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THE ADDISON OF DURHAM	4713 GARRETT ROAD DURHAM, NC 27707

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigationa and a COVID-19 focused Infection Control survey with a onsite visits on September 30, 2020 and October 5, 2020 and a desk review survey on October 1, 2020 to October 2, 2020 and October 6, 2020 to October 8, 2020 and a telephone exit on October 8, 2020.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to provide supervision for 1 of 3 sampled residents (Resident #1) in accordance with each resident's assessed needs and care plan with a history of frequent falls. The findings are: Review of the facility's "Falls Management Program Guideline" revealed: -The community will act in a proactive manner to identify and asses those residents who are at risk for falls, plan for preventive strategies and facilitate a safe environment. -A "fall" is defined as: unintentional coming to rest on the ground or other lower level. An episode where a resident lost his/her balance and would	D 270		

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have fallen if not for staff intervention, is considered a fall. A fall without injury is still a fall.
-All falls must be investigated to causative reasons/contributing factors.
-Fall program components included; notification of physician and family/responsible party, documentation, individualized service plan, address each fall, preventive methods and measures, establish goals, and intervention changes are completed after each fall.
-The goal is to identify interventions to reduce the number of falls and prevent serious injury from falls.

Review of Resident #1's current FL-2 dated 10/17/19 revealed:
-Diagnoses included Alzheimer's disease with behaviors, subdural hematoma, hyperglycemia, and type II diabetes mellitus.
-She was consistently confused.
-She was semi-ambulatory with a wheelchair.
-She was incontinent of bladder and bowel.
-She resided on the Memory Care Unit (MCU).

Review of the Resident Register for Resident #1 dated 11/09/19 revealed:
-Date of admission was 11/09/17.
-The residentd required assistance with dressing, bathing, nail care, getting in/out of bed, toileting, positioning and turning.
-Resident #1 was forgetful and needed reminders.
-The resident required the use of a wheelchair.

Review of Resident #1's current Care Plan dated 07/29/19 revealed:
-There was a note under social/mental health history "tries to be independent in standing, leading to falls. Does not always follow redirection".

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D 270	Continued From page 2 -The resident ambulated with the aid of devices and a note for devices needed "wheelchair-attempts to stand unassisted". -The resident required extensive assistance with all activities of daily living, including assistance with standing and "hands on" assistance with transferring. Observation of Resident #1 in the resident dining room on 09/30/20 at 8:47am revealed: -There was a large black, grey and green discoloration of her skin on the left side of her face. -The discoloration was one large area that covered her left check, her left temple to her hairline and continued above her left eyebrow. -There was a round, quarter size scab in the center of her forehead. Review of Resident #1's Incident and Accident Report dated 09/17/20 revealed: -On 09/17/20 at 5:56am she was found on the floor beside her bed wrapped in her bedsheet. -She was alert and responsive and had no injuries and was not transported to the hospital. -There was documentation the resident would be monitored for safety and latent (not yet visible) injuries for 72 hours. Review of Resident #1's Incident and Accident Report dated 09/25/20 revealed: -On 09/25/20 at 1:30pm Resident #1 attempted to stand up out of her wheelchair and fell on her left side. -She was alert and responsive and had a scratch and redness to her head; she was not transported to the hospital. -There resident stated she was not in pain. -There were no additional orders given after the facility staff notified the PCP.	D 270		

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-The staff would monitor (Resident #1) for latent injuries.
-There was no documentation of how long to monitor the resident.

Interview with a personal care aide (PCA) on 09/30/20 at 11:15am revealed:
-Resident #1 had fallen on the previous Friday, 09/25/20 or Saturday, 09/26/20; she was not there and did not know the exact day.
-The staff kept Resident #1 from falling by keeping her busy with activities including puzzles and coloring books or pushing her in her wheelchair around the SCU.
-The staff also kept her around the nurses' desk to "keep and eye on her 24/7".
-Resident #1 would slide out of her wheelchair and fall to the floor.
-Whenever a resident had a fall, she always went straight to the medication aide (MA) and reported the fall; there was always a MA on duty.
-She knew Resident #1 fell because it was on the 24-hour report.
-The reports were for internal use and were discarded after a couple of days.

Interview with a second PCA on 09/30/20 at 11:23am revealed:
-She witnessed Resident #1 fall on either 09/25/20 or 09/25/20 around 2:00pm but she could not remember the exact date.
-Resident #1 leaned forward in her wheelchair and fell to the floor on her face; the PCA notified the MA who then did an assessment.
-Resident #1 did not have any scratches on her face, but her face was red where she fell on it; the resident was not sent out to the hospital.
-Resident #1 moved around in her wheelchair a lot; she would lean forward and then backwards.
-After a resident had a fall the staff would monitor

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the resident the next day; monitoring was watching and checking on the resident.
-There were not a scheduled times for monitoring.
-She verbally told the staff on the next shift about Resident #1's fall so she could continue to be monitored.
-Monitoring was documented on the twenty-four-hour report; the twenty-four-hour report was an internal document and was destroyed after a day or two; staff did not share the report with anyone else.

Interview with the Resident Care Coordinator (RCC) on 10/05/20 at 12:27pm revealed:
-She was not aware of any protocol for a fall.
-With every fall she would do an assessment of the resident that fell, contact the family and the PCP and write a note in the resident's record.

A second telephone interview with the RCC on 10/07/20 at 11:33am revealed:
-She assessed Resident #1 after the fall on 09/25/20; the PCA told her the resident had fallen on the floor.
-She did not work in the SCU but was familiar with Resident #1 and knew she would slide out of her chair and then not do it again for a couple of days.
-She did not know what would trigger Resident #1 to slide from her wheelchair.
-She would report all falls to the Health and Wellness Director (HWD) and then call or fax the PCP and call the family; she would also call hospice.
-She would also complete an incident report if needed.
-Residents were monitored for three days after a fall.
-She was not aware of any interventions other

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than Resident #1 was brought to the common area to participate in group activities and to color or do arts and crafts.

Review of the progress notes for Resident #1 dated revealed:
-There was no documentation for increased supervision for fall prevention from 06/03/20 through 09/14/20.
-There was no documentation regarding the resident's condition each shift for 72 hours after each fall.
-On 06/03/20 at 6:30pm she was observed by staff at the nurses' station standing up from her wheelchair which resulted in a fall and the resident "hit her head on (the) nurses' desk".
-Resident #1's vitals were taken; the resident was transported to the local hospital by emergency medical services (EMS).
-On 06/04/20 at 7:40am Resident #1 returned to the facility with an abrasion to the left side of her forehead.
-There was a note "will continue to be monitored"; there was no documentation of how long to monitor or how often.
-On 06/05/20 at 11:00am the resident was "doing fine" and the abrasion looked better; "will continue to monitor the resident".
-On 06/06/20 at 10:15am the resident was doing well and was back to (her) normal self; "also will continue to monitor".
-On 09/07/20 at 10:00am Resident #1 was found "placing self out of wheelchair to floor"; she had "zero" complaint of pain and was returned to a seated position in the wheelchair and "monitoring continued".
-On 09/07/20 at 2:00pm Resident #1 "again slid out of chair onto the floor"; she was assessed and returned to her wheelchair.
-On 09/08/20 at 1:30pm Resident #1 was sliding

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out of chair onto the floor three times "today".
-The Memory Care Director (MCD) was advised to offer finings to the physician for further directives and recommendations.
-On 09/08/20 at 4:15pm the PCP increased Resident #1's Effexor (a medication used to treat anxiety) to 225mg once daily and to monitor for effectiveness.
-On 09/14/20 at 2:00pm the resident was observed sitting in her wheelchair participating in scheduled activities with no documentation of her sliding herself to the floor.
-There were no notes after 09/14/20.

Telephone interview with a third PCA on 10/07/20 at 10:48am revealed:
-She worked in the SCU but had never witnessed Resident #1 fall.
-She witnessed Resident #1 having "episodes" where she would "fly" out of her chair and fall out on the floor; her episodes were anxiety.
-Resident #1 would lift herself up and then would slide out of the chair onto the floor and then would position herself into the fetal position on the floor.
-Resident #1 never got hurt from one of her "episodes".
-She had seen Resident #1 have an "episode" but could not remember the last time she had seen one.
-Resident #1 used to have a sitter everyday and now she did not have that daily contact from the sitter due to the facility's visitor restrictions.
- "Every now and again" she would walk Resident #1; if she held the resident's hands, she could walk 6 or 7 feet and it would calm her down.
-Resident #1 was always better after a walk and calmer; she would walk with the resident at least once a week and sometimes two times a day.

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D 270	Continued From page 7 Telephone interview with the Activities Director on 10/07/20 at 11:50am revealed: -She had increased activities for Resident #1 soon after the pandemic and her personal sitter could no longer come into the facility; she decided to increase the activities for the resident on her own. -When Resident #1 was by herself the resident would slide out of her wheelchair. -She had not observed any changes in Resident #1's condition or behaviors. Telephone interview with Resident #1's PCP on 10/01/20 at 3:42pm revealed: -Resident #1 required assistance with walking and transfers. -She knew Resident #1 would slide out of her wheelchair; the resident had been seen by physical therapy in July 2019. A second telephone interview with Resident #1's PCP on 10/06/20 at 1:06pm revealed: -She received either a phone call or a fax every time Resident #1 had a fall. -She was aware Resident #1 tried to stand and would fall to the floor. -She left the choice to send Resident #1 out to the hospital with the facility; she trusted they would monitor the resident, even for a head injury. -She knew the family would request not to send Resident #1 to the hospital. -Resident #1's falls were multi factorial; emotional, related to her Alzheimer's diagnosis and her age. -The facility could be more aggressive and provide more one to one observation; Resident #1 acted out for some attention. -The facility staff could not keep an eye on the resident 24/7.	D 270		

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-Resident #1 would not gain from mental health care or from physical therapy due to her Alzheimer's diagnosis; she would not remember to do any mental health exercise or physical exercises or remember steps to take to prevent a fall.

Telephone interview with Resident #1's Hospice Registered Nurse (RN) on 10/06/20 at 2:48pm revealed:
-Resident #1 was admitted to hospice on 08/01/19.
-She had seen Resident #1 that morning, 10/06/20; the resident had a fall without injuries from a chair; Resident #1 had slid from the chair.
-She was always called when Resident #1 had a fall; she considered it a fall when Resident #1 fell head first out of her wheelchair.
-Resident #1 was steadily declining; her anxiety had increased, and she was sliding out of her chair from slouching.
-The foot rest for Resident #1's wheelchair was removed so she would not get hurt when she slid out of the wheelchair.
-She knew Resident #1 was closely monitored by staff and was usually in the common area when she visited on Tuesdays.
-Interventions that could be put into place for Resident #1 would be to increase supervision; she would always need someone in the room with her.
-If she had known about the last two falls she would have followed up with more interventions, like staff would be reeducated about fall preventions.

Telephone interview with the care aide from Resident #1's hospice agency on 10/06/20 at 3:29pm revealed:
-She had worked with Resident #1 for the past

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two months; she went to the facility two days a week.
-She bathed Resident #1 and would walk her or push her in her wheelchair, she would bathe her, fix her hair and cut her nails.
-About once a week Resident #1 would try to stand up from her wheelchair; she would redirect the resident to get her to sit down.
-Sometimes if she would walk with Resident #1, she would settle down a little bit; she would take her hands and let the resident take a few steps then sit her back into her wheelchair.
-There would be times she would give Resident #1 a snack to redirect her.

Telephone interview with Resident #1's responsible party on 10/01/20 at 10:38am revealed:
-Resident #1 fell frequently; the facility staff always called her when the resident had a fall.
-She was aware Resident #1 fell the previous week and she knew the resident fell on her face; she told the facility staff she was okay if the resident was not sent out to the hospital.
-Resident #1 had a private sitter that would spend time with her and help her walk around but the sitter had not been allowed to come into the facility since March 2020 due to the pandemic.
-She felt the staff did not pay enough attention to Resident #1 and that was why the resident frequently fell.

Second telephone interview with Resident #1's responsible party on 10/06/20 at 11:10am revealed:
-Resident #1 had a fall that morning, 10/06/20, the facility staff had called her and notified her at 10:52am; Resident #1 did not have any injuries from the recent fall.
-No one from the facility had ever talked to her

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about ways to prevent Resident #1 from falling.
-She thought Resident had been seen for physical therapy, but she could not remember when.
-She thought Resident #1 was falling more often because the private duty sitter was not coming into the facility.

Interview with the MCD on 10/05/20 at 11:29am revealed:
-The facility had a policy against chair and bed alarms.
-Frequent falls were when a resident fell two times in a week or two falls in two weeks.
-When a resident had frequent falls, the PCP would be called, and physical therapy may be recommended by the PCP.

A second telephone interview with the MCD on 10/06/20 at 12:01pm revealed:
-Resident #1 had fallen more since her personal sitter was not coming into the facility.
-The staff kept a close eye on her to keep her from falling.
-Resident #1's PCP had recently increased her anxiety medication to help prevent her from trying to stand or from sliding out of her wheelchair.
-Resident #1 was seated in a regular chair in the common living area when she began to slide out of the chair.
-The PCA turned back to Resident #1 and saw her slide out of the chair to the floor.

Interview with the Health and Wellness Director (HWD)on 10/05/20 at 11:43am revealed:
-The facility had a policy against chair and bed alarms.
-Frequent falls would be when a resident had two falls a month.
-Frequent falls would mean something was going

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on with the resident and the resident would need to be examined.
-Resident #1 had more interaction with staff; staff were always to see the resident and she was involved in group activities to prevent additional falls.
-Resident #1 had 15-minute checks for 72 hours after a fall and was on an every 20-minute toileting check.

Interview with the Executive Director (ED) on 10/05/20 at 1:36pm revealed:
-Falls were documented on the 24-hour report and the MCD kept the reports.
-Thirty-minute checks were done on a resident for 72 hours after a fall but were not documented anywhere.
-The HWD completed the incident report.
-Resident #1 had a history of falls and he knew the staff kept an "increased eye" on her; she may need physical therapy or a change in her medication.

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

_____

The failure of the facility to provide supervised care for Resident #1 when she had increased frequency of falling by failing to provide interventions to prevent falls was detrimental to the safety and welfare of Resident #1 and constitues a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on October 7, 2020 for this violation.

THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER

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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 B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 3 of 3 sampled residents (#1, #2, and #3) including notifying the Primary Care Provider (PCP) for a 7 percent weight loss (10 pounds) from June 2020 to September 2020 and ensure referral for an evaluation for physical therapy (PT) and occupational therapy (OT) were made (#2); left hand bruise of unknown origin (#3) and a missed physician's appointment blood pressure checks (#1). The findings are: 1. Review of Resident #2's current FL-2 dated 01/30/20 revealed: -Diagnoses included dementia, anxiety disorder, hypothyroidism and depressed affect. -The resident was constantly disoriented. -The resident was ambulatory. -The resident's recommended level of care was a special care unit (SCU). Review of Resident #2's care plan dated 09/24/20 revealed: -Resident #2 required limited assistance with	D 273		

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eating; staff prompted.
-Resident #2 required supervision with ambulation; at times staff assisted with holding the residents hands transferring.
-Resident #2 required limited assistance with transferring, for hygiene, and toileting.

a. Review of Resident #2's monthly vital sign record revealed:
-There was documentation the resident weighed 129.4 on 01/31/20.
-There was documentation the resident weighed 128.7 in February 2020 (no date recorded).
-There was documentation the resident weighed 129.8 in March 2020.
-There was documentation the resident weighed 128.4 in April 2020.
-There was documentation the resident weighed 128.6 in May 2020.
-There was documentation the resident weighed 128.2 in June 2020.
-There were no other recorded weights.

Observation of Resident #2's weight obtained by the Memory Care Director (MCD) on 09/30/20 at 11:15am revealed a weight of 118.8.

Interview with a personal care aide (PCA) on 09/30/20 at 11:19am revealed:
-Resident #2 looked like she had lost weight.
-Resident #2 ate 100 percent of her meals.
-Resident #2 walked a lot.
-She had not discussed Resident #2's weight loss with anyone.
-The medication aides (MA) weighed the residents monthly.
-"Sometimes we weigh the residents if we have time"; she did not recall the last time she weighed the residents.

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D 273	Continued From page 14 Interview with the Memory Care Director (MCD) on 09/30/20 at 11:47am revealed: -She did not have weights for Resident #2 for July 2020 or August 2020 recorded. -She had given Resident #2's weights to the previous Health and Wellness Director (HWD). Interview with the current HWD on 09/30/20 at 12:00pm revealed: -Her first day at the facility was on 08/31/20. -She did not know where Resident #2's July 2020 and August 2020 weights were recorded. -She knew September 2020 weights were recorded because she had asked to have all weights submitted to her by the 5th of the month. Review of Resident #2's weight on a September 2020 weight revealed Resident #2 had a recorded weight of 119.4. Telephone interview with Resident #2's guardian on 10/01/20 at 9:46am revealed: -Resident #2's food intake and weights "were on her radar." -Resident #2's weight had been steady based on the information she had been provided. -She had asked Resident #2's Primary Care Provider (PCP) about a nutritional supplement for Resident #2 but did not recall when it was discussed. -On 06/25/20 she had contacted Resident #2's PCP to discuss Resident #2's weight because Resident #2's family was concerned Resident #2 had weight loss. -Resident #2's PCP felt based on the information he had, Resident #2's weight had been stable. -The information provided to her by the PCP was a documented weight of 132 in March 2020 and a weight of 128 in June 2020 and the PCP was not concerned.	D 273		

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-The PCP did not feel supplements were needed at that time.
-She was not aware Resident #2 had a current weight of 118, or Resident #2's recorded weight for September 2020 was 119.
-She was concerned about the weights because she thought it was a significant change in Resident #2's recorded weight of 128 from June 2020 to September 2020.
-If she had known Resident #2 had lost weight, she would have re-addressed the need for supplements to prevent further weight loss and to ensure Resident #2 was getting enough calories.

Telephone interview with Resident #2's PCP on 10/01/20 at 10:52am revealed:
-He had not been notified Resident #2 had a weight loss.
-He would have expected to have been notified of a 10lb weight loss in 2-3 months.
-He would have ordered a supplement for Resident #2 had he known Resident #2 had a weight loss.

Interview with the MCD on 10/05/20 at 10:36am revealed:
-She thought there was a policy related to resident weights.
-The HWD was responsible for monitoring weights.
-The MA's gave resident weights to the HWD.

Interview with the HWD on 10/05/20 at 10:57am revealed:
-She was not aware of a weight-loss policy.
-She was new.
-The MCD and the Resident Care Coordinator (RCC) were responsible to make sure weights were obtained.
-She was not aware Resident #2 had a 10lb

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weight loss; had she known she would have talked to Resident #2's PCP.
-She knew Resident #2 had been on antibiotics and had an infection and that could have contributed to a weight loss.

Interview with the Administrator on 10/05/20 at 2:35pm revealed:
-There was a policy on weights.
-He knew resident weights were documented in a log to be reviewed.
-He expected the MAs to notify the HWD, family and the PCP of weight loss to discuss what could be done to prevent further weight loss.
-He was not aware Resident #2 had weight loss and felt a weight of 128 in June and 119 in September was a "significant weight loss."
-He was concerned the proper notifications were not made related to Resident #2's weights and therefore further weight loss was not prevented.

Review of the facility's policy on weights revealed:
-The policy was dated as reviewed and revised on 05/14/20.
-All residents would be weighed on admission.
-Weights would be recorded on the vital sign flow sheet or the electronic health record.
-All residents would be weighed monthly, by the 10th of the month with weights recorded on the vital sign flow sheet or the electronic health record.

Based on observation, interviews and record reviews, it was determined Resident #2 was not interviewable.

b. Review of Resident #2's physician's order dated 09/15/20 revealed:
-There was an order for physical therapy (PT) and Occupational therapy (OT) evaluation.

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-The order had a handwritten signature, date and time written in the lower right-hand corner.

Review of Resident #2's progress notes dated 09/05/20 revealed:
-Resident #2 had a fall on 09/04/20 and "appeared to be fine."
-Resident #2 would continue to be monitored.

Review of incident and accident reports provided for Resident #2 revealed:
-There was no incident and accident report available to be reviewed for the fall documented to have occurred on 09/04/20.
-There was an incident and accident report dated 09/12/20 for a bruise noted on Resident #2's chin.

Review of outside provider notes for Resident #2 revealed:
-Resident #2 received both PT and OT services in June 2020 and July 2020.
-There were no current PT and OT notes to review.

Telephone interview with the Clinical Manager for the facility's contracted home health provider on 10/05/20 at 8:36am revealed:
-Referrals were usually faxed to the agency by the facility staff.
-A referral was received for Resident #2 in June 2020 and therapy was provided at that time.
-A referral dated 09/15/20 had not been received for Resident #2 to be evaluated for PT and OT.
-Therapy would not be provided if Resident #2 was not "in the system."

Telephone interview with Resident #2's guardian on 10/01/20 at 9:46am revealed she did not know if PT and OT had evaluated Resident #2, but she had requested PT and OT evaluations due to

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D 273	Continued From page 18 Resident #2 having a fall. Interview with the Health and Wellness Director (HWD) on 10/05/20 at 11:12am revealed: -The Resident Care Coordinator (RCC) and the Memory Care Director (MCD) generally processed faxed orders received. -She was responsible in conjunction with the RCC and MCD for making sure orders were processed. -She was not aware of an order for PT and OT evaluations for Resident #2. -The PT and OT order for Resident #2 would have been faxed to the home health agency. -If the order was written on 09/15/20 she would have expected someone from the home health agency to have initiated an evaluation. -She was concerned Resident #2 had not been evaluated by PT and OT as of this date 10/05/20. Interview with a medication aide (MA) on 10/05/20 at 11:52am revealed: -All physician's orders were faxed to the pharmacy. -She signed, dated and time-stamped all faxes. -She confirmed it was her signature on the PT and OT order for Resident #2. -She had faxed Resident #2's order for PT and OT to the pharmacy because the order would be entered on Resident #2's MAR. -The Primary Care Provider (PCP) sent orders for therapy to the home health agency. Interview with the MCD on 10/05/20 at 12:00pm revealed: -The MAs faxed PT and OT orders to the home health agency. -Resident #2's guardian had requested Resident #2 be evaluated by PT and OT. -She had contacted Resident #2's PCP to obtain	D 273		

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the order for PT and OT.
-She told the HWD about the order for PT and OT for Resident #2 "about 1-2 weeks ago."
-She knew PT and OT had not been scheduled but was not sure where the lapse would have happened.

Interview with the Administrator on 10/05/20 at 2:35pm revealed:
-When an order was received for therapy, the MA would give the order to the MCD to set up the evaluation.
-The HWD was ultimately responsible, but the MCD should have coordinated the therapy referral.
-He was not aware Resident #2 had an order for PT and OT and had not been seen.
-The physical therapist had told him he had seen Resident #2.
-He was concerned the order for PT and OT was not followed through from start to finish.

Telephone interview with Resident #2's PCP on 10/06/20 at 12:21pm revealed:
-He ordered PT and OT evaluations for Resident #2 because Resident #2 was debilitated and had a fall.
-He expected the order for PT and OT to have been carried out.
-Resident #2 was at elevated risk for falls.
-He was not aware Resident #2 had not been evaluated by PT and OT but would like for the evaluations to be done now.

Based on observation, interviews and record reviews, it was determined Resident #2 was not interviewable.

2. Review of Resident #3's current FL-2 dated 08/05/20 revealed:

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D 273	Continued From page 20 -Diagnoses included recurrent urinary tract infection (UTI), encephalopathy, hypothyroidism, hypertension, and history of depression. -Resident #3 was oriented to person only. Review of Resident #3's assessment and care plan dated 6/24/19 revealed the resident was sometimes disoriented and forgetful, and she needed reminders. Observation of Resident #3's left hand on 09/30/20 at 9:10am revealed a black and blue area below the fingers which extended about an inch above the wrist. Review of Resident #3's record revealed there were no Progress Notes prior to 10/05/20 related to the bruise on Resident #3's left hand. Review of Resident #3's Progress Notes dated 10/05/20 at 1:00pm revealed: -There was a bruise on resident's left hand of unknown origin. -The resident could not verbalize what caused the bruise. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. Interview with a personal care aide (PCA) on 09/30/20 at 9:10am revealed: -She had noticed the bruise on Resident #3's left hand about 2 months ago, but she thought it was an old bruise from a hospital visit about 2 months ago. -She had not reported the bruise to the medication aide (MA) or the Health and Wellness Director (HWD). -The process was to report incidents to the MA or	D 273		

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the HWD.

Interview with a second PCA on 10/05/20 at 11:45am revealed:
-She had not noticed a bruise on the top of Resident #3's left hand.
-Resident #3 bruised easily.
-If she had known, she would have notified the HWD.
-The process was to report incidents to the MA or HWD.

Interview with a MA on 10/05/20 at 11:19am revealed:
-She had not noticed a bruise on Resident #3's left hand.
-Resident #3 bruised easily.
-If the MA had known, she would have notified the HWD and documented the information in Resident #3's progress notes.
-The process was to report incidents to the HWD.

Attempted telephone interview with Resident #3's family member on 10/05/20 at 5:09pm was unsuccessful.

Telephone interview with Resident #3's primary care provider (PCP) on 10/06/20 at 12:32 pm revealed:
-He did not know that Resident #3 had a bruise on her left hand.
-He would like to have been notified.
-He would not have made any changes in the plan of care for Resident #3.

Telephone interview with Resident #3's hospice nurse on 10/02/20 at 8:54am revealed:
-She did not know that Resident #3 had a bruise on her left hand.
-She had not been notified or noticed a bruise on

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Resident #3's left hand during a visit to the facility.

Telephone interview with the Memory Care Director (MCD) on 10/06/20 at 8:55am revealed:
-She was notified about the bruise on Resident #3's left hand on 10/01/20 by the PCA.
-She did not know how the bruise occurred.
-The MCD documented the information in the communication log, but she did not notify the HWD, Resident #3's physician or complete an incident report.
-She just documented the information in the communication log.
-The process was to report incidents to the HWD and notify the staff in the morning meeting.

Telephone interview with the HWD on 10/06/20 at 12:57pm revealed:
-She did not know Resident #3 had a bruise on the top of her left hand until 10/05/20.
-If a resident had a bruise, the HWD should be notified immediately.
-An incident report should be completed, and the resident's physician and family member should be notified.
-Any staff could document in the communication book.
-There was a communication book, and the MCD was responsible for reviewing the information in the book and for reporting information to the staff during the morning meeting.

Telephone interview with the Executive Director (ED) on 10/07/20 at 8:43am revealed:
-He did not know Resident #3 had a bruise on the top of her left hand.
-The process was the PCA should notify the MA, MCD and then the HWD
-An incident report should be completed, and the

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resident's physician and family member should be notified.
-There was a communication book, and the MCD was responsible for reviewing the information in the book and for reporting information to the staff during the morning meeting.

3. Review of Resident #1's current FL-2 dated 10/17/19 revealed diagnoses included Alzheimer's disease with behaviors, subdural hematoma, hyperglycemia, and Type II diabetes mellitus.

Telephone interview with Resident #1's family member on 10/01/20 at 10:38am and 10/06/20 at 10:57am revealed:
-She had not been inside the facility since March 2020.
-She had been contacted by the facilities Executive Director (ED) on 10/06/20 to inform her Resident #1 had missed an appointment on 09/18/20 and the appointment would need to be rescheduled.
-She notified the facility of Residents #1's primary care provider (PCP) appointment one week before 09/18/20; she was told by the RCC the family could not transport the resident to the appointment due to COVID-19 so the facility would take Resident #1 the appointment.
-The appointment for Resident #1 was for a follow up to monitor blood pressure and get a flu shot.
-She assumed Resident #1 had been taken to the PCP appointment by the facility.

Telephone interview with Resident #1's personal sitter on 10/07/20 at 8:20am revealed:
-She delivered and picked up Resident #1's

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personal documents to the facility on 09/18/20 prior to Resident #1's PCP appointment.
-She gave the documents to the Resident Care Coordinator (RCC) and picked them up from the Memory Care Director (MCD); the RCC acknowledged she would take the documents with Resident #1 when the facility staff took the resident to the PCP appointment.
-When she picked up the documents from the facility no one told her Resident #1 was not taken to the PCP appointment.

Telephone interview with the appointment scheduler for Resident #1's PCP on 10/06/20 at 11:31am revealed:
-There was an appointment scheduled for Resident #1 for 09/18/20; Resident #1 was a "no show and no call" for the appointment.
-Someone from the facility had called on 10/06/20 to reschedule the missed appointment.
-The appointment on 09/18/20 was scheduled for a blood pressure check and a flu shot.

Telephone interview with Resident #1's PCP on 10/06/20 at 1:06pm revealed:
-Resident #1 was scheduled for a follow up appointment to check her blood pressure and to check her electrolyte levels and to get a flu shot.
-She was not concerned about the missed appointment because it had been rescheduled.

Interview with the RCC on 10/05/20 at 12:19pm and on 10/06/20 at 11:27am revealed:
-During the pandemic the families were encouraged to schedule telemedicine appointments.
-Most of the time the families scheduled the appointments with the PCPs and notified the facility.
-The facility transported residents to

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appointments prior to the pandemic, now the families must transport the residents to their PCP appointments.
-She had been aware of the scheduled PCP appointment for Resident #1 for 09/18/20.
-The family cancelled Resident #1's PCP appointment that was scheduled for 09/18/20; the family called the facility.

Interview with the Health and Wellness Director (HWD) on 10/05/20 at 11:43am revealed:
-The scheduling of physicians' appointments was done by the MCD or the RCC.
-The MCD should follow through with the appointment to assure the resident attended the appointment.
-The families notified the facility of appointments and transported the residents to those appointments.
-She was not aware of an appointment for Resident #1 on 09/18/20.

Interview with the Executive Director (ED) on 10/05/20 at 12:34pm revealed:
-The RCC or the HWD scheduled PCP appointments for residents and the families transported due to the pandemic; the families transported the resident beginning in March 2020.
-Families would bring the appointment information back to the facility and the facility would make the follow up appointments.
-He was not aware of an appointment for Resident #1 on 09/18/20.

_____

The facility failed to assure referral and follow-up to meet the routine and acute health care needs for Resident #2 who had a ten pound weight loss from June 2020 to September 2020, Resident #3 who had a bruise of unknown origin and Resident #1 who missed a physician's appointment. The

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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 273	Continued From page 26 failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facilty provided a plan of protection in accordance with G.S. 131D-34 on October 7, 2020 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2020.	D 273		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations. 1.Based on observations, record reviews and interviews, the facility failed to provide supervision for 1 of 3 sampled residents (Resident #1) with frequent falls and injuries in accordance with each resident's assessed needs and care plan resulting in frequent falls.[Refer to Tag D270, 10A NCAC 13F .00901(b) Personal Care and Supervision (Type B Violation)]	D912		

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 _____	10/08/2020

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D912	Continued From page 27 2.Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 3 of 3 sampled residents (#1, #2, and #3) including notifying the Primary Care Provider (PCP) for a 7 percent weight loss (10 pounds) from June 2020 to September 2020 and ensure a referral for an evaluation for physical therapy (PT) and occupational therapy (OT) was made (#2); left hand bruise of unknown origin (#3) and a missed physician's appointment (#1). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]	D912		