Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow Up survey on 10/24/23-10/26/23.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to implement physician's orders for 2 of 5 sampled residents (#3, #4) related to an order for finger stick blood sugars (FSBS) three times daily (#3 and #4). The findings are: 1. Review of Resident #4's current FL-2 dated 07/11/23 revealed diagnoses included type II diabetes mellitus (DM). Review of Resident #4's physician's progress notes dated 08/16/23 revealed: -Resident #4 was ordered finger stick blood sugar (FSBS) checks three times daily. -Her most recent HgbA1C (an A1C test is a blood test that reflects your average blood glucose level over the past three months) result dated 08/10/23 was 8.9 percent. Review of Resident #4's August 2023 electronic	D 276	HWD, MCD and or designee will continue to run medication administration Aduit reports to verify for administration of medication, along with new orders. HWD, MCD and or designee will continue the review of the audit report with the ED weekly for the next 30 days to check for administration of medications. Ending date will be 12/31/2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patrice Davis — TITLE: Administrator — (X6) DATE: 12/01/2023

Received, reviewed, and acknowledged with addendums added on 12/07/23. kg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 1 medication administration record (eMAR) from 08/16/23 to 08/31/23 revealed: -There was an entry for FSBS checks once daily at 8:00am. -There was documentation Resident #4's FSBS were checked daily from 08/10/23 to 08/23/23 at 8:00am, but there were no FSBS results documented. -There was not an entry for documentation of FSBS checks scheduled three times daily beginning 08/16/23. -There was one entry for FSBS results at 12:00pm dated 08/17/23. -There were three entries for FSBS results at 4:00pm dated 08/17/23, 08/22/23, and 08/29/23. -There was an entry for Humalog 100unit/mL per sliding scale for FSBS results over 151; 151-200=1 unit (u), 201-250=2u, 2510-300=3u, 301-350=4u, or over 351 or greater=5u scheduled three times daily at 8:00am,12:00pm, and 4:00pm beginning 08/17/23. -In the eMAR exceptions there was documentation Resident #4's FSBS results once on 08/29/23 at 4:00pm. -There were no other FSBS results documented on Resident #4's August 2023 eMAR. Review of Resident #4's order administration tracking reports dated 08/17/23-08/31/23 revealed: -There was documentation at 8:00am for FSBS results for Resident #4 three times; there was no other documentation for 8:00am. -There was documentation at 12:00pm for four FSBS results for Resident #4 four times; there was no other documentation for 12:00pm. -There was documentation at 4:00pm for three FSBS results for Resident #4 three times; there was no other documentation for 4:00pm.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 2 Telephone interview with Resident #4's primary care provider (PCP) on 10/26/23 at 3:23pm revealed: -She depended on the staff to get Resident #4's FSBS correct. -She expected the staff to do the FSBS checks for Resident #4 prior to her meals. Interview with a medication aide (MA) on 10/26/23 at 1:44pm revealed: -The eMAR system would not go to the next medication for administration until the FSBS results were documented for Resident #4. -Resident #4's FSBS had to be done first then the SSI would be documented. -She did not know why the FSBS were not visible when viewed on the eMAR. -She did FSBS for Resident #4 every day and documented on the eMAR. -She documented Resident #4's FSBS results into a note book but did not have her notebook from August. Interview with the Resident Care Coordinator (RCC) on 10/26/23 at 11:03pm revealed: -The MAs must do FSBS checks and document them on the eMAR before they can move on to the next medication; including sliding scale. -She printed off the eMAR and reviewed it for holes or missing medication administrations, she looked at FSBS results to monitor highs and lows in the results. -She was not sure why the FSBS results were not documented on the eMAR. -Sometimes there was a "glitch" in the system and that was when the MAs would document FSBS results on the tracking report. -All FSBS results should have been documented on the eMAR. -The MAs were trained on how to enter	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 3 information in the eMAR and the eMAR notes. -If she could not view the FSBS results for Resident #4 then she could not track if the sliding scale had been followed and if Resident #4's Humalog was administered correctly. Interview with the Health and Wellness Director (HWD) on 10/26/23 at 2:19pm revealed Resident #4's FSBS results usually ran high, from 277 to 380 range. Refer to the interview with the HWD on 10/26/23 at 2:19pm and 3:23pm. Refer to the interview with the Administrator on 10/25/23 at 4:04pm. 2. Review of Resident #3's current FL-2 dated 03/22/23 revealed: -Diagnosis included type II diabetes mellitus (DM). -There was an order to obtain and record finger stick blood sugars (FSBS) three times a day. Review of Resident #3's August 2023 electronic medication administration record (eMAR) and order administration tracking reports dated 08/01/23-08/31/23 revealed: -There was a computer-generated entry to check FSBS at 8:00am, 12:00pm, and 4:00pm. -Resident #3's FSBS was checked daily at 8:00am between 08/01/23-08/31/23. -At 12:00pm, there was documentation Resident #3's FSBS was checked 28 out of 31 opportunities; there were three times there were no FSBS results documented. -At 4:00pm/5:00pm, there was documentation Resident #3's FSBS was checked 26 out of 31 opportunities; there were five times there were no FSBS results documented.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 4 Review of Resident #3's September 2023 eMAR revealed and order administration tracking reports dated 09/01/23-09/30/23: -There was a computer-generated entry to check FSBS at 8:00am,12:00pm, and 4:00pm. -Resident #3's FSBS was checked daily at 8:00am between 09/01/23-09/30/23. -At 12:00pm, there was documentation that Resident #3's FSBS was checked 23 out of 30 opportunities. there were seven times there were no FSBS results documented. -At 4:00pm/5:00pm, there was documentation Resident #3's FSBS was checked 23 out of 30 opportunities; there were seven times there were no FSBS results documented. Review of Resident #3's October 2023 eMAR between 10/01/23-10/24/23 and order administration tracking reports dated 10/01/23-10/24/23 revealed: -There was a computer-generated entry to check FSBS at 8:00am, 12:00pm, and 4:00pm. --Resident #3's FSBS was checked daily at 8:00am between 10/01/23-10/24/23. -At 12:00pm, there was documentation Resident #3's FSBS was checked 16 out of 24 opportunities; there were eight times there were no FSBS results documented. -At 4:00pm, there was documentation Resident #3's FSBS was checked 14 out of 23 opportunities; there were nine times there were no FSBS results documented. Interview with Resident #3 on 10/25/26 at 11:52am revealed: -Staff checked her FSBS before meals every day. -She had never refused to have her FSBS checked.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 5 -Sometimes, if the staff did not check her FSBS before she had started eating, they would not check her FSBS. Interview with medication aide (MA)/Memory Care Coordinator (MCC) on 10/25/26 at 10:33am revealed: -Resident #3 had never refused to have her FSBS checked for her. -She had never missed checking Resident #3's FSBS. -She forgot to document Resident #3's FSBS yesterday, 10/24/23 at 4:19pm, but went into the eMAR and documented the information. -She opened the computer screen to show an entry at 4:19pm and 4:23pm. -There was no information on the history of the 4:19pm or 4:23pm entry to show what the FSBS result was or how much insulin was administered. -She knew she documented the information and did not know why it was not recorded in the eMAR system. Interview with the Health and Wellness Director on 10/24/23 at 3:23pm revealed: -She was not aware of any reports showing Resident #3 had missed her FSBS. -The MAs should check Resident #3's FSBS daily. Telephone interview with Resident #3's Primary Care Provider (PCP) on 10/26/23 at 3:21pm revealed: -She expected the MAs to check and document Resident #3's FSBS before each meal. -Her concern would be she would make changes to Resident #3's insulin that were not warranted if the documentation was not correct. Refer to the interview with the HWD on 10/26/23	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 6 at 2:19pm and 3:23pm. Refer to the interview with the Administrator on 10/25/23 at 4:04pm. Interview with the Health and Wellness Director (HWD) on 10/26/23 at 2:19pm and 3:23pm revealed: -She believed the MAs were doing the FSBS correctly because she had discussions with them. -The eMAR had a problem or glitch in it about a month ago and she thought the issue had been corrected. -None of the MAs had told her they could not document FSBS results in the eMAR. -During clinical, they discussed if medications were not given, including FSBS, and why the medication was not administered to see if there were any problems or resident issues. -If a medication/task was not done, a report would "pop up" and that was how they tracked any issues; they would then talk about it. -Ideally, they ran reports daily, but sometimes due to circumstances they would not run them for a few days, but all the days would be captured. -If the FSBS results were not documented, there would be no way to show it had been done. Interview with the Administrator on 10/25/23 at 4:04pm revealed: -She expected orders to be carried out. -If the MA did not document on the eMAR, they could document what had been done on a progress note. -She thought the documentation was done but the reports were not capturing the data. -Documentation was needed for proof the FSBS had been checked and SSI administered if needed.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 7	D 296		
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 any resident's physician-ordered therapeutic diet 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 matching therapeutic diet menus for food service guidance for 2 of 2 sampled residents (#1 and #4) who had an order for a reduced concentrated sweets (RCS) diet (#4), a pureed diet (#1). The findings are: Observation of the kitchen on 10/24/23 at 10:25am revealed the regular menus were posted on a bulletin board in the kitchen, but there were no therapeutic menus that matched the regular menus, available in the kitchen for staff guidance. 1. Review of Resident #4's current FL-2 dated 07/11/23 revealed: -Diagnoses included type II diabetes mellitus (DM). -There was an order for an RCS diet. Review of the facility's undated therapeutic diet list posted in the kitchen on 10/24/23 at 10:25am	D 296	Facility to ensure that Therapeutic diet menu are visible in kitchen area for staff guidance. This will be ongoing as long as facility have therapeutic diets. Addendum 12/07/23: Dining Director and or Designee will check for posted therapeutic menu daily for 30 days (12/30/2023). kg	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 8 revealed Resident #4 was to be served a RCS diet. Review of the facility's week-at-a-glance menu for the lunch meal on Tuesday, 10/24/23, for regular diets revealed Soup of choice, turkey divan, broccoli, red beans, and caramel cake with beverage of choice were to be served. Observation and lunch meal service on 10/24/23 at 12:17 PM revealed Resident #4's was served turkey divan and broccoli over mashed potatoes, red beans, frosted cake with caramel drizzle and iced tea. Based on observation of the lunch meal service on 10/24/23, it could not be determined if Resident #4 was served the correct therapeutic diet due to no therapeutic diet menu available for staff guidance. Interview with Resident #4 on 10/24/23 at 9:10am revealed: -She watched what she ate. -She did not think she was on a physician ordered therapeutic diet. -She ate what ever the other residents ate. Refer to the interview with the cook on 10/24/23 at 10:26am. Refer to the interview with the Kitchen Manager (KM) on 10/24/23 at 10:34am. Refer to the interview with the Administrator on 10/24/23 at 3:30pm. Attempted telephone interview with Resident #4's primary care provider (PCP) on 10/24/23 at 3:48pm was unsuccessful.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 9 2. Review of resident number ones FL-2 dated 03/09/23 revealed diagnoses included dementia, hypertension, depression and insomnia. Review of Resident #1's physician's order dated 08/11/23 revealed an order for a pureed diet. Review of the facility's undated therapeutic diet list posted in the kitchen on 10/24/23 at 10:25am revealed Resident #1 was to be served a pureed diet. Review of the facility's week-at-a-glance menu for the lunch meal on Tuesday, 10/24/23, for regular diets revealed Soup of choice, turkey divan, broccoli, red beans, and caramel cake with beverage of choice were to be served. Observation and lunch meal service on 10/24/23 at 12:01pm revealed Resident #1's was served pureed turkey divan and broccoli over mashed potatoes, ice cream and iced tea. Based on observation of the lunch meal service on 10/24/23, it could not be determined if Resident #1 was served the correct therapeutic diet due to no therapeutic diet menu available for staff guidance. Refer to the interview with the cook on 10/24/23 at 10:26am. Refer to the interview with the Kitchen Manager (KM) on 10/24/23 at 10:34am. Refer to the interview with the Administrator on 10/24/23 at 3:30pm. Attempted telephone interview with Resident #1's	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 10 primary care provider (PCP) on 10/24/23 at 3:48pm was unsuccessful. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. Interview with the cook on 10/24/23 at 10:26am revealed: -She served all the residents the same food from the regular menu. -She did not know what a therapeutic menu was. -She pureed what was on the regular menu for the residents who were ordered at pureed diet. -She did not know what a reduced concentrated sweets (RCS) diet was. Interview with the Kitchen Manager (KM) on 10/24/23 at 10:34am revealed: -He used the regular menu as a reference when preparing meals. -He did not have a therapeutic menu to reference for residents who were ordered therapeutic diets. -He provided sugar free items for residents who were ordered a RCS diet and pureed the items on the regular menu for residents who were ordered a puree diet. Interview with the Administrator on 10/24/23 at 3:30pm revealed: -She knew what a therapeutic diet menu was. -She had seen the therapeutic diet menu in the kitchen but did not know if the staff was referencing it when preparing meals. -She did not know why the staff was not using the therapeutic diet menu when preparing meals. -She went into the kitchen about once a week and Meals were monitored by herself or other management staff at least once daily.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	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, record reviews, and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#3, #4) related to an order for sliding scale insulin (SSI) (#3 and #4). The findings are: 1. Review of Resident #4's current FL-2 dated 07/11/23 revealed diagnoses included type II diabetes mellitus (DM). Review of Resident #4's physician's progress notes dated 08/16/23 revealed: -Resident #4 was ordered finger stick blood sugar (FSBS) checks three times daily. -There was an order for Humalog (used to treat diabetes) 100unit/mL per sliding scale insulin (SSI) administer Humalog for FSBS over 151; 151-200=1 unit (u), 201-250=2u, 2510-300=3u, 301-350=4u, or over 351 or greater=5u. -Her most recent HgbA1C (an A1C test is a blood test that reflects your average blood glucose level over the past three months) result dated 08/10/23 was 8.9 percent.	D 358	HWD, MCD and or designee will continue to run medication administration Aduit reports to verify for administration of medication. HWD, MCD and or designee will continue the review of the audit report with the ED weekly for the next 30 days to check for administration of medications. Ending date will be 12/31/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12 Review of Resident #4's August 2023 electronic medication administration record (eMAR) from 08/16/23 to 08/31/23 revealed: -There was an entry for Humalog 100unit/mL per sliding scale for FSBS results over 151; 151-200=1 unit (u), 201-250=2u, 2510-300=3u, 301-350=4u, or over 351 or greater=5u scheduled three times daily at 8:00am,12:00pm, and 4:00pm beginning 08/17/23. -There was documentation Resident #'s Humalog had been administered 39 out of 39 opportunities from 08/17/23 to 08/31/23. -There was no documentation of how many units of Humalog were administered per sliding scale based on FSBS results from 08/17/23 to 08/31/23. -In the eMAR exceptions there was documentation Resident #4's Humalog was administered per sliding scale based on FSBS results once on 08/29/23 at 4:00pm. -There were no other FSBS results documented or units of Humalog administered per sliding scale on Resident #4's August 2023 eMAR. Review of Resident #4's order administration tracking reports dated 08/17/23-08/31/23 revealed: -There was documentation at 8:00am for FSBS results and the amount of Humalog administered to Resident #4 three times; there was no other documentation for 8:00am. -There was documentation at 12:00pm for four FSBS results and the amount of Humalog administered to Resident #4 four times; there was no other documentation for 12:00pm. -There was documentation at 4:00pm for three FSBS results and the amount of Humalog administered to Resident #4 three times; there was no other documentation for 4:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 Telephone interview with Resident #4's primary care provider (PCP) on 10/26/23 at 3:23pm revealed: -Resident #4's FSBS results were consistently high, around the 400 to 500 so she discontinued the order for her SSI in September 2023 and began scheduled insulin to achieve better FSBS results. -She would reference the eMAR to check the amount of Humalog Resident #4 had been administered. -They expected the staff to administer Resident #4's SSI per her scale. Interview with a medication aide (MA) on 10/26/23 at 1:44pm revealed: -The eMAR system would not go to the next medication for administration until the amount of SSI units were documented for Resident #4. -She documented the amount of Humalog she administered to Resident #4 in the notes on the eMAR. -Resident #4's FSBS had to be done first then the SSI would be documented. -She did not know why the SSI administrations were not visible when viewed on the eMAR. -She administered Resident #4's Humalog based on the sliding scale on her eMAR. -She documented Resident #4's SSI amounts into a note book but did not have her notebook from August. Interview with the Resident Care Coordinator (RCC) on 10/26/23 at 11:03pm revealed: -The MAs must administer SSI and document them on the eMAR before they can move on to the next medication. -She printed off the eMAR and reviewed it for holes or missing medication administrations, she looked at FSBS results to monitor highs and lows	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14 in the results. -Resident #4's SSI amounts should have been documented in the eMAR notes once administered. -The MAs were trained on how to enter information in the eMAR and the eMAR notes. -If she could not view the amount of Humalog Resident #4 was administered then she could not track if the sliding scale had been followed and if Resident #4's Humalog was administered correctly. Interview with the Health and Wellness Director (HWD) on 10/26/23 rat 2:19pm revealed: -Resident #4's FSBS results usually ran high, from 277 to 380 range. -If there was no documentation of SSI units administered then there was an error in the system somewhere; she was hard pressed to believe the MAs were not administering Humalog according to the sliding scale. Refer to the interview with the HWD on 10/26/23 at 2:19pm and 3:23pm. Refer to the interview with the Administrator on 10/25/23 at 4:04pm. 2. Review of Resident #3's current FL-2 dated 03/22/23 revealed: -Diagnoses included type II diabetes mellitus (DM). -There was an order to obtain and record finger stick blood sugars (FSBS) three times a day. -There was an order for Novolog (used to treat DM) insulin injection per sliding scale: 200-250=4un, 251-300=6u, 301-350=8u, or 351 or greater=10u. Review of Resident #3's August 2023 electronic	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 15 medication administration record (eMAR) revealed: -There was a computer-generated entry to check FSBS at 8:00am,12:00pm, and 4:00pm and use the sliding scale to administer Novolog for any FSBS over 200; 200-250=4 units (u), 251-300=6u, 301-350=8u, or 351 or greater=10u. -Resident #3's FSBS was checked daily at 8:00am between 08/01/23-08/31/23. -At 8:00am, there were 17 times out of 31 opportunities Resident #3's FSBS would have required the administration of Novolog based on the sliding scale. -In the exceptions, there was documentation Novolog SSI was administered 10 times between 08/01/23-08/31/23 at 8:00am. -At 12:00pm, there was documentation Resident #3's FSBS was checked 25 out of 31 opportunities; 24 of 25 FSBS readings would have required the administration of Novolog. -In the exceptions, there was documentation Novolog SSI was administered 12 times between 08/01/23-08/31/23 at 12:00pm. -At 4:00pm/5:00pm, there was documentation Resident #3's FSBS was checked 25 out of 31 opportunities; 20 of 25 readings would have required the administration of Novolog. -In the exceptions, there was documentation Novolog SSI was administered 10 times between 08/01/23-08/31/23 at 4:00pm/5:00pm. Review of Resident #3's order administration tracking reports dated 08/01/23-08/31/23 revealed: -At 8:00am, there was documentation of the amount of Novolog administered to Resident #3 eleven times; there were six times there was no documentation of the amount of Novolog administered. -At 12:00pm, there was documentation of the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 16 amount of Novolog administered to Resident #3 twenty-six times; there were three times there were no FSBS results documented to know if Novolog needed to be administered. -On 08/01/23 at 12:00pm there was documentation 8u of Novolog was administered and a second documentation 4u of Novolog was administered. -On 08/08/23 at 12:00pm, Resident #3's FSBS was documented as 220 which would require the administration of Novolog and there was no documentation Novolog was administered. -On 08/09/23 at 12:00pm there was documentation 6u of Novolog was administered and a second documentation 4u of Novolog was administered. -At 4:00pm/5:00pm, there was documentation of the amount of Novolog administered to Resident #3 twenty-one times; there were five times there were no FSBS results documented to know if Novolog needed to be administered. Review of Resident #3's September 2023 eMAR revealed: -There was a computer-generated entry to check FSBS at 8:00am, 2:00pm, and 4:00pm and use the sliding scale to administer Novolog for any FSBS over 200; 200-250=4 units (u), 251-300=6u, 301-350=8u, or 351 or greater=10u. -There was an entry for FSBS readings at 8:00am, 12:00pm and 4:00pm or 5:00pm. -Resident #3's FSBS was checked daily at 8:00am between 09/01/23-09/30/23. -At 8:00am, there were 15 times out of 31 opportunities Resident #3's FSBS would have required the administration of Novolog based on the sliding scale. -In the exceptions, there was documentation Novolog SSI was administered 6 times between 09/01/23-09/3023 at 8:00am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 17 -At 12:00pm, there was documentation Resident #3's FSBS was checked 21 out of 30 opportunities; 20 of 21 FSBS readings would have required the administration of Novolog. -In the exceptions, there was documentation Novolog SSI was administered 9 times between 09/01/23-09/30/23 at 12:00pm. -At 4:00pm/5:00pm, there was documentation Resident #3's FSBS was checked 20 out of 31 opportunities; 14 of 20 readings would have required the administration of Novolog. -In the exceptions, there was documentation Novolog SSI was administered 5 times between 09/01/23-09/31/23 at 4:00pm/5:00pm. Review of Resident #3's order administration tracking reports dated 09/01/23-09/30/23 revealed: -At 8:00am, there was documentation of the amount of Novolog administered to Resident #3 fourteen times; there was one time there was no documentation of the amount of Novolog administered. -At 12:00pm, there was documentation of the amount of Novolog administered to Resident #3 twenty-two times; there were seven times when there were no FSBS results documented to know if Novolog needed to be administered. -At 4:00pm/5:00pm, there was documentation of the amount of Novolog administered to Resident #3 fourteen times; there were seven times when there were no FSBS results documented to know if Novolog needed to be administered. Review of Resident #3's October 2023 eMAR between 10/01/23-10/24/23 revealed: -There was a computer-generated entry to check FSBS at 8:00am, 12:00pm, and 4:00pm and use the sliding scale to administer Novolog for any FSBS over 200; 200-250=4 units (u),	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 18 251-300=6u, 301-350=8u, or 351 or greater=10u. -Resident #3's FSBS was checked daily at 8:00am between 10/01/23-10/24/23. -At 8:00am, there were 21 times out of 24 opportunities Resident #3's FSBS would have required the administration of Novolog based on the sliding scale. -In the exceptions, there was documentation Novolog SSI was administered 2 times between 10/01/23-10/24/23 at 8:00am. -At 12:00pm, there was documentation Resident #3's FSBS was checked 15 out of 24 opportunities; 14 of 15 FSBS readings would have required the administration of Novolog. -In the exceptions, there was documentation Novolog SSI was administered 1 time between 10/01/23-10/24/23 at 12:00pm. -At 4:00pm, there was documentation Resident #3's FSBS was checked 13 out of 23 opportunities; 12 of 13 readings would have required the administration of Novolog. -In the exceptions, there was documentation Novolog SSI was administered 1 time between 10/01/23-10/23/23 at 4:00pm. -On 10/01/23 at 4:00pm, Resident #3's FSBS was documented as 217 which would require the administration of Novolog and there was no documentation Novolog was administered. Review of Resident #3's order administration tracking reports dated 10/01/23-10/24/23 revealed: -At 8:00am, there was documentation of the amount of Novolog administered to Resident #3 fifteen times; there were five times there was no documentation of the amount of Novolog administered. -At 12:00pm, there was documentation of the amount of Novolog administered to Resident #3 fourteen times; there were nine times when there	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 19 were no FSBS results documented to know if Novolog needed to be administered. -On 10/08/23 at 12:00pm there was documentation 8u of Novolog was administered and a second documentation 4u of Novolog was administered. -At 4:00pm, there was documentation of the amount of Novolog administered to Resident #3 twelve times; there were nine times there were no FSBS results documented to know if Novolog needed to be administered. -On 10/22/23 at 4:00pm there was documentation 8u of Novolog was administered and a second documentation 4u of Novolog was administered. Interview with Resident #3 on 10/25/26 at 11:52am revealed: -Staff checked her FSBS before meals every day. -She had never refused to have her FSBS checked. -Sometimes, if the staff did not check her FSBS before she had started eating, they would not check her FSBS. -The staff would usually say "out loud" how many units there were going to administer. -She did not know what her sliding scale order was but knew anything over 200 required the administration of Novolog. Interview with medication aide (MA)/Memory Care Coordinator (MCC) on 10/25/26 at 10:33am revealed: -Resident #3 had never refused to have her FSBS checked for her. -She had never missed checking Resident #3's FSBS. -When she administered Resident #3's SSI, she would sometimes forget to enter the amount of insulin administered, but she would go into the eMAR and document the FSBS results, and SSI	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 20 administered on another screen. -She forgot to document the amount she administered yesterday, 10/24/23 at 4:19pm, but went into the eMAR and documented the information. -She opened the computer screen to show an entry at 4:19pm and 4:23pm. -She stated the 4:23pm entry was where she went back in and documented the amount of Novolog she administered. -There was no information on the history of the 4:23pm entry to show what the FSBS result was or how much insulin was administered. -She knew she documented the information and did not know why it was not recorded in the eMAR system. Interview with a second MA on 10/26/23 at 2:30pm revealed: -She checked Resident #3's FSBS when she worked. -Once she had checked Resident #3's FSBS, she would look at the sliding scale order to determine how much insulin she needed to administer. -She had to go into another screen to document the FSBS and the amount of insulin administered. -She opened the other screen in the computer to show the process and noted that she had not documented the amount of insulin she had administered on the example she pulled up. -She should have documented the units, but she forgot. Telephone interview with Resident #3's Primary Care Provider (PCP) on 10/26/23 at 3:21pm revealed: -She had ordered Resident #3's SSI to see if she needed to titrate the mealtime insulin better. -The goal would be to titrate Resident #3 off her SSI.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 21 -If the documentation for Resident #3's SSI was not correct she would not be able to make changes appropriately. -She expected the MAs to administer and document SSI if needed based on the FSBS before each meal. -Her concern would be she would make changes to Resident #3's insulin that were not warranted if the documentation was not correct. Interview with the Health and Wellness Director (HWD) on 10/24/23 at 3:23pm revealed: -She was not aware of any reports showing Resident #3 had missed her SSI. -The MAs would check Resident #3's FSBS and use the SSI to determine how much insulin to administer. Refer to the interview with the HWD on 10/26/23 at 2:19pm and 3:23pm. Refer to the interview with the Administrator on 10/25/23 at 4:04pm. Interview with the Health and Wellness Director (HWD) on 10/26/23 at 2:19pm and 3:23pm revealed: -During clinical, they discussed if medications were not given, including FSBS, and why the medication was not administered to see if there were any problems or resident issues. -If a medication/task was not done, a report would "pop up" and that was how they tracked any issues; they would then talk about it. -The MAs had been trained about the importance of administering residents' their insulin; she wanted them to understand SSI. -She believed the MAs were doing the FSBS and SSI administration correctly because she had discussions with them.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 22 -The eMAR had a problem or glitch in it about a month ago and she thought the issue had been corrected. -None of the MAs had told her they could not document SSI amounts in the eMAR. -Ideally, they ran reports daily, but sometimes due to circumstances they would not run them for a few days, but all the days would be captured. -She expected the MAs to look at the eMAR to administer medications. -If the FSBS results and SSI administered were not documented, there would be no way to show it had been done. -She was concerned that without documentation one would not be able to monitor to ensure the amount given was correct. Interview with the Administrator on 10/25/23 at 4:04pm revealed: -She expected orders to be carried out. -If the MA did not document on the eMAR, they could document what had been done on a progress note. -She thought the documentation was done but the reports were not capturing the data. -Documentation was needed for proof the SSI was administered correctly if needed.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.	D 378	HWD, MCD and or designee will continue to in-service med techs on locking the med cart. HWD, MCD and or designee will continue to perform random med cart lock checks periodically. Addendum 12/07/23: completion date12/30/2023. kg	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 378	Continued From page 23 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication carts were locked when not under the direct supervision of a medication aide. The findings are: Observation of the first-floor medication cart on 10/24/23 at various times between 9:00am-10:35am revealed: -The medication cart was sitting in the hallway outside a resident's room. -The medication aide (MA) was administering medications to residents standing at the cart. -At 9:17am, the MA was not at the cart and the cart was unlocked. -At 9:41am, the MA was not at the cart and the cart was unlocked. -At 10:35am, the MA was not at the cart and the cart was unlocked. -There were residents in and out of their rooms in the hallway where the medication cart was located. Observation of the second-floor medication cart on 10/24/23 at 10:23am revealed the MA was not at the cart and she was not visible in the hallway. Interview with the MA on 10/14/23 at 10:38am revealed: -She locked the medication cart when she was not near the medication cart. -The last thing she did before leaving the medication cart was make sure it was locked. -She knew she had left the medication cart unlocked when she was on the first floor because she was in and out of residents' rooms and was close by.	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032133	A. BUILDING: _____ B. WING _____	R 10/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 378	Continued From page 24 -She was told as long as the narcotics were locked, she did not have to lock the medication cart. -If she was going to be in a resident's room for long, she would make sure she locked the medication cart. -She did not know the medication cart on the first floor was unlocked when she was on the second floor. Interview with the Resident Care Coordinator (RCC) on 10/24/23 at 10:53am revealed: -The medication carts should be locked when the MA was not at the medication cart. -Anything could happen if the medication cart was left unlocked and unattended; anyone could take medications. Interview with the facility's Registered Nurse (RN) on 10/25/23 at 3:23pm revealed: -The medication carts should be closed and locked when the MA was not in site of the medication cart. -She was concerned the medication cart was unlocked because anyone could go into the cart and do anything. Interview with the Administrator on 10/24/23 at 10:56am revealed: -Before the MA walked away from the medication cart, she should make sure the cart was locked and everything was secured. -She was concerned the medication cart had been left unlocked because someone could take medication from the cart.	D 378		