PRINTED: 08/27/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
345070		B. WING	B. WING		C 07/31/2024		
NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER				41	REET ADDRESS, CITY, STATE, ZIP CODE 1 S LASALLE STREET URHAM, NC 27705	,	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
F 755 SS=D	on 7/30/24 through 7/ The following intake v NC00219561. 1 of the resulted in deficiency	e 3 complaint allegations cedures/Pharmacist/Records	F	755			8/16/24
	drugs and biologicals them under an agree §483.70(g). The facil personnel to administ	ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed					
	pharmaceutical service that assure the accur- dispensing, and admi	es. A facility must provide ces (including procedures ate acquiring, receiving, nistering of all drugs and ne needs of each resident.					
	- ' '	onsultation. The facility n the services of a licensed					
	§483.45(b)(1) Provide aspects of the provisi the facility.	es consultation on all on of pharmacy services in					
		shes a system of records of n of all controlled drugs in able an accurate					
	§483.45(b)(3) Determ	nines that drug records are in					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E		TITLE		(X6) DATE

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

(X6) DATE

08/16/2024 **Electronically Signed**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070			` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING			C 07/31/2024		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	0 1/202 1
DUBLIAM	NUIDOINO O DELIADU IT	ATION CENTED		4	11 S LASALLE STREET		
DURHAM	NURSING & REHABILIT	ATION CENTER		D	OURHAM, NC 27705		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI) TAG	X 	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 755	Continued From page		F7	755			
		count of all controlled drugs					
	is maintained and pe						
	This REQUIREMENT by:	is not met as evidenced					
	Based on record rev	iew. staff interview.			F-755		
		ician interview the facility					
	failed to notify the pharmacy of missing insulin for				(1) How corrective action will be		
	1 of 3 resident review			accomplished for resident(s) found to			
	(Resident #2).				have been affected:		
	The findings included	·			Resident #2's insulin (Liraglutide) was ordered on 7/16/2024 and received fro	m	
	The infairigs included				the pharmacy on 7/16/2024 and the ne		
	Physician order dated			dose due was given on 7/17/2024.			
	Resident #2 Liraglution	de (an anti-diabetic			_		
		neous solution Pen injector			(2) How corrective action will be		
		ML. The order further stated			accomplished for resident(s) having the		
	inject 1.8 MG subcutaneously one time a day for diabetes.				potential to be affected by the same issued needing to be addressed:	sue	
	diabetes.				An audit was done by the Director of		
	Further review of the	MAR for July 2024 revealed			Nursing on 7/31/2024 for all residents		
	Resident #2 did not r				receiving insulin to ensure insulin		
		/9/24, 7/14/24, 7/15/24 and			availability and that no other residents		
		entified the medication was			were affected by failing to notify pharm		
	on hold, see nursing	note.			of missing insulin. Audit revealed that return other residents were noted to be affect		
	Medication Administr	ation note dated 7/16/24 at			other residents were noted to be affect	eu.	
		Nurse #1 stated Liraglutide			3) What measure(s) will be put in place	or	
		on pen-injector 10 MG/3 ML.			systemic changes made to ensure that		
		aneously one time a day for			the identified issue does not re-occur in	1	
	diabetes was held till	received on next delivery.			the future:		
	Deview of Resident t	Kala madical report revealed			On 7/31/2024 the Director of Nursing a		
		2's medical record revealed administration of Liraglutide			Unit Managers initiated re-education to licensed nurses to ensure insulin	all	
		on pen injector 18 mg/3 ml,			availability for all residents receiving		
		ineously one time a day for			insulin by monitoring the resident's sup	ply	
	diabetes on 7/16/24.	-			and to notify pharmacy in a timely man		
					to re-order before supply runs out.		
		#3 on 7/31/24 at 11:08 am				ĺ	
	revealed if she identi	fied a code of 5 on the MAR			In addition, in the event that insulin is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345070	B. WING _			,	C 7/31/2024
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	773172024
					11 S LASALLE STREET		
DURHAM	NURSING & REHAB	ILITATION CENTER			DURHAM, NC 27705		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 755	Continued From p	page 2	F	755			
		4/24, it would indicate the ot available. She further stated			unavailable, the pharmacy (to obtain re-fill) and physician (to adjust orders		
	she had not contacted the pharmacy regarding the missing medication.				accordingly) are to be notified immedia upon discovering.	ately	
		rse # 4 on 7/31/24 at 11:02 am			4) Indicate how the facility plans to		
		an agency nurse and assigned			monitor its performance to make sure		
	to Resident #2 on 7/15/24. She stated she				the solutions are achieved and sustain		
		#2's having no insulin to facility. She further stated she			To ensure insulin availability and timely	•	
		acting the pharmacy.			notification to pharmacy for re-ordering monitoring using the insulin availability	-	
	did flot recall cont	acting the pharmacy.			audit tool for all residents receiving ins		
	Interview with the	Consulting Pharmacist on			will be done by the Director of Nursing		
	7/31/24 at 10:45 am revealed the facility could				designee 5 days/week for 4 weeks, 3	O.	
		cy of a need for medication to			days/week for 4 weeks, and then 1		
		electronic system, pulling the			day/week for 4 weeks.		
		dication and fax it the pharmacy,					
	or contact the pha	armacy directly to refill an order.			The Administrator, Director of Nursing	, or	
	The facility should	l let the pharmacy know if a			designee will report findings of the		
	medication was ru	ınning low and Stat orders could			monitoring process to the facility Quali	ty	
	be completed. Th			Assurance and Performance			
	request for a refill			Improvement Committee for any			
		aglutide Subcutaneous solution			additional monitoring or modification o	f	
	pen-injector.				this plan. The QAPI Committee can		
		DON 7/04/04 -+ 44:00			modify this plan to ensure the facility		
		DON on 7/31/24 at 11:32 am			remains in substantial compliance.		
		tion was not available in the aff should identify if the					
	J .	vailable in back up. The DON			The facility alleges compliance on		
		he medication Liraglutide			8/16/2024		
		lution pen-injector would not be			0/10/2024		
		acility would have in back up					
		sing staff were to contact the					
		dication was not available in the					
		unsure as to why nursing staff					
		e pharmacy to obtain a refill on					
		iglutide Subcutaneous Solution					
	pen-injector. Furt	her, if medications were running					
	low, staff should r	eorder the medication to ensure					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 07/31/2024	
		345070					
NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 411 S LASALLE STREET DURHAM, NC 27705)E	0770172021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 760 SS=D	am revealed he sho medications were not he would need to know medication was not pharmacy should promonth once initially breakdown from the should send a notificinstance a medication. He further stated stapharmacy and see we replaced with so he medication as a repistated Liraglutide Supen-injector was not would the pharmacy the facility have to remedication that was pharmacy should haalerts them of medication was not staff should contact to obtain the medication was not staff should was not staff should was not staff should was	hysician on 7/31/24 at 11:18 uld be notified when of available in the facility, and now from nursing staff why the available. He stated the ovide the medication every prescribed. There was a pharmacy and the pharmacy cation to the facility in the on was not going to be sent. off should also contact the what medication could be could prescribe the lacement. The Physician ubcutaneous solution a new prescription so why on to deliver it and why does remind the pharmacy of already prescribed. The lave a system in place that cations they should deliver. In the instance a prescribed in stock in the facility, nursing the pharmacy in an attempt ation for administration. of Significant Med Errors Sure that its- ents are free of any significant IT is not met as evidenced	F 79	60		8/16/24	
	Based on record re	view, staff interview and		F-760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/31/2024	
		B. WING				
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 07/31/2024	
				411 S LASALLE STREET		
DURHAM	NURSING & REHABILI	TATION CENTER		DURHAM, NC 27705		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 760	physician order for pharmaceutical servent The findings include Resident #2 was ad 4/19/24 with a diagr diabetes (DM) and benecrosis. Review of Resident Set (MDS) assessment	the facility failed to follow of 3 residents reviewed for ices (Resident #2). d: mitted to the facility on osis that included type 2 idney failure with tubular #2's annual Minimum Data ent dated 7/11/24 revealed intact, had a diagnosis of		(1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #2's insulin (Tresiba) was ordered on 7/1/2024 and received from the pharmacy on 7/1/2024 and the new dose due was given on 7/2/2024. Resident #2's insulin (Liraglutide) was ordered on 7/16/2024 and received for the pharmacy on 7/16/2024 and the new dose due was given on 7/17/2024. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same in	om ext ss rom next	
	Care plan last updar #2 had a diagnosis of Resident #2 would r to DM. The interver medication as order A. Resident #2's ph stated administer Tr subcutaneous pen-i (insulin Degludec). units subcutaneousl Review of the Medical (MAR) for July 2024 receive Tresiba Flex MAR identified the r nursing note. The medical Record revidocumentation of Reference would be subcutaneously the subcutaneously and subcutaneously and the subcutaneously and the subcutaneously and subcutaneously and the subcutaneously and the subcutaneously and	nysician order dated 5/4/24 rebiba FlexTouch njector 100 unit/milliliter (ml) The order stated inject 30 ly one time a day for DM. reation Administration record revealed Resident #2 did not of Touch on July 1, 2024. The medication was on hold, see note was written by Nurse #2.		needing to be addressed: An audit was done by the Director of Nursing on 7/31/2024 for all residents receiving insulin to ensure insulin availability and that no other resident were affected by failing to follow physorders that led to a significant medical error. Audit revealed that no other residents were noted to be affected. 3) What measure(s) will be put in plat systemic changes made to ensure the the identified issue does not re-occur the future: On 7/31/2024 the Director of Nursing Unit Managers initiated re-education licensed nurses to ensure insulin availability for all residents receiving insulin by monitoring the resident's sit and to notify pharmacy in a timely material to re-order before supply runs out the ensuring that physician orders are be	s s sician ation ce or at in g and to all upply anner us	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
			A. BOILDIN			С	
		345070	B. WING _		07	//31/2024	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	'		
B				411 S LASALLE STREET			
DURHAM	NURSING & REHABILIT	TATION CENTER		DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 760	12:09 pm written by Touch Subcutaneous unit/ML. Inject 30 ur day for DM. The not medication was not of Interview with Nurse revealed she did recinsulin during medicated she recalle about 7:00 am on Ju medication administr had no insulin. Nurse Director of Nursing (Inpharmacy. B. Physician order of administer Resident anti-diabetic medicated Pen injector 18 milling further stated inject of time a day for diabet. Further review of the Resident #2 did not in Subcutaneously on 7/16/24. The MAR id on hold, see nursing. Medication Administratives and written by Subcutaneous solution in the su	ration note dated 7/1/24 at Nurse #2 stated Tresbia Flex is solution pen-injector 100 nit subcutaneous one time a te further stated the on hand. #2 on 7/31/24 at 10:24 am all Resident #2 not having ation administration. She tham of the medication. She diarriving on her shift at ly 1, 2024, and during ration realized Resident #2 te #2 stated she notified the DON) who notified the DON) who notified the lated 4/20/24 stated #2 Liraglutide (an tion) Subcutaneous Solution trams (mg)/3ML. The order 1.8 mg subcutaneously one tes. MAR for July 2024 revealed receive Liraglutide 7/10/24, 7/14/24, 7/15/24 and tentified the medication was note. ration note dated 7/16/24 at Nurse #1 stated Liraglutide on pen-injector 10 MG/3 ML. aneously one time a day for	F 7		curring. nat insulin is y (to obtain djust orders iffied immediately y plans to o make sure that d and sustained: rs are being bility to prevent a or, monitoring ity audit tool for ulin will be done y or designee 5 days/week for 4 eek for 4 weeks. or of Nursing, or rgs of the facility Quality nce for any nodification of mittee can e the facility mpliance.		
	Inject 1.8 mg subcutadiabetes was held til						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP	(X3) DATE SURVEY COMPLETED	
2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	C 31/2024	
NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705	31/2024	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 760 Continued From page 6 revealed she was an agency nurse. She indicated when she was administering Resident #2's medications she noticed it had not been given for 2 consecutive days. She stated she contacted the pharmacy to regarding the medication and was told the medication would be delivered. Review of Resident #2's medical record revealed no documentation of administration of Liraglutide Subcutaneous solution pen injector 18 mg/3 ml, inject 1.8 mg subcutaneously one time a day for diabetes on 7/16/24. Interview with Nurse #3 on 7/31/24 at 11:08 am revealed if she identified a code of 5 on the MAR on 7/9/24 and 7/14/24, it would indicate the medication was not available. She further stated she had not contacted the pharmacy regarding the missing medication. Interview with Nurse # 4 on 7/31/24 at 11:02 am revealed she was an agency nurse and assigned to Resident #2 on 7/15/24. She stated she recalled Resident #2's having no insulin to administer in the facility. She further stated she did not recall contacting the pharmacy. Interview with the DON on 7/31/24 at 11:02 am indicated in the instance a medication was not available, staff should contact the physician. The DON further stated the nurse should provide medications were not available. He further		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345070	B. WING		C 07/24/2024	
	ROVIDER OR SUPPLIER NURSING & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 760	Interview with the Ad 11:45 am revealed no physician when medi	ministrator on 7/31/24 at ursing staff should notify the	F 74	60		