STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted from 01/13/25 through 01/16/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 7EVD11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted from 1/13/25 through 1/16/25. Event ID # 7EVD11.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to place a resident's call light within reach to allow for the resident to request staff assistance if needed for 1 of 1 resident reviewed for accommodation of needs (Resident #78). Findings included: Resident #78 was admitted to the facility on 10/12/24. Review of the quarterly Minimum Data Set (MDS) assessment dated 11/ 5/24 revealed the resident was assessed as moderately cognitively impaired. The assessment indicated Resident	F 558	F-558 (1) How corrective action will be accomplished for resident(s) found to have been affected: Residents #78's call light was ensured to be in place by the Director of Nursing on 1/15/2025. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 1/16/2025 the Administrator conducted an audit of all residents to ensure that all resident call lights were within reach.	2/2/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/29/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 1 #78 had clear speech, could make herself understood and had the ability to understand others. Resident #78 was assessed with impairment on both sides related to functional limitation in range of motion for upper and lower extremities. The resident was dependent on staff for all activities of daily living (ADL) and needed substantial to maximum assistance to roll left or right. An observation of Resident #78 on 1/13/25 at 12:02 PM, revealed the resident's call bell was tied to the bed rail on her right side. It was noted to be on the floor beside the bed and out of reach of the resident. The resident was observed to be lying on her bed and did not speak with the surveyor when asked about her call bell and if she could use it. During an observation on 1/14/25 at 8:09 AM, the resident's call bell was observed lying on the floor. When the resident was asked where her call bell was, she pointed to the bed rail and when asked if she could reach it and use it, the resident demonstrated that she could not reach it, but nodded her head indicating she could use it. During an observation on 1/15/25 at 8:44 AM, Nurse #3 was observed leaving the resident's room. The resident was observed lying in her bed. The call bell was wrapped to the bed rail and was hanging off the bed on the right side. The call bell was out of reach of the resident. When the resident was asked if she knew where her call bell was, she looked at the surveyor and shook her head indicating "NO". During an observation and interview with the Director of Nursing (DON) on 1/15/25 at 8:50 AM	F 558	Audit revealed that all residents call lights were within reach. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 1/27/2025 the Director of Nursing and the Staff Development Coordinator initiated re-education to the nursing department to ensure that resident call lights are within reach each time they enter the room. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: An audit will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that all resident call lights are observed to be within reach. This monitoring process will take place weekly for 12 weeks observing 10 residents per week. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 2 in Resident # 78's room, the DON acknowledged the call bell was hanging to the side of the bed, and not within the reach of resident. The DON stated Resident #78 could use the call bell and was able communicate her needs to the staff. The DON placed the call bell within the reach of the resident by clipping it to the bed linen near the resident's chest. During an interview on 1/15/25 at 8:52 AM, Nurse #3 indicated Resident #78 was alert and oriented and was able to communicate her needs. The Nurse stated that the resident could use the call bell if she needed to. Nurse #3 stated she was in the resident's room earlier that morning administering medication. Nurse #3 indicated the resident could not turn or reposition independently and needed staff assistance with her ADL care. She indicated she was not paying attention and had not noticed the call bell hanging to the side of the bed and not within the reach of the resident. During an interview on 1/15/25 at 2:27 PM, Nurse Aide (NA) #1 verified she was the direct care NA for Resident #78 for the past 3 days (1/13/25 through 1/15/25) from 7:00 AM - 3:00 PM. NA #1 stated Resident #78 needed total assistance with ADL care and needed assistance with turning and repositioning. NA #1 indicated Resident #78 was alert and oriented, able to communicate her needs and only spoke to people she was familiar with. NA #1 further indicated the resident was able to use the call bell and would use it as needed. NA #1 stated she usually checked on Resident #78 first thing in the morning between 7:00 -7:30 AM and later after breakfast (between 8:30 -9:30 AM) to provide her morning care as the resident would like to be out of bed around 10	F 558	remains in substantial compliance. The facility alleges compliance on 2/2/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 3 AM. NA #1 indicated she had not noticed the call bell hanging to the side of the bed. NA #1 stated she usually placed the call bell wrapped to the bed rail and within reach of the resident. NA #1 indicated the resident could not turn to reach her call bell if it was hanging to the side of the bed. During an interview on 1/15/25 at 3:30 PM, the DON reiterated Resident #78 was alert and oriented and was able to use her call bell. The DON indicated the resident only spoke with people she was familiar with and could not move or roll over side to side and needed total assistance from staff for her care. The DON stated Resident # 78 could not reach the call bell if it was hanging to the side of her bed. The DON indicated nursing staff should always ensure that the resident's call bell was within reach of the resident after care was provided.	F 558		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Preadmission Screening and Resident Review (PASRR) Level II status (Resident #23), use of a hypoglycemic medication (a medication that helps to lower blood sugar levels in people diagnosed with diabetes) (Resident #23), use of an antianxiety medication (Resident #52) and hypoglycemic medication was inaccurately coded as insulin (Resident #4) for 3 of 21 residents	F 641	F-641 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #4 was corrected and coded accurately on the minimum data set by the Minimum Data Set Coordinator on 1/15/2025 and Residents #23 and #52 were corrected by the Minimum Data Set Coordinator on 1/16/2025.	2/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 whose MDS assessments were reviewed. The findings included: 1a. Resident #23 was admitted to the facility on 9/17/17 with a cumulative diagnosis which included major depressive disorder and schizophrenia. The resident's care plan included the following area of focus, in part: "I have a level two PASRR dx [diagnosis]: Schizophrenia" (Revised on: 5/27/19). Resident #23's most recent comprehensive Minimum Data Set (MDS) was an annual assessment dated 2/2/24. The "Identification Information" section of this MDS assessment did not report Resident #23 had a PASRR Level II determination. On the date of the review (1/15/25), Resident #23's profile in her electronic medical record (EMR) revealed she had a PASRR number ending with the letter "B," which was indicative of a PASRR Level II determination with no limitation on the timeframe. The results of the evaluation, including the determination of a PASRR Level II status, were used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care. An interview was conducted on 1/16/25 at 9:50 AM with MDS Nurse #2 related to Resident #23's annual assessment dated 2/2/24. MDS Nurse #1 joined the interview on 1/16/25 at 9:55 AM as the resident's PASRR determination was discussed. Upon review of Resident #23's 2/2/24 MDS	F 641	(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: A focused review was completed by the Minimum Data Set Coordinators on 1/22/2025 regarding the accuracy of coding on the minimum data set in accordance with the resident assessment instruments for all residents over the past 3 months regarding Ozempic, antianxiety medication, and level II PASRRs. The focused review revealed 4 additional coding discrepancies. All corrections were made as indicated by the Minimum Data Set Coordinator. This focused review was subsequently audited by the Director of Nursing on 1/22/2025 and verified to be accurate. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 1/24/2025 the Director of Nursing provided re-education to the Minimum Data Set Coordinators regarding the need for accurate coding on the minimum data set to reflect proper coding of Ozempic, antianxiety medication, and level II PASRRs. (4) Indicate how the facility plans to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5	F 641		

assessment, MDS Nurse #2 confirmed the assessment inaccurately indicated this resident had a PASRR Level I status when it should have noted she had a PASRR Level II status. MDS Nurse #1 acknowledged the MDS assessment was incorrect, but noted Resident #23 was care planned for a PASRR Level II (which was correct).

An interview was conducted on 1/16/25 at 11:17 AM with the facility's Director of Nursing (DON). During the interview, concerns identified during the review of Resident #23's MDS assessments were discussed. Upon inquiry, the DON reported she would expect the MDS assessments to be coded accurately.

1b. The resident's care plan included the following area of focus, in part: "The resident has potential for uncontrolled hypo/hyperglycemia [low and high blood sugar levels] r/t [related to] Diabetes Mellitus" (Revised on: 5/24/21).

Resident #23's November 2024 Physician's Orders and Medication Administration Record (MAR) revealed the following medications were used to manage the resident's diabetes between 11/3/24 and 11/9/24:
-- 2 mg/3 milliliters (ml) Ozempic (an injectable antidiabetic agent that helps to lower blood sugar and is considered a hypoglycemic medication) to be given as 1 mg injected subcutaneously (under the skin) one time a day every Monday for diabetes (ordered on 11/6/23).
-- 5 milligram (mg) glipizide Extended Release (ER) Tablet (an oral antidiabetic agent that helps to lower blood sugar and is considered a hypoglycemic medication) to be given as one tablet by mouth once a day for

monitor its performance to make sure that the solutions are achieved and sustained: The Director of Nursing or designee will randomly audit 5 minimum data set assessments weekly to monitor and ensure that Ozempic, antianxiety medications, and level II PASRRs are coded accurately on the minimum data set. This monitoring process will take place weekly for 12 weeks.

Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process to the facility Quality Assurance and Performance 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.

The facility alleges compliance on 2/2/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6	F 641		

diabetes (ordered on 12/14/22).

Based on the documentation provided by Resident #23's November 2024 Physician Orders and MAR, the resident did not receive an insulin injection between 11/3/24 and 11/9/24.

Resident #23's most recent Minimum Data Set (MDS) was a quarterly assessment dated 11/9/24. The "Medications" section of this MDS assessment indicated the resident received an insulin injection on one (1) day during the 7-day lookback period. Meanwhile, this MDS did not indicate Resident #23 received a hypoglycemic medication.

An interview was conducted on 1/16/25 at 9:50 AM with MDS Nurse #2. MDS Nurse #1 joined the interview on 1/16/25 at 9:55 AM as Resident #23's MDS assessments were discussed. Upon review of the medications classified on her quarterly MDS dated 11/9/24, the MDS nurses reported they were aware the Ozempic was inaccurately coded and needed to be corrected on the MDS.

An interview was conducted on 1/16/25 at 11:17 AM with the facility's Director of Nursing (DON). During the interview, concerns identified during the review of the Resident #23's MDS assessments were discussed. Upon inquiry, the DON reported she would expect the MDS assessments to be coded accurately and to ensure the medications were classified appropriately.

2. Resident #52 was admitted to the facility on 9/17/20 with reentry on 12/2/24 from a hospital. The resident's cumulative diagnoses included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7	F 641		

schizoaffective disorder.

The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 12/10/24. The "Medications" section of the 12/10/24 MDS assessment indicated Resident #52 received an antianxiety medication during the 7-day look back period.

Resident #52's December 2024 Physician Orders and Medication Administration Record (MAR) provided documentation which indicated the resident did not receive an antianxiety medication during the 7-day look back period from 12/4/24 to 12/10/24.

An interview was conducted on 1/16/25 at 9:50 AM with MDS Nurse #2. MDS Nurse #1 joined the interview on 1/16/25 at 9:55 AM as Resident #52's MDS assessments and electronic medical record (EMR) were reviewed. Upon review of the resident's Medications section of the quarterly MDS dated 12/10/24, MDS Nurse #1 reported he may have incorrectly coded this section to indicate the resident received an antianxiety medication. When asked if Resident #52 received an antianxiety medication during the 7-day lookback period, the MDS nurse stated he did not.

An interview was conducted on 1/16/25 at 11:17 AM with the facility's Director of Nursing (DON). During the interview, concerns identified during the review of the sample resident's MDS assessments were discussed. Upon inquiry, the DON reported she would expect the MDS assessments to be coded accurately and to ensure the medications were classified appropriately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 8	F 641		

3. Resident #4 was admitted on 10/21/24 and readmitted to the facility on 11/20/24 with diagnosis that included type 2 diabetes mellitus with diabetic peripheral angiopathy.

Review of the physician orders dated 10/22/24 revealed the following : Ozempic (an injectable, anti-diabetic medication used for the treatment of type 2 diabetes and an anti-obesity medication used for weight management) inject 0.75 milliliter subcutaneously in the morning every Friday for weight management.

Review of the Medication Administration Record (MAR) for November 2024 revealed Ozempic (1 milligram (mg)/dose) Subcutaneous Solution Pen-injector Inject 0.75 ml subcutaneously in the morning every Friday for weight management was marked as administered to the resident on Fridays (11/1/24; 11/8/24; 11/15/24; 11/22/24; and on 11/29/24.).

Review of the Admission/5-day Minimum Data Set (MDS) assessment dated 11/27/24 indicated she received one insulin injection during the seven day look back period.

During an interview on 1/13/25 at 10:44 AM, Resident #4 indicated she was diabetic and does not receive any insulin. She indicated she was on Ozempic for weight loss.

During an interview 1/14/25 at 1:53 PM, Nurse #4 indicated she was assigned to Resident #4. Nurse #4 stated Resident #4 was diabetic and received oral medication to manage the diabetes. Nurse #4 indicated the resident was not on any insulin and received injectable Ozempic for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9 weight loss. During an interview on 1/15/25 at 9:22 AM, MDS Coordinator #1 indicated Resident #4 was on Ozempic and per the "MDS 3.0 Drug Class Index" reference sheet that the MDS nurses utilize for medication classification, Ozempic was indicted as "INS". MDS Coordinator #1 indicated he had assumed "INS" was insulin and hence had marked as receiving insulin during the look back period. Review of the "MDS 3.0 Drug Class Index" sheet revealed drug class "INS" was classified as a hypoglycemic medication which included insulin. During an interview on 1/15/25 at 3:26 PM, the Administrator indicated the MDS Nurse had made an error. The Administrator stated Ozempic was a new medication and was used to lower blood sugar levels for diabetic residents, and the staff would be educated on this medication.	F 641		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to post cautionary	F 695	F-695	2/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 10 signage outside the resident's room to indicate supplemental oxygen was in use for 1 of 3 residents reviewed for respiratory care (Resident #85). The findings included: Resident #85 was admitted to the facility on 12/23/24 with diagnoses which included hypoxia. Review of Resident #85's physician's orders revealed she had an oxygen order dated 12/24/24 for oxygen supplementation at 2L (liters) every shift via nasal cannula (a device that delivers extra oxygen through a tube and into the nose) for hypoxia (low levels of oxygen in your body tissues). Resident #85's admission Minimum Data Set dated 12/29/24 revealed Resident #85 was assessed as cognitively intact and was coded for oxygen use. An observation on 1/13/25 at 12:05 PM revealed Resident #85 was lying on her bed in her room wearing a nasal cannula for supplemental oxygen. The oxygen concentrator indicated oxygen was flowing at 2 L/minute. There was no signage outside Resident #85's room indicating supplemental oxygen was in use. An observation on 1/14/25 at 8:37 AM revealed Resident #85 was in her room wearing a nasal cannula for supplemental oxygen. There was no signage outside Resident #63's room indicating supplemental oxygen was in use. An observation was conducted in conjunction with an interview on 1/14/25 at 9:00 AM. Resident #85 indicated she was receiving continuous oxygen	F 695	(1) How corrective action will be accomplished for resident(s) found to have been affected: On 1/14/2025 The Director of Nursing posted the cautionary signage outside Resident #85’s room to indicate supplemental oxygen in use. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: The Director of Nursing conducted an audit on 1/14/2025 of all residents that have oxygen to ensure that a cautionary sign is outside their rooms to indicate supplemental oxygen is in use. The audit revealed that there were not any additional residents affected. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 1/27/2025 the Director of Nursing and the Staff Development Coordinator initiated re-education to the nursing department regarding the need for cautionary signage to be posted outside the door of any resident that uses oxygen (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: An audit will be done by the Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 11 for her health issues. The oxygen concentrator indicated oxygen was flowing at 2 L/minute. An observation on 1/14/25 at 2:00 PM revealed Resident #85 was in her room wearing a nasal cannula for supplemental oxygen. There was no signage outside Resident #63's room indicating supplemental oxygen was in use. An interview was conducted on 1/14/25 at 2:05 PM with Nurse #4. She stated Resident #85 was on 2 L/min continuous oxygen therapy via nasal cannula for hypoxia since admission. She stated the admitting nurse was responsible for placing the oxygen signage on a resident's door. She added if the signage was not posted or missed by the admitting nurse then the assigned nurse would place the signage near the resident's room door. An interview was conducted on 1/14/25 at 2:43 PM with the Director of Nursing (DON). She stated nursing were responsible for putting oxygen signage on a resident's door. The DON indicated when any resident was on oxygen therapy, the admitting nurse or the Unit Manager was responsible to put the signage on the door. The DON further indicated the resident was on oxygen and the signage must have been missed by the nurses.	F 695	Nursing, or designee to monitor and ensure that through observation, any resident with oxygen has the proper cautionary signage outside their room to indicate supplemental oxygen in use. This monitoring process will take place weekly for 12 weeks. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process to the facility Quality Assurance and Performance 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. The facility alleges compliance on 2/2/2025	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		2/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 12 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to: 1) Label medications (meds) with the minimum information required, including the name of the resident, on 1 of 2 medication (med) carts observed (Med Cart #1); 2) Discard expired medications on 2 of 2 medication carts observed (Med Cart #1 and Med Cart #4) and in 1 of 1 Medication Storeroom (Nurse Station #2 Medication Storeroom); and 3) Store medications in accordance with the manufacturer's storage instructions on 1 of 2 med carts (Med Cart #1). The findings included: 1. An observation was conducted on 1/14/25 at 3:50 PM of Medication (Med) Cart #1 in the presence of Nurse #1. The observation revealed	F 761	F-761 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 1/16/2025, the Director of Nursing ensured that all medication was labelled with the minimum information required including name and any medication unlabeled properly was removed and discarded. In addition, all expired medications were removed and discarded as well. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 13 the following medications were stored on the med cart: a. According to the manufacturer, in-use prefilled pens of Insulin Glargine-yfgn should be stored at room temperature and used within 28 days. An opened and in-use prefilled pen of Insulin Glargine-yfgn was stored on the med cart without a resident's name on the label to indicate who the insulin pen belonged to. An auxiliary sticker placed on the pen included a blank space entitled, "Expiration Date." A handwritten date written on the blank indicated the insulin pen expired on 1/3/25 (11 days prior to the date of the observation). There was no date on the labeling to indicate when this insulin pen was dispensed from the pharmacy or when it had been put into use. An interview was conducted with Nurse #1 on 1/14/25 at 3:50 PM. When asked, Nurse #1 confirmed the insulin pen was not labeled with a resident's name. She did not know who the insulin pen belonged to. b. According to the manufacturer, in-use prefilled pens of Insulin Lispro should be stored at room temperature and used within 28 days. An opened and in-use prefilled pen of Insulin Lispro dispensed from the pharmacy for Resident #15 had an auxiliary sticker placed on the pen which included a blank space entitled, "Expiration Date." A handwritten date on this blank indicated the insulin pen expired on 12/28/24 (17 days prior to the date of the observation). There was no date on the labeling to indicate when this insulin pen was dispensed from the pharmacy or when it	F 761	needing to be addressed: On 1/16/2025 an audit of all 4 medication administration carts, the 2 medication rooms, and the 2 medication refrigerators was completed by the Director of Nursing to determine if any other medications had expired, were opened without an expiration date, and were labelled with the minimum information required including name. The audit revealed that all medications were stored and labeled appropriately. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 1/27/2025 the Director of Nursing and the Staff Development Coordinator initiated re-education to all licensed nurses and Medication Aides regarding the need to ensure that all medication is to be labelled with the minimum information required including name, any medication unlabeled properly is to be removed and discarded, and all expired medications are to be removed and discarded as well. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: An audit will be done by the Director of Nursing or designee to monitor and ensure that by observation, all 4 medication administration carts, the 2 medication rooms, and the 2 medication refrigerators have medications labelled with the minimum information required	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 14 had been put into use. An interview was conducted with Nurse #1 on 1/14/25 at 3:50 PM. Upon review of the insulin pen, Nurse #1 confirmed the expiration date written on the insulin pen indicated the medication was expired. c. According to the manufacturer, intact (unopened) bottles of latanoprost eye drops should be stored under refrigeration at 36 degrees Fahrenheit (o F) to 46 o F. An unopened bottle of 0.005% latanoprost eye drops dispensed from the pharmacy on 1/7/25 for Resident #15 was stored on the med cart. A pharmacy auxiliary sticker placed on the bottle read, "Keep in Refrigerator Do Not Freeze." An interview was conducted with Nurse #1 on 1/14/25 at 3:50 PM. When asked, the nurse confirmed the auxiliary sticker placed on the container of latanoprost indicated the eye drops should be stored in the refrigerator. An interview was conducted on 1/16/25 at 11:17 AM with the facility's Director of Nursing (DON). During the interview, the medication storage observations were discussed. When asked, the DON reported medications needed to be labeled with the minimum information required, including the name of the resident. She confirmed the insulin pen that was observed to be stored on the med cart without a resident's name needed to be discarded. Additionally, the DON stated the nursing staff should read the medication labels and store items as instructed and appropriate. Expired medications should be identified and discarded by placing them in the Drug Buster (a	F 761	including name, any medication unlabeled properly is removed and discarded, and all expired medications are to be removed and discarded as well. This monitoring process will take place weekly for 12 weeks. The Administrator, Director of Nursing, or designee will report the findings of the monitoring process to the facility Quality Assurance and Performance 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. The facility alleges compliance on 2/2/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 15	F 761		

solution that dissolves and deactivates oral tablets/capsules) or returning them to the pharmacy. Upon further inquiry, the DON reported the facility's unit managers were expected to perform a second check by inspecting the med carts and storerooms weekly to ensure all medications were within date and stored properly.

2. An observation was conducted on 1/15/25 at 11:25 AM of the Nursing Station #2 Medication Storage Room. The observation revealed the following medications were stored on the med cart:

a. According to the manufacturer, in-use vials of Novolin R insulin should be stored at room temperature and used within 42 days.

An opened vial of Novolin R insulin dispensed from the pharmacy on 9/27/24 for Resident #9 was observed to be stored in the refrigerator. Neither the insulin vial nor the plastic container it was stored in were dated as to when the vial was opened or its shortened expiration date. The label on the insulin vial indicated it was dispensed from the pharmacy 111 days prior to the date of the observation.

b. A bottle containing 8 ounces of a compounded drug product (2 milligrams/milliliter of omeprazole suspension) dispensed from the pharmacy for Resident #65 on 12/3/24 was stored in the Med Room refrigerator. Omeprazole is a medication which may be used for the treatment of gastroesophageal reflux disease (GERD). The pharmacy labeling on the omeprazole suspension indicated this medication had an expiration date of 12/9/24 (37 days prior to the date of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 16	F 761		

observation).

c. A bottle containing 6 ounces of a compounded drug product (2 milligrams/milliliter of omeprazole suspension) dispensed from the pharmacy for Resident #65 on 12/30/24 was stored in the Med Room refrigerator. The pharmacy labeling on the omeprazole suspension indicated this medication had an expiration date of 1/13/25 (2 days prior to the date of the observation).

On 1/15/25 at 2:55 PM, Nurse #2 was shown the expired medications stored in the med room refrigerator. As the nurse reviewed these medications, Nurse #2 confirmed they were expired and stated she would need to pull them from the refrigerator for disposal.

An interview was conducted on 1/16/25 at 11:17 AM with the facility's Director of Nursing (DON). During the interview, the medication storage observations were discussed. When asked, the DON reported expired medications should be identified and discarded by placing them in the Drug Buster (a solution that dissolves and deactivates oral tablets/capsules) or returning them to the pharmacy. Upon further inquiry, the DON reported the facility's unit managers were expected to perform a second check by inspecting the med carts and storerooms weekly to ensure all medications were within date and stored properly.

3. An observation was conducted on 1/15/25 at 2:40 PM of Medication (Med) Cart #4 in the presence of Nurse #3. The observation revealed the following medications were stored on the med cart:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 17	F 761		

a. One stock bottle of Poly-Iron 150 capsules (originally containing 100 capsules) with approximately 80 capsules remaining in the bottle was observed to have a manufacturer expiration date of December 2024. Poly-Iron 150 is an iron supplement used to treat iron-deficiency anemia.

b. One stock bottle of 100 milligram (mg) Thiamine B-1 (originally containing 100 tabs) with approximately 60 tablets remaining in the bottle was observed to have a manufacturer expiration date of December 2024. Thiamine B-1 is a B-vitamin supplement used to treat a vitamin deficiency.

An interview was conducted on 1/15/25 at 2:50 PM with Nurse #3. During the interview, the nurse examined the labeling on the stock medications identified with a concern. Upon review, Nurse #3 confirmed these medications were expired and needed to be pulled off the medication cart.

An interview was conducted on 1/16/25 at 11:17 AM with the facility's Director of Nursing (DON). During the interview, the medication storage observations were discussed. When asked, the DON reported expired medications should be identified and discarded by placing them in the Drug Buster (a solution that dissolves and deactivates oral tablets/capsules) or returning them to the pharmacy. Upon further inquiry, the DON reported the facility's unit managers were expected to perform a second check by inspecting the med carts and storerooms weekly to ensure all medications were within date and stored properly.