STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING ______ B. WING ______	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	**202 SMOKETREE WAY LOUISBURG, NC 27549**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 8/27/24 through 8/28/24. Event ID# SOU911. The following intakes were investigated NC00219718 and NC00220724. 1 of the 7 complaint allegations resulted in deficiency.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		9/17/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/13/2024

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.

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F 755	Continued From page 1 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, Pharmacist and Medical Director Interview, the facility failed to ensure medication was available as ordered for 1 of 3 residents reviewed for administration of medication to meet needs of the resident. (Resident #2) The findings included: Resident #2 was admitted to the facility on 12/1/23 with diagnoses that included malignant neoplasm of the left breast and bipolar schizoaffective disorder. a.Review of a physician ' s order dated 2/22/23 revealed Resident #2 was to receive Aripiprazole 5 MG (milligram): Give 1 tablet by mouth one time a day for schizophrenia. Review of Resident #2 ' s electronic Medication Administration Record (MAR) for July 2024 revealed she had not received Aripiprazole as ordered on the following dates: On 7/20/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate "other/see nurses notes". A nurses note dated 7/20/24 revealed Resident #2 did not receive her Aripiprazole due to medication being "on order". The note did not indicate the pharmacy or Director of Nursing was notified. An interview was conducted with Nurse #1 on 8/28/24 at 9:13 AM. Nurse #1 stated she had not	F 755	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F755 1. Corrective action for resident(s) affected by the alleged deficient practice: A. Corrective action was received for resident # 2 on 08/16/2024 when the facility received a replenishment of residents Aripiprazole from the pharmacy. On 08/27/2024, the Medical Director (MD) was notified of the medication not being administered on 7/20/2024, 07/21/2024, 08/12/2024, and 08/13/2024 without MD or pharmacy notification and there were no new orders. B. Corrective action was received for resident # 2 on 08/21/2024 when the facility received a replenishment of residents Letrozole from the pharmacy. On 08/27/2024, the Medical Director (MD) was notified of the medication not being administered on 08/12/2024 and 08/13/2024 without MD or pharmacy	

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F 755

Continued From page 2

received education on the process for missing medications. The nurse stated she had attempted to order the medication from the pharmacy and was made aware that the medication would be arriving that evening in the pharmacy delivery. Nurse #1 stated she did not notify the charge nurse or Director of Nursing that Resident #2 did not have the medication.

On 7/21/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate "other/see nurses notes". A nurses note dated 7/21/24 revealed Resident #2 did not receive her Aripiprazole due to medication being "on order". The note did not indicate the pharmacy or Director of Nursing was notified.

Multiple attempts to reach Nurse #2 were unsuccessful.

Review of Resident #2 ' s electronic Medication Administration Record (MAR) for August 2024 revealed she had not received Aripiprazole as ordered on the following dates:

On 8/12/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate "other/see nurses notes". A nurses note dated 8/12/24 revealed Resident #2 did not receive her Aripiprazole due to medication being "on order". The note did not indicate the pharmacy or Director of Nursing was notified.

An interview was conducted with Nurse #3 on 8/27/24 at 3:13 PM. Nurse #3 stated she was able to reorder a medication through the electronic MAR. The nurse stated she did not

F 755

notification and there were no new orders. No further corrective action was required.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:

On 09/03/2024, the Registered Nurse Supervisor (RN) initiated an audit of 100% of the Medication Administration Notes for the last 14 days from 08/21/2024 - 09/03/2024 for all current residents. The audit consisted of a review of the EMAR progress notes to to identify any medications that were not administered due to not being available. This was completed: 09/04/2024. The results included: There were residents identified as not receiving medications because they were on order. On 09/04/2024 , the pharmacy was contacted for any medications that were identified as not being available and the medications were delivered to the facility.

On 09/05/2024 the Director of Nurses (DON) or designee will have ongoing random review of the Medication Administration Notes for current residents to identify any medications that were not administered due to not being available. This random audit will be continued through 09/17/2024.

Additionally, from 09/05/2024 to 09/16/2024 the DON initiated medication administration post tests and medication administration observations to audit compliance with medication availability.

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F 755	Continued From page 3 follow up with the pharmacy to see when the medication would arrive. Nurse #3 stated she had not been made aware of the use of a backup pharmacy and she did not report the missing medication to the charge nurse or Director of Nursing. On 8/13/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate "other/see nurses notes". A nurses note dated 8/13/24 revealed Resident #2 did not receive her Aripiprazole due to medication being "on order". The note did not indicate the pharmacy or Director of Nursing was notified. Multiple attempts to reach Nurse #4 were unsuccessful. An interview was conducted with the Pharmacist on 8/27/24 at 4:14 PM. The Pharmacist stated the first medication request for Aripiprazole for Resident # 2 was entered into the electronic system on 7/19/24. A second request for Aripiprazole was entered on 7/22/24. The Pharmacist stated there was no documentation in the system stating anyone from the facility had called about the medication not being available. The Pharmacist reported that a 30-day supply of Aripiprazole was sent to the facility on 7/23/24. Further interview with Pharmacist revealed there was a local backup pharmacy to aid in the administration of resident ' s medications. During an interview with the Medical Director on 8/27/24 at 4:18 PM, she stated there were no side effects if the resident missed doses of the medication Aripiprazole.	F 755	3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 09/05/2024, the Director of Nurses (DON) began educating all Licensed Nurses, RN□s, Licensed Practical Nurses (LPN□s), Medication Aides, full time, part time, including agency staff, and PRN (as needed) on the following topics: " How to obtain medications from the back up pharmacy " The importance of ensuring that medications are always available to be given to the resident as ordered by the Physician. " Understand the steps necessary to obtain medications from the Pharmacy during business hours and after business hours for all situations. " Preventing medication errors " 6 rights of medication administration The DON or designee will be responsible for ensuring Pharmacy Service & Medication Error Prevention Education will be integrated into the standard orientation training and in the required in-service refresher courses for all Licensed Nurses, RN□s, Licensed Practical Nurses (LPN□s), Medication Aides, full time, part time, including agency staff, and PRN staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any RN, LPN, Medication Aides who does not receive scheduled in-service training by	

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F 755	Continued From page 4 b. Review of a physician ' s order dated 2/22/23 revealed Resident #2 was to receive Letrozole 2.5 MG (milligram) -Give 1 tablet by mouth one time a day for Breast CA. Review of Resident #2 ' s electronic Medication Administration Record (MAR) for August 2024 revealed she had not received Letrozole as ordered on the following date: On 8/12/24 at 9:00 AM, the MAR showed no dose of Letrozole was administered. A chart code of 9 was documented on the MAR to indicate "other/see nurses notes". A nurses note dated 8/12/24 revealed Resident #2 did not receive her Aripiprazole due to medication being "on order". An interview was conducted with the Pharmacist on 8/27/24 at 4:14 PM. The Pharmacist stated the medication request for Letrozole for Resident # 2 was entered into the electronic system on 8/12/24. The Pharmacist stated the request was filed too soon to be filled. The Pharmacist stated there was no other documentation of request for the medication. The Pharmacist reported that a 30-day supply of Letrozole was sent to the facility on 8/21/24. Further interview with Pharmacist revealed there was a local backup pharmacy to aid in the administration of resident ' s medications. During an interview with the Medical Director on 8/27/24 at 4:18 PM, she stated there were no side effects if the resident missed doses of the medication Letrozole. During an interview with the Director of Nursing	F 755	09/16/2024 will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory/requirements. The Director of Nurses, or designee will monitor compliance utilizing the F755 Monitoring Tools weekly x 3 weeks then monthly x 2 months. The monitoring will review Pharmacy Services and Medication availability procedures to ensure medications are available and administered as ordered to meet needs of the resident. The facility will monitor 5 random residents EMAR progress notes on different days, shifts to ensure compliance with medication availability and complete 4 random medication administration observations. Reports will be presented to the monthly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, Social Worker, Maintenance Director, Business Office Manager, and the Dietary Manager. Date of Compliance: 09/17/2024	

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F 755	Continued From page 5 on 8/27/24 at 3:40 PM. The DON stated she expected that the nurse assigned to a resident with missing medications would notify the charge nurse and DON. The DON explained the pharmacy should have been notified and the missing medication picked up from the backup pharmacy until the medication refill could be received at the facilit	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and Medical Director Interview, the facility failed to prevent a significant medication error by not following physicians order and failing to administer Aripiprazole (an antipsychotic medication used to treat schizophrenia and Letrozole (an antineoplastic medication used to treat breast cancer) for 1 of 3 residents (Resident #2) reviewed for significant medication error. The findings included: Resident #2 was admitted to the facility on 12/1/23 with diagnoses that included malignant neoplasm of the left breast and bipolar schizoaffective disorder. Review of Resident #2 ' s most recent quarterly Minimum Data Set (MDS) 6/6/24 revealed the resident was cognitively intact. The MDS also revealed the resident had received antipsychotics for 7 days of the lookback period.	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F760 1. Corrective action for resident(s) affected by the alleged deficient practice: A. Corrective action was received for resident # 2 on 08/16/2024 when the facility received a replenishment of residents Aripiprazole from the pharmacy and resident has received the dose as ordered. On 08/28/2024, the Medical Director (MD) was notified of the	9/17/24

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Review of Resident #2 ' s care plan dated 12/15/23 revealed the resident had a care plan for receiving antipsychotic medication related to her diagnosis of Schizophrenia. The interventions included in part administer medication as ordered by the physician. Review of the care plan also revealed a focus area of diagnosis of left breast cancer. The interventions included give medications as ordered.

a. Review of a physician ' s order dated 2/22/23 revealed Resident #2 was to receive Aripiprazole 5 MG (milligram): Give 1 tablet by mouth one time a day for schizophrenia at 9:00 AM.

An interview with Resident #2 on 8/27/24 at 2:36 PM revealed she had missed some medication for two days in July and two days in August due to the medication being out. Resident #2 stated she was concerned about missing this medication because it was important she take it daily.

Review of Resident #2 ' s electronic Medication Administration Record (MAR) for July 2024 and August 2024 revealed she had not received Aripiprazole as ordered on the following dates:

On 7/20/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate "other/see nurses notes". A nurses note dated 7/20/24 written by Nurse #1 revealed Resident #2 did not receive her Aripiprazole due to medication being "on order".

An interview was conducted with Nurse #1 on 8/28/24 at 9:13 AM. Nurse #1 stated she had not received education on the process for missing

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medication not being administered. On 08/28/2024, the resident was assessed for any change in condition related to the medication error, there were no observed adverse effects as evidenced by no changes in resident #2s clinical condition. No further corrective action was required.

B. Corrective action was received for resident # 2 on 08/21/2024 when the facility received a replenishment of residents Letrozole from the pharmacy and resident has received the dose as ordered. On 08/28/2024, the Medical Director (MD) was notified of the medication not being administered. On 08/28/2024, the resident was assessed for any change in condition related to the medication error, there were no observed adverse effects as evidenced by no changes in resident #2s clinical condition. No further corrective action was required.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

On 09/03/2024, the Registered Nurse Supervisor (RN) initiated an audit of 100% of the Medication Administration Notes for the last 14 days from 08/21/2024 - 09/03/2024 for all current residents. The audit consisted of a review of the EMAR progress notes to identify any medications that were not administered and where physicians order wasnt followed. This was completed: 09/04/2024. The results included: There were residents identified with medications not administered and

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medications. The nurse stated she had attempted to order the medication from the pharmacy and was made aware that the medication would be arriving that evening in the pharmacy delivery.

On 7/21/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate "other/see nurses notes". A nurses note dated 7/21/24 written by Nurse #2 revealed Resident #2 did not receive her Aripiprazole due to medication being "on order".

Multiple attempts to reach Nurse #2 were unsuccessful.

On 8/12/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate "other/see nurses notes". A nurses note dated 8/12/24 written by Nurse #3 revealed Resident #2 did not receive her Aripiprazole due to medication being "on order".

An interview was conducted with Nurse #3 on 8/27/24 at 3:13 PM. Nurse #3 stated she was able to reorder a medication through the electronic MAR. The nurse stated she did not follow up with the pharmacy to see when the medication would arrive. Nurse #3 stated she had not been made aware of the use of a backup pharmacy.

On 8/13/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate "other/see nurses notes". A nurses note dated

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where physicians□ orders weren□t followed. On 09/04/2024 , the pharmacy was contacted for any medications that were identified as not being available and the medications were delivered to the facility for administration.

Additionally, from 09/05/2024 to 09/16/2024 the DON initiated medication administration post tests and medication administration observations to audit compliance with following physicians□ orders and administering medications.
3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:
Education:
On 09/05/2024, the Director of Nurses began education of All Full Time, Part Time, and as needed (PRN) Nurses; RNs, Licensed Practical Nurses (LPNs), and Medication Aides on the following:

" How to obtain medications from the back up pharmacy
" The importance of ensuring that medications are always available to be given to the resident as ordered by the Physician.
" Understand the steps necessary to obtain medications from the Pharmacy during business hours and after business hours for all situations.
" Preventing medication errors
" 6 rights of medication administration

On 09/05/2024, the DON initiated Medication administration post tests and medication administration observations to

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8/13/24 written by Nurse #4 revealed Resident #2 did not receive her Aripiprazole due to medication being "on order".

Multiple attempts to reach Nurse #4 were unsuccessful.

During an interview with the Medical Director on 8/27/24 at 4:18 PM, she stated there were no side effects if the resident missed doses of the medication Aripiprazole.

b. Review of a physician ' s order dated 2/22/23 revealed Resident #2 was to receive Letrozole 2.5 MG (milligram) -Give 1 tablet by mouth one time a day for Breast Cancer at 9:00 AM.

Review of Resident #2 ' s electronic Medication Administration Record (MAR) for August 2024 revealed she had not received Letrozole as ordered on the following date:

On 8/12/24 at 9:00 AM, the MAR showed no dose of Letrozole was administered. A chart code of 9 was documented on the MAR to indicate "other/see nurses notes". A nurses note dated 8/12/24 written by Nurse #3 revealed Resident #2 did not receive her Aripiprazole due to medication being "on order".

An interview was conducted with Nurse #3 on 8/27/24 at 3:13 PM. Nurse #3 stated she was able to reorder a medication through the electronic MAR. The nurse stated she did not follow up with the pharmacy to see when the medication would arrive. Nurse #3 stated she had not been made aware of the use of a backup

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audit compliance with following physicians orders.

The DON or designee will be responsible for ensuring Pharmacy Service & Medication Error Prevention Education will be integrated into the standard orientation training and in the required in-service refresher courses for all Licensed Nurses, RNs, Licensed Practical Nurses (LPNs), Medication Aides, full time, part time, including agency staff, and PRN staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any RN, LPN, Medication Aides who does not receive scheduled in-service training by 09/16/2024 will not be allowed to work until training has been completed.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The DON or designee will monitor compliance utilizing F760 Quality Assurance Tools weekly x 3 weeks then monthly x 2 months. Monitoring tools completed by the DON or designee will monitor 4 RNs, LPNs, or Medication Aides for compliance with following physicians order completing medication administration post tests and medication administration observations. Reports will be presented to the monthly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored

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LOUISBURG HEALTHCARE & REHABILITATION CENTER	**202 SMOKETREE WAY LOUISBURG, NC 27549**

(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) COMPLETION DATE
F 760	Continued From page 9 pharmacy and she did not report the missing medication to the charge nurse or Director of Nursing. During an interview with the Medical Director on 8/27/24 at 4:18 PM, she stated there were no side effects if the resident missed doses of the medication Letrozole. During an interview with the Director of Nursing on 8/27/24 at 3:40 PM. The DON stated she expected that the nurse assigned to a resident with missing medications would notify the charge nurse and DON. The DON explained the pharmacy should have been notified and the missing medication picked up from the backup pharmacy until the medication refill could be received at the facility.	F 760	and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 09/17/2024	