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 _____	C 07/31/2024

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 000	INITIAL COMMENTS A complaint investigation survey was conducted on 7/30/24 through 7/31/24. Event ID# K0NY11. The following intake was investigated NC00219561. 1 of the 3 complaint allegations resulted in deficiency.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		8/16/24

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

Electronically Signed | 08/16/2024

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F 755	Continued From page 1 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, pharmacist and physician interview the facility failed to notify the pharmacy of missing insulin for 1 of 3 resident reviewed for pharmacy services (Resident #2). The findings included: Physician order dated 4/20/24 stated administer Resident #2 Liraglutide (an anti-diabetic medication) Subcutaneous solution Pen injector 18 milligrams (MG)/3ML. The order further stated inject 1.8 MG subcutaneously one time a day for diabetes. Further review of the MAR for July 2024 revealed Resident #2 did not receive Liraglutide Subcutaneously on 7/9/24, 7/14/24, 7/15/24 and 7/16/24. The MAR identified the medication was on hold, see nursing note. Medication Administration note dated 7/16/24 at 11:28 am written by Nurse #1 stated Liraglutide Subcutaneous solution pen-injector 10 MG/3 ML. Inject 1.8 MG subcutaneously one time a day for diabetes was held till received on next delivery. Review of Resident #2's medical record revealed no documentation of administration of Liraglutide Subcutaneous solution pen injector 18 mg/3 ml, inject 1.8 mg subcutaneously one time a day for diabetes on 7/16/24. Interview with Nurse #3 on 7/31/24 at 11:08 am revealed if she identified a code of 5 on the MAR	F 755	F-755 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #2's insulin (Liraglutide) was ordered on 7/16/2024 and received from the pharmacy on 7/16/2024 and the next dose due was given on 7/17/2024. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: An audit was done by the Director of Nursing on 7/31/2024 for all residents receiving insulin to ensure insulin availability and that no other residents were affected by failing to notify pharmacy of missing insulin. Audit revealed that no other residents were noted to be affected. 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 7/31/2024 the Director of Nursing and Unit Managers initiated re-education to all licensed nurses to ensure insulin availability for all residents receiving insulin by monitoring the resident's supply and to notify pharmacy in a timely manner to re-order before supply runs out. In addition, in the event that insulin is	

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F 755	Continued From page 2 on 7/9/24 and 7/14/24, it would indicate the medication was not available. She further stated she had not contacted the pharmacy regarding the missing medication. Interview with Nurse # 4 on 7/31/24 at 11:02 am revealed she was an agency nurse and assigned to Resident #2 on 7/15/24. She stated she recalled Resident #2's having no insulin to administer in the facility. She further stated she did not recall contacting the pharmacy. Interview with the Consulting Pharmacist on 7/31/24 at 10:45 am revealed the facility could notify the pharmacy of a need for medication to include using an electronic system, pulling the sticker on the medication and fax it the pharmacy, or contact the pharmacy directly to refill an order. The facility should let the pharmacy know if a medication was running low and Stat orders could be completed. The consulting agency received a request for a refill by the facility on 7/16/24 to refill the medication Liraglutide Subcutaneous solution pen-injector. Interview with the DON on 7/31/24 at 11:32 am stated if a medication was not available in the facility, nursing staff should identify if the medication was available in back up. The DON further indicated the medication Liraglutide Subcutaneous solution pen-injector would not be a medication the facility would have in back up medications. Nursing staff were to contact the pharmacy if a medication was not available in the facility. She was unsure as to why nursing staff did not contact the pharmacy to obtain a refill on Resident #2's Liraglutide Subcutaneous Solution pen-injector. Further, if medications were running low, staff should reorder the medication to ensure	F 755	unavailable, the pharmacy (to obtain re-fill) and physician (to adjust orders accordingly) are to be notified immediately upon discovering. 4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: To ensure insulin availability and timely notification to pharmacy for re-ordering, monitoring using the insulin availability audit tool for all residents receiving insulin will be done by the Director of Nursing or designee 5 days/week for 4 weeks, 3 days/week for 4 weeks, and then 1 day/week for 4 weeks. The Administrator, Director of Nursing, or designee will report 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 8/16/2024	

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F 755	Continued From page 3 the resident does not run out. Interview with the Physician on 7/31/24 at 11:18 am revealed he should be notified when medications were not available in the facility, and he would need to know from nursing staff why the medication was not available. He stated the pharmacy should provide the medication every month once initially prescribed. There was a breakdown from the pharmacy and the pharmacy should send a notification to the facility in the instance a medication was not going to be sent. He further stated staff should also contact the pharmacy and see what medication could be replaced with so he could prescribe the medication as a replacement. The Physician stated Liraglutide Subcutaneous solution pen-injector was not a new prescription so why would the pharmacy not deliver it and why does the facility have to remind the pharmacy of medication that was already prescribed. The pharmacy should have a system in place that alerts them of medications they should deliver. Interview with the Administrator on 7/31/24 at 11:45 am revealed in the instance a prescribed medication was not in stock in the facility, nursing staff should contact the pharmacy in an attempt to obtain the medication for administration.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and	F 760	F-760	8/16/24

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F 760	Continued From page 4 physician interview the facility failed to follow physician order for 1 of 3 residents reviewed for pharmaceutical services (Resident #2). The findings included: Resident #2 was admitted to the facility on 4/19/24 with a diagnosis that included type 2 diabetes (DM) and kidney failure with tubular necrosis. Review of Resident #2's annual Minimum Data Set (MDS) assessment dated 7/11/24 revealed he was cognitively intact, had a diagnosis of diabetes and received insulin during the look back period. Care plan last updated 7/11/24 indicated Resident #2 had a diagnosis of DM. The goal stated Resident #2 would not have complications related to DM. The interventions included diabetes medication as ordered by the physician. A. Resident #2's physician order dated 5/4/24 stated administer Trebiba FlexTouch subcutaneous pen-injector 100 unit/milliliter (ml) (insulin Degludec). The order stated inject 30 units subcutaneously one time a day for DM. Review of the Medication Administration record (MAR) for July 2024 revealed Resident #2 did not receive Tresiba Flex Touch on July 1, 2024. The MAR identified the medication was on hold, see nursing note. The note was written by Nurse #2. Medical Record review revealed no documentation of Resident #2 receiving Tresiba Flex Touch subcutaneous pen injector 100 unit/ML one time a day on 7/1/24.	F 760	(1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #2's insulin (Tresiba) was ordered on 7/1/2024 and received from the pharmacy on 7/1/2024 and the next dose due was given on 7/2/2024. Resident #2's insulin (Liraglutide) was ordered on 7/16/2024 and received from the pharmacy on 7/16/2024 and the next dose due was given on 7/17/2024. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: An audit was done by the Director of Nursing on 7/31/2024 for all residents receiving insulin to ensure insulin availability and that no other residents were affected by failing to follow physician orders that led to a significant medication error. Audit revealed that no other residents were noted to be affected. 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 7/31/2024 the Director of Nursing and Unit Managers initiated re-education to all licensed nurses to ensure insulin availability for all residents receiving insulin by monitoring the resident's supply and to notify pharmacy in a timely manner to re-order before supply runs out thus ensuring that physician orders are being followed to prevent a significant	

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F 760	Continued From page 5 Medication Administration note dated 7/1/24 at 12:09 pm written by Nurse #2 stated Tresbia Flex Touch Subcutaneous solution pen-injector 100 unit/ML. Inject 30 unit subcutaneous one time a day for DM. The note further stated the medication was not on hand. Interview with Nurse #2 on 7/31/24 at 10:24 am revealed she did recall Resident #2 not having insulin during medication administration. She could not recall the name of the medication. She indicated she recalled arriving on her shift at about 7:00 am on July 1, 2024, and during medication administration realized Resident #2 had no insulin. Nurse #2 stated she notified the Director of Nursing (DON) who notified the pharmacy. B. Physician order dated 4/20/24 stated administer Resident #2 Liraglutide (an anti-diabetic medication) Subcutaneous Solution Pen injector 18 milligrams (mg)/3ML. The order further stated inject 1.8 mg subcutaneously one time a day for diabetes. Further review of the MAR for July 2024 revealed Resident #2 did not receive Liraglutide Subcutaneously on 7/10/24, 7/14/24, 7/15/24 and 7/16/24. The MAR identified the medication was on hold, see nursing note. Medication Administration note dated 7/16/24 at 11:28 am written by Nurse #1 stated Liraglutide Subcutaneous solution pen-injector 10 MG/3 ML. Inject 1.8 mg subcutaneously one time a day for diabetes was held till received on next delivery. Interview with Nurse #1 on 7/31/24 at 10:40 am	F 760	medication error from occurring. In addition, in the event that insulin is unavailable, the pharmacy (to obtain re-fill) and physician (to adjust orders accordingly) are to be notified immediately upon discovering. 4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: To ensure physician orders are being followed for insulin availability to prevent a significant medication error, monitoring using the insulin availability audit tool for all residents receiving insulin will be done by the Director of Nursing or designee 5 days/week for 4 weeks, 3 days/week for 4 weeks, and then 1 day/week for 4 weeks. The Administrator, Director of Nursing, or designee will report 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 8/16/2024	

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F 760	Continued From page 6	F 760		

revealed she was an agency nurse. She indicated when she was administering Resident #2's medications she noticed it had not been given for 2 consecutive days. She stated she contacted the pharmacy to regarding the medication and was told the medication would be delivered.

Review of Resident #2's medical record revealed no documentation of administration of Liraglutide Subcutaneous solution pen injector 18 mg/3 ml, inject 1.8 mg subcutaneously one time a day for diabetes on 7/16/24.

Interview with Nurse #3 on 7/31/24 at 11:08 am revealed if she identified a code of 5 on the MAR on 7/9/24 and 7/14/24, it would indicate the medication was not available. She further stated she had not contacted the pharmacy regarding the missing medication.

Interview with Nurse # 4 on 7/31/24 at 11:02 am revealed she was an agency nurse and assigned to Resident #2 on 7/15/24. She stated she recalled Resident #2's having no insulin to administer in the facility. She further stated she did not recall contacting the pharmacy.

Interview with the DON on 7/31/24 at 11:02 am indicated in the instance a medication was not available, staff should contact the physician. The DON further stated the nurse should provide medications according to physician order.

Interview with the Physician on 7/31/24 at 11:18 am revealed he should be notified when medications were not available. He further indicated staff should follow his orders as written.

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F 760	Continued From page 7 Interview with the Administrator on 7/31/24 at 11:45 am revealed nursing staff should notify the physician when medications were not administered according to physician orders.	F 760		