Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on February 21-22, 2023.	D 000		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a therapeutic diet menu for 1 of 2 sampled residents (#6) with a diet order for a no-concentrated sweets diet (#6). The findings are: Observation of the kitchen during the initial tour on 02/21/23 at 10:11am revealed: -There was a report posted on the kitchen wall labeled as diet type, next to the serving table. -The diet type report listed residents' names and the type of diet they were ordered. -A no-concentrated sweet (NCS) diet was listed on the diet type report as a diet ordered for Resident #6. -There was no therapeutic diet menu available for staff to reference to serve a NCS diet. Review of Resident #6's current FL2 dated 10/27/22 revealed: -There was a diagnosis of moderate dementia. -There was no diet order listed.	D 296	10a NCAC 13F .0904(c)(7) Although community had access to therapeutic diets through the menu management system, this was not shared at survey. Community will have established, posted and Dietician approved extensions that meet community diets offered. Executive Director, AIT, Dining Service Director, and Cooks will be inserviced on menu extensions by the Regional Director of Dining Services. Regional Director of Dining, Regional Director of Operations and/or designee will monitor during site visits to verify menus are available to the dining staff and that Calyx residents are receiving the diet as outlined per policy and physician order. Completion Date: March 31, 2023	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 03/13/2023

Reviewed & Acknowledged
Wanda Edwards
03/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(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 296	Continued From page 1	D 296		

Review of Resident #6's physician's signed diet order dated 10/25/22 revealed a diet order for NCS diet.

Review of Resident #6's signed 6-month physician's orders dated 11/04/22 revealed:
-There was a diagnosis of diabetes mellitus type 2.
-There was an order for a NCS diet.

Review of Resident #6's Licensed Health Professional Support (LHPS) assessments dated 11/08/22 and 02/06/23 revealed Resident #6 had a diagnosis of diabetes mellitus type 2 and her diabetes was controlled by a NCS diet.

Interview with a Personal Care Aide (PCA) on 02/22/23 at 9:12am revealed:
-There was a report posted on the inside door of the insulated food cart titled diet type the staff used to reference when serving plates.
-Four residents received chopped meats; their plates were easily identified.
-Resident #6 was listed on the diet type report as having a NCS diet.
-Resident #6 was served the same plate of food as everyone, except the four residents with chopped meats.
-Resident #6 would receive a different dessert most days.

Interview with the Memory Care Director (MCD) on 02/22/23 at 9:20am revealed:
-She knew Resident #6 had an order for NCS; she saw it on the diet type report.
-Resident #6 was the only resident in the Memory Care Unit (MCU) with an order for a NCS diet.
-She thought the facility would serve a NCS diet.
-Resident #6 was served the same meal as the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(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 296	Continued From page 2	D 296		

other residents.

Interview with the Dietary Manager (DM) on 02/22/23 at 9:25am and 2:38pm revealed:
-He did not have a therapeutic menu to refer to when preparing a NCS diet.
-Resident #6 was served the same entrée as the residents on a regular diet, with the exception, of the dessert.
-Resident #6 was served a sugar-free dessert.
-He used his judgment regarding what desserts to serve to Resident #6.
-He would use a sugar substitute in the desserts for Resident #6.
-He did not have a NCS menu to reference when preparing meals.

Interview with the Regional Director of Dining on 02/22/23 at 9:28am revealed:
-Resident #6 was the only resident in the facility with a NCS diet.
-He did not realize there were two additional residents listed on the diet type report who were to receive a NCS diet.
-He did not know what a therapeutic menu was.
-He wrote the menus for the facility and sent them to the contracted facility dietician for approval.
-He thought substituting a sugar-free dessert for Resident #6 was appropriate.

Interview with the Administrator-in-Training on 02/22/23 at 9:40am and 4:06pm revealed:
-She knew a therapeutic menu was to be used to meet the needs of residents with a therapeutic diet order.
-The therapeutic menu had to be signed by a Registered Dietician.
-She thought the therapeutic menus were printed electronically for the kitchen staff to reference.
-She thought the kitchen staff referencing the diet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(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 296	Continued From page 3	D 296		

type report was adequate.
-She did not realize the kitchen staff required a therapeutic menu to follow when preparing a NCS diet.

Interview with the Administrator on 02/22/23 at 10:01am revealed:
-The facility only provides a regular and a NCS diet.
-The facility refers to a therapeutic menu as NCS alternative.
-Therapeutic menus were accessible to the DM to prepare a NCS diet.
-The NCS diet plate should be identified so the staff could serve the correct plate to Resident #6.

Interview with the contracted Registered Dietician on 02/22/23 at 11:41am revealed:
-The Regional Director of Dining would send her menus every 3 months.
-She would make changes as needed and approve the menus.
-She last approved menus on 11/02/23 for a regular diet.
-She did not prepare a therapeutic menu for a NCS diet.
-She did not know the facility had residents who were ordered a NCS diet.
-She had not been contacted regarding a therapeutic menu for a NCS diet until today.
-The Regional Director of Dining notified her regarding residents who had a NCS diet order.
-She had not been asked to prepare a therapeutic menu for NCS.

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

Attempted telephone interview with Resident #6's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(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 296	Continued From page 4 Primary Care provider (PCP) on 02/22/23 at 2:02pm was unsuccessful.	D 296		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#2 and #3), related to an inhaler (#2) and medication for inflamed gums (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 01/10/23 revealed: -Diagnosis included chronic obstructive pulmonary disease (COPD). -There was an order for Incruse Ellipta 62.5mcg (used to treat pulmonary disease) one puff daily. Review of Resident #2's signed 6-month physician orders dated 01/24/23 revealed an order for Incruse Ellipta 62.5mcg inhale one dose (one click) into lungs daily. Review of Resident #2's January 2023 electronic medication administration record (eMAR) from	D 358	10a NCAC 13F .1004 (c) EMAR audits will be conducted weekly by the RCD, RCC, ED, AIT, Regional Team and/or other designated team members to verify medications are being administered. RCD and/or Regional Nursing will inservice all staff that administer medications on the importance of passing all resident medications per orders including inhalers and other medications such as chlorhexidine gluconate. Regional Nursing will conduct EMAR audits monthly and spot check the medication carts quarterly to identify and patterns that are indicators of deficient practices. Any concerns are to be identified and addressed immediately upon identification with action items sent to AIT/ED and RDO. Completion Date: March 31, 2023 and Ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 5	D 358		

01/10/23 to 01/31/23 revealed:
-There was an entry for Incruse Ellipta 62.5mcg one puff to be administered every morning with a scheduled administration time of 9:00am.
-There was documentation Resident #2 was administered Incruse Ellipta 62.5mcg from 01/10/23 to 01/11/23 and 01/13/23 to 01/31/23.
-There was no exception documented on 01/12/23.

Review of Resident #2's February 2023 eMAR from 01/01/23 to 01/21/23 revealed:
-There was an entry for Incruse Ellipta 62.5mcg one puff to be administered every morning with a scheduled administration time of 9:00am.
-There was documentation Resident #2 was administered Incruse Ellipta 62.5mcg from 02/01/23 to 02/21/23.

Observation of Resident #2's medications on hand on 02/21/23 at 3:27pm revealed:
-There was a zip lock bag that contained an Incruse Ellipta 62.5mcg in the top drawer of the medication cart with a dispensed date of 01/19/23.
-There was a handwritten date on the prescription label of 1/23/23.
-There were 25 of 30 inhalations of Incruse Ellipta remaining in the inhaler.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 02/22/23 at 2:02pm revealed:
-Incruse Ellipta was used for better breathing and decreased flare-ups of pulmonary diseases.
-The pharmacy had an order for Resident #2 for Incruse Ellipta 62.5mcg one puff every morning.
-The pharmacy dispensed an inhaler for Resident #2 on 01/19/23 and 02/21/23.
-One inhaler had 30 inhalations of medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 6	D 358		

-The inhaler was designed to countdown as inhalations were administered.

Interview with a Medication Aide (MA) on 02/21/23 at 3:20pm revealed:
-She administered Resident #2 Incruse Ellipta inhaler in the morning as scheduled.
-Resident #2 did not refuse Incruse Ellipta.
-The dispensed date on the prescription label was 01/19/23
-She did not know why there were 25 inhalations still available to be administered.

Interview with a MA on 02/22/23 at 12:05pm revealed:
-She administered Resident #2 her Incruse Ellipta inhaler each morning.
-She did not know why the dispense date was over a month ago and there were still 25 inhalations remaining in the inhaler.
-Resident #2 had not complained of any breathing problems.

Interview with the Administrator-in-Training on 02/22/23 at 4:06pm revealed she did not know why the Incruse Ellipta inhaler dispensed on 01/19/23 still had 25 inhalations available for administration.

Interview with the Regional Director of Nursing on 02/22/23 at 5:04pm revealed:
-She was working in the facility as the Resident Care Coordinator (RCD) until a RCD was hired.
-The Incruse Ellipta inhaler was dispensed on 01/19/23 but was opened until 01/23/23, indicating when the inhaler was opened for use.
-She did not know why there were 25 inhalation doses left in the inhaler.

Based on observations, interviews, and record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 7	D 358		

reviews it was determined Resident #2 was not interviewable.

Attempted telephone interview with Resident #2's Primary Care provider (PCP) on 02/22/23 at 2:02pm was unsuccessful.

Attempted telephone interview with the Administrator on 02/22/23 at 11:47am was unsuccessful.

Refer to the interview with the Administrator-in-Training on 02/22/23 at 4:06pm.

Refer to the interview with the Regional Director of Nursing on 02/22/23 at 5:04pm.

2. Review of Resident #3's current FL-2 dated 04/08/22 revealed diagnoses included late-onset Alzheimer's disease, osteoarthritis, hypertension, chronic kidney disease, hypercholesterolemia, and hypothyroidism.

Review of Resident #3's signed 6-month physician orders dated 09/13/22 revealed an order for chlorhexidine gluconate solution 0.12% use 15mls to soak toothbrush and coat teeth and gums twice a day.

Review of Resident #3's September 2022 electronic medication administration record (eMAR) from 09/29/22 to 09/30/22 revealed:
-There was an entry for chlorhexidine gluconate solution 0.12% use 15mls to soak toothbrush and coat teeth and gums to be administered twice daily with a scheduled administration time of 9:00am and 8:00pm.
-There was documentation Resident #3 was administered chlorhexidine gluconate solution 0.12% on 09/29/22 and 09/30/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 8	D 358		

Review of Resident #3's October 2022 eMAR revealed:
-There was an entry for chlorhexidine gluconate solution 0.12% use 15mls to soak toothbrush and coat teeth and gums to be administered twice daily with a scheduled administration time of 9:00am and 8:00pm.
-There was documentation Resident #3 was administered chlorhexidine gluconate solution 0.12% from 10/01/22 and 10/31/22.

Review of Resident #3's November 2022 eMAR revealed:
-There was an entry for chlorhexidine gluconate solution 0.12% use 15mls to soak toothbrush and coat teeth and gums to be administered twice daily with a scheduled administration time of 9:00am and 8:00pm.
-There was documentation Resident #3 was administered chlorhexidine gluconate solution 0.12% from 11/01/22 and 11/30/22.

Review of Resident #3's December 2022 eMAR revealed:
-There was an entry for chlorhexidine gluconate solution 0.12% use 15mls to soak toothbrush and coat teeth and gums to be administered twice daily with a scheduled administration time of 9:00am and 8:00pm.
-There was documentation Resident #3 was administered chlorhexidine gluconate solution 0.12% from 12/01/22 and 12/31/22.

Review of Resident #3's January 2023 eMAR revealed:
-There was an entry for chlorhexidine gluconate solution 0.12% use 15mls to soak toothbrush and coat teeth and gums to be administered twice daily with a scheduled administration time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 9	D 358		

9:00am and 8:00pm.
-There was documentation Resident #3 was administered chlorhexidine gluconate solution 0.12% from 01/01/23 and 01/31/23.

Review of Resident #3's February 2023 eMAR from 01/01/23 to 01/21/23 revealed:
-There was an entry for chlorhexidine gluconate solution 0.12% use 15mls to soak toothbrush and coat teeth and gums to be administered twice daily with a scheduled administration time of 9:00am and 8:00pm.
-There was documentation Resident #3 was administered chlorhexidine gluconate solution 0.12% from 02/01/23 to 02/21/23.

Observation of Resident #3's medications on hand on 02/22/23 at 12:01pm revealed a bottle of chlorhexidine gluconate solution 0.12% in the side drawer of the medication cart with a dispensed date of 09/29/22; the bottle was 1/8 full.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 02/22/23 at 2:02pm revealed:
-The pharmacy had an order for Resident #3 for chlorhexidine gluconate solution 0.12% use 15mls to soak toothbrush and coat teeth and gums twice a day.
-Chlorhexidine gluconate was used to treat gum disease.
-The pharmacy dispensed at 473ml bottle of Chlorhexidine gluconate for Resident #3 on 04/08/22 and 09/29/22.
-A 473ml bottle of chlorhexidine gluconate would last 15 days if administered twice a day.

Interview with a Medication Aide (MA) on 02/22/23 at 3:10pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 10	D 358		

-She did not know why there was medication still available to administer that was dispensed on 09/29/23.
-She would pour 15mls into a plastic medication cup and use a brush to rub the medication on Resident #3's gums.
-Resident #3 would hold her mouth closed sometimes, but she worked with her to open her mouth and rub the medication on her gums as best as she could.

Interview with the Administrator-in-Training on 02/22/23 at 4:06pm revealed:
-She did not know why the bottle of chlorhexidine gluconate solution 0.12% was still being used with a dispensed date of 09/29/22.
-She would expect the MAs to look at the dispense date of the medication and realize it was dispensed months ago.

Interview with the Regional Director of Nursing on 02/22/23 at 5:04pm revealed:
-She was working in the facility as the Resident Care Director (RCD) until one was hired.
-She did not know the MAs were administering medication from a bottle that was dispensed on 09/29/22.
-The staff did not use 15mls each twice a day; they would pour a smaller amount in the medication cup because Resident #3 would clinch her mouth closed.

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

Attempted telephone interview with Resident #2's Primary Care provider (PCP) on 02/22/23 at 2:02pm was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032134	A. BUILDING: _____ B. WING _____	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 11 Attempted telephone interview with the Administrator on 02/22/23 at 11:47am was unsuccessful. Refer to the interview with the Administrator-in-Training on 02/22/23 at 4:06pm. Refer to the interview with the Regional Director of Nursing on 02/22/23 at 5:04pm. Interview with the Administrator-in-Training on 02/22/23 at 4:06pm revealed: -The MAs were responsible for ordering medications. -The medication carts were audited weekly by the Resident Care Director (RCD). -She did not know what the medication cart audit consisted of. Interview with the Regional Director of Nursing on 02/22/23 at 5:04pm revealed: -She would audit the medication carts occasionally. -When the RCD and Resident care coordinator was here, they audited each cart weekly. -She looked for expired and discontinued medications and medications that needed to be re-ordered. -She would print the eMAR and compare all medications on the medication cart with the medications listed on the eMAR.	D 358		

Edwards, Wanda A

From: Sylvester, Jeff <Jeff.Sylvester@carillonassistedliving.com>
Sent: Tuesday, March 14, 2023 10:36 AM
To: Edwards, Wanda A
Cc: Moore, Jennifer
Subject: [External] Calyx Living of Durham 2023-02-22 SODL QTOZ11
Attachments: Annual Survey Completed 2-22-2023.pdf

Please see attached: Signed and dated

Jeff Sylvester | Regional Director of Operations
Calyx Living of Durham
4214 Guess Rd.
Durham NC 27712
919-471-0091

Calyx Living

Jeff Sylvester | Regional Director of Operations
Carillon Assisted Living
4901 Waters Edge Drive | Suite 200
Raleigh NC 27606
336-420-7693