOMBER. | A. BUILDING: _ | . BUILDING: | |
| | | HAL092219 | B. WING | | R 05/08/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, STA | TE, ZIP CODE | |
| THE ADD | ISON OF FUOLIAY VARIA | 6516 JOHN | ISON POND R | OAD | |
| THE ADDISON OF FLICHAY VARINA | | | ARINA, NC 27 | 526 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE |
| {D 358} | Continued From page | e 13 | {D 358} | | |
| | Review of Resident # revealed: -There was an entry funits/gm, apply to gro 8:00pm Nystatin Powder 10: documented as drug 05/08/24. Observation of Resid hand on 05/08/24 at 4#6's container of Nys | fo's May 2024 eMAR for Nystatin Powder 100,000 oin twice daily at 8:00am and 0,000 units/gm was not given (DNG) on ent #6's medications on 12:51pm revealed Resident | | | |
| | on 05/08/024 at 12:18 -She did not usually v living (AL) cart, but sh morning, 05/08/24She documented DN for Nystatin Powder 1 | mory Care Director (MCD) Bpm revealed: work on the B hall assisted ne was helping staff this IG on Resident #6 eMAR 100,000 units/gm because nedication on the medication | | | |
| | revealed: -Resident #6 had Nysmedication cart in the -The MCD did not see Powder on the medicadminister Resident # morning, 05/08/24. Interview with Reside 11:27am revealed: -Nystatin Powder wasmedication was order -All medications orde | e top drawer. e Resident #6's Nystatin ation cart and did not #6's Nystatin Powder this ent #6's PCP on 05/08/24 at s important because the | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 14 of 30

| Division of | of Health Service Regu | lation | | | | |
|--------------------------|---|---|---------------------|---|-----------------------|--------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE S COMPLI | |
| | | HAL092219 | B. WING | | 05/0 | R 08/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| THE ADDI | SON OF FUQUAY VARIN | Α | NSON POND R | | | |
| | | FUQUAY | VARINA, NC 27 | 526 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {D 358} | Continued From page | e 14 | {D 358} | | | |
| {D 358} | any doses of any med-Resident #6 was at rinfection, skin redneshe did not have the North Interview with Residerevealed: -He was not currently breathHe could not recall his breath or swelling in his -He was not having a aware of at this timeHe took medicationshe was unsure what medications wereHe was unsure if he medications or missemedications. Interview with the HW revealed: -She started at the factory of the medication of the medicationshes with the HW revealed: -The facility's contractionshe was unsured. | dications. isk for worsening fungal s, and irritation of the groin if dystatin Powder applied. Int #6 on 05/08/24 at 3:50pm Inhaving any shortness of aving any shortness of aving any shortness of his feet or legs recently. In your constipation that he was every day. Ithe names of his Inhad been out of any Ithe any doses of any of his Ither any doses of any of his | {D 358} | | | |
| | | to contact the pharmacy to eded refills on their | | | | |
| | medicationsShe did not recall se | eing any notifications from | | | | |
| | 20mEqResident #6's medical | Potassium Chloride ER ations were sent in a the facility's contracted | | | | |
| | pharmacyThe facility's contract | ted pharmacy delivered all e routinely administered in | | | | |

STATE FORM 6899 OLFH12 If continuation sheet 15 of 30

| DIVISION | of Health Service Regu | lation | | | | |
|------------|-------------------------|--------------------------------|------------------|---------------------------------|-------------|----------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | URVEY |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPL | ETED |
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| | | | | | F | ₹ |
| | | HAL092219 | B. WING | | 05/0 | 8/2024 |
| | 20,4252 02 01 22 152 | 0.775.7.1 | | TF 710 0005 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, STA | ALE, ZIP CODE | | |
| THE YOU | SON OF FUQUAY VARIN | 6516 JOH | NSON POND R | OAD | | |
| IIIL ADDI | SON OF TOQUAL VAININ | FUQUAY | VARINA, NC 27 | 7526 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | J | (X5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | | COMPLETE |
| TAG | REGULATORY OR I | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | IATE | DATE |
| | | | | DEFICIENCY) | | |
| (D.050) | 0 " 15 | 45 | (D.050) | | | |
| {D 358} | Continued From page | 9 15 | {D 358} | | | |
| | the monthly cycle fill. | | | | | |
| | | nave Furosemide 40mg, | | | | |
| | | | | | | |
| | | R 20mEq, or Miralax in the | | | | |
| | | use he was out of refills. | | | | |
| | | e a container of Nystatin | | | | |
| | | s/gm in the top drawer of the | | | | |
| | medication cart. | | | | | |
| | -She was unsure how | / long Resident #6 had been | | | | |
| | out of the medications | s but did not think it was for | | | | |
| | long. | | | | | |
| | -She thought that she | recalled seeing the | | | | |
| | medications on the ca | | | | | |
| | | as doing some training with | | | | |
| | a MA. | rae deing deine training with | | | | |
| | -MAs should contact | the pharmacy if a | | | | |
| | | | | | | |
| | | n the medication cart during | | | | |
| | the medication pass. | | | | | |
| | | ny medications not available | | | | |
| | | t to the RCC, MCD, or | | | | |
| | HWD. | | | | | |
| | -She contacted Resid | <u> </u> | | | | |
| | 05/08/24, and reques | ted refills of the | | | | |
| | medications. | | | | | |
| | -She was concerned | that Resident #6 could have | | | | |
| | side effects, changes | in condition, or be | | | | |
| | hospitalized if he did | not receive medications as | | | | |
| | ordered by his PCP. | | | | | |
| | , | | | | | |
| | Interview with the Adr | ministrator on 05/08/24 at | | | | |
| | 2:50pm revealed: | 11111011 at 61 00/00/21 at | | | | |
| | • | ations were supposed to be | | | | |
| | | cle fill and delivered to the | | | | |
| | • • | | | | | |
| | | contracted pharmacy. | | | | |
| | | of refills for some of his | | | | |
| | | why the medications were | | | | |
| | | cart this morning, 05/08/24. | | | | |
| | -She was unsure if the | e dispensing information | | | | |
| | obtained from the fac | ility's contracted pharmacy | | | | |
| | | , Potassium Chloride ER | | | | |
| | 20mEq, and Miralax v | | | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 16 of 30

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: | | | |
|--|---|--|---|--|-----------------------------------|--------------------------|
| | | HAL092219 | B. WING | | 05 | R 5/ 08/2024 |
| | ROVIDER OR SUPPLIER | 6516 JOI | DDRESS, CITY, STATE | AD | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | FION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| {D 358} | -She thought Resider brought in some med the length of time it h medications were filled pharmacy. -MAs should notify the medications were noted. It was important for the medications as order. Interview with Resided 05/08/24 at 3:12pm in the resident #6 moved. Resident #6 received the facility's contracted. Resident #6 had not another pharmacy simple facility. -She had not brought facility for Resident #6. Resident | at #6's family may have ications to the facility due to ad been since the ad by the facility's contracted are RCC, MCD, or HWD if available to administer, the residents to get their ed by their PCP. Int #6's family member on evealed: into the facility in July 2022. In all his medications from ad pharmacy. In gotten medication filled at the moved into the any medications to the facility in July 2022. In any medications to the facility in July 2022. In any medications from ad pharmacy. In any medications to the facility in July 2022. In any medications to the facility in July 2022. In any medications from any medications to the facility in July 2022. In any medications from any medications to the facility in July 2022. In any medications from any medications to the facility in July 2022. In any medications from any medications to the facility in July 2022. In any medications from | {D 358} | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 17 of 30

PRINTED: 05/28/2024 FORM APPROVED

Division of Health Service Regulation

| A. BUILDING: | R |
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| | R |
| HAL092219 B. WING | 05/08/2024 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| THE ADDISON OF FUQUAY VARINA 6516 JOHNSON POND ROAD | |
| FUQUAY VARINA, NC 27526 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE CONTROL OF THE APP | BE COMPLETE |
| {D 358} Continued From page 17 {D 358} | |
| medication pass on 05/08/24 from 8:32am to 8:43am revealed: -The medication aide (MA) dialed 2 units on Resident #3's Lantus insulin pen. -The MA did not perform a 2-unit air shot prior to dialing the insulin pen to 2 units to ensure no air bubbles were present and insulin was flowing from the pen. -The MA cleaned an area on the back of Resident #3's right upper arm with an alcohol swab. -At 8:41am, the MA injected 2 units of Lantus into Resident #3's right upper arm, pressed the button on the pen, and held the pen in place. Interview with the MA on 05/08/24 at 8:49am revealed: -She approached the surveyor and informed the surveyor she administered Lantus 2 units to Resident #3. -She had not administered Lantus 25 units to Resident #3. -She had not administered the remaining 23 units of Lantus because she wanted the surveyor to be aware that she realized she did not administer enough Lantus to Resident #3. -Second observation of the SCU 8:00am medication pass on 05/08/24 from 8:51am to 9:00am revealed: -The MA dialed 23 units on Resident #3's Lantus insulin pen. -The MA did not perform a 2-unit air shot prior to dialling the insulin pen to 2 units to ensure no air bubbles were present and insulin was flowing from the pen. -The MA cleaned an area on the back of Resident #3's left upper arm with an alcohol swab. -At 8:57am, the MA injected 23 units of Lantus into Resident #3's right upper arm, pressed the | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 18 of 30

| DIVISION | n nealth Service Negu | lation | | | |
|------------|-------------------------|---|------------------|--|------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED |
| | | | 1 | | _ |
| | | | D. WING | | R |
| | | HAL092219 | B. WING | | 05/08/2024 |
| NAME OF PE | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE ZIP CODE | |
| | | | , , | , | |
| THE ADDI | SON OF FUQUAY VARIN | Α | NSON POND R | | |
| | | FUQUAY | /ARINA, NC 27 | 7526 | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (- / |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | |
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| | | | | , | |
| {D 358} | Continued From page | e 18 | {D 358} | | |
| | D : (D :1 /// | 01.140004 | | | |
| | | 3's May 2024 electronic | | | |
| | medication administra | ation record (eMAR) | | | |
| | revealed: | | | | |
| | | or Lantus Solostar Pen, | | | |
| | - | aneously every morning. | | | |
| | | , 25 units subcutaneously | | | |
| | was documented as a | administered on 05/08/24 at | | | |
| | 8:00am. | | | | |
| | | | | | |
| | Second interview with | n the MA on 05/08/24 at | | | |
| | 12:09pm revealed: | | | | |
| | -She started working | at the facility in 2012. | | | |
| | -She had training on i | nsulin pen administration | | | |
| | sometime during her | employment at the facility | | | |
| | but was unsure of the | date. | | | |
| | | ing trained on priming the | | | |
| | insulin pen with an air | | | | |
| | T | ne reason why the insulin | | | |
| | pen should be primed | | | | |
| | insulin. | a boloro dariiiniotoriing | | | |
| | -She did not perform | the air shot prior to | | | |
| | - | nt #3's insulin because she | | | |
| | forgot. | iii #3 3 iiisuiiii because siie | | | |
| | lorgot. | | | | |
| | Interview with the Me | mory Care Director (MCD) | | | |
| | on 05/08/24 at 12:25p | • | | | |
| | · | | | | |
| | | g on insulin administration | | | |
| | and diabetic care yea | | | | |
| | | ith the facility's contracted | | | |
| | • | diabetic training with the | | | |
| | MAs. | | | | |
| | | en the MA had training on | | | |
| | insulin pen administra | | | | |
| | | primed the insulin pen by | | | |
| | - | emove any air bubbles. | | | |
| | -The MA should have | administered Resident #3's | | | |
| | Lantus in one dose th | is morning. | | | |
| | | | | | |
| | Interview with the Res | sident Care Coordinator | 1 | | |

Division of Health Service Regulation

(RCC) on 05/08/24 at 2:27pm revealed:

STATE FORM 6899 OLFH12 If continuation sheet 19 of 30

| DIVISION | or riealin Service Regu | iation | | | | |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE S | | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETE | |
| | | | | | F | , |
| | | HAL092219 | B. WING | | 1 | 8/2024 |
| | | TIALUSZZIS | | | 1 03/0 | 0/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, STA | TE, ZIP CODE | | |
| | | 6516 JOH | NSON POND R | OAD | | |
| THE ADDI | SON OF FUQUAY VARIN | IA FUQUAY | VARINA, NC 27 | 7526 | | |
| (VA) ID | SLIMMARY ST | ATEMENT OF DEFICIENCIES | - 15 | PROVIDER'S PLAN OF CORRECTION | J | (VE) |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETE |
| TAG | REGULATORY OR I | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | RIATE | DATE |
| | | | | DEFICIENCY) | | |
| {D 358} | Continued From page | <u> 19</u> | {D 358} | | | |
| (=) | Continuou i rom page | 3 10 | (333, | | | |
| | | sher course on medication | | | | |
| | administration in Mar | | | | | |
| | | inistration refresher course | | | | |
| | | nurse from the facility's | | | | |
| | corporate office. | | | | | |
| | -MAs should prime th insulin. | e insulin pen before giving | | | | |
| | | en was a way to make sure | | | | |
| | | ing the right amount of | | | | |
| | insulin, and the insuli | • | | | | |
| | administration. | • | | | | |
| | | | | | | |
| | Interview with the Hea | alth and Wellness Director | | | | |
| | (HWD) on 05/08/24 a | t 12:35pm revealed: | | | | |
| | -She was unsure whe | en the last time the MAs had | | | | |
| | training on insulin per | n administration. | | | | |
| | -The MA should have | done an air shot, dialed the | | | | |
| | | se, then administered the | | | | |
| | insulin. | | | | | |
| | | ortant to ensure there were | | | | |
| | · · | en was working properly, and | | | | |
| | the resident received | the correct dose of insulin. | | | | |
| | | | | | | |
| | 2:50pm revealed: | ministrator on 05/08/24 at | | | | |
| | -She was unsure whe | en the last time MAs had | | | | |
| | specific training on in | sulin pen administration. | | | | |
| | -She was not familiar | with performing an air shot | | | | |
| | | administered with an insulin | | | | |
| | pen. | | | | | |
| | | of the importance of an air | | | | |
| | · · · · · · · · · · · · · · · · · · · | ering insulin with an insulin | | | | |
| | | after doing some research. | | | | |
| | | ny the MA did not administer | | | | |
| | _ | nless the MA was nervous. | | | | |
| | | t get her insulin properly, | | | | |
| | she was at risk for he | r blood sugar to be too high | | | | |
| | or too low. | | | | | |
| | | | | | | |
| | The facility failed to a | dminister medications as | | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 20 of 30

| | OF DEFICIENCIES OF CORRECTION | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------------------|---|-----------------|
| | | | A. BUILDING: _ | | |
| | | HAL092219 | B. WING | | R 05/08/2024 |
| NAME OF D | | | DE00 0171/ 074 | TE 7/D 00DE | 1 00/00/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | RESS, CITY, STA ISON POND RO | • | |
| THE ADD | SON OF FUQUAY VARIN | Δ | ARINA, NC 27 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE |
| {D 358} | Continued From page | 20 | {D 358} | | |
| | ordered to 2 of 3 resignedication passes on medication error rate. administered a medic retention and was with four months putting his congestive heart failural a medication used to potassium levels and for more than 3 month potassium deficiency, administer medication resident at substantial harm and constitutes. The facility provided a accordance with G.S. this violation. | dents observed during the 105/08/24 resulting in a 16% Resident #6 was not ation used to treat fluid hout this medication for over im at risk for worsening re and was not administered prevent or treat low was without this medication as putting him at risk for The failure of the facility to as as ordered placed the I risk of serious physical a Type A2 Violation. In plan of protection in 131D-34 on 05/08/24 for | | | |
| {D 367} | (j) The resident's med record (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for admort reatment; (5) reason or justificate medications or treatment. | Medication Administration dication administration e accurate and include the cation or treatment order; ge or quantity of medication ministering the medication cion for the administration of tents as needed (PRN) and liting effect on the resident; | {D 367} | | |

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STATE FORM 6899 OLFH12 If continuation sheet 21 of 30

PRINTED: 05/28/2024 FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | | 7 tt 20122 tt 40 | | R | |
| | | HAL092219 | B. WING | | 1 | 8/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| THE ADDI | SON OF FUQUAY VARIN | Δ | SON POND R | | | |
| | | FUQUAY V | ARINA, NC 27 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {D 367} | Continued From page | 21 | {D 367} | | | |
| {D 367} | (7) documentation of medications or treatmomission, including re (8) name or initials of the medication or treasignature equivalent the documented and main administration record. This Rule is not metabased on observation reviews, the facility fathe medication administration | any omission of ents and the reason for the fusals; and, the person administering timent. If initials are used, a to those initials is to be ntained with the medication (MAR). as evidenced by: as, interviews, and record filed to ensure accuracy of istration record for 1 of 3 the medication pass (#6) n used to treat fluid n used to treat or prevent and a medication used to fipation. 6's current FL2 dated gnoses included congestive fease, atrial fibrillation, flyroid disorder. | {D 367} | | | |
| | Furosemide 40mg on a medication used to by congestive heart fa Review of Resident # medication administra revealed: | e tablet daily (Furosemide is treat fluid retention caused ailure). 6's March 2024 electronic | | | | |
| | tablet dailyFurosemide 40mg wadministered at 8:00a | as documented as | | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 22 of 30

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTIO A. BUILDING: | COMPLETED |
|---|--|--|---|
| | HAL092219 | B. WING | R 05/08/2024 |
| NAME OF PROVIDER OR SUPP | ER STREET A VARINA 6516 JC | DDRESS, CITY, STATE, ZIP CODE HNSON POND ROAD VARINA, NC 27526 | , 00.00.202. |
| PREFIX (EACH D | ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) | PREFIX (EAC | ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE |
| revealed: -There was artablet dailyFurosemide 4 administered: 2024On 04/02/24 was documented and administered: 2024On 04/02/24, pharmacy" do Resident #6's Review of Resident #6's Review of Resident #6's Review of Resident #6's -There was artablet dailyFurosemide 4 administered: 2024On 05/08/24, documented and 2024On 05/08/24, pharmacy on notes section Observation of hand revealed: 40mg on the resident pharmacy on the facility of 105/08/24 at 1: Refer to interval coordinator (Figure 11). | dent #6's April 2024 eMAR entry for Furosemide 40mg, one omg was documented as 18:00am on 28 of 30 days in April and 04/04/24, Furosemide 40mg ed as drug not given (DNG). here was an entry "contact umented in the notes section of MAR. dent #6's May 2024 eMAR entry for Furosemide 40mg, one omg was documented as 18:00am on 7 of 8 days in May furosemide 40mg was drug not given (DNG). here was an entry "will call redication" documented in the f Resident #6's eMAR. Resident #6's medications on Resident #5 had no Furosemide redication cart. | {D 367} | |

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STATE FORM 6899 OLFH12 If continuation sheet 23 of 30

| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SU | |
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| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLE | IED |
| | | | | | R | |
| | | HAL092219 | B. WING | | 05/08 | 3/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE, ZIP CODE | | |
| THE ADDI | SON OF FUQUAY VARIN | 6516 JOI | HNSON POND R | OAD | | |
| | | FUQUAY | VARINA, NC 27 | 526 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| {D 367} | Continued From page | 23 | {D 367} | | | |
| | | terview with Resident #6's | | | | |
| | 10/19/23 revealed the Potassium Chloride E mouth once daily (Po | t #6's current FL2 dated ere was an order for ER 20mEq take one by tassium Chloride ER is an dication used to treat or | | | | |
| | medication administrative revealed: -There was an entry for 20mEq, one tablet on a Potassium Chloride | or Potassium Chloride ER ce daily. ER 20mEq was nistered at 8:00am from | | | | |
| | 20mEq, one tablet on - Potassium Chloride documented as admir 30 days in April 2024 -On 04/02/24 and 04/ER 20mEq was docu (DNG)On 04/02/24 and 04/"contact pharmacy" d section of Resident # | for Potassium Chloride ER ce daily. ER 20mEq was nistered at 8:00am on 28 of 04/24, Potassium Chloride mented as drug not given 04/24, there was an entry ocumented in the notes 6's eMAR. | | | | |
| | Review of Resident # revealed: -There was an entry f | 6's May 2024 eMAR or Potassium Chloride ER | | | | |

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20mEq, one tablet once daily

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|---|----------------------------------|------------------------|
| | | 7 ii 30123 ii 101 | A. Boilbiro. | | | |
| | | HAL092219 | B. WING | | 05 | R 5/ 08/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, STATE | , ZIP CODE | | |
| | | | INSON POND ROA | | | |
| THE ADD | ISON OF FUQUAY VARIN | Α | VARINA, NC 2752 | | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | CORRECTION | (X5) |
| PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE | TON SHOULD BE THE APPROPRIATE | COMPLETE DATE |
| {D 367} | Continued From page | e 24 | {D 367} | | | |
| | - Potassium Chloride ER 20mEq was documented as administered at 8:00am on 7 of 8 days in May 2024On 05/08/24, Potassium Chloride 20mEq was documented as drug not given (DNG)On 05/08/24, there was an entry "will call pharmacy on medication" documented in the notes section of Resident #6's eMAR. Observation of Resident #6's medications on hand revealed Resident #6 had no Potassium Chloride ER 20mEq on the medication cart. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 05/08/24 at 1:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/08/24 at 2:35pm. | | | | | |
| | | | | | | |
| | Director (HWD) on 05 Refer to interview wit 05/08/24 at 2:50pm. | 5/08/24 at 3:40pm. h the Administrator on | | | | |
| | family member on 05 c. Review of Residen 10/19/23 revealed the 17gm, mix 17 gm with once daily (Miralax is or prevent constipation Review of Resident # medication administrative revealed: -There was an entry for with suitable liquid and the side of the side | t #6's current FL2 dated ere was an order for Miralax n suitable liquid and drink a medication used to treat en). 6's March 2024 electronic ation record (eMAR) for Miralax 17gm, mix 17gm and drink once daily. locumented as administered | | | | |

Division of Health Service Regulation

STATE FORM 6899 OLFH12 If continuation sheet 25 of 30

| DIVISION | n riealth Service Negu | lation | | | | |
|---|---|------------------------------|-----------------|---------------------------------|----------|---------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: | | COMPLETED | | |
| | | | | _ | | |
| | | 5 | | R | | |
| | | HAL092219 | B. WING | | 05/08/20 | 024 |
| NAME OF D | DOVIDED OD CUDDUED | CTDEET ADE | RESS, CITY, STA | TE 710 CODE | | |
| NAIVIE OF PI | ROVIDER OR SUPPLIER | | , , | • | | |
| THE ADDI | SON OF FUQUAY VARIN | 6516 JOHN | ISON POND R | OAD | | |
| THE ADDI | OON OF TOWORT VAILIN | FUQUAY V | ARINA, NC 27 | 526 | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD | | OMPLETE |
| TAG | REGULATORY OR L | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPROPR | IATE | DATE |
| | | | | DEFICIENCY) | | |
| | | | 4 | | | |
| {D 367} | Continued From page | e 25 | {D 367} | | | |
| | | | | | | |
| | D | CL- A COOA - MAD | | | | |
| | Review of Resident # | o s Aprii 2024 eiviAR | | | | |
| | revealed: | | | | | |
| | | or Miralax 17gm, mix 17gm | | | | |
| | with suitable liquid an | d drink once daily. | | | | |
| | - Miralax 17gm was d | ocumented as administered | | | | |
| | at 8:00am on 29 of 30 | days in April 2024. | | | | |
| | | 17 gm was documented as | | | | |
| | drug not given (DNG) | | | | | |
| | -On 04/02/24, there was an entry "contact | | | | | |
| pharmacy" documented in the notes section of | | | | | | |
| | • | | | | | |
| | Resident #6's eMAR. | | | | | |
| | | | | | | |
| | Review of Resident #6's May 2024 eMAR | | | | | |
| | revealed: | | | | | |
| | -There was an entry f | or Miralax 17gm, mix 17gm | | | | |
| | with suitable liquid an | d drink once daily. | | | | |
| | | locumented as administered | | | | |
| | at 8:00am on 7 of 8 d | | | | | |
| | | was documented as drug | | | | |
| | | was documented as drug | | | | |
| | not given (DNG). | | | | | |
| | -On 05/08/24, there w | | | | | |
| | pharmacy on medication" documented in the | | | | | |
| | notes section of Resid | dent #6's eMAR. | | | | |
| | | | | | | |
| | Observation of Reside | ent #6's medications on | | | | |
| | hand revealed Reside | ent #6 had no Miralax on the | | | | |
| | medication cart. | | | | | |
| | | | | | | |
| | Refer to telephone int | terview with a pharmacist | | | | |
| Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on | | | | | | |
| | | пастеч рнаннасу ОП | | | | |
| | 05/08/24 at 1:00pm. | | | | | |
| | | | | | | |
| | Refer to interview with | | | | | |
| | Coordinator (RCC) or | n 05/08/24 at 2:35pm. | | | | |
| | | | | | | |
| | Refer to interview with | h the Health and Wellness | | | | |
| | Director (HWD) on 05 | 5/08/24 at 3:40pm. | | | | |
| | (| | | | | |

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Refer to interview with the Administrator on

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| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | | |
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| AND PLAN OF CORRECTION IDENTIF | | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | | | | |
| | | | | | | | | | |
| | | HAL092219 | B. WING | | 05/08/2024 | | | | |
| NAME OF P | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | |
| THE VDDI | SON OF FUOLIAY VARIA | 6516 JOI | HNSON POND R | OAD | | | | | |
| IIIL ADDI | THE ADDISON OF FUQUAY VARINA FUQUAY VARINA, NC 27526 | | | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE | | | | |
| {D 367} | Continued From page | e 26 | {D 367} | | | | | | |
| | 05/08/24 at 2:50pm. | | | | | | | | |
| | 03/00/24 at 2.30pm. | | | | | | | | |
| | Refer to telephone in family member on 05 | terview with Resident #6's /08/24 at 3:12pm. | | | | | | | |
| | Telephone interview | with a pharmacist from | | | | | | | |
| | facility's contracted pharmacy on 05/08/24 at | | | | | | | | |
| | 1:00pm revealed: | | | | | | | | |
| | -Resident #6's Furosemide 40mg was last filled on 11/22/24 and 30 tablets were sent to the | | | | | | | | |
| | facility. | | | | | | | | |
| | -Resident #6's Potassium Chloride ER 20mEq | | | | | | | | |
| | was last filled on 12/21/24 and 30 tablets were | | | | | | | | |
| | sent to the facility. | | | | | | | | |
| | -Resident #6's Miralax was last filled on 08/16/23 and a 510 gm container was sent to the facility, | | | | | | | | |
| | which should last 30 | | | | | | | | |
| | | nd Potassium Chloride ER | | | | | | | |
| | 20mEq were both cyc | | | | | | | | |
| | | d not be sent to the facility | | | | | | | |
| | because he was out of | | | | | | | | |
| | -The pharmacy attempted to contact Resident #6's primary care provider (PCP) several times to request a new order for Furosemide 40mg and | | | | | | | | |
| | | | | | | | | | |
| | Potassium Chloride ER 20mEq but had not | | | | | | | | |
| | | for either medication. | | | | | | | |
| | | a notification via fax to the efill was needed so the | | | | | | | |
| | | re that a refill was needed | | | | | | | |
| | and could also notify the PCP. | | | | | | | | |
| | | -Miralax was not sent on a cycle fill each month | | | | | | | |
| and must be reordered since it was a bulk productResident #6 had refills remaining on Miralax, but | | ed since it was a bulk | | | | | | | |
| | | | | | | | | | |
| | | quested since August 2023. | | | | | | | |
| | Interview with the Resident Care Coordinator | | | | | | | | |
| | (RCC) on 05/08/24 at | t 2:35pm revealed: | | | | | | | |
| -Resident #6's medications were on cycle fill from | | | | | | | | | |

Division of Health Service Regulation

the facility's contracted pharmacy, so the

STATE FORM 6899 OLFH12 If continuation sheet 27 of 30

| Division of | <u>of Health Service Regu</u> | lation | | | | |
|--------------------------|--|------------------------------|----------------------------|---|------------------|--|
| | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
| | | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED | |
| | | | | | | |
| | | HAL092219 | B. WING | | R 05/08/2024 | |
| | | TIALUSZZIS | | | 1 03/00/2024 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, STAT | TE, ZIP CODE | | |
| THE VUUI | ISON OF EHOHAV VADIN | 6516 JOH | HNSON POND RO | DAD | | |
| I UE ADDI | SON OF FUGUAL VAININ | FUQUAY | VARINA, NC 27 | 526 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE | |
| {D 367} | Continued From page | e 27 | {D 367} | | | |
| | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 367) Continued From page 27 medications were delivered automatically to the facility each month. -The staff did not have to reorder Resident #6's scheduled medications since the medications were on cycle fill. -Resident #6's medications were delivered to the facility each month from the facility's contracted pharmacy. -The facility's contracted pharmacy did not notify the facility if a resident needed a refill on a medication. -The facility staff had to call the pharmacy to inquire if a resident needed a refill on a medication. -She was unsure why Resident #6 did not have Furosemide 40mg, Potassium Chloride ER 20mEq, Miralax in the medication cart. -MAs were instructed to document drug not given (DNG) if a medication was not available on the medication cart. -If a medication was not on the medication cart, MAs should contact the pharmacy and report to the RCC, MCD, or HWD. -The medication aides (MA), RCC, Memory Care Director (MCD), and Health and Wellness Director (HWD) were responsible for medication cart audits to make sure residents' medications were available. -The medication cart audits were conducted randomly by the MAs, RCC, MCD, and HWD. -She knew Resident #6 had medications that were not in the cart during some of the audits but was not aware of any current medications that were not available. Interview with the Health and Wellness Director (HWD) on 05/08/24 at 3:40pm revealed: -The facility's contracted pharmacy did not let the | | | | | |
| | | lent needed refills on their | | | | |

medications.

STATE FORM 6899 OLFH12 If continuation sheet 28 of 30

| Division of | <u>of Health Service Regu</u> | lation | | | |
|--|---|---|-------------------------------|---|-------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: _ | (X3) DATE SURVEY COMPLETED | | |
| HAL092219 | | B. WING | | R 05/08/2024 | |
| NAME OF P | PROVIDER OR SUPPLIER | | DDRESS, CITY, STAT | TE ZIP CODE | 1 |
| TYANIE OI . | NOVIDER OR CO. 1 E.E.R. | | HNSON POND RO | | |
| THE ADD | ISON OF FUQUAY VARIN | NA . | VARINA, NC 27 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETE |
| {D 367} | Continued From page | e 28 | {D 367} | | |
| | needed refills was if the contracted pharmacy - Medications that were to the facility in the cyfacility's contracted pharmacy - Mas should not docubeen given if the medication cart. -Resident #6 did not he Potassium Chloride Emedication cart becauses - She contacted Resides 05/08/24, and requese medications. Interview with the Adresside 12:50pm revealed: -Resident #6's medication cycle fill and delives the facility's contractered - Resident #6 was out medications, which is not in the medication - She was unsure if the obtained by the facility Furosemide 40mg, Postained by the facility Furosemide 40mg, Postained by the facility in some meditime it had been since by the facility's contrasident - MAs should notify the medications were not Telephone interview we member on 05/08/24 | re given routinely were sent ycle fill delivery from the harmacy each month. ument that a medication had dication was not in the have Furosemide 40mg, ER 20mEq, Miralax in the use he was out of refills. It dent #6's PCP today, sted refills of the ministrator on 05/08/24 at eations were supposed to be ered to the facility monthly by ed pharmacy. It of refills for some of his is why the medications were cart this morning, 05/08/24, are dispensing information the dispensing information the dispensing information the dispension of the the medications were filled acted pharmacy. The RCC, MCD, or HWD if the available to administer. With Resident #6's family | | | |

-Resident #6 got all his medications from the

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| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE ADDISON OF FUQUAY VARINA 6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE R 05/08/2024 | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | | | |
|---|---|---|---|--|-------------------------------|-------------|--|--|--|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE ADDISON OF FUQUAY VARINA FUQUAY VARINA, NC 27526 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX B. WING O5/08/2024 STREET ADDRESS, CITY, STATE, ZIP CODE 6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526 (X5) COMPL COMPL | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: | | COMPLETED | | | | |
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| TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) | | SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE | | BE COMPLETE | | | |
| {D 367} Continued From page 29 {D 367} | {D 367} | Continued From page | = 29 | {D 367} | | | | | |
| (D 367) Continued From page 29 facility's contracted pharmacyResident #6 had not gotten medication filled at another pharmacy since he moved into the facilityShe had not brought any medications to the facility for Resident #6. | {D 367} | facility's contracted p -Resident #6 had not another pharmacy sir facilityShe had not brought | harmacy. gotten medication filled at nce he moved into the any medications to the | {D 367} | | | | | |

Division of Health Service Regulation

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