STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026068	A. BUILDING: _____ B. WING _____	R-C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey 09/29/21- 09/30/21.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up for 1 of 5 sampled residents (#5) who was ordered an orthopedic follow up, a neurology consul and a bone density test and a Reclast infusion. (Reclast is used to treat certain types of bone disease that cause abnormal and weak bones). The findings are: Review of Resident #5's current FL2 dated 05/17/21 revealed diagnoses included cognitive impairment, Parkinson's disease and unspecified osteoarthritis. Review of Resident #5's discharge summary dated 5/19/21 revealed: -She needed a follow up with the orthopedic physician in 1-2 months. -She had been hospitalized for right hip pain. Review of Resident #5's physician note dated 06/21/21 revealed: -She had a fall last month. -She was hospitalized for 6 days with right hip	D 273		

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pain.
-She had a right hip repair in 2019.
-An orthopedic was consulted while Resident #5 was in the hospital for possible loosening of right hip prosthesis.
-No surgical intervention was recommended.
-She was to follow up with the orthopedic in 1-2 months.
-She continued to complain of right upper thigh pain.

Review of Resident #5's physician order dated 07/16/21 revealed:
-There was an order for a neurology consult for medication adjustment due to Parkinson's disease.
-There was an order for a bone density(measures strength of bones and prevent fractures) for osteoporosis
-There was an order for Reclast infusion.

Observation of Resident #5 on 09/29/21 at 8:35am standing in her room with her walker trying to fold her blanket.

Observation of Resident #5 on 09/30//21 at 8:15am slowly walking to her room with her walker.

Interview with the Administrator on 09/29/21 at 4:15pm revealed:
-Referrals were the responsibility of the Health and Wellness Director (HWD).
-The HWD started working on 09/27/21.
-The orders should have been faxed to the appropriate offices and then placed in a holding file until an appointment was made.

Interview with the HWD on 09/30/21 at 8:00am revealed:

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D 273	Continued From page 2 -He had the confirmation sheet where the order for the neurology referral was faxed to the neurology office on 07/22/21. -There was no follow up to make sure the appointment was scheduled. -There was no appointment made for the follow up with the orthopedic. -He was not working at the facility at the time and did not know why the appointment was not made. -His concerns would be these consults were ordered for a reason. -The referrals should have been followed up on in 1 -2 days if the physician offices had not called back with an appointment. -The referral should have been followed up by the previous HWD or the person who faxed the order. -He was not aware of the process prior to this week. Interview with the Administrator on 09/30/21 at 8:10am revealed: -Sometimes the transporter would make the doctor appointments or referrals. -The order should be placed in a holding file after it was faxed to the appropriate office until the appointment was made. -Her concern was that the process was falling apart. -The facility had had a lot of staff transitions (staff leaving). -Her expectation would be to make sure the order was sent to the physician office and followed up on daily until an appointment was made. -At one week if there had been no appointment made with the physician office then the facility should have notified the primary care provider (PCP). -The former HWD would have been responsible to make sure the appointment was made.	D 273		

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D 273	Continued From page 3 Interview with the transporter on 09/30/21 at 8:35am revealed: -She was not aware of the orthopedic referral for Resident #5. -She was the one that faxed Resident #5's neurology referral to the neurology physician office on 07/22/21. -She also called the neurology office on 07/22/21 to make sure they received the fax. -She did not document the call. -She then gave the referral to the former HWD. -She was not aware what happened after that. -She did not schedule the bone density appointment and the Reclast infusion appointment for Resident #5. -The transportation calendar was kept at the front desk. -The Administrator and the Resident Care Coordinator (RCC) had access to be able to put appointments on the calendar. Telephone interview with the receptionist at the orthopedic physician office on 09/30/21 at 10:10am revealed: -There was never an appointment made for Resident #5. -She received the first referral about 30 minutes ago from the facility for Resident #5. -She would be calling them back with an appointment. Interview with the RCC on 09/30/21 at 10:20am revealed: -She was not in the RCC role in May of 2021. -She had not been responsible for the referrals until yesterday. -In May 2021 and July 2021, the former HWD would have been responsible to make the appointments. -She was not aware there were referrals that	D 273		

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D 273	Continued From page 4 needed to be completed. Telephone interview with Resident #5's primary care provider (PCP) on 09/30/21 at 2:10pm revealed: -She had been made aware today the referrals did not get done. -She was not concerned about the orthopedic appointment because Resident #5 continued to ambulate. -Resident #5 could tell when she was hurting. -The facility had a lot of transition with staff meaning staff had quit and new staff came to work. -There were some concerns that the neurology appointment was not made. -She wanted the Neurologist to look at Resident #5's medication and see if anything could be adjusted to help prevent falls. -The bone density was to see what the status of her bones were. -She wanted to prevent any breaking of bones. -Resident #5 would need a yearly Reclast infusion. -None of these orders were life threatening and still need to be completed. -Her expectation would be for the staff to follow her orders and if they could not get them scheduled for some reason she should be notified. Based on observations, record reviews and interviews Resident #5 was not interviewable. Attempted telephone interview with Resident #5's neurology physician office on 09/30/21 at 9:30am was unsuccessful. Attempted telephone interview with Resident #5's family on 09/30/21 at 2:00pm was unsuccessful.	D 273		

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D 273	Continued From page 5 The facility failed to ensure 1 of 5 sampled residents (#5) was followed up by an orthopedic after a six day hospitalization due to a fall which caused right hip pain and with a history of right hip repair which resulted in continued pain and failed to ensure a neurology consult was made to evaluate the resident's medication regarding her Parkinson's disease which could help prevent falls. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/30/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2021.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer	D 358		

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medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (#4) related to an anti-hypertensive medication and a diabetic medication.

The findings are:

Review of Resident #4's current FL-2 dated 02/18/21 revealed diagnoses included dementia, diabetes mellitus, heart failure, primary hypertension, and atrial fibrillation.

a. Review of Resident #4's physician orders dated 02/18/21 revealed there was a medication order for Losartan Potassium (K)-HCTZ 100-25mg (used to treat high blood pressure) one tablet daily.

Review of Resident #4's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Losartan K-HCTZ 100-25mg take one tablet daily, scheduled for 8:00am.
-There was documentation of administration of Losartan K-HCTZ 100-25mg from 08/03/21 to 08/31/21 at 8:00am.
-There were 2 doses of Losartan K-HCTZ not documented as administered on 08/01/21 and 08/02/21 at 8:00am.

Review of Resident #4's September 2021 eMAR revealed:
-There was an entry for Losartan K-HCTZ 100-25mg take one tablet daily, scheduled for 8:00am.
-There was documentation of administration of Losartan K-HCTZ from 09/01/21 to 09/12/21, from 09/16/21 to 09/18/21, 09/21/21 to 09/26/21 and 09/29/21 at 8:00am.

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D 358	Continued From page 7 -There were 12 doses of Losartan K-HCTZ not documented as administered on 09/13/21 to 09/15/21 09/19/21 to 09/20/21 and 09/22/21 to 09/25/21 and 09/27/21 to 09/28/21 and 09/30/21 at 8:00am. Observation of Resident #4's medications on hand on 09/29/21 at 3:35pm revealed there were no Losartan K-HCTZ 100-25mg tablets available for administration. Interview with a medication aide (MA) on 09/29/21 at 3:35pm revealed: -She administered medications to Resident #4. -She did not recall any of Resident #4's medications not being available to administer. -She thought the Resident Care Coordinator (RCC) had notified the family and reordered them. -Resident #4's medications came from the army hospital pharmacy and the POA would pick them up and bring them to the facility. -She was not sure how long Resident #4 had missed her blood pressure medicine. Interview with a second MA on 09/30/21 at 7:46am revealed Resident #4's Losartan had been out about 2 weeks or maybe a little longer. Review of the fax confirmation provided by the facility dated 09/27/21 revealed: -The date/time stamp fax confirmation was 09/27/21 at 3:51pm for when it was sent. -The return fax confirmation date/time stamp was 09/30/21 at 8:47am. -The Losartan Potassium 100-25mg was documented as ordered by the PCP. -The Metformin HCl 1000mg was documented as ordered by the PCP. -The staff signature of who completed the fax	D 358		

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D 358	Continued From page 8 request was from one of the MA's. Based on observations, record reviews, and interview it was determined Resident #4 was not interviewable. Attempted telephone interview with Resident #4's Power of Attorney (POA) on 09/29/21 at 3:58pm was unsuccessful. Attempted telephone interview with a pharmacist at Resident #4's pharmacy on 09/29/21 at 4:30pm was unsuccessful. Refer to interview with a second MA on 09/30/21 at 7:46am. Refer to interview with the RCC on 09/30/21 at 8:12am. Refer to interview with the Administrator on 09/30/21 at 9:44am. Refer to interview with Resident #4's PCP on 09/30/21 at 2:15pm. b. Review of Resident #4's physician's orders dated 02/18/21 revealed there was a medication order for Metformin HCl 1000mg (used as a first line medication to treat diabetes) one tablet twice daily. Review of Resident #4's August 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Metformin 1000mg take one tablet daily twice daily scheduled for 8:00am and 8:00pm. -There was documentation of administration of Metformin 1000mg from 08/03/21 to 08/31/21 at	D 358		

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8:00am and 8:00pm.
-There were 3 doses of Metformin not documented as administered on 08/01/21 for 8:00am and 8:00pm and 08/02/21 at 8:00am.

Review of Resident #4's September 2021 eMAR revealed:
-There was an entry for Metformin 1000mg take one tablet twice daily, scheduled for 8:00am and 8:00pm.
-There was documentation of administration of Metformin from 09/01/21 to 09/22/21 at 8:00am and 8:00pm, and on 09/26/21 at 8:00am and 09/28/21 at 8:00pm..
-There were 13 doses of Metformin not documented as administered on 09/23/21 to 09/29/21 at 8:00am and 8:00pm and on 09/30/21 at 8:00am.

Observation of Resident #4's medications on hand on 09/29/21 at 3:35pm revealed there was no Metformin available for administration.

Interview with the second MA on 09/30/21 at 7:46am revealed Resident #4 had been out of Metformin for about a week.

Review of the fax confirmation provided by the facility dated 09/27/21 revealed:
-The date/time stamp fax confirmation was 09/27/21 at 3:51pm for when it was sent.
-The return fax confirmation date/time stamp was 09/30/21 at 8:47am.
-The Metformin HCl 1000mg was documented as ordered by the PCP.
-The staff signature of who completed the fax request was from one of the MAs.

Based on observations, record reviews, and interview it was determined Resident #4 was not

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D 358	Continued From page 10 interviewable. Attempted telephone interview with Resident #4's Power of Attorney (POA) on 09/29/21 at 3:58pm was unsuccessful. Attempted telephone interview with a pharmacist at Resident #4's pharmacy on 09/29/21 at 4:30pm was unsuccessful. Refer to interview with a second MA on 09/30/21 at 7:46am. Refer to interview with the RCC on 09/30/21 at 8:12am. Refer to interview with the Administrator on 09/30/21 at 9:44am. Refer to interview with Resident #4's PCP on 09/30/21 at 2:15pm. _____ Interview with a second MA on 09/30/21 at 7:46am revealed: -She administered medications to Resident #4. -She had told the RCC when she noticed Resident #4's medications were low, and thought the RCC had reordered them (she did not remember the exact date). -The normal process was to inform the RCC when the resident was close to a 7-day supply remaining. -That process worked well with the "bubble packs" of medications but Resident #4's medications were in bottles and difficult to count. -Resident #4's medications came from the army hospital pharmacy and her family would pick them up and bring them to the facility. Interview with the RCC on 09/30/21 at 8:12am	D 358		

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revealed:
-She had contacted the PCP and pharmacy already to get the medications refilled.
-She did not remember when she had contacted them but would provide the fax confirmation.
-The process for medications to be reordered were the MAs would place the reorder stickers and fax to the facility pharmacy.
-Resident #4 did not use the facility pharmacy; she used the army hospital pharmacy.
-The MAs would let her know when Resident #4's medications would get low and she would reorder them and let the family know to pick them up.

Interview with the Administrator on 09/30/21 at 9:44am revealed:
-She did not know before, 09/30/21, that Resident #4 had not received medications as ordered by her PCP.
-She expected MAs to request refills when there were 7 to 14 tablets remaining.
-The MAs were responsible for reporting to the RCC if residents were getting low or out of medications.
-The RCC was responsible for ensuring medication orders were entered into the eMAR system.

Interview with Resident #4's PCP on 09/30/21 at 2:15pm revealed:
-She had not been notified of Resident #4 being out of her Losartan or Metformin.
-She had received a fax to refill her medications a few days ago and had ordered them.
-She expected to be notified at least 2-3 days before the resident ran out of medications to allow time to get them refilled.
-If Resident #4 was out of her Metformin, her blood sugar could have been elevated (hyperglycemia) that could result in other signs

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D 358	Continued From page 12 and symptoms like shortness of breath, nausea, vomiting, abdominal pain and confusion. -Missing approximately 17 days of Losartan was unacceptable due to the fact that Resident #4 had hypertension and could have caused her to have a stroke or a heart attack with her multiple disease processes. -If she had known Resident #4 had been out of her medications, she could have called the medications in to the back up pharmacy for an emergency supply to be dispensed until a regular supply could be obtained from the army hospital pharmacy she normally used. _____ The facility failed to administer medications as ordered resulted in not having medications on hand to be administered for diabetes and hypertension (#4) which could have resulted in increased blood sugar and elevated blood pressure which could result in a heart attack or stroke. This failure was detrimental to the health, safety, and welfare of the residents and constitutes an Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/30/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 30, 2021.	D 358		
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	D912		

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THE ADDISON OF FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(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
D912	Continued From page 13 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 are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and medication administration. 1. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up for 1 of 5 sampled residents (#5) who was ordered an orthopedic follow up, a neurology consul and a bone density test and a Reclast infusion. (Reclast is used to treat certain types of bone disease that cause abnormal and weak bones).[Refer to Tag D 358 10 A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (#4) related to an anti-hypertensive medication and a diabetic medication. [Refer to Tag D 358 10 A NCAC 13F .1004(A) Medication Administration (Type B Violation)].	D912		