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	HAL032134	A. BUILDING: _____ B. WING _____	07/24/2025

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CALYX LIVING OF DURHAM	4214 GUESS ROAD DURHAM, NC 27712

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up and annual survey on 07/22/25-07/24/25 with an exit conference via telephone on 07/24//25.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 5 of 5 exit doors that were accessible to a resident who had a diagnosis of dementia and presented as having short-term memory impairment (#2) had a sounding device that was responded to by staff for the safety of the residents.	D 067		

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The findings are:

Review of the facility's current license, effective 01/01/25 revealed the facility was licensed for 36 assisted living beds.

Review of the facility's census on 07/22/25 revealed there were 33 residents residing in the assisted living facility.

Review of the facility's floor plan map displayed in the hallway revealed 5 exit doors in the assisted living section.

Review of Resident #2's current FL2 dated 04/03/25 revealed:
-Diagnoses included dementia, hypertension, chronic kidney disease, and arthritis.
-There was no information on orientation status.

Review of Resident #2's previous FL2 dated 01/09/23 revealed:
-Diagnoses included dementia, hypertension, kidney disease, and arthritis.
-He was intermittently disoriented.

Review of Resident #2's previous FL2 dated 02/06/24 revealed:
-Diagnoses included dementia, hypertension, kidney disease, and arthritis.
-He was intermittently disoriented.

Review of Resident #2's Resident Register revealed:
-There was no admission date documented.
-The form was signed by the resident's family member on 01/03/23.

Review of Resident #2's current care plan dated 04/01/25 revealed:

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-The nurse completed the care plan on 02/04/25.
-The primary care provider (PCP) signed the care plan on 04/01/25.
-The resident was documented as alert and oriented.
-He was independent with eating; remind as needed for meals.
-He was ambulatory with a walker; remind as needed.

Review of Resident #2's previous care plan dated 02/27/23 revealed:
-Resident #2 was oriented.
-Resident #2 was forgetful and needed reminders.
-There was a handwritten note that Resident #2 was alert and oriented with intermittent confusion, he was forgetful and needed reminding and supervising.

Review of Resident #2's Licensed Health Professional Services (LHPS) assessment dated 02/28/25 revealed he used a rollator walker and/or cane for ambulation with reminders.

Review of Resident #2's LHPS assessment dated 05/30/25 revealed he used a rollator walker and/or cane for ambulation with reminders.

Observation of the facility's exit doors on 07/22/25 and 07/23/25 at various times between 8:15am and 5:00pm revealed that no audible sounding device was heard when the doors were opened.

Observation of an exit door on the D-hall on 07/22/25 at 8:29am revealed:
-No audible alarm was activated when the surveyor exited the facility through an exit door at the end of the D-hall.
-The exit door went out to a sidewalk at the end

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of the parking lot.
-No staff members came to the exit door at the end of the D-hall.

Observation of an exit door on the A-hall on 07/22/25 at 8:48am revealed:
-No audible alarm was activated when the surveyor exited the facility through an exit door at the end of the A-hall.
-The exit door went out to a sidewalk at the entrance of the parking lot.
-No staff members came to the exit door at the end of the A-hall.
-Resident #2's room was beside the exit door.

Observation of an exit door off the dining room on 07/22/25 at 9:03am revealed:
-No audible alarm was activated when the surveyor exited the facility through an exit door off the dining room.
-The area was open to go out to either end of the grounds to the parking lot.
-No staff members came to the exit door in the dining room.

Interview with Resident #2 on 07/22/25 at 3:56pm revealed:
-Upon entering the room, the surveyor introduced herself, and he responded that he had a family member with the same name.
-He used voltaren cream (a nonsteroidal anti-inflammatory gel used for arthritis pain) every day on his knees after he took a shower.
-He showed the surveyor the tube of voltaren and returned the tube to his bathroom.
-When he sat back down, the surveyor asked him if he used the voltaren on any other body parts, and he responded that he had a salve he used on his knees.
-He returned from his bathroom with the same

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tube of voltaren and told the surveyor the same scenario of when and where he used the voltaren.
-He stated the current year was 2023.
-He stated he had been a resident at the facility for one month.
-He said he did not go outside often.
-While exiting his room, he asked the surveyor her name, and when he was told the name of the surveyor, he responded that he had a family member with the same name.

Interview with a personal care aide (PCA) on 07/23/25 at 11:44am and 3:26pm revealed:
-When the door alarm went off, an alert was received on their telephone to show which door was opened.
-The staff members were responsible for going to the door to see why the door alarm was activated.
-The exit doors were alarmed from 7:00pm-7:00am.
-She did not work with Resident #2 very much because he only came out of his room for lunch during her shift.
-Resident #2 kept his door locked, and during her rounds, he was usually asleep.
-Resident #2 was "pretty independent".

Interview with a medication aide (MA) on 07/23/25 at 2:14pm revealed:
-Resident #2 remembered to get up and get dressed without any prompting.
-All of the exit doors in the assisted living were alarmed from 7:00pm-7:00am.
-During the daytime business hours, the exit doors were not alarmed.

Interview with the Resident Care Director on 07/23/25 at 2:31pm and 3:43pm revealed:
-The door alarm system was attached to the call

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bell system.
-If an alarm went off, the staff would be alerted on their telephones.
-Resident #2 was very alert and oriented.
-Resident #2 recently had a severe ear infection and was having difficulty hearing.
-She had never asked Resident #2 questions multiple times, so she would not know if he repeated himself or not.
-The PCAs and MAs were responsible for checking the door and making sure all residents were accounted for.
-Resident #2 had never attempted to elope.
-If Resident #2 presented with any signs of elopement, she would check to ensure he did not have a urinary tract infection or anything else going on.

Interview with the Director of Maintenance on 07/23/25 at 4:01pm revealed:
-There were 5 exit doors in the assisted living area.
-When a door alarm was activated, it alerted all managers, PCAs, and MAs on their telephones.
-The PCAs and MAs were responsible for responding to the alert.
-Doors were alarmed at 7:00pm.

Interview with the Administrator on 07/23/25 at 4:32pm revealed:
-The door alarms were not on during the day, but were turned on from 7:00pm-7:00am.
-Resident #2 would repeat himself if he did not hear what the person was saying.
-Resident #2 recently had an ear infection.
-Resident #2 had a routine he adhered to.
-He would go to the front entrance and read the newspaper.
-He walked in the hallway and went into the activities room.

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D 067	Continued From page 6 -Resident #2 never went outside. -Resident #2 was not exit-seeking. -Resident #2 did the same routine every day. Attempted telephone interview with Resident #2's PCP on 07/23/25 at 8:16am was unsuccessful. Attempted telephone interview with Resident #2's family member on 07/23/25 at 1:18pm was unsuccessful.	D 067		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food stored was protected from contamination related to foods stored in the	D 283		

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walk-in cooler that were not labeled or dated and food and beverages that were not covered.

The findings are:

Observation of the lunch meal service 07/22/25 at 12:00pm revealed:
-The residents were served pasta salad.
-The residents were served a choice of apple or peach pie with a cream topping.

Observations of the walk-in cooler on 07/23/25 at 10:33am revealed:
-There was a pack of deli meat that was opened; it was not labeled or resealed.
-There was a container of cooked meat; it was not labeled as to the contents or dated.
-There was a large container of pasta; it was not dated.
-There was an individual container of pasta; it was not dated.
-There were 8 slices of pies with a cream topping; they were not completely covered or dated.

Observations of the walk-in freezer on 07/23/25 at 10:36am revealed:
-There were 16 cups of ice cream sitting on a tray; the ice cream was not covered nor dated.
-There was a bag of individual frozen pieces of chicken inside a cardboard box.
-The bag was open; a piece of chicken was lying in the box.

Observation of a refrigerator in the kitchenette on 07/23/25 at 10:38am revealed a pitcher of tea that was not covered.

Interview with the Dietary Manager (DM) on 07/23/25 at 3:16pm revealed:
-He was working on cleaning out the walk-in

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D 283	Continued From page 8 cooler today, 07/23/25. -A new employee had forgotten to label the items placed in the refrigerator. -The deli-meat was opened today, 07/23/25. -The pie slices were cut today, 07/23/25. -The container of cooked meat was chicken that was cooked today, 07/23/25. -The cupped ice cream was put into cups today, 07/23/25. -He had not seen the frozen chicken in the freezer. -The chicken should have been resealed. -All food should be labeled and dated. Interview with the Administrator on 07/23/25 at 4:32pm revealed: -The DM was responsible for ensuring food was covered and labeled. -She expected the DM to look at the walk-in cooler and freezer daily, upon arrival, to ensure all foods are labeled and dated. -The tea and ice cream should be covered. -The chicken in the freezer should have been resealed. -She typically went into the kitchen to do an inspection daily but had not been in the kitchen today 07/23/25 or yesterday, 07/22/25.	D 283		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by:	D 310		

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Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 5 sampled residents (#4) including a resident that was ordered a regular, bite size meats with gravy diet.

The findings are:

Review of Resident #4's current FL2 dated 05/07/25 revealed diagnoses included hemiplegia and hemiparesis following a stroke.

Review of Resident #4's signed physician's orders dated 06/05/25 revealed an order for a regular texture, bite size meats with gravy diet.

Observation of the lunch meal service on 07/23/25 from 12:15pm-12:51pm revealed:
-Resident #4 was served a salad and a bowl of soup; he ate without any problems observed.
-At 12:37pm, Resident #4 was served two chicken legs.
-At 12:51pm, Resident #4 was coughing.
-At 12:56pm, Resident #4 was still intermittently coughing, and a PCA asked him if he was okay.
-Resident #4 ate 100% of the chicken from the bone by holding the chicken legs and biting off the meat.

Interview with Resident #4 on 07/23/25 at 2:16pm revealed:
-He had a stroke a few years ago and had difficulty swallowing.
-His meat was supposed to be cut up.
-At lunch today, he wanted to eat chicken drumsticks off the bone.
-He did not want his wife to cut up his food during lunch today.
-He was scheduled to have a swallow study done in the next month.

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D 310	Continued From page 10 Interview with a personal care aide (PCA) on 07/23/25 at 11:44am revealed Resident #4's meats were supposed to be cut up into bite-sized pieces. Second interview with the PCA on 07/23/25 revealed: -Resident #4 was on a cut up meats diet. -The kitchen was supposed to cut up the meat before it got served to the resident. -At lunch today, she was prepared to take Resident #4 a plate with cut up chicken, but he already had a plate of chicken legs that were not cut -Resident #4 sometimes refused to have the meat cut up. Interview with a medication aide (MA) on 07/23/25 at 2:44pm revealed: -Resident #4 had to have his meat cut up. -The kitchen cut up the meat for Resident #4. -The Dietary Manager (DM) said it was okay for Resident #4 to have the chicken legs that were served at lunch on 07/23/25. -She thought Resident #4 needed his meat cut up because he had trouble chewing and had choking episodes. -She had not witnessed Resident #4 choke during meals. -Resident #4 did cough sometimes during his meals. -If the kitchen did not send Resident #4's food out already cut up, she would cut it up for him. -He did not refuse to have his food cut up. Interview with the DM on 07/23/25 at 2:55pm revealed: -Resident #4 was on a regular, bite size meat with gravy diet.	D 310		

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-The cook was responsible for cutting up Resident #4's meat.
-He was the cook today during the lunch meal service.
-He did cut up Resident #4's meat today and used gravy.
-Resident #4 refused the cut up meat plate today.
-Resident #4 wanted to eat the chicken legs off the bone.
-He felt like he had to respect the residents wishes.
-He had not heard Resident #4 cough or choke during a meal.
-He did not know what Resident #4 was on a regular, bite size meat diet.

Interview with a Speech Therapist (ST) on 07/23/25 at 4:25pm revealed:
-Resident #4 had difficulty swallowing and communicating.
-The main reason a speech therapy was initiated for Resident #4 was due to his voice; he was very soft spoken, and staff had difficulty understanding him.
-She saw him 3 times and they worked on small bites and small sips.
-Resident #4 was on a bite size meat diet.
-She did observe Resident #4 cough during meals, but it was more after liquids than solid food.
-Resident #4 was due to have a swallow study to better determine the appropriate diet.

Interview with the Resident Care Director (RCD) on 07/23/25 at 2:31pm revealed:
-Resident #4 had to have his meat cut up secondary to recommendations by the ST.
-The cook was responsible for serving the diet as ordered.
-All staff were responsible for knowing what diet

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residents were on.
-If the diet was not served as ordered from the kitchen, the PCA or MA should send it back to the kitchen.
-She heard Resident #4 cough once, but it was not reported to her that he had choking episodes.

Interview with the Administrator on 07/23/25 at 4:22pm revealed:
-There was a list in the kitchen that had resident diets.
-The cook was responsible for preparing resident diets as ordered.
-Resident #4's meat was to be cut up so he could not eat a chicken leg.
-The PCA or MA that served the food should have sent it back to the kitchen to have the meat cut up.
-She was concerned Resident #4 would bite off too much if he ate the chicken off the bone.
-No one had reported to her that Resident #4 had trouble with coughing or choking.
-She expected diets to be served as ordered.

Telephone interview with Resident #4's primary care provider (PCP) on 07/23/25 at 3:21pm revealed:
-Resident #4 had a history of dysphagia and was at risk for aspiration.
-She had not observed Resident #4 eat and had not been made aware of any choking episodes.
-It was critical to adhere to the diet ordered secondary to the dysphagia.
-Once Resident #4 had a swallow study completed, the appropriate diet could be better determined, but until it was complete, the bite sized meat with gravy diet should be followed.

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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 related to medications for depression (#3), and high blood pressure and anxiety (#5). The findings are: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents related to medications for depression (#3), and high blood pressure and anxiety (#5). The findings are: 1. Review of Resident #5's current FL2 dated 06/30/25 revealed diagnoses included hypertension and depression. a. Review of Resident #5's current FL2 dated 06/30/25 revealed an order for amlodipine (used to treat high blood pressure (BP)) 5mg once daily. Review of Resident #5's July 2025 electronic medication administration record (eMAR) from	D 358		

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0701/25-07/23/25 revealed:
-There was an entry for amlodipine 5mg scheduled for 9:00am.
-There was documentation that amlodipine was administered at 9:00am from 07/01/25-07/23/25.
-There were no exceptions documented.

Observation of Resident #5's medications on hand on 07/23/25 at 10:44am revealed:
-There was a punch card for amlodipine 5mg labeled with a start date of 07/18/25.
-There were 27 of 28 tablets remaining on the punch card.

Telephone interview with a pharmacy assistant on 07/23/25 at 2:07pm revealed:
-A punch card for amlodipine 5mg was dispensed on 07//01/25; 17 tablets were dispensed to get the resident in line with the facility's cycle-filled medication.
-On 07/13/25, 28 tablets of amlodipine were dispensed, which was in line with the facility's cycle filled medication.

Telephone interview with a pharmacist on 07/23/25 at 2:53pm revealed amlodipine was for high blood pressure.

Based on observations, interviews, and record reviews, from 07/17/25 to 07/23/25 that there should have been 7 tablets of amlodipine 5mg administered; however, only 1 amlodipine tablet had been administered from the punch card.

Interview with a medication aide (MA) on 07/23/25 at 2:14pm revealed:
-She administered Resident #5's amlodipine today, 07/23/25.
-She did not know why there was only one tablet missing from Resident #5's amlodipine punch

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D 358	Continued From page 15 card dated to start on 07/18/25. Telephone interview with Resident #5's primary care provider (PCP) on 07/24/25 at 3:15pm revealed: -Amlodipine was an antihypertensive medication used to lower blood pressure. -If Resident #5's amlodipine was not administered as ordered, the resident could experience high blood pressure and headaches. Observation of Resident #5's BP on 07/23/25 at 4:00pm was 124/68. b. Review of Resident #5's current FL2 dated 06/30/25 revealed an order for citalopram (used to treat depression) 10mg once daily. Review of Resident #5's July 2025 electronic medication administration record (eMAR) from 0701/25-07/23/25 revealed: -There was an entry for citalopram 10mg scheduled for 9:00am. -There was documentation that amlodipine was administered at 9:00am from 07/01/25-07/23/25. -There were no exceptions documented. Observation of Resident #5's medications on hand on 07/23/25 at 10:44am revealed: -There was a punch card for citalopram 10mg labeled with a start date of 07/18/25. -There were 27 of 28 tablets remaining on the punch card. Telephone interview with a pharmacy assistant on 07/23/25 at 2:07pm revealed: -A punch card for citalopram 10mg was dispensed on 07//01/25; 17 tablets were dispensed. -On 07/13/25, 28 tablets of citalopram were	D 358		

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dispensed, which was in line with the facility's cycle filled medication.

Telephone interview with a pharmacist on 07/23/25 at 2:53pm revealed citalopram was for anxiety, so the resident could experience an increase in her anxiety if the medication was not administered as ordered.

Based on observations, interviews, and record reviews, from 07/17/25 to 07/23/25 that there should have been 7 tablets of citalopram 10mg administered; however, only 1 citalopram tablet had been administered from the punch card.

Telephone interview with Resident #5's PCP on 07/24/25 at 3:15pm revealed:
-Citalopram was an antidepressant used to improve mood.
-She preferred to titrate antidepressants, even if just for a couple of days.
-Her primary concern would be if Resident #5's mood had changed.

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Observation of Resident #5 on 07/23/25 from 12:10PM-12:39pm revealed Resident #5 was very lethargic during the lunch meal; staff woke her up several times.

Interview with Resident #5 on 07/23/25 at 12:39pm and 3:49pm revealed:
-She did not feel well today, 07/23/25.
-She did not know what medications she took or if she had missed taking any.
-She had a headache now (07/23/25), and she thought it was "just a residual headache".

Interview with a MA on 07/23/25 at 10:46am and 3:04pm revealed:
-All cycle-filled medication was started on the

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same day.
-Even if the current punch card of medication had remaining tablets, the new cycle filled punch cards would be started, and the remaining medication would be returned to the pharmacy.
-The RCD changed out the cycle-filled punch cards on the medication cart every month.
-She tried to use the scanner every time she administered medications, but sometimes the barcode did not work, and she had to enter the medication manually.

Interview with the RCD on 07/23/25 at 11:28am and 2:31pm revealed:
-She and another staff member transitioned out the "old batch" of cycle-filled medication and started the new batch of cycle-filled medication.
-The punch cards were returned to the pharmacy even if medications remained on the card, unless a punch card was not delivered for an active medication.
-She would keep that punch card until the new card was delivered.
-This month's cycle-filled medication started earlier than the cards were labeled; the batch was started in the afternoon on 07/16/25.
-Resident #5's medications were administered from the punch cards from the facility's contracted pharmacy upon admission.
-She had medications that Resident #5's family provided, but the staff had not used the medications.
-Anytime a resident did not get their medication, she was concerned because the resident needed the medication for whatever reason the PCP ordered it for.

Interview with the Administrator on 07/23/25 at 4:32pm revealed:
-She expected all medications to be administered

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as ordered.
-The MA should pull the medication from the medication cart.
-The MA could scan the medication packet or enter it manually.
-She preferred the MA to scan the packet of information.
-If a medication was missed, the medication would be "red" to indicate it had been missed.
-Her concern would be if the resident had any health issues resulting from the missed medication.

2. Review of Resident #3's current FL2 dated 05/12/25 revealed:
-Diagnoses included vascular dementia, diabetes mellitus type 2, sleep apnea, hyperlipidemia, hypertension, osteoarthritis, and dysphagia.
-There was an order for Lexapro (an antidepressant) 10mg daily.

Review of Resident #3's Resident Register revealed an admission date of 05/15/25.

Review of Resident #3's record revealed there was no discontinue order on file for the Lexapro 10mg daily.

Review of Resident #3's May 2025 from 05/15/25 to 05/31/25, June 2025, and July 2025 from 07/01/25 to 07/03/25 electronic medication administration record (eMAR) revealed:
-There was no entry for Lexapro 10mg daily.
-Lexapro 5mg daily was started on 07/03/25.

Telephone interview with a representative from the facility's contracted pharmacy on 07/23/25 at 8:19am revealed:
-The facility faxed new admission FL2's to the pharmacy and the pharmacy technician entered

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the orders into the system.
-The Lexapro 10mg daily for Resident #3 got missed during the order entry process and did not get added to the eMAR.
-Lexapro 10mg was not dispensed from the pharmacy when Resident #3 was admitted.
-The error was caught when the pharmacy consultant did a review on 07/02/25.
-The pharmacy received a new order from the facility for Lexapro 5 mg daily on 07/03/25 that was added to the eMAR.
-Lexapro 5mg was dispensed on 07/03/25.
-Resident #3 could have experienced changes in mood, increased sleepiness, and appetite changes because of the medication being missed.

Telephone interview with the pharmacy consultant on 07/23/25 at 11:05am revealed:
-When she completed the medication review on 07/02/25 she noticed the Lexapro 10mg daily was not on Resident #3's eMAR.
-She could not find an order that the Lexapro 10mg daily was discontinued.
-She sent a message to the pharmacy so they could enter Lexapro 10mg daily onto the eMAR and informed the facility's Administrator.

Observation of Resident #3 on 07/22/25 at 12:10pm revealed:
-She ate 100% of her lunch meal.
-She smiled when the surveyor approached and nodded her head that the food was good.

Interview with a medication aide (MA) on 07/23/25 at 2:20pm revealed:
-Resident #3 did not have an order for Lexapro 10mg daily.
-Resident #3 started Lexapro 5mg daily on 07/03/25.

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-She did not notice any signs or symptoms of increased depression in Resident #3.
-Resident #3 had a good appetite.

Telephone interview with a registered nurse (RN) from Resident #3's primary care providers (PCP) office on 07/23/25 at 11:50am revealed:
-The PCP was made aware Resident #3 was not administered Lexapro 10mg from his admission date to 07/03/25.
-It was possible to have some side effects if Lexapro was stopped abruptly such as dizziness, headache, and irritability.
-Most of the time, side effects are quite mild and do not pose a serious safety risk.
-The PCP had not been made aware that Resident #3 had any symptoms of increased depression or side effects from the abrupt discontinuation of the Lexapro.

Interview with the Resident Care Director (RCD) on 07/23/25 at 9:45am revealed:
-The clinical team was responsible for faxing new admission FL2s to the pharmacy.
-The pharmacy entered the orders from the FL2.
-Once the pharmacy entered the orders, the clinical team was responsible for making sure all the orders entered matched the FL2.
-When the medications arrived from the pharmacy, the clinical team was responsible for making sure all the medications arrived that were ordered on the FL2.
-She did not know how the Lexapro 10mg daily for Resident #3 got missed.

Interview with the Administrator on 07/23/25 at 4:22pm revealed:
-She was made aware Resident #3 was not administered Lexapro 10mg daily as ordered when the pharmacy consultant informed her after

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D 358	Continued From page 21 she completed her review. -She was not made aware Resident #3 had any symptoms of increased depression or any other side effects. -She expected the RCD to check the FL2s against the eMAR and the medications that arrive from the pharmacy to ensure all medications have arrived and have been entered in the eMAR. Based on observations, record review, and staff interviews, Resident #3 was not interviewable.	D 358		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 1 of 5 sampled residents (#2) had a physician's order to self-administer a non-steroidal anti-inflammatory cream.	D 375		

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D 375	Continued From page 22 The findings are: Review of the facility's resident self-administration policy and procedure dated April 2024 revealed: -The Resident Care Director (RCD) or designee would assess the resident's mental and physical capacity to self-administer medications. -If the resident was deemed competent by the RCD or designee, an order must be obtained from the physician stating the resident may self-administer medications. -If the resident was to keep the medications in their room, the order must also state, ok to keep medications at the bedside. -Additional compliance with this process would be assessed in the License Health Professional Services (LHPS) assessment tool. -The quarterly tool must include verification that the resident had the appropriate medications on hand and continued to demonstrate compliant knowledge of the medication regimen. -If issues were identified, the RCD or designee would obtain an order to discontinue self-administration. -When residents self-administer medications, the medication was to be written on the resident's medication administration record (MAR), and the word self-administer would be written on the MAR. Review of Resident #2's current FL2 dated 04/03/25 revealed: -Diagnoses included dementia, hypertension, chronic kidney disease, and arthritis. -There was an order for diclofenac gel 1% apply 2 grams to affected areas four times daily as needed. Do not exceed 32 grams in overall joints in 24 hours. Review of Resident #2's LHPS assessment form	D 375		

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dated 05/30/25 revealed there was no information that Resident #2 self-administered his medications.

Review of Resident #2's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for diclofenac gel 1% apply 2 grams to affected areas four times daily as needed. Do not exceed 32 grams in overall joints in 24 hours.
-There was no documentation that the diclofenac gel was used from 05/01/25-05/31/25.

Review of Resident #2's June 2025 eMAR revealed:
-There was an entry for diclofenac gel 1% apply 2 grams to affected areas four times daily as needed. Do not exceed 32 grams in overall joints in 24 hours.
-There was no documentation that the diclofenac gel was used from 06/01/25-06/30/25.

Review of Resident #2's July 2025 eMAR from 07/01/25-07/23/25 revealed:
-There was an entry for diclofenac gel 1% apply 2 grams to affected areas four times daily as needed. Do not exceed 32 grams in overall joints in 24 hours.
-There was no documentation that the diclofenac gel was used from 07/01/25-07/23/25.

Observation of Resident #2's medications on hand on 07/23/25 at 4:01pm revealed that a tube of diclofenac gel 1% was available to be administered; there was no label from the pharmacy.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/23/25 at

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4:10pm revealed:
-Resident #2 had a current order for diclofenac gel 1% that was profiled on 04/03/25; not filled.
-Resident #2's diclofenac gel was filled on 07/02/24.
-Diclofenac gel was used topically as an anti-inflammatory cream.
-She did not see any orders for Resident #2 to self-administer the diclofenac gel.
-If Resident #2 had an order to self-administer the diclofenac gel, it was entered on the eMAR as may be kept beside.
-If Resident #2 exceeded the recommended daily amount of diclofenac gel, the resident could experience thinning of his blood.

Interview with Resident #2 on 07/22/25 at 3:56pm revealed:
-He used diclofenac gel cream every day on his knees after he took a shower.
-He kept the cream in his bathroom.

Observation of Resident #2's bathroom on 07/23/25 at 11:58am revealed a tube of diclofenac gel cream on the top of a cabinet beside the toilet.

Interview with a personal care aide (PCA) on 07/23/25 at 11:44am revealed:
-Resident #2 kept his door locked, and during her rounds, he was usually asleep.
-Resident #2 was "pretty independent".
-She had never seen diclofenac gel cream in Resident #2's room.
-She had not looked in Resident #2's bathroom; she usually just grabbed his trash.

Interview with a medication aide (MA) on 07/23/25 at 2:14pm revealed:
-Resident #2 had an order for diclofenac gel to be

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applied by the MAs.
-She had applied Resident #2's diclofenac gel before.
-She did not know Resident #2 had a tube of diclofenac gel in his room.
-She thought one of the other MAs may have left the diclofenac gel in Resident #2's room by accident.

Interview with the facility's LHPS nurse on 07/23/25 at 2:24pm revealed:
-If a resident wanted to self-administer their medication, an order had to be obtained from the primary care provider (PCP), and then she would assess the resident.
-There were no residents in AL who had an order to self-administer their medication.
-Resident #2 would have to have an order to apply the diclofenac gel himself.

Interview with the Resident Care Director on 07/23/25 at 2:31pm revealed:
-The PCP would have to order Resident #2's diclofenac gel to be self-medicated; she did not know if there was an order or not.
-The LHPS nurse would also have to assess Resident #2.
-She would want to make sure the medication was being applied correctly.

Interview with the Administrator on 07/23/25 at 4:32pm revealed:
-If a resident wanted to self-administer medication, the LHPS nurse would do a cognitive assessment.
-She was not aware Resident #2 had a tube of diclofenac gel in his room and was applying it himself.
-Resident #2 should not have the diclofenac gel in his room without an order.

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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 375	Continued From page 26 Attempted telephone interview with Resident #2's PCP on 07/23/25 at 8:16am was unsuccessful. Attempted telephone interview with Resident #2's family member on 07/23/25 at 1:18pm was unsuccessful.	D 375		