	-	D HUMAN SERVICES				RM APPROVED
	S FOR MEDICARE & I					IO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>′</i>	LE CONSTRUCTION		E SURVEY IPLETED
		345070	B. WING		1'	C 1/05/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER		411 S LASALLE STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	0		
	for a complaint survey surveyor returned to t complete a complaint exit conference was of 11/05/24. Therefore t 11/05/24. Event ID #V The following intakes NC00221797, NC002 NC00223523. Intake	were investigated 22298, NC00223174 and NC00223174 and I in immediate jeopardy.				
F 580 SS=J	CFR 483.25 at tag F6 The tag F684 constitu Care. Immediate Jeopardy I removed on 11/02/24 was conducted. Notify of Changes (Inj CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must imm consult with the reside consistent with his or representative(s) whe (A) An accident involv results in injury and h	all a scope and severity J all a scope and severity J began on 10/07/24 and was began on 10/07/24 and was all a scope and severity of began on 10/07/24 and was all a scope and severity of began on 10/07/24 and was all a scope and severity of began on 10/07/24 and was all a scope and severity of began on 10/07/24 and was all a scope and severity J began on 10/07/24 and was all a scope and severity J began on 10/07/24 and was all a scope and severity of began on 10/07/24 and was began on 10/07/24 and was be	F 58			11/22/24 (X6) DATE
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally Signed					11/22/2024

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.

		MEDICAID SERVICES			OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345070	B. WING _		C 11/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE
DURHAM	NURSING & REHABILIT	ATION CENTER		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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
F 580	mental, or psychosoc deterioration in health status in either life-thi clinical complications (C) A need to alter tree a need to discontinue treatment due to adve commence a new form (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informativ is available and provi- physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulatio (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclose its physical configuration locations that comprise	n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or ); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and	F 5	580	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	M APPROVE D. 0938-039
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	Сом	E SURVEY PLETED
		345070	B. WING			C 11/05/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11	/03/2024
0.002					11 S LASALLE STREET		
DURHAM	NURSING & REHABILIT	ATION CENTER			URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 580	Continued From pag	e 2	F!	580			
		en its different locations					
	This REQUIREMEN	Γ is not met as evidenced					
	-	riews, and staff, Nurse			F-580		
	Practitioner (NP), res						
	interviews, the facility			(1) How corrective action will be			
	and responsible part	y of changes in condition for			accomplished for resident(s) found to		
		esident #7). Resident #7 had			have been affected:		
	-	a history of stroke and on			Resident #7 was sent to the hospital		
		nately 9:00 PM he reported to			10/22/24.		
		had pain and numbness in					
	-	The NA aide reported this to			(2) How corrective action will be		
		ext shift at approximately			accomplished for resident(s) having the		
		informed another NA he			potential to be affected by the same is needing to be addressed:	sue	
		side. The NA reported this 22/24 between 7:00 and 7:15			An audit to determine if any residents	had	
		M) #1 was called to the room			reported any new change in condition		
		sed Resident #7 and found			was not reported to the healthcare	unat	
		ed, his left arm and leg did			provider by a licensed nurse of reside	nts	
		and they did not have any			with a brief interview for mental status		
		rse Practitioner was in the			(BIMS) score of 13 or higher was		
		Resident #7 and had him			completed by the Administrator on		
		nergency Department (ED)			10/25/2024. The Audit revealed that n	0	
		ke symptoms. There were no			other residents were noted to be affect	ted.	
		es entered on 10/21/24 or					
		otification of the physician or			An audit was completed on 10/25/24	-	
		arding the change in			the Director of Nursing of progress no		
		on until the note entered by at 8:25 AM. Resident #7			for the past 7 days to ensure that any	one	
		ergency Department (ED)			reporting a change of condition had provider notification. The audit revealed	he	
		h changes and inability to use			that no one else was affected.	50	
		ver extremities. Diagnoses					
		scular accident (CVA-			From 10/31/24-11/1/24 the Director of		
		following cognitive deficits			Nursing or Staff Development Coordin		
		ulty swallowing) post CVA. It			interviewed all nursing assistants	-	
		#7 was outside of the window			regarding knowledge of any residents		
		of Alteplase (tPA) which is a			having change of conditions in the las		
		es blood clots used to treat			days that were not reported to the		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 11/05/2024
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CO	
DURHAM	NURSING & REHABILIT	ATION CENTER		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 580	ischemic strokes. Rei the critical care stroke on 10/29/24. Immediate jeopardy & Resident #7 he repor numb and a medical party were not notifie removed on 11/02/24 implemented a credit jeopardy removal. Th compliance at a scop actual harm with pote harm that is immedia education is complete are in place and are of Findings included: Resident #7 was adm 8/29/24, with diagnos hemiparesis/hemiples paralysis of one side) related to a stroke an The quarterly Minimu 9/10/24 indicated Res intact. An interview with NA revealed she worked shift on 10/21/24 and Resident #7 at 6:30 F concerns. When she 9:00 PM, the resident numbness in his left a she went to tell Nurse	sident #7 was admitted to e unit and was discharged began on 10/21/24 for ted his left arm and leg were provider and responsible d. Immediate jeopardy was when the facility ble allegation of immediate e facility will remain out of e and severity of "D" (no ential for more than minimal te jeopardy) to ensure ed and monitoring systems effective. hitted to the facility on ses of history of right gia (partial or complete o with right side weakness d Type 1 diabetes mellitus. m Data Set (MDS) dated sident #7's cognition was # 5 at 10/29/24 4:33 PM the 3:00 pm to 11:00 PM did first rounds with PM and he did not have any did her second round at t told her he had pain and arm and leg. NA #5 indicated	F 58	<ul> <li>healthcare provider. No negwere noted.</li> <li>From 10/25/24-10/28/24, the Nursing also questioned all on urses regarding knowledge residents having had a chan condition that deviated from and did not have healthcare notification. Signatures accouthe education and the quest residents were noted to be a</li> <li>(3) What measure(s) will be or systemic changes made to the identified issue does not the future: On 10/25/2024 the Director of initiated education to all licer complete a clinical assessme minimum vital signs and per systems once notified of a c condition to include accident injuries of unknown source, change in residents physica or mental condition which care elevated vital signs, altered blurred vision, headaches, m tingling to body parts, uncom etc., to notify the healthcare immediately of findings once assessment is complete and responsible party as well. Exponsible p</li></ul>	e Director of of the licensed e of any oge in their baseline provider ounted for both ionnaire. No affected. put in place to ensure that re-occur in of Nursing nsed nurses to ent of a tinent body hange in t or incident, significant I, emotional, an include mental status, numbness or ntrolled pain, provider e the d to notify the ducation also ted by nursing rese that has /2024 will be the educated
	she went to tell Nurse numbness and pain,	e #5 Resident #7 had		taken off the schedule until t	he educated hires will be

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/2024 FORM APPROVED OMB NO. 0938-0391		
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345070	B. WING		C 11/05/2024		
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	11/00/2024		
DURHAM	NURSING & REHABILIT	ATION CENTER		11 S LASALLE STREET DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
F 580	Continued From page	2.4	F 580				
	on Resident #7, that s	she was aware of.		orientation. The Director of Nursi ensure all licensed nurses are in-	•		
	PM revealed she wor PM shift on 10/21/24. #7's bedside to take h The Resident did not issues. Nurse #5 did Resident #7 was havi An interview with NA revealed at 6:00 AM ( stated, "I can't feel my tell Nurse #6 and Nur down but did not com stated she went back Resident #7 she repo #6 and went on with h An interview with Nur PM revealed on 10/2 #4 reported to her that wasn't feeling right. N an assessment when medication and check around 6:00 AM. She with him while doing t Resident #7 did not in at that time. Nurse #7 given any kind of repo anything was going o An interview with NA	Arted his symptoms to Nurse her assignment. se #6 on 10/30/24 at 12:47 1/24 at around 6:00 AM NA at Resident #7's left side lurse #6 stated that she did she gave Resident #7 his ked his blood sugar at stated she briefly spoke the blood sugar and ndicate anything was wrong ' stated she had not been port from the prior shift that		On 11/1/2024, the Regional Direct Clinical Services educated the Administrator, The Director of Nu Staff Development Coordinator, a Human Resource Director on the orientation process for nursing st will include education on recogniz change in condition, timely assess and monitoring of change in cond effective communication during a emergency, importance of notifyin healthcare provider, and effective communication during a medical emergency. On 11/1/2024, the Director of Nursing/Staff Development Coord re-educated all nursing assistants change in condition of residents to recognizing signs and symptoms stroke such as blurred vision, slu speech, weakness to one side of body, and facial drooping. Educa included the importance of report change in condition or any of the symptoms to their nurse Any nurs assistant that has not received th education on 11/1/2024 will be ta the schedule until the education for received. The Director of Nursing ensure all nursing assistant education	dinator son to include of a rred the tion also ting any se sing e ken off has been y will		
	how he was doing. He haven't felt well since	am and asked Resident #7 e said, "I am not well" and "I last night" and he couldn't this had started after dinner.		(4) Indicate how the facility plans monitor its performance to make the solutions are achieved and su The Director of Nursing or design	sure that ustained:		

Facility ID: 923264

		ND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 11/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
DURHAM	NURSING & REHABILIT	ATION CENTER		411 S LASALLE STREET DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO
F 580	blurred on the left sid could not feel anythin stated she noticed his A review of the media were no nursing prog 10/21/24 notification regarding a change in condition. An interview with Uni 10/29/24 at 11:40 AM requested by NA #8 t room as soon as pos 10/22/24). Upon arriv with left-sided paralys left leg. UM #1 furthe stated he had been u since last night after began her assessme Practitioner (NP). UM arm and leg were flac when she raised ther assessed Resident # called because Resident the family member/re she was called by NA 10/22/24) and was to sent to the hospital for A phone interview wit at 5:30 PM revealed could not feel his left nurse aide was trying not help due to the la	evealed that his vision was le, and he was numb and og on the left side. NA #8 s speech was slurred too. cal record revealed there gress notes entered on to the family or physician in Resident #7's change in it Manager (UM) #1 on A revealed she was to come to Resident #7's usible at 7:15 AM (on val, she found Resident #7 sis, including the left arm and or revealed Resident #7 inable to move his left side dinner. UM #1 stated she int and called for the Nurse A #1 stated Resident #7's left ccid, dropping to the bed m up. The NP arrived, 7 and asked for EMS to be dent #7 had had a stroke. 10/29/24 at 4:48 PM with esponsible party revealed A #8 around 8:15 AM (on old that Resident #7 had been	F 58	<ul> <li>monitor the 24 hour summary and progress notes for any indication of change in condition and will intervisistaff member and 2 residents with of 13 or higher for any indication of change in condition to ensure assessment, notification, and provide follow up as indicated. Monitoring place 5x/wk for 4 weeks, 3x/wk for weeks, and 1x/wk for 4 weeks.</li> <li>The Administrator, Director of Nursidesignee will report findings of the monitoring process to the facility of Assurance and Performance Improvement Committee for any additional monitoring or modification this plan. The QAPI Committee camodify this plan to ensure the facili remains in substantial compliance</li> <li>The facility alleges compliance on 11/22/2024.</li> </ul>	of a iew 2 a BIMS of a rider will take r 4 sing, or Quality on of in lity

Facility ID: 923264

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		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 12/03/2024 FORM APPROVED IB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		DNSTRUCTION		) DATE SURVEY COMPLETED
		345070	B. WING _				C 11/05/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP COD	)E	
	NURSING & REHABILIT			411	S LASALLE STREET		
DORHAM	NORSING & REHABILIT	ATION CENTER		DUF	RHAM, 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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 580	because one person stated he usually cou side with the use of th his hip to the turning noticed he couldn't m came in and he told h arm or left leg, and he going on. Resident # not respond. Resident should have checked Resident #7 explaine same until NA #4 can told NA #4 he could n went and told Nurse room around 6:00 am medicine. Resident # assess him or ask if a the first shift NA (NA 7:15 AM, Resident #7 and she asked what told her he could not #8 immediately called came in and assesse local hospital. An interview with the revealed she was cal on 10/22/24 because Resident #7 had a stu EMS. NP #1 stated n been done when his evening of 10/21/24 a sent out to the ED on indicated if Resident he first was having nu- nursing staff had calle would have instructed to the hospital where	e 6 couldn't do it. He further ild position himself on his he bed rails and a push on side. This was when he ove his left side. Nurse #5 her he couldn't move his left e did not know what was 7 further stated Nurse #5 did at #7 indicated Nurse #5 him and called the doctor. d his condition stayed the ne in on third shift and he not feel his left side and she #6. Nurse #6 came into his n or so and gave him his 7 indicated Nurse #6 did not anything was wrong. When #8) came in with breakfast at 7 told her he was not himself was going on. Resident #7 move his left side, and NA d Unit Manager #1. NP #1 ed him then sent him to the NP on 10/29/24 at 4:40 pm led by the Unit Manager #1 funit Manager #1 thought roke, and that UM #1 called euro-checks should have symptoms started on the and he should have been n 10/21/24. She further #7 had been assessed when umbness (after dinner), and ed our on-call provider, we d them to send Resident #7 his condition could have #1 confirmed Resident #7	F	580			

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CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION		FORM	D: 12/03/2024 APPROVED D: 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, í				COMF	C
		345070	B. WING			-		05/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER			11 S LASALLE STREET URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	had been admitted to side stroke. An interview with DOI revealed that when the something was wrong goes in and does an a provider, she then nor The Emergency Depa 10/22/24 indicated Re history significant for chronic renal insufficie disease, and prior strok Resident #7 presente Department with new inability to use his left extremities. Stroke co A National Institute of was documented as a to moderately severe reported he was unab 6:00 PM on 10/21/24, The computed tomog right posterior frontal edema which could be acute/subacute infarc was outside of the win of Alteplase (tPA) whi dissolves blood clots strokes. Resident #7 stroke service. Reside pressure 162/59, puls and oxygen saturation impression after evalue	the local hospital with a left N 10/29/24 4:07 PM le NA tells the nurse that g with a Resident, the nurse assessment and notifies the tifies the party responsible. Artment (ED) note dated esident #7 had a medical congested heart failure, ency, coronary artery oke with left-sided deficits. d to the Emergency onset vision changes and supper and lower ode was called upon arrival. Health Stroke Scale (NIH) an 8 which indicated a mild stroke. Resident #7 ole to move his arm or leg at which was new for him. raphy (CT) scan showed a lobe hypodensity concerning e related to an t. It was noted Resident #7 ndow for the administration ch is a medicine that used to treat ischemic was admitted to neurology ent #7's vitals were blood se rate 60, temperature 98.5, n 90%. The clinical	F	580				

Facility ID: 923264

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TATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		TE SURVEY MPLETED
		345070	B. WING		1	C 1/05/2024
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO		
			41 <sup>.</sup>	1 S LASALLE STREET		
DURHAM	NURSING & REHABILIT	ATION CENTER	DL	JRHAM, 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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From page	2.8	F 580			
1 000		ased to a skilled nursing	F 360			
	The Administrator wa jeopardy 10/29/24 at	s notified of the immediate 2:15 PM.				
	The facility provided the allegation of IJ remove					
		pients who have suffered, or erious adverse outcome as npliance:				
	with left sided weaking Assistant (NA) #7 on experiencing pain and Nursing assistant #7 did not identify any accomplete a neurologi signs, did not notify he emergency medical si 11:30 PM the resident moving slowly and co Nursing assistant #4 did not identify any accomplete a neurologi signs, did not notify he emergency medical si reported further symp at 6:00 AM about beit side who then reported identify any acute cha	-				

Facility ID: 923264

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345070	B. WING				。 05/2024
NAME OF P	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER			411 S LASALLE STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	had slurred speech and left side. The CNA im change in condition to Manager #1 assessed left side to be flaccid. complaining of blurry he had been able to r night after dinner. The assessed the residen to be sent out to the r Medical Services bec The resident was adm acute stroke on 10/22 An audit to determine reported any new chan not reported to the he licensed nurse of resi for mental status (BIN was completed by the 10/25/2024. The Audi residents were noted An audit was complet Director of Nursing of 7 days to ensure that of condition had provi revealed that no one As part of the staff ed 10/25/24-10/28/24, th questioned all of the I knowledge of any res in condition that devia did not have healthcan Signatures accounted	hd was unable to move his mediately reported the o Unit Manager #1. Unit d the resident and found his The Resident was also vision. Resident stated that nove his left side since last e Nurse Practitioner then t and directed the resident toospital via Emergency ause he had had a stroke. hitted to the hospital with an //24. if any residents had inge in condition that was althcare provider by a dents with a brief interview IS) score of 13 or higher e Administrator on t revealed that no other to be affected. ed on 10/25/24 by the progress notes for the past anyone reporting a change der notification. The audit else was affected.	F	580			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	1 APPROVED 0. 0938-0391			
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .			LETED			
		345070	B. WING				C 05/2024			
NAME OF PI	ROVIDER OR SUPPLIER		-	;	STREET ADDRESS, CITY, STATE, ZIP CODE					
	NURSING & REHABILIT			411 S LASALLE STREET						
DORNAIW	NORSING & REHADIEIT	ANON CENTER			DURHAM, NC 27705					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	EDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE			
TAG F 580	Continued From page From 10/31/24-11/1/2 Staff Development Conursing assistants regresidents having char 7 days that were not reprovider. No negative (2) Specify the action the process or system adverse outcome from when the action will b On 10/25/2024 the Dieducation to all licenss clinical assessment of pertinent body system in condition to include injuries of unknown ser residents physical, en which can include elemental status, blurred numbness or tingling pain, etc., to notify the immediately of finding complete. Education reported by nursing a nurse that has not be will be taken off the set has been received. Al by the Director of Nur Director of Nursing wi are in-serviced.	e 10 4 the Director of Nursing or pordinator interviewed all garding knowledge of any nge of conditions in the last reported to the healthcare findings were noted. the entity will take to alter n failure to prevent a serious n occurring or recurring, and e complete: rector of Nursing initiated led nurses to complete a f a minimum vital signs and ns once notified of a change accident or incident, purce, significant change in notional, or mental condition vated vital signs, altered I vision, headaches, to body parts, uncontrolled		580	DEFICIENCY)	ATE	DATE			
	Services educated the Director of Nursing, S Coordinator, and The on the orientation pro	e Administrator, The								

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/03/2024 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	
		345070	B. WING				C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
					411 S LASALLE STREET		
DURHAM	NURSING & REHABILITA	ATION CENTER			DURHAM, NC 27705		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F 580	change in condition, eduring a medical emenotifying the healthcal communication during. On 11/1/2024, the Dir Development Coordinassistants on change include recognizing sistroke such as blurred weakness to one side drooping. Education a of reporting any change these symptoms to the assistant that has not 11/1/2024 will be take education has been re Nursing will ensure al educated. The facility alleges real educated. The facility alleges real isopardy on 11/02/2020 An on-site validation of the immediate jeopardy or 11/02/2020 An on-site validation of the included daily 24-hou clinical assessments fand vital signs were of Multiple interviews we aides and licensed nurse in-service education, working their shift. The nurses consistently real in-service education, working their shift. The nurses consistently real in-service education, working their shift. The nurses consistently real in-service education, working their shift. The nurses consistently real in-service education, working their shift. The nurses consistently real in-service education is the service education of the in-service education is the service education is the ser	ssment and monitoring of effective communication rgency, importance of re provider, and effective g a medical emergency. ector of Nursing/Staff ator re-educated all nursing in condition of residents to gns and symptoms of a d vision, slurred speech, of the body, and facial also included the importance ge in condition or any of eir nurse Any nursing received the education on n off the schedule until the eceived. The Director of I nursing assistant moval of immediate 24. of the facility's ir credible allegation of emoval was conducted on e completed facility audits r resident report, resident to include neurological, pain ocumented in the record. ere conducted with nurse rises to ensure the was provided prior to e nurse aides and licensed	F	580			

Facility ID: 923264

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 12/03/202 MAPPROVEI <u>O. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY IPLETED
		345070	B. WING		C 11/05/2024	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO		
DURHAM	NURSING & REHABILIT	ATION CENTER		1 S LASALLE STREET JRHAM, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 580 F 583 SS=D	assessment and verifi facility provider prior for nursing staff were edu documentation proce condition on the daily resident record. An interview with the Development Coordin confirmed that re-edu nurse aides and licen condition of residents of stroke, the importa of condition and docu healthcare providers The Director of Nursin reviews and monthly ensure the assessme was maintained. The immediate jeopa was validated. Personal Privacy/Cor CFR(s): 483.10(h)(1) §483.10(h) Privacy an The resident has a rig confidentiality of his cor records. §483.10(h)(I) Persona accommodations, me telephone communica and meetings of famile	At's change of condition fying any new orders with a to initiating the orders. All ucated on the reporting and ss of any signs of change of 24-hour report and in the Director of Nursing and Staff hator on 11/4/24 at 3:00 PM ucation was done for all used nurses on the change of including signs/symptoms nce of reporting any change imentation of notifying of a medical emergency. Ing stated daily record monitoring will be done to ents and notification process rdy removal date of 11/02/24 Infidentiality of Records -(3)(i)(ii) and Confidentiality. ght to personal privacy and or her personal and medical al privacy includes edical treatment, written and ations, personal care, visits, ly and resident groups, but the facility to provide a	F 580			11/22/24

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		345070	B. WING		11/05/2024
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
DURHAM	NURSING & REHABILIT	ATION CENTER		411 S LASALLE STREET DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 583	§483.10(h)(2) The factor residents right to person right to privacy in history written, and electronic the right to send and mail and other letters materials delivered to including those deliver than a postal service. §483.10(h)(3) The reson and confidential person (ii) The resident has the of personal and medic provided at §483.70(h federal or state laws. (iii) The facility must a Office of the State Lo to examine a resident administrative records law. This REQUIREMENT by: Based on observation facility failed to maintar resident's record by le laptop unattended, wi information exposed in visible to the public, for (Zone 1 medication car The findings included An observation of the completed on 10/23/2 the medication cart la The laptop displayed information including	cility must respect the sonal privacy, including the or her oral (that is, spoken), c communications, including promptly receive unopened , packages and other the facility for the resident, ered through a means other sident has a right to secure onal and medical records. he right to refuse the release cal records except as h)(2) or other applicable llow representatives of the ng-Term Care Ombudsman t's medical, social, and s in accordance with State t is not met as evidenced ns and staff interviews, the ain the privacy of a eaving a medication cart ith resident health in an area accessible and or 1 of 4 medication carts art).	F 5	<ul> <li>F-583</li> <li>(1) How corrective action will b accomplished for resident(s) for have been affected: On 10/23/2024, Nurse #4 close laptop lid immediately.</li> <li>(2) How corrective action will b accomplished for resident(s) haptop lid immediately.</li> <li>(2) How corrective action will b accomplished for resident(s) haptop lid immediately.</li> <li>(2) How corrective action will b accomplished for resident(s) haptop lid immediately.</li> <li>(2) How corrective action will b accomplished for resident(s) haptop lid immediately.</li> <li>(3) What measure(s) will be put</li> </ul>	ound to ed the e aving the same issue I to be

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/20 FORM APPROV OMB NO. 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED C		
		345070	B. WING		11/05/2024		
	ROVIDER OR SUPPLIER	ATION CENTER	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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIO E APPROPRIATE DATE		
F 583	An interview with Nur 10/23/24 at 9:59 AM. medication cart was I closed or locked her I resident personal hea displayed. An interview with the was completed on 10 DON verbalized that locked her laptop scru to moving away from An interview with the completed on 10/23/2	on cart during this time. The se #4 was completed on Nurse #4 stated her ocked but she should have laptop screen so that alth information was not Director of Nursing (DON) 0/23/24 at 12:22 PM. The Nurse #4 should have een with the lock button prior the medication cart. Administrator was 24 at 12:31 PM. He lock the laptop screen prior	F 58	<ul> <li>or systemic changes made to the identified issue does not it the future:</li> <li>On 10/23/2024, the Director of re-educated Nurse #4 regard requirement that at any time a cart laptop is unattended, the be closed or locked so that repersonal health information is displayed.</li> <li>On 10/23/2024, the Director of and designee(s) initiated re-ea all licensed nursing staff inclumed-aides and agency staff requirement that at any time a cart laptop is unattended, the be closed or locked so that repersonal health information is displayed.</li> <li>On 10/23/2024, the Director of and designee(s) initiated re-ea all licensed nursing staff inclumed-aides and agency staff requirement that at any time a cart laptop is unattended, the be closed or locked so that repersonal health information is displayed. Any newly hired M licensed nurses will be educated orientation upon hire.</li> <li>(4) Indicate how the facility pl monitor its performance to mathe solutions are achieved an Through the utilization of an of monitoring tool, the Director of designee(s) will monitor 5x/w weeks, 3x/wk for 4 weeks, an weeks to ensure that the 4 m cart laptops remain free of dis resident personal health information is resident personal health information of an of an on tattended.</li> <li>The Administrator, Director of designee will report findings of monitoring process to the factor of designee and Performance</li> </ul>	re-occur in of Nursing ing the a medication screen is to esident a not of Nursing education to uding regarding the a medication e screen is to esident a not led-Aides or ated during lans to ake sure that nd sustained: observation of Nursing or k for 4 edication splaying mation when		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 11/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
DURHAM	NURSING & REHABILIT	ATION CENTER		11 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 583	Continued From page	e 15	F 583	Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	f
F 684 SS=J	CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatmen facility residents. Bas assessment of a resid that residents receive accordance with profe	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered	F 684	The facility alleges compliance on 11/22/2024.	11/22/24
	This REQUIREMENT by: Based on observatio family member, staff, Technician (EMT), Pr Practitioner (NP) inter comprehensively ass who had untreated of condition that causes blocked during sleep, airflow) to determine abdominal pain, chan migraines that occurr last 6 months in conju (CO2) levels near the range (a set of number	is not met as evidenced n, record review, resident, Emergency Medical hysician, and Nurse rviews, the facility failed to ess a resident (Resident #1) pstructive sleep apnea (a the upper airway to become		<ul> <li>F-684</li> <li>(1) How corrective action will be accomplished for resident(s) found to have been affected:</li> <li>On 10/7/2024 At 4:08 PM, Resident #1 had an acute change in status and was unable to answer questions and was s to the hospital.</li> <li>Resident #7 was admitted to the hospital on 10/22/24.</li> <li>(2) How corrective action will be accomplished for resident(s) having the second s</li></ul>	s ent tal

Facility ID: 923264

DURHAM NU PREFIX TAG F 684 C b V C ir ir ir a m t t 4 5 5 "C X 8 5 C W	(EACH DEFICIENC REGULATORY OR L Continued From page be normal) in August When breathing is rec can lead to a decreas	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING ID PREFI TAG	S1 41 D	TREET ADDRESS, CITY, STATE, ZIP CODE 11 S LASALLE STREET URHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	11/	C /05/2024
DURHAM NU PREFIX TAG F 684 C b V C ir ir ir a m t t 4 5 5 "C X 8 5 C W	URSING & REHABILIT/ SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L Continued From page be normal) in August When breathing is red can lead to a decreas	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	41 D	11 S LASALLE STREET URHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG F 684 C b V C ir ir ir a m t 4 5 5 "C X 8 8 5 C W	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR I Continued From page be normal) in August When breathing is reaction	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		URHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG F 684 C b V C ir ir ir a m t 4 5 5 "C X 8 8 5 C W	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR I Continued From page be normal) in August When breathing is reaction	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	IX	PROVIDER'S PLAN OF CORRECTION	_	
F 684 C b V C C ir ir ir ir 4 5 5 "C X 8 S C W	(EACH DEFICIENC REGULATORY OR L Continued From page be normal) in August When breathing is rec can lead to a decreas	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI			_	
b V c ir ir a m th th 4 5 5 " v x 8 S C W	be normal) in August When breathing is rec can lead to a decreas				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
b V c irr ir a m th th 4 5 5 " v x 8 S C W	be normal) in August When breathing is rec can lead to a decreas			684			
V c irr a m th 4 re 5 "c x 8 s C W	When breathing is rec can lead to a decreas		F	004			
c ir ir a m th 4 re 5 "c x 8 s c v w	can lead to a decreas	be normal) in August 2024 and October 2024.			potential to be affected by the same iss	sue	
ir a m tr 4 5 5 " v x 8 S C W		When breathing is reduced due to sleep apnea it			needing to be addressed:		
ir a n tr 4 5 5 "o x 8 s C W	can lead to a decrease in oxygen and an increase in CO2 in the blood. The facility also failed to				An audit was done on 10/24/2024 by th		
a m th 4 5 5 "c x 8 s C W		s orders for Resident #1 for			Director of Nursing in the last 6 months determine if any other residents missed		
m th 4 5 5 "c x 8 8 S C W	a Continuous positive Airway Pressure (CPAP)				any appointments due to needing any	4	
tt 4 5 "c 8 8 8 S 0 V 0 W		at sleep apnea by keeping			special accommodations due to weight		
4 76 5 "0 8 8 5 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		le sleeping) ordered on			and any other residents with diagnoses		
re 5 "c 8 s C W		onsultation (insurance			obstructive sleep apnea for any untreat		
5 "( 8 s C w		ning the CPAP) ordered on			signs and symptoms. The audit reveale		
"( X 8 S C W	-	onsultation (ordered for			that that no other residents were affected		
8 S C W	'constant migraines")	ordered on 8/24/24, and an					
s C W	k-ray (ordered for abo	dominal pain) ordered on			An audit to determine if any residents h	ad	
C W	8/24/24. On 10/6/24 F	Resident #1 was excessively			reported any new change in condition t	hat	
w		ouse, and had no oral intake.			was not followed up on by a licensed		
	•	cy Medical Service (EMS)			nurse of residents with a brief interview	for	
l a		tered mental status changes			mental status (BIMS) score of 13 or		
		sment Resident #1 was			higher was completed by the		
		c (low oxygen saturation)			Administrator on 10/25/2024. The Audit	t	
		saturation of 60% (normal			revealed that no other residents were		
		level in the 90's (normal			noted to be affected.		
	,	s Glasgow Coma Scale				<b>b</b>	
	•	re a person's level of			An audit was completed on 10/25/2024	-	
	-	red she was in a comatose ssessed at the hospital with			the Director of Nursing of progress note for the past 7 days to ensure that anyou		
		tention with elevated CO2			reporting a change of condition had a		
		stemic hypoxemia/severe			prompt follow up and provider notification	on	
		ute kidney injury, and			The audit revealed that no one else wa		
		vel of liver enzymes in the			affected.	-	
		to the prolonged systemic					
	<i>,</i> .	spiratory failure. The			From 10/25-10/28, the Director of Nurs	ing	
		cluded untreated obstructive			also questioned all of the licensed nurs	-	
	5	nt #1 was admitted to the			regarding knowledge of any residents		
l Ir	ntensive Care Unit (I	CU) on 10/7/24 and spent			having had a change in condition that		
	10 days in the hospita				deviated from their baseline with no foll	ow	
					up. Signatures accounted for both the		
lr	n addition, the facility	/ failed to identify the			education and the questionnaire. No		
s	seriousness of a char	nge in condition, complete			residents were noted to be affected.		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 11/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				411 S LASALLE STREET	
URHAM	NURSING & REHABILIT	ATION CENTER	1	DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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)	LD BE COMPLETIC
F 684	Continued From pag	e 17	F 684		
	identify the urgent neresident with a histor had intact cognition a approximately 9:00 F aide (NA) he had pai arm and leg. The N/ nurse. On the next s AM Resident #7 info not feel his left side. nurse. There were nere comprehensive asse either nurse. On 10/ AM a NA took Resider Resident #7 stated h his left side, and his side, and this had all 10/21/24). Unit Man room and assessed speech was slurred, have any feeling, and muscle tone. The Nu	eed for medical attention for a y of a stroke. Resident #7 and on 10/21/24 at PM he reported to a nurse n and numbness in his left A aide reported this to the shift at approximately 6:00 rmed another NA he could The NA reported this to the o documented ssments for Resident #7 by 22/24 between 7:00 and 7:15 ent #7 his breakfast and e was not well, couldn't feel vision was blurred on the left started after dinner (on ager #1 was called to the Resident #7 and found his his left arm and leg did not d they did not have any urse Practitioner was in the		<ul> <li>On 10/31-11/1/2024 the Director of Nursing or Staff Development Coor interviewed all nursing assistants regarding knowledge of any resider having change of conditions in the days that were not addressed. No negative findings were noted.</li> <li>(3) What measure(s) will be put in por systemic changes made to ensure the identified issue does not re-occ the future:</li> <li>On 10/23/2024 the Regional Nurse Consultant re-educated the administ nursing team that consists of the D of Nursing, Staff Development Coordinator and the 2-Unit Manage following physician orders to includ consultations, diagnostics, special equipment, and to ensure compreh assessments are done as indicated</li> </ul>	rdinator hts last 7 blace re that ur in strative irector ers on e ensive
	transferred to the En for evaluation of stro presented to the ED changes and inability lower extremities. D vascular accident (C following cognitive de (difficulty swallowing Resident #7 was out administration of Alte medicine that dissolv ischemic strokes. Re the critical care strok on 10/29/24.	I Resident #7 and had him hergency Department (ED) ke symptoms. Resident #7 with new onset vision $\prime$ to use his left upper and iagnoses included cerebral VA- ischemic stroke) with eficits and dysphagia ) post CVA. It was noted side of the window for the eplase (tPA) which is a $\prime$ es blood clots used to treat esident #7 was admitted to re unit and was discharged e occurred for 2 of 3 or professional standards of		<ul> <li>On 10/24/2024 the Director of Nursing/Designee re-educated all r on following physician orders to inco consultations, diagnostics, special equipment and to ensure comprehe assessments are done as ordered. nurse who has not received the edu will not be permitted to work after 10/24/2024 until the education has completed.</li> <li>Beginning 10/24/2024, to ensure al orders are implemented for consult diagnostics, and special equipment Director of Nursing/designee will at order listing report in morning clinic meeting.</li> </ul>	lude ensive Any ucation been l ation, t the udit the

Facility ID: 923264

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/03/2024 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345070	B. WING _			C 11/05/2024	
NAME OF P	ROVIDER OR SUPPLIER		- <b>I</b>	ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER			1 S LASALLE STREET URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		ЗE	(X5) COMPLETION DATE	
F 684	Continued From page	2 18	F6	684			
	10/7/24 when Reside change in condition a with an O2 saturation the 90s and immediat 10/25/24. Immediate 10/21/24 for Resident left arm and leg were assessment was not of medical interventions jeopardy ended for Re Immediate jeopardy v when the facility imple allegation of immedia facility will remain out and severity of "D" (n for more than minima jeopardy) to ensure e monitoring systems a The findings included Resident #1 was adm 5/22/22 with multiple tachycardia (increase obstructive sleep apn have a diagnosis of m A Physician order dat Resident #1 was to re milligrams (mg) every headache. A Physician order for	jeopardy began on #7 when he reported his numb and a comprehensive completed to determine if were necessary. Immediate esident #7 on 11/02/24. vas removed on 11/02/24. was removed on 11/02/24. was removed on 11/02/24. emented a credible te jeopardy removal. The of compliance at a scope o actual harm with potential I harm that is immediate ducation is completed and re in place and are effective. : itted to the facility on diagnoses that included d heart rate), asthma, and ea. The resident did not nigraines on admission. ed 3/28/23 revealed eceive Fioricet 50-300-40 of hours as needed for Resident #1 dated 7/11/23 cid reflux medication) 40			Beginning 10/24/2024, the nurse administrative team will review the orce listing report and progress notes durin clinical morning meeting to ensure that any consultations and diagnostics have been completed and results provided the practitioners so that a complete ar accurate comprehensive assessment be completed. In the event a consultar or diagnostics was not completed as ordered, the Director of Nursing or Un Manager will notify the Physician to determine further recommendation. Th Unit Managers were educated on this process by the Director of Nursing on 10/24/2024. Beginning 10/24/2024, all alternate transportation companies will be contacted by the Transportation Scheduler should weight limits exceed normal transportation capabilities. Transportation is scheduled when the appointment is received. If unable to f alternative transportation, the Transportation Scheduler will notify th Director of Nursing or Unit Manager. Director of Nursing or Unit Manager. Director of Nursing or Unit Manager. Director of Nursing or Unit Manager with notify the provider to determine if appointment can be re-scheduled or if emergent transportation is necessary. transportation Scheduler and the Unit Managers were educated on this proc on 10/24/2024 by the Director of Nurs The Director of Nursing will train any r transportation schedulers and Unit Managers upon hire.	g t re to nd can tion it ne it ne ind e The ill c The ess ing.	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
		345070	B. WING		1'	C 1/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
DURHAM	NURSING & REHABILIT	ATION CENTER		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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From page	e 19	F 684	4		
	A Physician order for indicated Propranolol times a day for heada A Physician order for	Resident #1 dated 11/8/23 I (beta blocker) 20mg three		Beginning 10/24/2024, any requires a treatment/test tha performed in the hospital wi by the Director of Nursing o importance of why the hosp is recommended.	at can only be Il be educated n the	
	A Physician order dated 4/13/24 revealed an order for Resident #1 to receive a CPAP machin for obstructive sleep apnea. Another Physician order dated 5/10/24 revealed Resident #1 was to receive a pulmonology consult for her obstructive sleep apnea and CPA machine.	to receive a CPAP machine apnea. der dated 5/10/24 revealed eceive a pulmonology active sleep apnea and CPAP		On 10/25/2024 the Director initiated education to all lice complete a clinical assessm minimum vital signs and per systems once notified of a c condition/medical emergence accident or incident, injuries source, significant change in physical, emotional, or men which can include elevated	nsed nurses to nent of a rtinent body change in cy to include of unknown n residents tal condition vital signs,	
	order for Acetaminop times a day for pain.	dated 4/12/24 revealed an hen 325mg give 2 tablets 3		altered mental status, blurred headaches, numbness or tin parts, uncontrolled pain, etc and to notify the healthcare	ngling to body ., to call 911 provider of	
	10/22/24 at 3:52pm. written the order for F CPAP machine and a He stated he had ord April 2024 first becau	curred with Physician #1 on Physician #1 verified he had Resident #1 to receive a a Pulmonology consultation. ered the CPAP machine in ise he understood Resident AP machine. Physician #1		findings once the assessme and the assessment is doc the medical record. Educati included any changes repor assistants. Any licensed nu not been educated by 10/28 taken off the schedule until	umented in on also ted by nursing rse that has 3/2024 will be	
	stated Resident #1 re her obstructive sleep stated "about" a mon remember from who) have a CPAP machin	equired a CPAP machine for apnea. The Physician th later he learned (could not that Resident #1 did not ue and needed a		has been received. All new educated by the Director of orientation. The Director of ensure all licensed nurses a	Nursing during Nursing will are in-serviced.	
	machine, so he wrote consultation in May 2 know if Resident #1 e	ation but said he knew		On 11/1/2024, the Regional Clinical Services educated t Administrator, The Director Staff Development Coordina Human Resource Director c orientation process for nursi	he of Nursing, ator, and The on the	

Event ID: WJLJ11

Facility ID: 923264

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STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	IO. 0938-039 TE SURVEY MPLETED	
		345070	B. WING		C 11/05/2024		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				411 S LASALLE STREET			
DURHAM	NURSING & REHABILIT			DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 684	Continued From page 20		F 68	4			
				will include education on recog	nizing		
	During a telephone ir	nterview with Physician #2 on		change in condition, timely ass			
	10/22/24 at 3:36pm,			and monitoring of change in co			
		uired by insurance to receive		recognizing a medical emerger			
	•	ation prior to receiving a		effective communication during	a medical		
		explained that the insurance		emergency, and calling 911.			
		oof and severity of Resident					
		p apnea before they would for a CPAP machine. The		On 11/1/2024, the Director of N Staff Development Coordinator			
		sident #1 required a CPAP		re-educated all nursing assista			
		obstructive sleep apnea.		change in condition of residents			
		Resident #1 was never able		recognizing signs and symptom			
	-	tation due to transportation		stroke such as blurred vision, s			
	difficulties.			speech, weakness to one side	of the		
				body, and facial drooping. Educ			
		nsport Staff occurred on		included the importance of resi			
		Transport Staff confirmed		receiving immediate medical at			
	she was responsible			should any of these signs be id			
	appointments. She al	ing alternate transportation if		Any nursing assistant that has received the education on 11/1.			
	-	in the facility's van. Transport		be taken off the schedule until t			
		dent #1 being too large to		education has been received. T			
		hair van and would need		Director of Nursing will ensure			
	non-emergency stret	cher transport. She stated tract with a non-emergency		assistants are educated.	5		
	transport company bi	ut said "they are always		(4) Indicate how the facility plar	ns to		
		rt Staff discussed not		monitor its performance to mak			
	receiving the consult	•		the solutions are achieved and			
		30/24. She stated since		The Director of Nursing or design	• • • •		
		n periodically trying to		once a change of condition is in			
	would also meet the	ment with Pulmonology that		will monitor if the change of cor identified appropriately as urge			
		ule. She stated she had been		non-urgent, if a comprehensive			
		ng Resident #1 to the		assessment has been complete			
	Pulmonologist.	<u> </u>		appropriate follow up steps wer			
	5			conducted. Monitoring will take			
	A review of a Physici	ans note dated 6/19/24		x/wk for 4 weeks, 3x/wk for 4 w	•		
		#1 revealed Resident #1 had		1x/wk for 4 weeks.			
	episodic altered awa	areness", ongoing chronic					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/20 FORM APPROVE OMB NO. 0938-03		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345070	B. WING		C 11/05/2024		
	ROVIDER OR SUPPLIER	ATION CENTER	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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 684	(migraine medication medication) as needed tiredness during the of as being treated with up with a Pulmonolog The quarterly Minimu 8/8/24 revealed Resid intact, no rejection of breath. The MDS also did not have a CPAP documented as havin The MDS documented that occasionally inte and that she received The physician order of order for lab work that count (CBC), compre (CMP), lipid panel (for (for diabetes). Resident #1's lab work her CO2 level was 30 On 8/24/24 there was Resident #1 to receive for constant migraine There was an order of receive an x-ray for a A nurses note dated a revealed the x-ray ted was unable to be per weighed more than the The care plan dated a	being treated with Topamax ) daily and Fioricet (migraine ed, and insomnia with day which was documented a CPAP machine and follow gist. Im Data Set (MDS) dated dent #1 was cognitively care, and no shortness of to documented Resident #1 machine. Resident #1 was og a weight of 430 pounds. In the resident also had pain rfered with her daily routine d pain medication. Idated 8/18/24 revealed an it included a complete blood hensive metabolic panel r cholesterol), and an A1C rk dated 8/20/24 revealed 0. Is a physician order for re a neurology consultation s. In 8/24/24 for Resident #1 to bdominal pain. B/25/24 written by Nurse #3 chnician told her the x-ray formed because Resident #1	F 6	<ul> <li>84</li> <li>The Administrator, Director of designee will report findings a monitoring process to the face Assurance and Performance Improvement Committee for additional monitoring or modify this plan. The QAPI Committee modify this plan to ensure the remains in substantial complete The facility alleges compliantee 11/22/2024.</li> </ul>	of the cility Quality any ification of ee can e facility iance.		

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/03/2024 RM APPROVED O. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			E SURVEY IPLETED C	
		345070	B. WING		11	U/05/2024	
NAME OF P	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CO			
DURHAM	NURSING & REHABILIT	ATION CENTER	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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	plan also did not inclumigraines, abdominal A Physician's order refioricet 50-300-40 mi as needed for headact 9/8/24. Nursing documentation Manager #1 revealed get out of bed due to headache. A Physician order for indicated Fioricet 50- every 6 hours as nee On 9/14/24 a nursing of Nursing (DON) rev requested Fioricet be resident's headaches Review of Resident # Administration Record through August 2024 received as needed ( in September 2024 R on 9/3, 9/7, 9/25, 9/26 of a headache. The resident's medicate evidence the orders w CPAP ordered on 4/1 consultation ordered consultation and x-ray	<ul> <li>Inea. The resident's care ude information on I pain, or refusals of care.</li> <li>Inevealed Resident #1's illigrams (mg) every 6 hours che was discontinued on</li> <li>Inon on 9/11/24 written by Unit I Resident #1 did not want to not feeling well and having a</li> <li>Resident #1 dated 9/14/24 300-40 milligrams (mg) ded for headache.</li> <li>Inote written by the Director realed Resident #1 ere-started as needed for the 3.</li> <li>It's Medication d (MAR) from October 2023 revealed Resident #1 PRN) Fioricet 39 times and resident #1 received Fioricet 6, and 9/30/24 for complaints</li> <li>al record revealed no were implemented for the 3/24, pulmonology on 5/10/24, or the neurology y ordered on 8/24/24.</li> <li>#1 was administered PRN</li> </ul>	F 684				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	
		345070	B. WING				05/2024
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER		411 S LASALLE STREET DURHAM, NC 27705			
(X4) ID PREFIX TAG			DED BY FULL PREFIX (EACH CORRECTIVE ACTION SH		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	A Physician order dat indicated Protonix 400 Protonix order indicat was lowered from the of Protonix 40mg twice The Nurse Practitioner revealed Resident #1 of headaches that we current treatment. Th seeing Resident #1 to of stomach pain rating worst pain). She doc resident's size, imagin be completed, so no in NP noted that Reside the emergency room she would go if the pa She documented Reside that exert and the stomach pain NP noted that Reside migraines were return neurological deficits. pain was to order lab documented plan for migraines. The NP was interview The NP discussed 10 had ever seen Reside Resident #1 on 10/4/2 abdominal pain. The she had ordered the I doing lab work it woul #1 had an abdominal her pain. She stated fix- rays had been orde	ted 10/4/24 for Resident #1 mg once a day. This ed Resident #1's medication initial order dated 7/11/23 ee a day. er (NP) note dated 10/4/24 had continued to complain ere not responding to the e NP documented she was oday (10/4/24) for complaints g a 9 out of 10 (10 being the umented due to the ng such as x-rays could not imaging had been done. The ent #1 had refused to go to but that the resident told her ain became "intolerable." sident #1's stomach pain t then documented Resident when she is not eating. The ent #1 expressed that her ning daily without other The NP's plan for stomach work. There was no Resident #1's increased	F	684			

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					I APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
	oonaconon	DERTH TO THOM DER.	A. BUILDI	NG _					
		345070	B. WING			C 11/05/2024			
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2024		
				4	411 S LASALLE STREET				
DUKHAIVI	NURSING & REHABILIT	ATION CENTER		I	DURHAM, NC 27705				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION		
PREFIX TAG	(	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE		
					DEFICIENCY)				
F 684	Continued From page		F	684	1				
		ger #1 why the x-ray had not nursing supervisor told her it							
	-	nt #1 did not fit into the							
	facility van. She state								
		spital to have the x-rays							
		but the resident refused.							
		in the high range since							
		ed Resident #1 did not show							
	any signs of respirato	•							
	Resident #1's lab wor her CO2 level was 31	k dated 10/5/24 revealed							
	Ther CO2 level was 51								
	On 10/5/24 Resident	#1 was provided with PRN							
	Fioricet for complaints	s of a headache.							
	Review of Resident #	1's intake for 10/6/24							
	revealed she did not l	have any intake.							
	Review of Resident #	1's medical record revealed							
	no nursing documenta								
	· · ·	A) #1 was interviewed on							
		NA #1 stated she worked ne night of 10/6/24 to the							
	morning of 10/7/24 wi	-							
	-	of her shift Resident #1 was							
		, which NA #1 stated was							
		e, but then said Resident #1 I to be warmed between							
	•	ed the resident did not							
		o be warmed up. NA #1							
		he saw Resident #1 was							
		n. She said at that time the groggy" but interacting with							
	-	d she did not notice anything							
		a one did not notice anything uld have told the nurse.							
	During a talanhana in	tomious with Numer #4 cr							
	During a telephone in	terview with Nurse #1 on							

Facility ID: 923264

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/03/2024 FORM APPROVEI B NO. 0938-039
	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVE COMPLETED	
		345070	B. WING				C 11/05/2024
NAME OF P	ROVIDER OR SUPPLIER	1		STR	REET ADDRESS, CITY, STATE, ZIP CODE		
	NURSING & REHABILIT			411	S LASALLE STREET		
DORITAI	NORSING & REHABIEIT			DU	IRHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	familiar with Resident worked with the resid to 3:00pm shift. Nurse Resident #1 was talka quiet and slow. She s remember if the resid but said Resident #1 NA #2 was interviewe The NA confirmed sh on 10/6/24 on the 3:0 stated she had been #2 discussed residen talkative, alert, and on Resident #1 was "ver wake up. The NA stat resident to arouse he would say "I'm awake #1 would fall right bac telling the nurse on sl nurses name) and the signs then telling her just gave her an Ativa #1 would become ver medication, so she st anything was wrong. did not eat or drink ar Review of Resident # revealed, the resident Ativan (antianxiety me There were no vital si Resident #1 on 10/6/2	t the nurse discussed being t #1 and confirmed she ent on 10/6/24 from 7:00am e #1 stated on 10/6/24 ative, but her speech was stated she could not lent ate or appeared sleepy took all her medications. ed on 10/23/24 at 11:35am. e worked with Resident #1 00pm to 11:00pm shift and familiar with the resident. NA t being usually very riented but said on 10/6/24 ry sleepy" and difficult to ted she had to shake the rr and then the resident ck to sleep. She discussed hift (could not remember the e nurse performing vital Resident #1 was "ok" and "I an." NA #2 stated Resident ry sleepy after receiving tated she did not think The NA stated Resident #1 hything during her shift. e1's MAR for 10/6/24 t had not received any edication).	F	684			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/03/2024 MAPPROVED D. 0938-0391
STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION UMBER:				E CONSTRUCTION		(X3) DATE COMF	
		345070	B. WING					05/2024
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE,	, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER			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 PREF TAG		(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 684	had been assigned to 10/6/24. She stated of "very sleepy" and had stated had not happe assigned to her. The remember if Resident drink. NA #3 stated sl Resident #1 refusing Review of Resident # revealed she did not 10 The NP note dated 10 #1 was sleeping, wou respond to questions She documented that reporting abdominal p with nursing to ensure receiving medication headaches. The NP of continued abdominal testing to rule out an noted related to Reside documentation/plan fo CO2 level. There wa NP offered for Reside A nursing progress no dated 10/7/24 docum that Resident #1 was "simple questions." T Resident #1 was hard Doctor (MD) was at th documented Residen refused her 2:00pm n	th Resident #1 but said she o her a "few" times before on 10/7/24 Resident #1 was d refused care which the NA ned before when she was NA said she could not t #1 had anything to eat or he informed Nurse #1 of care. e1's intake for 10/7/24 have any intake. 0/7/24 documented Resident IId open her eyes, and but remained "very sleepy". t Resident #1 was still oain and that she checked e Resident #1 was still for her continued documented her plan for the pain was to order further infection. There was no plan dent #1's headaches or or the resident's increased s no documentation that the ent #1 to go to the hospital. Dete written by Nurse #1 ented at 2:16pm revealed alert and able to answer, he note documented d to arouse and the Medical he bedside. Nurse #1 t #1 refused care and	F	684				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
	245070 PROVIDER OR SUPPLIER		B. WING				C / <b>05/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL				411 S LASALLE STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	saw a difference in Re the resident was not to and difficult to arouse and got the NP to ass the NP offered Reside but the resident refus about her documenta would "only answer s explained Resident # answers but on 10/7/2 provide 1-2-word ans Resident #1 remained to arouse her whole s Resident #1 started c hurting and not feeling offered to send the re the resident refused. Resident #1 having sy abdominal pain, and s not remember for how symptoms. Unit Manager #1 was 5:47pm. The Unit Mai #1 "being off" in her " morning. She explain was quiet, and that th not feel well. The Unit offered to send Resid 10/7/24 in the morning prominent noticeable when she stopped in noticed the resident th and thought Resident The Unit Manager sta asked Nurse #2 to as	at 7:00am on 10/7/24, she esident #1. She explained valking, excessively sleepy, . The nurse stated she went sess Resident #1, and that ent #1 to go to the hospital, ed. Questioned Nurse #1 tion and what she met by imple questions." Nurse #1 1 would usually provide long 24 Resident #1 would only wers. Nurse #1 stated d sleepy, and it was difficult whift and late in the shift omplaining of her stomach g well. The nurse stated she sident to the hospital, but Nurse #1 discussed ymptoms of a headache, sleepiness "often" but could v long the resident had the interviewed on 10/22/24 at nager discussed Resident demeanor" on 10/7/24 in the ed Resident #1's speech e resident told her she did	F	684			

Facility ID: 923264

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DEPARTMENT OF HEA					PRINTED: 12/03/202 FORM APPROVE OMB NO. 0938-039		
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345070	B. WING		C 11/05/2024		
NAME OF PROVIDER OR SUPP	PLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE		
				411 S LASALLE STREET			
DURHAM NURSING & RE	HABILITATION C	INIER		DURHAM, NC 27705			
PREFIX (EACH D		OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE		
it was mention CPAP machin discussed Re headaches, a least 6 month not aware Resident #1 h 10/7/24. Nurse #2 wro documented a Resident #1 w her mouth dro use right hand questions. Th and the reside During an inte skills develop 5:32pm, the r see Resident NP. Nurse #2 10/7/24 after by Unit Mana- saw Resident documented o Nurse #2 des drooping to th drooping, una- unable to ans Resident #1 w (person, place Nurse #2 exp #1 on 10/7/24	d she remembe ned that Residen ned that Residen ie. The Unit Mar sident #1 having bdominal pain, a s. The Unit Man nad no oral intak te a progress no at 4:08pm. Nurs- vas observed wi poping, right eye d, and was unab e note showed 9 ent was transfer erview with Nurs- ment coordinato purse clarified that #1 on 10/7/24 b explained she s being asked to a ger #1. When as #1 she stated it on her note whic cribed Resident te right side of h able to squeeze 1 was normally ale a, time, and situal alained as soon a she immediate	hager also g periods of and sleepiness for at hager stated she was e on 10/6/24 or be on 10/7/24 e #2 documented th the right side of e drooping, unable to ble to answer 911 was contacted red to the hospital. e #2 (the facility's bor) on 10/22/24 at at an MD did not but that it was the saw Resident #1 on assess the resident sked what time she it was the time sh was 4:08pm. #1 on 10/7/24 with er mouth, right eye her hands, and	F 6				

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/03/2024 DRM APPROVED NO. 0938-0391	
STATEMENT	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				ATE SURVEY DMPLETED	
		345070	B. WING			C 11/05/2024		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
DURHAM	NURSING & REHABILIT	ATION CENTER			S LASALLE STREET RHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	abdominal pain. Nurraware Resident #1 di on 10/6/24 or 10/7/24 The Emergency Med dated 10/7/24 revealed at 3:56pm, dispatch warrived at the facility a Resident #1's bedsid documented upon the sitting on her bed cor me to the hospital." E altered and could not was, where she was, Resident #1's skin wa constricted, oxygen s 90-100%) and her CC documented they pla oxygen with improver milligrams (mg) of Nar reverse opioid effects pupils being constrict overdose) with impro show improvement b become confused ag A telephone interview Medical Technician (ff 5:17pm. The EMT dis facility "shortly" after stated he was escorted the facility's reception arrived at Resident # in bed with the head position and Residen explained the resider only responded to pa when she did open here.	se #2 stated she was not d not have any oral intake d. ical Service (EMS) report ed a call was placed to 911 vas notified at 4:00pm, EMS at 4:07pm and was at e at 4:09pm. EMS eir arrival Resident #1 was fused and repeating "take MS noted Resident #1 was tell the EMS staff who she or what was going on. as cold and sweaty, pupils ats were 60% (normal D2 was 90. The EMS staff ced Resident #1 on high flow ment and provided 2 ircan (medication used to a) due to Resident #1's	F	684				

Facility ID: 923264

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		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDI	NG _			
		345070	B. WING				C 05/2024
NAME OF P	ROVIDER OR SUPPLIER			6	STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	03/2024
				411 S LASALLE STREET			
DURHAM	NURSING & REHABILIT	ATION CENTER			DURHAM, NC 27705		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· · ·		PREFI		(EACH CORRECTIVE ACTION SHOULD E		COMPLETION DATE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		5/112
			_				
F 00 4							
F 684	Continued From page		F	684	<b>1</b>		
		wake for a 'few" seconds.					
		ately 5 minutes" of being in					
		an older nurse" entered and					
		lled because of "abnormal"					
	-	T stated the vital signs the					
		with in normal range. EMT					
		sessment Resident #1 had ns, altered mental status,					
		explained Narcan was given					
		aving constricted pupils					
		l occur if there was an opioid					
		so explained the overdose					
		Itentional but said if Resident					
		conscious when given her					
		ad an infection, this could					
		being able to fully process					
		igh her system causing an					
	overdose. He stated I	Resident #1's high CO2					
	levels would not have	caused constricted pupils					
	but would have cause	ed the altered mental status.					
	The EMT said upon le	eaving the facility Resident					
	was unconscious and	l not talking.					
	Review of Resident #	1's medical record revealed					
		vital signs on 10/7/24.					
		-					
	Review of Resident #	•					
		was admitted on 10/7/24					
	-	)/17/24. Upon admission,					
	Resident #1's CO2 le						
	oxygen level was 73%						
		ital with hypercapnia (CO2					
		d CO2 levels), prolonged					
		severe respiratory failure, nd transaminitis (high level					
		e blood) suspected due to					
	the prolonged system						
		ne contributing factors					
		ostructive sleep apnea. The					

Facility ID: 923264

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/03/2024 FORM APPROVED JB NO. 0938-0391	
STATEMENT	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				3) DATE SURVEY COMPLETED	
		345070	B. WING			C 11/05/2024		
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE			
				411	S LASALLE STREET			
DURHAM NURSING & REHABILITATIO		ATION CENTER		DUF	RHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	resident had a Glasg which showed Reside state. She was transf where Resident #1 w machine (a machine and remove CO2 fron hypercapnia. The hos Resident #1's migrain untreated sleep apne medication. An interview with Res 10/22/24 at 12:08pm change in condition the explained she slept at 10/7/24 then woke up hospital on 10/8/24. If not remember having staff, taking any med to eat on 10/6/24 or 15 she never had a CPA been in the facility. S Physician (Physician needing to see a Pulli ago" and explained to needed so she could stated she never saw a CPAP machine. Res another Physician (P her he wanted her to months ago" and hav was told by the facility that the facility could her to the pulmonolog CPAP machine. Resi there was no transpo someone her size. Th periods of excessive	ow Coma Scale completed ent #1 was in a comatose ferred to intensive care vas treated with a BiPAP that helps to provide oxygen m the lungs) for her spital records documented hes exacerbated due to ea and the resident was given sident #1 occurred on . Resident #1 discussed her hat started on 10/6/24. She all day on 10/6/24 and o in intensive care at the Resident #1 stated she did g any conversations with ications or having anything 10/7/24. Resident #1 stated AP machine since she has he explained that the #1) had discussed with her monologist "several months o her the appointment was obtain a CPAP machine but v a Pulmonologist or received esident #1 also explained hysician #2) had also told see a Pulmonologist a "few ve a CPAP machine but she y (could not remember who) not find transportation to get gist so she could receive the dent #1 stated she was told ortation available for he resident discussed	F	684				

Facility ID: 923264

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/03/2024 MAPPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C 11/05/2024	
		345070	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD		
				411 S LASALLE STREET		
DURHAM	NURSING & REHABILIT	ATION CENTER		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 684	the Physician's had on Neurologist for her her x-ray of her abdomer appointments happer remembering a mobil but said she was told she was too large for Discussed with Resid the hospital. Residen the NP offered to sen not think she needed 10/7/24 she said she talking to the NP or s to the hospital. The re explained to her that see a Pulmonologist have an x-ray at the for one explained to her could have been caus levels. Resident #1 st information, she woul hospital. The NP stated she sa "early morning" of 10 sleeping. She explain be "shaken" to wake due to it being "so ear resident told her "I an The NP commented I "sleepy." She stated s #1 did not have any of 10/7/24. The NP state #1 again on 10/7/24. aware Resident #1 w back in April 2024 or order to see a Pulmo	6 months". She stated one of ordered her to see a eadaches and to have an	F 68	4		

Facility ID: 923264

If continuation sheet Page 33 of 76

		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/03/2024 ORM APPROVED 3 NO. 0938-0391
STATEMENT (	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				DATE SURVEY COMPLETED
		345070	B. WING				C 11/05/2024
NAME OF P	NAME OF PROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP COD	DE	
DURHAM	NURSING & REHABILIT	ATION CENTER			S LASALLE STREET RHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 684	that Resident #1 had appointments due to Discussed with the N symptoms of headacd and abdominal pain. Resident #1's sympto by her increased CO2 Resident #1's CO2 le out of range she did r her symptoms could I CO2 levels. The NP of to assess CO2 levels blood gas test which completed in the hosy arterial blood gas test from the arteries which oxygen levels. She st 10/4/24 and 10/7/24 th hospital but the reside she did not know if Re going to the hospital of The Director of Nursin by telephone on 10/2 explained she had no Resident #1 and that any concerns to her. Resident #1 was not scheduled appointme issues and explained non-emergency trans a month in advance r not coordinate transp appointments. The D aware of Resident #1 that Resident #1 did r 10/6/24 or 10/7/24. S	on order in August 2024 or not attended any of these transportation issues. P Resident #1's periodic nes, altered mental status, The NP confirmed all of oms could have been caused 2 levels. She stated since vels were not considered not inform Resident #1 that be caused by her increased commented that the only way was to conduct an arterial she stated was normally bital. She explained the t would draw blood directly th would show higher tated she had offered on to send Resident #1 to the ent refused. The NP stated esident #1 understood why was important. Ing (DON) was interviewed 9/24 at 10:09am. The DON t had much contact with the resident never voiced She stated she was aware able to attend any of her ents due to transportation the need for portation company required notice and the facility could ortation with the time of the ON discussed not being 's increased CO2 levels or not have any intake on	F	684			

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STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         AND PLAN OF CORRECTION       345070       B. WING		-	ID HUMAN SERVICES				FORM	M APPROVED D. 0938-0391
345070     B. WING     11//05/2024       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       DURHAM NURSING & REHABILITATION CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       00000000000000000000000000000000000	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMF	E SURVEY PLETED
DURHAM NURSING & REHABILITATION CENTER     411 S LASALLE STREET DURHAM, NC 27705       (x4) ID PREYIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTOR ECTION NOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTOR EACTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     Completing Output the DEFICIENCY       F 684     Continued From page 34 left the facility. The DON stated Resident #1 was awake but "looked drowsy."     F 684       The Administrator was interviewed on 10/23/24 at 3:20pm. The Administrator discussed being aware Resident #1 was unable to attend her scheduled appointments due to transportation issues. He had no comments related to Resident #1's hospitalization or how the lack of follow-through with Resident #1's appointments correlated to her hospitalization.     F 684       The Administrator was notified of immediate jeopardy on 10/23/24 at 3:20pm.     The Administrator was notified of immediate jeopardy on 10/23/24 at 3:20pm.       The Administrator was notified of immediate jeopardy on 10/23/24 at 3:20pm.     The Administrator was notified of immediate jeopardy on 10/23/24 at 3:20pm.       The facility provided the following credible allegation of immediate jeopardy removal: (1) Identify those recipients who have suffered, or are likely to suffer a serious adverse outcome		<b>345070</b> B. W		B. WING				•
DURHAM NURSING & REHABILITATION CENTER         DURHAM, NC 27705           (X4) JD 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-REFERENCE TO THE APPROPRIATE DEFICIENCY)         COMPLETION DEFICIENCY)           F 684         Continued From page 34 left the facility. The DON stated Resident #1 was awake but "looked drowsy."         F 684           The Administrator discussed being aware Resident #1 was unable to attend her scheduled appointments due to transportation issues. He had no comments related to Resident #1's hospitalization or how the lack of follow-through with Resident #1's appointments correlated to her hospitalization.         F 684           The Administrator was notified of immediate jeopardy on 10/23/24 at 3:20pm.         The facility provided the following credible allegation of immediate jeopardy removal: (1) Identify those recipients who have suffered, or are likely to suffer a serious adverse outcome         III and the series adverse outcome	NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETION DATE         F 684       Continued From page 34 left the facility. The DON stated Resident #1 was awake but "looked drowsy."       F 684       F 684         The Administrator was interviewed on 10/23/24 at 3:20pm. The Administrator discussed being aware Resident #1 was unable to attend her scheduled appointments due to transportation issues. He had no comments related to Resident #1's hospitalization or how the lack of follow-through with Resident #1's appointments correlated to her hospitalization.       The Administrator was notified of immediate jeopardy on 10/23/24 at 3:20pm.       The facility provided the following credible allegation of immediate jeopardy removal:         (1) Identify those recipients who have suffered, or are likely to suffer a serious adverse outcome       suffered, or	DURHAM	NURSING & REHABILIT	ATION CENTER					
left the facility. The DON stated Resident #1 was awake but "looked drowsy."         The Administrator was interviewed on 10/23/24 at 3:20pm. The Administrator discussed being aware Resident #1 was unable to attend her scheduled appointments due to transportation issues. He had no comments related to Resident #1's hospitalization or how the lack of follow-through with Resident #1's appointments correlated to her hospitalization.         The Administrator was notified of immediate jeopardy on 10/23/24 at 3:20pm.         The facility provided the following credible allegation of immediate jeopardy removal:         (1) Identify those recipients who have suffered, or are likely to suffer a serious adverse outcome	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETION
because of the noncompliance: The facility failed to comprehensively assess a resident (Resident #1) who had untreated obstructive sleep apnea to determine the root cause of periodic abdominal pain, change in mental status, and migraines that occurred intermittently over the last 6 months in conjunction with elevated CO2 levels on labs completed in August and October 2024. The facility also failed to implement physician's orders for Resident #1 for a CPAP ordered on 4/13/24, pulmonology consultation (insurance requirement for obtaining CPAP) ordered on 8/10/24, neurology consultation ordered on 8-24-24 (ordered for "constant migraines"), x-rays and ultrasound ordered on 8/24/24 (ordered for abdominal pain). Resident #1 was identified as being affected by the noncompliance.	F 684	left the facility. The D awake but "looked dra The Administrator wa 3:20pm. The Adminis aware Resident #1 was cheduled appointme issues. He had no cou #1's hospitalization or follow-through with Re- correlated to her hosp The Administrator wa jeopardy on 10/23/24 The facility provided to allegation of immedia (1) Identify those reci- are likely to suffer a sis because of the nonco The facility failed to co resident (Resident #1 obstructive sleep apn cause of periodic abd mental status, and mi intermittently over the conjunction with eleva completed in August a facility also failed to in for Resident #1 for a pulmonology consultatio (ordered for "constant ultrasound ordered on abdominal pain). Res	ON stated Resident #1 was owsy." s interviewed on 10/23/24 at trator discussed being as unable to attend her ints due to transportation mments related to Resident to how the lack of esident #1's appointments obtalization. s notified of immediate at 3:20pm. the following credible te jeopardy removal: pients who have suffered, or erious adverse outcome impliance: comprehensively assess a ) who had untreated ea to determine the root ominal pain, change in graines that occurred e last 6 months in ated CO2 levels on labs and October 2024. The mplement physician's orders CPAP ordered on 4/13/24, ation (insurance requirement ordered on 5/10/24, n ordered on 8-24-24 t migraines"), x-rays and n 8/24/24 (ordered for ident #1 was identified as	F	684			

Facility ID: 923264

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/03/2024 RM APPROVED NO. 0938-0391
STATEMENT	NT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345070	B. WING			1	C 1/05/2024
NAME OF P	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				41	1 S LASALLE STREET		
DURHAM	NURSING & REHABILIT	Allon CENTER		DI	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 684	10/7/2024 and it was transferred to hospital refused to go to the h 10/7/2024 at 2:36 PW this time; Resident #1 assessed by the nurs recommended she go Resident # 1 refused On 10/7/2024 at 4:08 acute change in statu questions and was se #1 was diagnosed in mental status, acute it kidney injury, transan Resident #1 was place to an intensive care u and supplemental oxy done due to transami steatosis. In addition, order for Fioricet for r Resident # 1's pulmo consultations were di upon discharge to ho facility on 10/17/2024 any new orders for put follow up as she curro Upon review, Residen dioxide levels were w documentation review carbon dioxide levels On 5/10/2024 a pulm received for CPAP. T	r performed a ssment on 10/4/2024 and recommended that she be il on both dates. Resident #1 ioospital on 10/4/2024. On 1 a note was documented at 1 was comprehensively be practitioner who to to the hospital. However, to go. 9 PM, Resident #1 had an is and was unable to answer ent to the hospital. Resident the hospital with altered respiratory failure, acute ninitis, and migraines. 2ed on a BIPAP and admitted unit. She received IV Lasix ygen. An Ultrasound was initis which demonstrated Resident #1 received an migraines. nary and neurology scontinued on 10/7/2024 spital. Upon return to the the self and the self and the self almonology consultation or ently has BIPAP in place. In the self and the self and the self and the self were within normal limits. Upon v, Resident #1's October were within normal limits.	F	684			

Facility ID: 923264

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345070	B. WING				C 105/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
DURHAM	NURSING & REHABILIT	ATION CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 684	consultation was not of On 8/24/2024 an x-ra for abdominal pain. M the facility on 8/25/20 procedure due to Ress Practitioner note on 1 to go to Emergency D abdominal x-ray that w in house due to Reside alternative methods w 10/4/2024. The root cause for no address Resident # 1 facility's failure to acq transportation method Resident #1's sympto provide education to B importance of the need further testing. An audit was done on of Nursing in the last other residents misses needing any special a weight and any other obstructive sleep apn and symptoms. The a residents were affected (2) Specify the action the process or system adverse outcome from when the action will b On 10/23/2024 the Res	completed. y ultrasound was ordered lobile x-ray technician was in 24 and was unable to do the ident #1's weight. Per Nurse 0/4/2024, resident refused bepartment to have was unable to be completed lent # 1's weight. No other vere attempted prior to t implementing orders to 's symptoms was due to the uire alternative ds, failure to look at ms as a whole, and to Resident #1 on the ed to go to the hospital for 10/24/2024 by the Director 6 months to determine if any d any appointments due to residents with diagnoses of ea for any untreated signs udit revealed that no other ed. the entity will take to alter n failure to prevent a serious n occurring or recurring, and e complete: egional Nurse Consultant nistrative nursing team that or of Nursing, Staff	F	684	4		

Facility ID: 923264

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/03/2024 MAPPROVED
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345070	B. WING				C 105/2024
NAME OF PI	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
DURHAM	NURSING & REHABILIT	ATION CENTER		4	411 S LASALLE STREET		
DONIAN				I	DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page Managers on followin consultations, diagno and to ensure compre- done as indicated. On 10/24/2024 the Di- re-educated all nurses orders to include cons- special equipment an assessments are don who has not received permitted to work after education has been co- Beginning 10/24/2024 implemented for cons- special equipment the Nursing/designee will in morning clinical me Beginning 10/24/2024 team will review the op progress notes during ensure that any const have been completed practitioners so that a comprehensive assess the event a consultati completed as ordered Unit Manager will not determine further reco- Managers were educa Director of Nursing or Beginning 10/24/2024 companies will be cor Transportation Sched exceed normal transport	e 37 g physician orders to include stics, special equipment, ehensive assessments are rector of Nursing/Designee s on following physician sultations, diagnostics, d to ensure comprehensive e as ordered. Any nurse the education will not be er 10/24/2024 until the ompleted. 4, to ensure all orders are ultation, diagnostics, and e Director of audit the order listing report eting. 4, the nurse administrative rder listing report and g clinical morning meeting to ultations and diagnostics and results provided to the complete and accurate ssment can be completed. In on or diagnostics was not a, the Director of Nursing or fy the Physician to commendation. The Unit ated on this process by the n 10/24/2024. 4, all alternate transportation ntacted by the uler should weight limits portation capabilities.		684	DEFICIENCY)		
	-	ortation capabilities.					

Facility ID: 923264

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 12/03/2024 // APPROVED ). 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345070	B. WING				C <b>05/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
				4	411 S LASALLE STREET			
DURHAM	NURSING & REHABILITA	ATION CENTER			DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	CTION SHOULD BE COMPLÉTIC O THE APPROPRIATE DATE		
	REGULATORY OR L Continued From page appointment is receiv alternative transportat Scheduler will notify the Unit Manager. The D Manager will notify the appointment can be re- transportation is nece Scheduler and the Un- on this process on 10 Nursing. The Director new transportation sc upon hire. Beginning 10/24/2024 a treatment/test that of hospital will be educa Nursing on the import treatment is recomment Alleged immediate jeo 10/25/24 On 10/29/24 the facilit removal was validated The facility provided of immediate jeopardy re- completed by the Director included residents that transportation accomments, chart reviews residents with diagnos apnea for any untreat were not treated and/ and accuracy of docu revealed there were re- were not reported to to notes were accurate. any new orders for put	A 38 ed. If unable to find tion, the Transportation he Director of Nursing or irector of Nursing or Unit e provider to determine if e-scheduled or if emergent ssary. The transportation hit Managers were educated /24/2024 by the Director of of Nursing will train any hedulers and Unit Managers 4, any resident who requires can only be performed in the ted by the Director of ance of why the hospital ended. bpardy removal date: ty's immediate jeopardy d by the following: documentation to support emoval that included audits ector of Nursing. The audits at may need special modation within the last 6 s of 8 residents for any other ses of obstructive sleep ed signs and symptoms that or reported to the provider, mentation. These audits no untreated symptoms that he provider and all progress Resident #1 did not have ulmonology consultation or	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
	notes were accurate. any new orders for pu	Resident #1 did not have						

Facility ID: 923264

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		ND HUMAN SERVICES MEDICAID SERVICES				ED: 12/03/202 RM APPROVE O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY IPLETED
		345070	B. WING		1	C I/ <b>05/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO	DE	
			41	1 S LASALLE STREET		
DURHAM	NURSING & REHABILIT	ATION CENTER	DI	URHAM, 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 OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	BIPAP in place. Anot orders to ensure they consultations, diagno equipment. The resu orders, consultations assessments were du diagnostics were com provided documentat provided. One Educa event a consultation completed as ordere Unit Manager will not determine further rec Managers were educ Director of Nursing. T the following: physici x-rays, special equip consultations. The tra nurses, the Director of and the Staff Develop on 10/23/24 and end Documentation show Scheduler, and the L on 10/24/2024 by the education included a companies will be co Transportation Sched exceed normal transp Transportation was s appointment was rec alternative transporta Scheduler will notify Unit Manager. The D	ther audit tool examined y were implemented for ostics, and special Its showed that all other s, comprehensive one as ordered and inpleted. The facility also tion on the education they ation included that in the or diagnostics was not d, the Director of Nursing or tify the Physician to commendation. The Unit cated on this process by the The education also included an orders to include labs, ment, diagnostics, and aining was provided to all of Nursing, Unit Managers, pment Coordinator starting ing on 10/24/24. ved the Transportation Unit Managers were educated e Director of Nursing. The II alternate transportation untacted by the duler should weight limits portation capabilities. scheduled when the seived. If unable to find ation, the Transportation the Director of Nursing or Director of Nursing or Unit he provider to determine if the e re-scheduled or if	F 684			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/03/2024 MAPPROVED D: 0938-0391	
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMPLETED		
		345070	B. WING				C 05/2024	
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
DURHAM	NURSING & REHABILITA	ATION CENTER			411 S LASALLE STREET			
					DURHAM, NC 27705			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
F 684	Continued From page 40		F	684				
	2 Resident #7 was a	dmitted to the facility on						
	8/29/24, with diagnost							
		gia (partial or complete						
		with right side weakness /pe 1 diabetes mellitus.						
		m Data Set (MDS) dated						
		dent #7 was cognitively nal impairment of the lower						
		with use of a wheelchair,						
	set up assistance for	eating and oral						
	hygiene/care, depend							
	shoes, and maximum	xtremity dressing including assistance for						
		rom lying, and transfers.						
	The care plan dated 9	9/7/24 indicated that						
	Resident #7 had a co	mmunication problem						
	related to hearing loss hemiplegia/hemipares							
	needed assistance wi							
		cal record revealed there ress notes entered on						
	10/21/24.							
	The Medication Admi	inistration Record (MAR)						
	indicated Resident #7	inistration Record (MAR) / had his blood sugar						
	checked at 10/21/24 a	at 5:00 PM by Nurse #5.						
	Resident #7's blood s	•						
		sulin lispro. Resident #7 was hing oral medication at 9:00						
	PM by Nurse #5.							
	An interview with Nurs	se # 5 on 10/29/24 at 6:06						
		ked the 3:00 PM to 11:00						
		Nurse #5 went to Resident his blood sugar at 5:00 PM.						

Facility ID: 923264

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 11/05/2024
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CO	
				411 S LASALLE STREET	
DURHAM	NURSING & REHABILIT	Allon CENTER		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 684	issues. Nurse #5 did Resident #7 was hav An interview with NA revealed she worked shift on 10/21/24 and Resident #7 at 6:30 F concerns. When she 9:00 PM, the resident numbness in his left a she went to tell Nurse numbness and pain, # #5. NA #5 stated Nur on Resident #7, that st An interview with NA revealed she came in about 11:30 PM on 10 told Resident #7 she him. Resident #7 said use my left arm." NA complain, just said he further indicated that help himself using the AM, Resident #7 said NA #4 went to tell Nu something down but NA #4 further stated s and told Resident #7 to Nurse #6 and went #4 did not take vital s the nurse for further i	mention he was having any not recall NA #5 telling her ing any change in condition. # 5 on 10/29/24 at 4:33 PM the 3:00 pm to 11:00 PM did first rounds with PM and he did not have any did her second round at t told her he had pain and arm and leg. NA #5 indicated e #5 Resident #7 had and Nurse #5 nodded to NA se #5 did not go in to check she was aware of. #4 on 10/29/24 at 5:05 PM and started her rounds 0/21/24. NA #4 stated she was coming in to change d, "I'm moving slowly, I can't s #4 stated Resident #7 didn't e was moving slowly. She Resident #7 was able to e bedrail prior to this. At 6:00 d, "I can't feel my left side". rse #6 and Nurse #6 wrote did not come with NA #4. she went back to the room she reported his symptoms t on with her assignment. NA igns, as she was waiting on	F 68		
	Nurse #6 when comin	e did not receive report from ng on to her shift. She did er that Resident #7 was not side, and NA #5 had			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/202 FORM APPROVE OMB NO. 0938-039		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED			
		345070	B. WING		C 11/05/2024		
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CO	DE		
DURHAM	NURSING & REHABILIT	ATION CENTER		11 S LASALLE STREET PURHAM, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 684	informed Nurse #5, a head. A review of Resident record (MAR) indicate injection of 42 units L subcutaneously in the 10:41 PM. A review of the medic did a fingerstick blood 10/22/24 and obtaine no other documentatic condition. An interview with Nur PM revealed on 10/2 #4 reported to her that wasn't feeling right. N an assessment when medication and check around 6:00 AM. She with him while doing f Resident #7 did not in at that time. Nurse #7 given any kind of rep- anything was going of An interview with NA revealed she worked shift on 10/22/24 and resident around 7:15 how he was doing. H haven't felt well since feel his left side, and Resident #7 further re- blurred on the left side	nd Nurse #5 just nodded her #7's medical administration ed Nurse #6 gave an antus insulin e left arm on 10/21/24 at cal record indicated Nurse #6 d sugar at 6:30 AM on ed a result of 112. There was ion regarding Resident #7's rse #6 on 10/30/24 at 12:47 1/24 at around 6:00 AM NA at Resident #7's left side lurse #6 stated that she did a she gave Resident #7 his ked his blood sugar at e stated she briefly spoke the blood sugar and ndicate anything was wrong 7 stated she had not been ort from the prior shift that	F 684				

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		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 12/03/2024 FORM APPROVED IB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			) DATE SURVEY COMPLETED
		345070	B. WING				C 11/05/2024
NAME OF P	ROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER			S LASALLE STREET		
		-		DU	RHAM, NC 27705		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	<ul> <li>F 684 Continued From page 43</li> <li>She further stated that the resident told her he had reported to NA #4, Nurse #5 and NA #5 he was numb in his left arm and leg and could not move them.</li> <li>An interview with NA #6 on 10/29/24 at 3:31 PM revealed he had been called to Resident #7's room by NA #8 on 10/22/24 at about 7:15 AM to help NA #8 sit Resident #7 up. NA #6 stated that Resident #7 told NA #8 and him (NA #6) that he could not move his left side, and NA #8 went to get the nurse. Unit Manager #1 and NP #1 came in to assess Resident #7 and the Unit Manager asked NA #8 to call 911.</li> <li>The nursing progress note dated 10/22/24 at 8:25 AM by Unit Manager #1 indicated she was called to Resident #7's room by NA #8. Resident #7 was alert and oriented, and stated he could not move</li> </ul>		F	684			
	back to the bed. Resi his left foot or toes. R was gone in his left e (NP) was called to the written to transfer Re Department. The note was made aware. EM Resident #7 to the loc 10/22/24. An interview with Uni 10/29/24 at 11:40 AM requested by NA #8 t room as soon as pos 10/22/24. Upon arriva with left-sided paralys left leg. UM #1 furthe	o come to Resident #7's					

Facility ID: 923264

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/03/2024 FORM APPROVED B NO. 0938-0391	
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345070	B. WING				C 11/05/2024	
NAME OF PROVIDER OR S	JPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				4	11 S LASALLE STREET			
DURHAM NURSING &		Allon CENTER		D	DURHAM, NC 27705			
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
began her Practitione arm and le when she i assessed I called beca An addition 4:40 PM re before she morning of with the re yelled out i resident. U and Reside arm and le were not re curved side NP #1 cam to the ED f was inform to the hosp had not be change in A phone in at 5:30 PM could not f nurse aide not help du NA #9 (3:0) because o stated he u side with th his hip to ti	ight after of assessme r (NP). UM g were flac aised then Resident # ause Resid al intervie vealed Re left on 10/ 10/22/24   sident to g or her to c M #1 state ent #7 was g were flac eacting or fl e of a pape e in imme or a stroke e d. EMS ital. UM # revealed Re left on 10/ 10/22/24   sident to g or her to c M #1 state e of a pape e in imme or a stroke e el. EMS condition c terview wit revealed Re left on 10/ 20/22/24   sident to g or her to c M #1 state e of a pape e el in imme or a stroke e el. EMS condition c terview wit revealed Re e l his left was trying to the la 0 PM to 11 ne person un euse of the teruring couldn't m d he told h	e 44 dinner. UM #1 stated she nt and called for the Nurse I #1 stated Resident #7's left ccid, dropping to the bed n up. The NP arrived, 7 and asked for EMS to be lent #7 had had a stroke. w with UM #1 on 10/29/24 at sident #7 was doing fine '21/24 after 1st shift. On the NA #8 and NA #6 were in et him out of bed. NA #8 ome quickly to check the ed she did an assessment talking differently, his left ccid, and his arm and leg feeling when she ran the er clip down his arm and leg. diately and said to send him e. UM #1 stated the family came and took Resident #7 1 further revealed that there cumentation to support the of Resident #7 on 10/21/24. th Resident #7 on 10/21/24 he arm and left side when the to change him. He could ck of movement. NA #5 and 1:00 PM shift) helped him couldn't do it. He further ld position himself on his ne bed rails and a push on side. This was when he to ve his left side. Nurse #5 ner he couldn't move his left e did not know what was	F	684				

Facility ID: 923264

If continuation sheet Page 45 of 76

	-	ID HUMAN SERVICES				FORM	/ APPROVED		
				TIDI		OMB NO. 0938-0391			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	LETED		
			A. BOILD				c		
		345070	B. WING				05/2024		
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
DUDUAM					411 S LASALLE STREET				
DURHAM	NURSING & REHABILIT	ATION CENTER			DURHAM, NC 27705				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO			COMPLETION DATE		
IAO					DEFICIENCY)				
F 684	Continued From page	e 45	F	684	4				
	going on. Resident #7	7 further stated Nurse #5 did							
	-	nt #7 explained his condition							
	-	NA #4 came in on third							
		e could not feel his left side d Nurse #6. Nurse #6 came							
		6:00 am or so and gave him							
		nt #7 indicated Nurse #6 did							
		t if anything was wrong.							
		A (NA #8) came in with							
		Resident #7 told her he she asked what was going							
		her he could not move his							
		nmediately called Unit							
	-	came in and assessed him							
	then sent him to the lo	ocal hospital.							
	•	NA #9 on 10/30/24 were not							
	successful.								
	A phone interview on	10/29/24 at 4:48 PM with							
		vealed she was called by							
		M (on 10/22/24) and was							
	told that Resident #7	had been sent to the The DON told the family							
	- ·	reported the symptoms to							
		rse (no name was given)							
	then went in and aske	ed if he was ok, and he							
	replied yes. The famil								
		ny assessment by a nurse							
		t morning (10/22/24). The r stated if Resident #7 could							
		hospital what had happened							
	to him the day before	(10/21/24), he certainly							
		a nurse came to check on							
	him.								
	A review of NP #1'e n	rogress note dated 10/22/24							
	-	ical assessment, Resident							
		t arm drop. The Resident							

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/20 FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 11/05/2024
NAME OF PF	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	ODE
DURHAM	NURSING & REHABILIT	ATION CENTER		411 S LASALLE STREET	
				DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE COMPLETION COMPLETION SHOULD BE DATE
F 684	Continued From page	e 46	F 68	4	
	slightly slurred. He w with his eyes but rep Emergency Medical 3 activated for stroke s vital signs were blood saturation 99% on ro The patient had a his and cerebrovascular according to both the had been able to mo leg previously. Now, mobility on his left sid his left arm and leg. to the Emergency De stroke symptoms. An interview with the revealed she was ca on 10/22/24 because Resident #7 had a st EMS. The NP stated Manager #1 his symp before. The NP indic Resident #7, and he dinner, but she did ne stated his numbness had gotten worse thr neuro-checks should symptoms started on he should have been 10/21/24. She further	Services (EMS) were ymptoms. The residents' d pressure 161/77, oxygen om air, and blood sugar 192. story of left-sided weakness accident (CVA), but e patient and the nurse, he ve and feel his left arm and he has completely lost de and reported numbness in The resident was transferred epartment for evaluation of NP on 10/29/24 at 4:40 PM led by the Unit Manager #1 e Unit Manager #1 thought roke, and that UM #1 called she was told by Unit otoms started the night			
	could have been man	ital his worsening condition naged. NP #1 confirmed n admitted to the local de stroke.			
	The Emergency Dep	artment (ED) note dated			

Facility ID: 923264

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/03/2024 RM APPROVED NO. 0938-0391	
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345070	B. WING			1	C 1/05/2024	
NAME OF P	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
DURHAM	NURSING & REHABILIT	ATION CENTER			411 S LASALLE STREET DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 684	history significant for chronic renal insufficient disease, and prior struct Resident #7 presente Department with new inability to use his left extremities. Stroke co A National Institute of was documented as a to moderately severe reported he was unab 6:00 PM on 10/21/24. The computed tomog right posterior frontal edema which could b acute/subacute infarce was outside of the win of Alteplase (tPA) whi dissolves blood clots strokes. Resident #7 stroke service. Reside pressure 162/59, puls and oxygen saturation impression after evalue Cerebral vascular acc cognitive deficits and phase) post CVA. A review of the Emerge admission summary of Resident #7 presente left hemiplegia and st move his left side. Re- reported it to the facili nothing was done. Re- this morning to the N/ was transported to the	esident #7 had a medical congested heart failure, ency, coronary artery oke with left-sided deficits. d to the Emergency onset vision changes and upper and lower ode was called upon arrival. Health Stroke Scale (NIH) an 8 which indicated a mild stroke. Resident #7 ole to move his arm or leg at , which was new for him. raphy (CT) scan showed a lobe hypodensity concerning e related to an d. It was noted Resident #7 ndow for the administration ch is a medicine that used to treat ischemic was admitted to neurology ent #7's vitals were blood se rate 60, temperature 98.5, n 90%. The clinical uation findings were cident (CVA) with following dysphagia (oropharyngeal gency Department (ED) dated 10/22/24 indicated that d the ED at 8:45 AM with ated that he was unable to esident #7 stated he had ity staff last evening and esident #7 reported it again A and 911 was called. He	F	684				

Facility ID: 923264

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		D HUMAN SERVICES				FORM	APPROVED
							0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	LETED
			A. DOILD	- UNI		(	C
		345070	B. WING				05/2024
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	00/2024
				4	411 S LASALLE STREET		
DURHAM	NURSING & REHABILIT	ATION CENTER		6	DURHAM, NC 27705		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG					DEFICIENCY)		
			1				
F 684	Continued From page	2 48	F	684			
	- 15	inst gravity, and falls, left					
	leg having no movem						
		#7 was admitted to the					
	· ·	e stroke. Resident #7 was					
		at 2:14 PM to the hospital					
	posterior right frontal	nit, with a stroke on the					
	revealed no grip in the						
		flexion, motor response to					
		er extremities are flaccid					
		ength. The right side was					
		akness in the right lower					
	extremity.	ased to a skilled nursing					
	facility on 10/29/24.	ased to a skilled fidising					
	An interview with DOI	N 10/29/24 4:07 PM					
		e NA tells the nurse that					
		with a Resident, the nurse					
	0	assessment and notifies the tifies the tifies the party responsible.					
		cument the findings. She					
		cumentation is done by					
		ndicated she interviewed					
		#5 stated did not find any					
		or Resident #7 on 10/21/24,					
		ng notified of any change. ed Nurse #6 reported when					
		t # 7's blood sugar on					
		she did not see any change					
		further revealed that she					
		e investigation but had					
		es of paper that she had not					
	put into a report yet.						
	The Administrator wa	s notified of the immediate					
	jeopardy on 10/29/24						
	The facility provided t	he following credible					

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	-	ND HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER:					PLETED
							С
		345070	B. WING			11/	05/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER			411 S LASALLE STREET		
					DURHAM, NC 27705		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION
TAG	· · ·	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 684	15		F	684			
	allegation of immedia	ite jeopardy removal:					
	(4)   -  + + + + +	a i an ta cala a la ana an <b>ff</b> ana al an					
		pients who have suffered, or erious adverse outcome as					
	a result of the noncor						
	Resident #7, who ha	s a history of a prior stroke					
		ess, reported to Nursing					
	. ,	10/21/24 at 9:00 PM he was					
		d numbness to his left side. reported to the nurse who					
		cute changes, did not					
		cal assessment or obtain					
		ot initiate emergency medical					
		4 at 11:30 PM the resident					
		was moving slowly and					
		ft arm. Nursing assistant #4					
		who did not identify any ot complete a neurological					
	-	vital signs, and did initiate					
		ervices. The resident					
		otoms to NA #4 on 10/22/24					
		ng unable to move his left					
		ed to the nurse who did not					
		anges, did not complete a					
	-	nent or obtain vital signs, and ency medical services.					
	NA took Resident #7	his breakfast tray on					
		and 7:15 AM, the resident					
		nd was unable to move his					
		mediately reported the					
		o Unit Manager #1. Unit d the resident and found his					
	•	The Resident was also					
		vision. Resident stated that					
		to move his left side since					
	last night after dinner	. The Nurse Practitioner					
	then assessed the re-	sident and directed the					

Facility ID: 923264

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345070	B. WING				C / <b>05/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
DURHAM	NURSING & REHABILIT	ATION CENTER			411 S LASALLE STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	had a stroke. The res hospital with an acute An audit to determine reported any new cha not followed up on by residents with a brief (BIMS) score of 13 or the Administrator on 7 revealed that no other affected. An audit was complet Director of Nursing of 7 days to ensure that of condition had a pro- notification. The audit was affected. As part of the staff ed the Director of Nursin licensed nurses regar residents having had deviated from their bas Signatures accounted the questionnaire. No affected. On 10/31-11/1/2024 ti Staff Development Co- nursing assistants reg- residents having char 7 days that were not a findings were noted. (2) Specify the action	It to the hospital via Services because he had ident was admitted to the e stroke on 10/22/24. If any residents had ange in condition that was	F	684			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/20 FORM APPROVI OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345070	B. WING		C 11/05/2024	
NAME OF PR	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP COD	Ε	
DURHAM	NURSING & REHABILIT	ATION CENTER		1 S LASALLE STREET		
				URHAM, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIO E APPROPRIATE DATE	
F 684	Continued From page	e 51	F 684			
		m occurring or recurring, and				
		irector of Nursing initiated				
	clinical assessment of	sed nurses to complete a of a minimum vital signs and ns once notified of a change				
		emergency to include				
		injuries of unknown source,				
	significant change in					
		condition which can include				
		altered mental status, blurred umbness or tingling to body				
		ain, etc., to call 911 and to				
		provider of findings once the				
		ete and the assessment is				
		edical record. Education				
	•	anges reported by nursing				
		sed nurse that has not been 024 will be taken off the				
	-	ucated has been received.				
		educated by the Director of				
		ation. The Director of				
	Nursing will ensure a in-serviced.	Il licensed nurses are				
		egional Director of Clinical				
	Services educated th					
	Director of Nursing, S	e Human Resource Director				
		bcess for nursing staff that				
	•	on recognizing change in				
	condition, timely asse	essment and monitoring of				
		, recognizing a medical				
	emergency, effective medical emergency,	communication during a and calling 911.				
		rector of Nursing and Staff				
	Development Coordi	nator re-educated all nursing				

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/03/202 RM APPROVEI NO. 0938-039	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345070	B. WING				C 11/05/2024	
NAME OF PF	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
DURHAM	NURSING & REHABILIT	ATION CENTER			411 S LASALLE STREET DURHAM, NC 27705			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRI	ECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	COMPLETION DATE	
F 684	Continued From page	a 52		684				
1 001				004				
		in condition of residents to igns and symptoms of a						
		d vision, slurred speech,						
		e of the body, and facial						
		also included the importance						
	of residents receiving							
	attention should any	of these signs be identified.						
		t that has not received the						
		24 will be taken off the						
		ucation has been received.						
	assistants are educat	ng will ensure all nursing						
		idiate jeopardy removal:						
	11/2/2024	ulate jeopardy removal.						
	An on-site validation	•						
	-	eir credible allegation of						
		emoval was conducted on e completed facility audits						
		ir resident report, resident						
		to include neurological, pain						
		documented in the record.						
	•	flected a narrative of the						
	•	and the change of condition						
	reported to the medic	al team. Multiple interviews						
		nurse aides and licensed						
		in-service/ education was						
		king their shift. The nurse						
		urses consistently reported						
	they received in-servi	of condition assessment						
		of facility neurological and						
		ns/symptoms of stroke, vital						
		ew orders with a facility						
		ting the orders. All nursing						
	staff were educated o							
		ss of any signs of change of						
	-	24-hour report and in the						
	resident record.							

Facility ID: 923264

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 11/05/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
DURHAM	NURSING & REHABILIT	ATION CENTER		11 S LASALLE STREET URHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 684	Continued From page	53	F 684		
F 730 SS=E	Development Coordir confirmed that re-edu nurse aides and licen condition of residents of stroke, the importa of condition and docu healthcare providers of The Director of Nursir reviews and monthly ensure the assessme maintained. The IJ removal date of Nurse Aide Peform Re CFR(s): 483.35(d)(7) §483.35(d)(7) Regula The facility must com of every nurse aide at months, and must pro- education based on the reviews. In-service the requirements of §483 This REQUIREMENT by: Based on record revis facility failed to comple every 12 months for 5 reviewed (NA # 4, #5, The findings included a. Review of Nurse Air revealed a date of him- file for NA #4 did not in	of a medical emergency. Ing stated daily record monitoring will be done to Ints process was of 11/02/24 was validated. eview-12 hr/yr In-Service r in-service education. plete a performance review c least once every 12 ovide regular in-service the outcome of these aining must comply with the .95(g). is not met as evidenced ews and staff interviews, the ete a performance review 5 of 5 nurse aides (NAs) NA 7, NA #9 and NA #10).	F 730	F-730 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were noted to be affected (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same iss needing to be addressed:	e

Event ID: WJLJ11

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/03/2024 MAPPROVED D. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345070	B. WING			C 11/05/2024		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				4 <sup>.</sup>	11 S LASALLE STREET			
DUKHAM	NURSING & REHABILIT	ATION CENTER		D	URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 730	Continued From page	2 54	F	730				
	including April 2024.			,00	All residents have the potential to be affected.			
	date of hire of 3/28/23 #5 did not include and documents based on March 2024. c. Review of NA #7's date of hire of 10/18/2 #7 did not include and documents based on October 2023 and Oc d. Review of Nurse A revealed the date of H employee file for NA # performance review of date of hire including e. Review of NA #10's date of hire of 1/31/23 #10 did not include and documents based on January 2023 and Ja An interview was con- with the Director of N hired in May 2024 an facility's process for m competency skills tra reviews. She was una requirements for nurs performance reviews and 2024 for several was unable to provide training done prior to	ide #9's employee file hire of 11/9/22. The #9 did not include annual documents based on the November 2023. s employee file revealed the 3. The employee file for NA nnual performance review the date of hire including nuary 2024. ducted 11/4/24 at 3:15 PM ursing who stated she was d was unaware of the naintaining nurse aide ining and performance aware the mandatory se aide training/competency had not been done for 2023 employees. She stated she e any evidence of any her employment. She stated			<ul> <li>(3) What measure(s) will be put in place or systemic changes made to ensure the identified issue does not re-occur in the future:</li> <li>On 11/4/2024, the Director of Nursing re-educated the Staff Development Coordinator regarding the requirement that a performance review of every nuraide is required at least once every 12 months along with the 12 hours of required in-service training.</li> <li>On 11/11/2024, The Director of Nursing and the Staff Development Coordinator initiated in-service training to all Nursin Assistants regarding the 12 hours of required training along with a performate evaluation. This training will be completed on 11/21/2024. Any Nursing Assistant has not had the training by then will be taken off the schedule and will not be permitted to work until the training is completed.</li> <li>(4) Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustain The Director of Nursing or designee(s) monitor weekly for 12 weeks of any ne nursing assistants hired receive a performance review and receives the necessary 12 hours of required in-servitraining during orientation.</li> </ul>	hat n rse g rse eted that eted: will w vice		
		ng the documentation and ng with the initiation of a new			The Administrator, Director of Nursing, designee will report findings of the	, or		

Facility ID: 923264

If continuation sheet Page 55 of 76

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/03/2024 M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
		345070	B. WING			C 11/05/2024		
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DURHAM	NURSING & REHABILIT	ATION CENTER			11 S LASALLE STREET IURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 730	system developed wi Coordinator that start 9/25/24 when the face educate and provide reinforce skills and be skills used daily for the term care setting in a healthcare regulation An interview was com PM with the Staff Dev (SDC) who stated she was not aware of the maintaining nurse aid and performance reviews and 2024. She indica new employee orients competencies. She st the role of SDC for ve- started to review employee training nursing staff performance evaluation During an interview of Administrator stated a ssessment /competencies and annually. a performance review address the needs of stated at this time the provide documentation annual performance of The Administrator indo- competencies evaluation aperformance review and stated at this time the provide documentation annual performance of the Administrator indo- competencies evaluation aperformance review and competencies evaluation annual performance of the Administrator indo- competencies evaluation aperformance review and competencies evaluation aperformance review	th the Staff Development teed with the new hires on ility's skill fair was started to nurse aide training to est practices to practice he care of residents in a long ccordance with the s. ducted on 11/4/24 at 3:30 velopment Coordinator he was hired on 8/26/24 and facility's process for de competency skills training iews. She indicated after yee files it was discovered etency skills and had not been done for 2023 ted she was currently doing ation in-services and stated she had not been in ery long and she had not ployee training files or in order to complete annual ons or review. In 11/4/24 at 4:00 PM the Nurse Aides' skills encies should be completed The facility was unable to on to indicate Nurse Aides' reviews were completed. Licated the skill	F	730	monitoring process to the facility Qua Assurance and Performance Improvement Committee for any additional monitoring or modification this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/22/2024.	-		

Facility ID: 923264

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		MEDICAID SERVICES					<u>D. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVE COMPLETED	
		345070	B. WING				C / <b>05/2024</b>
NAME OF PF	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER			11 S LASALLE STREET		
-		-		D	URHAM, NC 27705		_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 730	Continued From page	e 56	F	730			
		Administrator stated the					
		over in the SDC position,					
	resulting in no eviden						
	training/education wa	is completed and					
E 745	documented.			- 4 -			44/00/04
F 745 SS=E		y Related Social Service	F	745			11/22/24
00-L	OF IX(3): 400.40(0)						
	§483.40(d) The facilit	ty must provide					
	-	ial services to attain or					
		practicable physical, mental					
		II-being of each resident.					
	by:	is not met as evidenced					
	Based on record rev	iew, resident, staff			F-745		
		Practitioner (NP) interviews					
		nsure a resident (Resident			(1) How corrective action will be		
	· ·	consultation appointment			accomplished for resident(s) found to		
		8/24 and again on 5/10/24.			have been affected:		
		nosed with obstructive sleep			Resident #1 has no current outstandin	-	
		ntment was required so			appointments or diagnostics at this time	e.	
		tain a continuous positive AP) machine (used to treat			(2) How corrective action will be		
		ing the airways open while			accomplished for resident(s) having the	÷	
		dered on 4/13/24. The facility			potential to be affected by the same iss		
		Resident #1 attended a			needing to be addressed:		
	÷.	on appointment ordered on			An audit for the last 30 days was done		
		ade due to Resident #1			10/24/2024 by the Director of Nursing t		
		ant migraines/headaches.			determine if any other residents missed	1	
	medically related soc	f 3 residents reviewed for			any appointments due to needing any special accommodations due to weight		
	modically related 500				The audit revealed that that no other	•	
	The findings included	l:			residents were affected.		
	Resident #1 was adm	nitted to the facility on			(3) What measure(s) will be put in place	е	
		diagnoses that included			or systemic changes made to ensure th		
	tachycardia (increase	ed heart rate), asthma,			the identified issue does not re-occur in		
	morbid obesity and c	obstructive sleep apnea.			the future:		

Facility ID: 923264

		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/03/2024 DRM APPROVEI NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		ONSTRUCTION		ATE SURVEY OMPLETED
		345070	B. WING				C 11/05/2024
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER			S LASALLE STREET RHAM, NC 27705		
				DUI			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 745	Continued From page	e 57	F 74	45			
_	The resident did not l				On 10/23/2024 the Regional Nur	se	
	migraines on admissi	8			Consultant re-educated the nurse		
	0				management team that consists	of the	
		ated 4/13/24 revealed an			Director of Nursing, Staff Develo		
		to receive a Pulmonary			Coordinator, the 2-Unit Manager	s, and the	
		PAP machine for obstructive			Transportation Scheduler that	or	
	sleep apnea.				transportation is to be provided p physician order. The order is prir		
	Another Physician #1	order dated 5/10/24			nursing and given to the transport	•	
	revealed Resident #1				scheduler. If services are unable		
	pulmonology consult	for her obstructive sleep			provided via the facility due to ex		
	apnea and CPAP ma	-			weight, upon the Transportation		
					Scheduler's review of the weekly		
		curred with Physician #1 on			log, all available resources that p		
		Physician #1 verified he had			accommodations for bariatric res		
		Resident #1 to receive a a pulmonology consultation.			are to be contacted to ensure the appointment will be fulfilled. The		
		ered the pulmonology			Nurse Consultant provided a list	-	
		AP machine in April 2024			additional non emergent bariatric		
		od Resident #1 already had			transport companies to the nurse		
		t it was not present at the			management team and the Trans		
	facility. Physician #1	stated Resident #1 required			Scheduler.	-	
		her obstructive sleep apnea.			Beginning 10/24/2024, all alterna		
	•	"about" a month later he			transportation companies will be		
	•	member from who) that			contacted by the Transportation		
		ave a CPAP machine and gy appointment to obtain a			Scheduler should weight limits ex normal transportation capabilities		
		e wrote an order for a			Transportation will be scheduled		
		ation in May 2024. Physician			appointment is received. If unabl		
		not remember writing the			alternative transportation, the		
		ation in April 2024 when he			Transportation Scheduler will not	tify the	
		May 2024. He stated he did			Director of Nursing or Unit Mana		
	not know if Resident				Director of Nursing or Unit Mana		
		ation but said he knew			notify the provider to determine it		
	Resident #1 never ha	ad a CPAP machine.			appointment can be re-schedule emergent transportation is neces		
	A follow-up telephone	e interview with Physician #1			entergent aranoportation to house	.cury.	
	occurred on 11/4/24 a	at 11:03am. Physician #1			On 10/24/2024, the Director of N		
	discussed due to Res	sident #1's weight, the lack			provided education to the Transp	ortation	

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION	(X3) DAT	O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			. ,	IPLETED
			A. BOILDING			С
		345070	B. WING		1.	/05/2024
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, Z		100/2024
				411 S LASALLE STREET		
DURHAM	NURSING & REHABILIT	ATION CENTER		DURHAM, NC 27705		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED DEFICI	TO THE APPROPRIATE	COMPLETION
F 745	Continued From page	e 58	F 74	5		
	of follow-through with	her Pulmonology		Scheduler and the Unit	Managers	
		ogy consultation, and lack of		regarding this process.		
		achine could not have		Nursing will train any ne		
	caused her hospitaliz	ation on 10/7/24. He 1 had been stable without		Schedulers and Unit Ma	anagers upon hire.	
	her CPAP prior to her			(4) Indicate how the fac	ility plans to	
				monitor its performance		
	During a telephone ir	nterview with Physician #2 on		the solutions are achiev		
		Physician #2 explained he		The Administrator or the	e Director of	
	began seeing Reside	nt #1 after Physician #1 had		Nursing will audit all res	ident	
	left the facility. The P	hysician stated Resident #1		appointments weekly to	ensure that no	
	was required by insu	rance to receive a pulmonary		appointments have bee	n unable to be	
		eceiving a CPAP machine.		scheduled due to exces		
	He explained that the	e insurance company needed		monitoring will take place	ce weekly for 12	
	proof and severity of	Resident #1's obstructive		weeks.		
		hey would approve Resident				
		ne. The Physician stated		The Administrator, Direc	-	
		a CPAP machine due to her		designee will report find		
		nea. Physician #2 stated		monitoring process to the		
		er able to receive the		Assurance and Perform		
	consultation due to tr	ansportation difficulties.		Improvement Committe		
				additional monitoring or		
		nsport Staff occurred on		this plan. The QAPI Cor		
		Transport Staff confirmed		modify this plan to ensu	•	
	she was responsible			remains in substantial c	ompliance.	
	appointments. She al	5				
	-	ing alternate transportation if nthe facility's van. Transport		The facility allogas som	nliance on	
		dent #1 being too large to		The facility alleges com 11/22/2024.		
		hair van and would need				
		cher transport. She stated				
		tract with a non-emergency				
	-	ut said "they are always				
		rt Staff discussed not				
	receiving the consult					
	-	30/24. She stated since				
		n periodically trying to				
		ment with Pulmonology and				
	Neurology that would					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 12/03/2024 RM APPROVED IO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE SURVEY COMPLETED		
		345070	B. WING			1	C 1/05/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
DURHAM	NURSING & REHABILIT	ATION CENTER			11 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 PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 745	Transport staff explai would try to call both the Neurology office p company every 2-3 w schedules. She state unsuccessful in gettir Pulmonologist. The T discussed her neurolo Resident #1 was not consultations due to of transportation with th transportation compa Unit Manager #1 and failed attempts to arra The quarterly Minimu 8/8/24 revealed Resid intact, no rejection of breath. The MDS also did not have a CPAP documented as havin Resident #1 was doc impairment on one si extremities, depende upper and lower dress with bed mobility, and On 8/24/24 there was Physician #3 for Resi neurology consultation The resident #1 pulmonology consultation.	sportation schedule. The ned "periodically" met she the Pulmonology office and olus the transportation veeks to try to arrange the d she had been ng Resident #1 to the transport Staff also ogy consultation. She stated able to attend the not being able to arrange e non-emergency ny. She stated she kept the DON up to date in her ange the appointments. Im Data Set (MDS) dated dent #1 was cognitively care, and no shortness of o documented Resident #1 machine. Resident #1 machine. Resident #1 was ng a weight of 430 pounds. umented as having de for her upper and lower nt on toileting, bathing, sing, substantial/max assist d dependent with transfers. a physician order from dent #1 to receive a on for constant migraines. al record revealed no ented that Resident #1 The medical record also	F	745				

Facility ID: 923264

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		ND HUMAN SERVICES				1 APPROVE ). 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		LETED
		345070	B. WING			C 05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
		TATION CENTER		411 S LASALLE STREET		
DURHAM NURSING & REHABILITATION CENTER			DURHAM, NC 27705			
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 745	Continued From page	ge 60	F 74	5		
		sed not being aware Resident				
		but said she remembered at				
		mentioned that Resident #1				
	needed a CPAP ma	chine. She also stated she				
		t #1 was unable to attend her				
	Neurology consultat	-				
	consultation due to i	transportation issues.				
	An interview with Re	esident #1 occurred on				
		n. Resident #1 stated she				
	never had a CPAP machine since she had been					
	in the facility. She ex	xplained that the Physician				
		discussed with her needing to				
		t "several months ago" and				
		appointment was needed so				
		CPAP machine but stated she nologist or received a CPAP				
		#1 also explained another				
		n #2) had also told her he				
		Pulmonologist a "few months				
	ago" and have a CP	AP machine but she was told				
		not remember who) that the				
	-	transportation to get her to				
		o she could receive the CPAP				
		#1 stated she was told there on available for someone her				
		iscussed periods of excessive				
		remembering, headaches,				
		"for at least the past 6				
	months". She stated	l one of the Physician's had				
	ordered her to see a	-				
		none of the appointments				
		dent stated no one explained d have been able to see a				
	Pulmonologist and/c					
	The NP was intervie	ewed on 10/23/24 at 8:18am.				
		not aware Resident #1 was				
	ordered a CPAP ma	chine or to see a				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/03/202 RM APPROVE NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C	
		345070				1	1/05/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	NURSING & REHABILIT	ATION CENTER			S LASALLE STREET HAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 745 F 761 SS=D	<ul> <li>#1 had an order to see 2024. She also stated had been a Neurology August 2024 or that F attended any of these transportation issues.</li> <li>The Director of Nursin by telephone on 10/29 explained she had no Resident #1 and that any concerns to her. 3 Resident #1 was not a scheduled appointme issues and explained non-emergency trans a month in advance n not coordinate transpo- appointments.</li> <li>The Administrator was 3:20pm. The Adminisis aware Resident #1 was scheduled appointme issues. He had no con of follow-through with appointments.</li> <li>Label/Store Drugs an CFR(s): 483.45(g)(h)(</li> </ul>	h April 2024 or that Resident e a Pulmonologist in May d she was not aware there y consultation order in Resident #1 had not e appointments due to hg (DON) was interviewed 9/24 at 10:09am. The DON t had much contact with the resident never voiced She stated she was aware able to attend any of her nts due to transportation the need for portation company required totice and the facility could ortation with the time of the s interviewed on 10/23/24 at trator discussed being as unable to attend her nts due to transportation mments related to the lack Resident #1's d Biologicals (1)(2)		745			11/22/24
	Drugs and biologicals	y and cautionary					

Facility ID: 923264

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345070	B. WING _				C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				41	11 S LASALLE STREET		
DURHAM	NURSING & REHABILITA	ATION CENTER		D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	62	F7	761			
	§483.45(h) Storage o	f Drugs and Biologicals					
	Federal laws, the faci biologicals in locked of temperature controls, personnel to have acc	-					
	locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when t package drug distribut quantity stored is mini- be readily detected.	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can					
	Based on observation facility failed to secure an unattended medica medication carts (Zon The findings included	e 1 medication cart). :			F-761 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 10/22/2024, Nurse #3 locked the medication cart immediately.		
	10/22/24 at 5:20 PM r was unlocked and una mechanism on the rig cart was observed to unlocked position. Sta				<ul> <li>(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same iss needing to be addressed:</li> <li>All residents have the potential to be affected.</li> <li>(3) What measure(s) will be put in place</li> </ul>	sue	
	approaching the medi	PM Nurse #3 was observed ication cart from a resident's observed to lock the cart			or systemic changes made to ensure the identified issue does not re-occur in the future:	nat	

Facility ID: 923264

		ID HUMAN SERVICES				I	NTED: 12/03/2024 FORM APPROVED B NO. 0938-0391
STATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345070	B. WING				C 11/05/2024
NAME OF P	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DURHAM	DURHAM NURSING & REHABILITATION CENTER				11 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 PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 761	cart. An interview was she stated she was g a resident in the resid stated the medication locked when she was cart. Observation of f contained resident me medicated ointments An interview was com Nursing (DON) on 10	r items on the top of the as completed with Nurse #3, iving evening medications to lent's room. Nurse #3 a cart should have been a not in attendance of the the medication cart edications, insulin pens, and medicated eye drops. hpleted with the Director of /23/24 at 12:22 PM. The hould lock their medication	F	761	On 10/22/2024, the Director of Nurs re-educated nurse #3 regarding the requirement that at any time a medi cart is unattended, the medication of to be locked to secure resident medications. On 10/22/2024, the Director of Nurs and designee(s) initiated re-educate all licensed nursing staff including med-aides and agency regarding th requirement that at any time a medi cart is unattended, the cart is to be I securing resident medications. Any hired Med-Aides or licensed nurses educated during orientation upon hi (4) Indicate how the facility plans to monitor its performance to make sus the solutions are achieved and sust Through the utilization of an observa- monitoring tool, the Director of Nurs designee(s) will monitor 5x/wk for 4 weeks, 3x/wk for 4 weeks, and 1x/w weeks to ensure that the 4 medicati carts are locked when not attended. The Administrator, Director of Nursi designee will report findings of the monitoring process to the facility Qu Assurance and Performance Improvement Committee for any additional monitoring or modificatior this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	cation art is ing on to e cation ocked newly will be re. re that ained: ation ing or rk for 4 on ng, or lality	

Facility ID: 923264

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		PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
ND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING B. WING		
		345070			C 11/05/2024
NAME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C	
	NURSING & REHABILIT	ATION CENTER		411 S LASALLE STREET	
DONNAM				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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 761	Continued From page	a 64	F 76	31	
1 /01	Communed From page			The facility alleges complia 11/22/2024.	nce on
F 812 SS=E		tore/Prepare/Serve-Sanitary 2)	F 81	12	11/22/24
	§483.60(i) Food safe The facility must -	ty requirements.			
	§483.60(i)(1) - Procus approved or consider state or local authorit	ed satisfactory by federal,			
	(i) This may include for	ood items obtained directly subject to applicable State			
	(ii) This provision doe facilities from using p	es not prohibit or prevent roduce grown in facility			
	safe growing and foo	ompliance with applicable d-handling practices. es not preclude residents			
	from consuming food	s not procured by the facility.			
	serve food in accorda	prepare, distribute and ance with professional			
	standards for food se This REQUIREMENT by:	rvice safety. is not met as evidenced			
	Based on observatio and service technicia	ns, record review, and staff n interviews the facility failed		F-812	
	preparation; keep for	id wear gloves during food od service equipment clean and maintain a clean kitchen		<ul> <li>(1) How corrective action w accomplished for resident(single been affected)</li> </ul>	
	environment; label an of 1 walk in coolers; r	nd date open food items in 1 maintain and monitor the		No residents were directly being affected.	identified as
		e that was utilized to clean ing utensils to ensure the		(2) How corrective action w	/ill be
	machine's wash cycle temperature reached	e and rinse cycle		accomplished for resident( potential to be affected by	s) having the

Event ID: WJLJ11

Facility ID: 923264

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CENTERS FOR MEDICARE & MEDICAID SERVICES           TATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA         (X2) MULTIPLE CONSTRUCTION           ND PLAN OF CORRECTION         IDENTIFICATION NUMBER:         A DUI NONCOMPANY			OMB NO. 0938-03 (X3) DATE SURVEY				
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING			COMPLETED	
		345070				C 11/05/2024	
NAME OF PR	ROVIDER OR SUPPLIER	R STREET ADDRESS, CITY, STATE, ZIP CODE		IREET ADDRESS, CITY, STATE, ZIP CODE	1		
	NURSING & REHABILIT			41	11 S LASALLE STREET		
DOILITAIN				D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	65		812			
1 012		dry before they were stacked		012	All residents have the potential to be		
	for use.				affected.		
	The findings included	:			(3) What measure(s) will be put in plac		
	1 On 10/22/24 at 4:1	1 DM Distory Aids #2 was			or systemic changes made to ensure t		
	1. On 10/22/24 at 4:1 observed placing lids			the identified issue does not re-occur in the future:	n		
		e with no gloves or facial			On 11/15/2024 the Administrator		
	•	etary Aide #2 was observed			re-educated the Dietary Director regard	•	
		eard). Dietary Aide #2			the requirements of covering facial hai	r	
		n the kitchen and placed but no facial hair covering			and to wear gloves during food preparation. Keep food service equipm	nent	
	-	g lids on the insulated mugs			clean and free of debris and maintain a		
	full of liquid for meal				clean kitchen environment. Label and		
	<b>.</b>				date open food. Maintain and monitor	the	
		ation on 10/23/24 from 10:16 aled Cook #2 used a spatula			kitchens dish machine to ensure the machines wash cycle and rinse cycle		
		h filets from a large pan to a			temperature reach a minimum		
		iner while not wearing			temperature of 120 degrees Fahrenhe	it.	
	gloves.				And insulated dome lids and bases are		
	During an interview w	<i>i</i> ith the Dietary Supervisor on			be dry before they are stacked for use.		
	•	she indicated facial hair			On 11/15/2024, the Dietary Director		
		n place while in the kitchen.			re-educated the dietary staff regarding	the	
		acial hair coverings available			requirements of covering facial hair an		
		The Dietary Supervisor also			wear gloves during food preparation, k		
	stated gloves should preparation.	be worn during lood			food service equipment clean and free debris and maintain a clean kitchen	01	
	P. operation.				environment, label and date open food	l,	
	-	ok #2 on 10/23/24 at 10:18			maintain and monitor the kitchens dish		
		ould have been wearing			machine to ensure the machines wash		
		g the food but thought it was she was using a spatula.			cycle and rinse cycle temperature reac minimum temperature of 120 degrees	ла	
	allight not to boodust	one was doing a spatala.			Fahrenheit, and insulated dome lids ar	nd	
		Administrator on 10/23/24 at			bases are to be dry before they are		
		aff should have facial hair			stacked for use. Any newly hired dieta		
	coverings in place wh wear gloves for food	nile in the kitchen and should			employee will be educated during new		

Facility ID: 923264

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CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	345070	B. WING		C 11/05/2024
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP OF         DURHAM NURSING & REHABILITATION CENTER       411 S LASALLE STREET         DURHAM, NC 27705       DURHAM, NC 27705		STREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
following. -Continuous observa 10/22/24 from 4:11 P 3-compartment sink f compartments with for light brown substance stuck to the inside was sink was observed at An interview on 10/22 Dietary Supervisor re- cleaned every Thurso -Observation of the d 10/23/24 at 8:00 AM surrounding the garb control box attached the dish washing area decaying, chipped, at matter/ growth. Observation and inter Maintenance Director The Maintenance Dir garbage disposal elearea needed repair. F around the garbage of was decaying, chipped matter/growth prior to	n of the kitchen revealed the tion of the kitchen on M to 4:26 PM revealed the neavily soiled in all 3 bod debris, a greasy jelly-like e and a deceased insect all of the right end sink. The t 4:15 PM. 2/24 at 4:26 PM with the evealed the kitchen was deep day. Tish washing area on revealed wooden material age disposal electrical to the wall in the corner of a. The wooden material was nd covered with black rview completed with r on 10/23/24 at 8:03 AM. ector discussed knowing the ctrical control box wooded He stated the wooden area disposal electrical control box ed and covered with black	F 812	<ul> <li>(4) Indicate how the facility plans is monitor its performance to make as the solutions are achieved and su Through the utilization of an obsermonitoring tool, the Dietary Direct designee will monitor 5x/wk for 4 was/wk for 4 weeks, and 1x/wk for 4 was/wk for 4 weeks, and 1x/wk for 4 to ensure that facial hair is covere gloves are warn during food preparation of a debris and a clean kitchen environment is maintained, open fabeled and dated, maintain and rest the kitchens dish machine to ensure machines wash cycle and rinse cystemperature reach a minimum temperature of 120 degrees Fahre and insulated dome lids and base be dry before they are stacked for The Administrator, Director of Nurr designee will report findings of the monitoring process to the facility (Assurance and Performance Improvement Committee for any additional monitoring or modificati this plan. The QAPI Committee carmodify this plan to ensure the facility alleges compliance on 11/22/2024.</li> </ul>	sure that stained: rvation or or weeks, 4 weeks d and aration, an and food is nonitor ure the ycle enheit, s are to use. sing, or e Quality on of an lity s.

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		345070	B. WING			C 11/05/2024			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
DURHAM	DURHAM NURSING & REHABILITATION CENTER				411 S LASALLE STREET DURHAM, NC 27705				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 812	Continued From page	9 67	F	812	2				
	10/22/24 at 4:26 PM in responsible for comple- cooler each morning at in the cooler that was was opened and an en- Supervisor did not reac- cooler this morning. An interview with the 12:35 PM revealed for cooler should be prop- 4. A continuous obset temperature dish made from 9:39 AM to 9:48 machine temperature degrees Fahrenheit (In rinse cycle with a load compartment. The dis observed for three mo- including one cycle ea- cups, 32 fruit bowls at temperature gauge re- Dietary Aide #1 was ri- machine during the of Review of the manufa- temperatures affixed machine for wash spe- should reach a minim degrees F. The n- recommended temper the dish machine sho- temperature of 120 de	eting a walk-through of the and checked that each item open had a date when it expiration date. The Dietary call seeing these items in the Administrator on 10/23/24 at od items in the walk-in berly dated. Twation of the low chine in use on 10/23/24 AM showed the dish gauge reading at 102 F) for both the wash and d of dishes in the sh machine was then bre wash and rinse cycles ach for 20 plastic drinking and 26 dinner plates with the emaining at 102 degrees F. noted to be operating the bservations. acturers' recommended to the front of the dish ecified the dish machine um temperature of 120 ommended temperature of manufacturers ratures for rinse revealed uld reach a minimum							

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 12/03/2024 FORM APPROVED MB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345070	B. WING				C 11/05/2024
NAME OF P	NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER		•	STF	REET ADDRESS, CITY, STATE, ZIP COD	E.	
DURHAM					S LASALLE STREET RHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 812	An interview on 10/23 Aide #1 indicated he machine temperature prior to starting the di indicated once his ini completed, he did no gauge to make sure f maintaining the minin degrees F. An observation and in 10/23/24 at 9:45 AM regarding the dish ma- temperature gauge re The Dietary Supervisor vo would initially comple cycles to make sure f reaching temperature cleaning process. The explained that staff co but the temperature we the dish cleaning pro An observation and in 10/23/24 at 10:08 AM Director regarding the the dish machine was not complete repairs. remained at 102 degi temperature gauge we reading the water ten the dish machine. On 10/23/24 at 10:18 was conducted with the dish machine was a f machine and water ten	B/24 at 9:42 AM with Dietary spot checked the dish at the beginning of his shift ish washing process. He tial temperature check was t recheck the temperature the dish machine was num temperature of 120 therview were conducted on with the Dietary Supervisor achine which revealed the emaining at 102 degrees F. or stated she would contact ely for a service call. The biced that the Dietary Aides the several wash and rinse the dish machine was a prior to starting the dish ne Dietary Supervisor ompleted the initial check, was not checked throughout cess. Therview were conducted on 4 with the Maintenance e dish machine. He stated is leased and that he could The temperature gauge rees F and he stated the vas probably not properly mperatures cycling through 6 AM a telephone interview he Service Manager for the ocompany. He stated the	F	812			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED		
		345070	B. WING				C 105/2024	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
DURHAM	NURSING & REHABILIT	ATION CENTER			411 S LASALLE STREET			
					DURHAM, NC 27705			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 812	120 degrees F but the temperature should b The service manager temperature gauges w time and not read the or stay fixed on a cert to be replaced. He st facility was installed in further explained the serviced 8 weeks ago Service Manager void was in route to the fac machine. Review of the dish may service report for the revealed the dish may temperature reading of service call. No other recommendations not Review of the dish may service report for the 10/23/24 revealed the temperature reading of from the service tech gauge was replaced w gauge. No other com- noted. A continuous observa 10/23/24 from 11:45 A interview with the dish Service Technician wa The observation reve- installed, and the old disconnected. The S old gauge was not wo	e recommended e at least 140 degrees F. explained the dish machine would become faulty over correct water temperature tain temperature and need tated the dish machine at the n February of 2023. He dish machine was last (no date given). The ced the service technician cility to assess the dish achine service company dish machine dated 8/9/24 chine had a water of 128 degrees F during this r concerns or ted. achine service company dish machine dated e dish machine dated e dish machine had a water of 115 degrees F. Remarks nician noted the temperature with a new temperature cerns or recommendations tion of the dish machine on M to 11:51 AM and an n machine service company as conducted at 11:45 AM. aled that a new gauge was gauge had been ervice Technician stated the orking properly and did not	F	812				
	old gauge was not wo							

Facility ID: 923264

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CENTER	MENT OF HEALTH AN S FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345070	B. WING		C 11/05/2024	
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
OURHAM	NURSING & REHABILIT	ATION CENTER		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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE	
F 812	completed several wa indicated the temperat properly at this time ware ading showing about temperature gauge ward degrees F. An interview with the 12:35 PM revealed ware temperature gauge in should notify the vent corrected. 5. On 10/23/24 at 10: light brown 4-compar- insulated dome lids at of wet insulated dome compartment. The co 31 insulated dome lids During an interview of Dietary Aide #3 state insulated dome lids at the items in the 4-com- he was rushing. An interview on 10/22 Dietary Supervisor re- sure the insulated do- before storing them in During an interview of the Administrator he in	ng. The Service Technician ash and rinse cycles and ature gauge was working with the temperature gauge ve 120 degrees F. The ras observed to read 128 Administrator on 10/23/24 at then staff notice the ot working properly, they dor so the issues could be 03 AM an observation of the tment trolley holding nd bases revealed a stack e lids and bases in 1 ompartment held a total of ls and bases. In 10/23/24 at 10:16 AM d he forgot to let the nd bases dry prior to placing npartment trolley. He stated 8/24 at 10:17 AM with the vealed staff should make me lids and bases are dry in the trolley. In 10/23/24 at 12:35 PM with ndicated items should be	F 81			
F 842	properly dried and the Resident Records - lo CFR(s): 483.20(f)(5),	en stored. dentifiable Information	F 84	12	11/22/24	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345070	B. WING		C 11/05/2024
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•
DURHAM	NURSING & REHABILIT	ATION CENTER		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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 842	§483.20(f)(5) Residen (i) A facility may not r resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co- agrees not to use or of except to the extent to to do so. §483.70(h) Medical re- §483.70(h)(1) In acco- professional standard must maintain medical that are- (i) Complete; (ii) Accurately docum (iii) Readily accessibl (iv) Systematically or §483.70(h)(2) The fac- all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, par operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purp purposes, research p medical examiners, fa a serious threat to he	nt-identifiable information. elease information that is o the public. elease information that is o an agent only in intract under which the agent disclose the information he facility itself is permitted ecords. ordance with accepted ds and practices, the facility al records on each resident ented; e; and ganized cility must keep confidential hed in the resident's records, n or storage method of the n release is- or their resident permitted by applicable law; yment, or health care ted by and in compliance	F 84		

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/03/20 FORM APPROVE OMB NO. 0938-039
CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         345070		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		B. WING		C 11/05/2024	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	
DURHAM	NURSING & REHABILIT	ATION CENTER		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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 842	Continued From page	e 72	F 8	42	
	<ul> <li>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</li> <li>§483.70(h)(4) Medical records must be retained for-</li> <li>(i) The period of time required by State law; or</li> <li>(ii) Five years from the date of discharge when</li> </ul>				
	there is no requireme (iii) For a minor, 3 yea legal age under State	ars after a resident reaches			
	(i) Sufficient informati (ii) A record of the res	edical record must contain- ion to identify the resident; sident's assessments; ve plan of care and services			
	(iv) The results of any and resident review e determinations condu				
	professional's progre (vi) Laboratory, radio services reports as re				
	Based on record rev Physician interviews,	iew, resident, staff, and the facility failed to maintain		F-842	
		· · · · · ·		<ul> <li>(1) How corrective action accomplished for resident have been affected: Physician #1 no longer pr to the facility.</li> </ul>	(s) found to
	The findings included	I		(2) How corrective action	will be
	5/24/22 with multiple	nitted to the facility on diagnoses that included lea (a condition that causes		accomplished for resident potential to be affected by needing to be addressed:	i(s) having the v the same issue

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12 FORM APP OMB NO. 09	PROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURV COMPLETE	/EY
		345070	B. WING		C 11/05/2	024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
				411 S LASALLE STREET		
DURHAM NURSING & REHABILITATION CENTER		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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COM	(X5) MPLETION DATE
F 842	Continued From page	e 73	F 842			
	the upper airway to b reducing or stopping The quarterly Minimu 8/8/24 revealed Resid intact with no rejectio documented that Resid Continuous positive A machine (used to treat the airways open white Review of a Physician by Physician #1 revea- initiate Resident #1 of follow up with outpati documented was that and to continue the unight. A phone interview occ 10/22/24 at 3:52pm. If written the note on 6/ thought Resident #1 machine for her obstra not aware Resident # machine or the inabili Pulmonologist. An interview with Resi 10/22/24 at 12:08pm. never had a CPAP m in the facility. She exp (Physician #1) had di	Pecome blocked during sleep, airflow). Im Data Set (MDS) dated dent #1 was cognitively on of care. The MDS also sident #1 did not have a Airway Pressure (CPAP) at sleep apnea by keeping ile sleeping). In note dated 6/19/24 written aled documentation to on CPAP 5/10 settings and ent Pulmonology. Also t Resident #1 was "stable" use of the CPAP machine at curred with Physician #1 on Physician #1 verified he had (19/24. He explained he had received her CPAP ructive sleep apnea and was f1 did not have the CPAP ity to follow up with the sident #1 occurred on . Resident #1 stated she achine since she had been plained that the Physician iscussed with her needing to		<ul> <li>On 11/21/2024 the Director of Nursaudited provider progress notes for last 7 days to ensure that no other resident was being documented for having a CPAP that did not have of Audit revealed that no other resider were affected.</li> <li>(3) What measure(s) will be put in or systemic changes made to ensure the identified issue does not re-occ the future:</li> <li>On 11/21/2024, the Director of Nurre-educated the current attending physician and the nurse practitioner regarding the requirement for main accurate documentation in the merecord.</li> <li>(4) Indicate how the facility plans to monitor its performance to make s the solutions are achieved and sus The Director of Nursing or designer audit all provider notes daily 5x/wk weeks to ensure accuracy.</li> <li>The Administrator, Director of Nursi designee will report findings of the monitoring process to the facility C Assurance and Performance Improvement Committee for any additional monitoring or modification this plan. The QAPI Committee campatible campatible</li></ul>	or the or one. or one. ents place ure that cur in rsing ers ntaining dical o ure that stained: ee(s) will c for 12 sing, or Quality on of n	
	explained to her the a she could obtain a Cl	"several months ago" and appointment was needed so PAP machine but stated she blogist or received a CPAP		modify this plan to ensure the facil remains in substantial compliance. The facility alleges compliance on 11/22/2024.		

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		ND HUMAN SERVICES MEDICAID SERVICES					APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070		ICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			C 11/05/2024			
NAME OF PROVIDER OR SUPPLIER		ł	ST	REET ADDRESS, CITY, STATE, ZIP CODE				
DURHAM	NURSING & REHABILIT	ATION CENTER			1 S LASALLE STREET URHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 842	by telephone on 11/1 stated the facility did Physician's documen Resident #1 never ha her hospitalization. T unaware Physician #	e 74 ng (DON) was interviewed /24 at 9:53am. The DON not review or monitor the tation. She confirmed ad a CPAP machine prior to he DON stated she was 1 was documenting that had her CPAP machine.	F	842				
F 921 SS=E	Safe/Functional/Sani CFR(s): 483.90(i)	tary/Comfortable Environ	F	921			11/22/24	
	The facility must prov sanitary, and comfort residents, staff and th This REQUIREMENT by:	vide a safe, functional, able environment for			F-921			
	facility failed to maint environment as evide growth buildup in and observed and various	ain a clean and sanitary enced by the presence of a d on 1 of 2 ice machines s colored growths on the vations that were conducted			<ul> <li>(1) How corrective action will be accomplished for resident(s) found to have been affected:</li> <li>No residents were directly identified as being affected.</li> </ul>			
	The findings included On 10/22/24 at 4:11 F observations were m	<sup>D</sup> M the following			(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same iss needing to be addressed:			
	blackish brown spots facing of the ice mach of the ice machine ar The inside of the ice black colored matter	ocated in a room with on Zone/hall 3 revealed of matter on the external hine between the top portion ad the ice machine door. machine revealed pinkish/ on the internal ceiling of the ill brownish-black spots on			<ul> <li>All residents have the potential to be affected.</li> <li>3) What measure(s) will be put in place systemic changes made to ensure that the identified issue does not re-occur in the future:</li> <li>On 10/22/2024, the Maintenance Direct deep cleaned the affected ice machine</li> </ul>	1		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070				PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		B. WING		1	C 1/05/2024		
NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CC			
			411 S LASALLE STREET DURHAM, NC 27705				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 921	behind the ice machi along the molding an and decayed wood, I growths among the b and corner molding. material was also ob- among the blackish r colored growths. An interview and obs PM with the Maintenar was not aware of the condition. He explain used by staff, and he concerns related to n staff. The Maintenar cleaned the ice mach quarterly. He verball the blackish or light b matter was on the flo suspected that it was certain." The Mainte that he would shut do the ice machine out, and repair the floorin An interview with the 12:35 PM revealed ic weekly by staff and n Administrator stated	er molding in the right corner ne revealed blackish matter id underneath the exposed ight beige colored puffy blackish matter on the floor Yellow matted stringy served on the floor and matter and light beige ervation on 10/22/24 at 5:26 ance Director revealed he ice machine being in this ned that the ice machine was had not received any mold in the ice machine from ines in the building zed he was not certain what beige or yellow colored for or the corner molding. He is mold but "not 100% nance Director explained own the ice machine, empty complete a chemical clean, g around the ice machine. Administrator on 10/23/24 at is machines were checked	F 92	<ul> <li>and removed any growth but Maintenance Director also or removed the various colored the floor around the ice machine any growth buildup and to end flooring around the ice machine any growth buildup and to end flooring around the ice machine and sanitary environment.</li> <li>4) Indicate how the facility p monitor its performance to n the solutions are achieved a The Maintenance Director o will audit the ice machines a around the ice machines to remain free of any growth but for 12 weeks.</li> <li>The Administrator, Director of designee will report findings monitoring process to the fa Assurance and Performance for additional monitoring or mod this plan. The QAPI Commit modify this plan to ensure th remains in substantial comp</li> <li>The facility alleges compliant 11/22/2024.</li> </ul>	leaned and d growth on hine. rator se department ain a cleaning es to prevent nsure the nine remains sure a clean lans to nake sure that ind sustained: r designee(s) and flooring ensure they uildup weekly of Nursing, or of the cility Quality e any dification of tee can ne facility liance.		

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