

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

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

F84W11

If continuation sheet 1 of 5

Reviewed and acknowledged 09.15.25

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL032157	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER TOWER OF BLESSING A REFUGE TO SEEK # 3			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
C 330	Continued From page 1 from 07/01/25 to 07/31/25, and 08/01/25 to 08/14/25. Observation of Resident # 's medications on hand on 08/05/25 at 10:37am revealed: -There was one box of 30 packets of testosterone 50mg/5Gm 1% gel with a dispensed date of 03/25/25. -There were 9 packets of testosterone 50mg/5Gm 1% gel in the box. -There was no other testosterone 50mg/5Gm 1% gel available for administration for Resident #3. Interview with Resident #3 on 08/05/25 at 1:49pm revealed: -He took the medication the staff gave him. -He thought he used the testosterone gel every day. -He felt good; his mood was pleasant; he had no problems with increased fatigue or low energy. Interview with a representative with the facility's contracted pharmacy on 08/14/25 at 11:48am revealed: -Resident #3 was on testosterone because he had testicular hypofunction. -There was not a discontinue order for the testosterone 1% for Resident #3. -Thirty packets of testosterone 50mg/5Gm were sent to the facility on 03/25/25. -There were no dispensed dates after March 2025 for the testosterone. -One box of 30 packets of testosterone 1% gel would last a month. -If the testosterone 1% gel was not administered as ordered, Resident #3 could experience low levels of testosterone and increased fatigue. -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	THE DOCTOR WAS CALLED AND SHE HAS PLACED AN ORDER TO GET BLOOD WORK TO CHECK ON TESTOSTERONE LEVELS. ADMIN. WILL FOLLOW UP IF AND WHEN THE LABCORP WILL COME OUT, THE ADMIN & THE DOC WILL MONITOR APPLICATION & RESULTS.	8/15/25	

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C 330	Continued From page 2 medications. Interview with the medication aide (MA) on 08/14/25 at 12:30pm revealed: -Resident #3 did not refuse his medications. -Resident #3 was able to apply the testosterone 1% gel to his arm or abdomen himself. -She could not explain why there was still packets left of the testosterone 1% gel from March 2025. Telephone interview with Resident #3's primary care provider (PCP) on 08/14/25 at 12:49pm revealed: -Resident #3 was prescribed testosterone 1% gel due to testicular hypofunction. -The testosterone 1% gel was used as a supplement to maintain function. -She could not locate a testosterone level in Resident #3's record. -Resident #3 could experience low energy and increased fatigue if he was not taking the medication as ordered. Interview with the Administrator on 08/14/25 at 2:43pm revealed: -She had another staff member check the medication cart once or twice a month. -One box of testosterone for Resident #3 was sent back to the pharmacy because it was expired. -She thought another box must have been sent back as well and that was why they had an old box. -Resident #3's testosterone order was not discontinued. -She expected the MAs to administer the medications as ordered.	C 330	THE PHARMACY WAS CALLED TO SET UP A MEDICATION TRAINING FOR STAFF. ADMIN IS WAITING ON THE DATE FOR TRAINING.	8/17/25	

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C 353 C 353	Continued From page 3 10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .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. This Rule is not met as evidenced by: 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. The findings are: Observation of the facility on 08/14/25 from 8:10am to 8:23am revealed: -The medication cart was in the dining room where the residents ate their meals. -The medication cart was unlocked. -One resident was cleaning in the kitchen, which was located next to the dining area. -There was no medication aide (MA) in view of the medication cart. Observation of the facility on 08/14/25 at 10:23am revealed the medication cart remained unlocked with no MA in view. 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. 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 C 353	THE STAFF WAS GIVEN THE KEY FOR THE MEDICATION CART AND WAS TOLD THAT THE MEDICATION CART SHOULD BE LOCKED AT ALL TIMES. ADMIN GAVE HER A COPY OF THE KEYS.	8/14/25	

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