| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL032157 | A. BUILDING: _____ B. WING _____ | 08/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TOWER OF BLESSING A REFUGE TO SEEK # 3 | 407 NORTH HYDE PARK AVENUE DURHAM, NC 27703 |

| (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 |
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| C 000 | Initial Comments<br><br>The Adult Care Licensure Section completed an annual survey on August 14, 2025. | C 000 | | |
| C 330 | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents including a hormonal supplement (#3).<br><br>The findings are:<br><br>Review of Resident #3's current FL2 dated 12/12/24 revealed:<br>-Diagnoses included low testosterone.<br>-There was an order for testosterone 50mg/5Gm 1% gel apply daily.<br><br>Review of Resident # 's June 2025, July 2025, and August 2025 from 08/01/25 to 08/14/25 revealed<br>-There was an entry for testosterone 50mg/5Gm 1% gel apply daily with a scheduled administration time of 8:00am.<br>-Testosterone 1% gel was documented as administered daily from 06/01/25 to 06/30/25, | C 330 | | |

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| C 330 | Continued From page 1<br>from 07/01/25 to 07/31/25, and 08/01/25 to 08/14/25.<br><br>Observation of Resident # 's medications on hand on 08/05/25 at 10:37am revealed:<br>-There was one box of 30 packets of testosterone 50mg/5Gm 1% gel with a dispensed date of 03/25/25.<br>-There were 9 packets of testosterone 50mg/5Gm 1% gel in the box.<br>-There was no other testosterone 50mg/5Gm 1% gel available for administration for Resident #3.<br><br>Interview with Resident #3 on 08/05/25 at 1:49pm revealed:<br>-He took the medication the staff gave him.<br>-He thought he used the testosterone gel every day.<br>-He felt good; his mood was pleasant; he had no problems with increased fatigue or low energy.<br><br>Interview with a representative with the facility's contracted pharmacy on 08/14/25 at 11:48am revealed:<br>-Resident #3 was on testosterone because he had testicular hypofunction.<br>-There was not a discontinue order for the testosterone 1% for Resident #3.<br>-Thirty packets of testosterone 50mg/5Gm were sent to the facility on 03/25/25.<br>-There were no dispensed dates after March 2025 for the testosterone.<br>-One box of 30 packets of testosterone 1% gel would last a month.<br>-If the testosterone 1% gel was not administered as ordered, Resident #3 could experience low levels of testosterone and increased fatigue.<br>-Testosterone 1% gel was not part of the facility's cycle fill system for medications; someone from the facility would have to call and reorder the | C 330 | | |

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| C 330 | Continued From page 2<br>medications.<br><br>Interview with the medication aide (MA) on 08/14/25 at 12:30pm revealed:<br>-Resident #3 did not refuse his medications.<br>-Resident #3 was able to apply the testosterone 1% gel to his arm or abdomen himself.<br>-She could not explain why there was still packets left of the testosterone 1% gel from March 2025.<br><br>Telephone interview with Resident #3's primary care provider (PCP) on 08/14/25 at 12:49pm revealed:<br>-Resident #3 was prescribed testosterone 1% gel due to testicular hypofunction.<br>-The testosterone 1% gel was used as a supplement to maintain function.<br>-She could not locate a testosterone level in Resident #3's record.<br>-Resident #3 could experience low energy and increased fatigue if he was not taking the medication as ordered.<br><br>Interview with the Administrator on 08/14/25 at 2:43pm revealed:<br>-She had another staff member check the medication cart once or twice a month.<br>-One box of testosterone for Resident #3 was sent back to the pharmacy because it was expired.<br>-She thought another box must have been sent back as well and that was why they had an old box.<br>-Resident #3's testosterone order was not discontinued.<br>-She expected the MAs to administer the medications as ordered. | C 330 | | |

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| C 353 | Continued From page 3 | C 353 | | |
| C 353 | 10A NCAC 13G .1006 (b) Medication Storage<br><br>10A NCAC 13G .1006 Medication Storage<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure the medication cart, which was in the dining area, was locked when not under the direct supervision of a medication aide.<br><br>The findings are:<br><br>Observation of the facility on 08/14/25 from 8:10am to 8:23am revealed:<br>-The medication cart was in the dining room where the residents ate their meals.<br>-The medication cart was unlocked.<br>-One resident was cleaning in the kitchen, which was located next to the dining area.<br>-There was no medication aide (MA) in view of the medication cart.<br><br>Observation of the facility on 08/14/25 at 10:23am revealed the medication cart remained unlocked with no MA in view.<br><br>Interview with the MA on 08/14/25 at 12:30pm revealed she should keep the medication cart locked when she walked away from it.<br><br>Interview with the Administrator on 08/14/25 at 2:43pm revealed she expected the medication cart to be locked at all times when there was not a MA present. | C 353 | | |

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