| DEPART | MENT OF HEALTH AN | ID HUMAN SERVICES | | | | RM APPROVED |
|--------------------------|--|--|---------------------|---|---------|----------------------------|
| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | NO. 0938-0391 |
| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | | TE SURVEY MPLETED |
| | | 345358 | B. WING | | 0 | C 8/28/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 0/20/2024 |
| LOUISBUI | RG HEALTHCARE & REH | ABILITATION CENTER | | 202 SMOKETREE WAY | | |
| | | | | LOUISBURG, NC 27549 | | |
| (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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS | | F 00 | 00 | | |
| F 755 SS=D | from 8/27/24 through SOU911. The followi NC00219718 and NC complaint allegations Pharmacy Srvcs/Proc | ng intakes were investigated 00220724. 1 of the 7 resulted in deficiency. cedures/Pharmacist/Records | F 75 | 55 | | 9/17/24 |
| | drugs and biologicals them under an agree §483.70(f). The facili personnel to administ | ide routine and emergency to its residents, or obtain ment described in ty may permit unlicensed | | | | |
| | pharmaceutical servic that assure the accur dispensing, and admi | es. A facility must provide ces (including procedures ate acquiring, receiving, inistering of all drugs and ne needs of each resident. | | | | |
| | - , , | onsultation. The facility n the services of a licensed | | | | |
| | §483.45(b)(1) Provide aspects of the provisi the facility. | es consultation on all on of pharmacy services in | | | | |
| | | shes a system of records of n of all controlled drugs in able an accurate | | | | |
| | §483.45(b)(3) Determ | nines that drug records are in | | | | |
| | | SUPPLIER REPRESENTATIVE'S SIGNATURI | E | TITLE | | (X6) DATE |
| Electroni | callv Signed | | | | | 09/13/2024 |

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

PRINTED: 10/17/2024

| | | | 0.00 | TIP: - | | 1 | <u>D. 0938-039</u> |
|--------------------------|--|---|--------------------|--|--|-------------------------------|----------------------------|
| | DF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , í | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | | A. BUILDING | | | C 08/28/2024 | |
| | | 345358 | | | | | |
| | ROVIDER OR SUPPLIER | | | | IREET ADDRESS, CITY, STATE, ZIP CODE | 00 | /20/2024 |
| | | | | | 2 SMOKETREE WAY | | |
| LOUISBUI | RG HEALTHCARE & RE | HABILITATION CENTER | | | OUISBURG, NC 27549 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 755 | Continued From page | | F | 755 | | | |
| | | count of all controlled drugs | | | | | |
| | is maintained and pe | - | | | | | |
| | | | | | | | |
| | by: Based on record rev | | | The statements made on this plan of | | | |
| | Pharmacist and Med | | | correction are not an admission to and | do | | |
| | facility failed to ensur | | | not constitute an agreement with the | uo | | |
| | • | residents reviewed for | | | alleged deficiencies. | | |
| | administration of med | dication to meet needs of the | | | To remain in compliance with all federa | al | |
| | resident. (Resident # | 2) | | | and state regulations the facility has ta | lken | |
| | | | | | or will take the actions set forth in this | | |
| | The findings included | | | plan of correction. The plan of correction | on | | |
| | | | | constitutes the facility s allegation of | | | |
| | Resident #2 was adn | | | compliance such that all alleged | | | |
| | 12/1/23 with diagnos neoplasm of the left t | | | deficiencies cited have been or will be | | | |
| | schizoaffective disord | | | corrected by the dates indicated. F755 | | | |
| | | | | | 1. Corrective action for resident(s) | | |
| | a.Review of a physic | ian ' s order dated 2/22/23 | | | affected by the alleged deficient practic | ce: | |
| | | 2 was to receive Aripiprazole | | | | | |
| | | ve 1 tablet by mouth one time | | | A. Corrective action was received for | | |
| | a day for schizophrer | nia. | | | resident # 2 on 08/16/2024 when the | | |
| | | | | | facility received a replenishment of | | |
| | | 2's electronic Medication | | | residents Aripiprazole from the pharma | • | |
| | | d (MAR) for July 2024 | | | On 08/27/2024, the Medical Director (| | |
| | | t received Aripiprazole as | | | was notified of the medication not bein | | |
| | ordered on the follow | my uales. | | | administered on 7/20/2024, 07/21/202- 08/12/2024, and 08/13/2024 without M | | |
| | On 7/20/24 at 9:00 A | M, the MAR showed no dose | | | or pharmacy notification and there wer | | |
| | | dministered. A chart code of | | | no new orders. | - | |
| | | n the MAR to indicate | | | | | |
| | other/see nurses no | tes". A nurses note dated | | | B. Corrective action was received for | | |
| | | sident #2 did not receive her | | | resident # 2 on 08/21/2024 when the | | |
| | | nedication being "on order". | | | facility received a replenishment of | | |
| | | cate the pharmacy or | | | residents Letrozole from the pharmacy | | |
| | Director of Nursing w | as notified. | | | On 08/27/2024, the Medical Director (| | |
| | An intonviou was sar | nducted with Nurse #1 on | | | was notified of the medication not bein | g | |
| | | Nurse #1 stated she had not | | | administered on 08/12/2024 and 08/13/2024 without MD or pharmacy | | |

Facility ID: 923313

If continuation sheet Page 2 of 10

| | | MEDICAID SERVICES | | | | | <u>NO. 0938-03</u> |
|---------------|------------------------|--|---------------|----|--|-------|--------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | | TE SURVEY |
| | | | A. BUILDING | | | С | |
| | | 345358 | | | | | |
| | ROVIDER OR SUPPLIER | 040000 | | | REET ADDRESS, CITY, STATE, ZIP CODE | (| 8/28/2024 |
| | | | | | 2 SMOKETREE WAY | | |
| OUISBU | RG HEALTHCARE & RE | HABILITATION CENTER | | | DUISBURG, NC 27549 | | |
| (X4) ID | SUMMARY ST | ATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PRÉFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | | (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | COMPLETIC |
| F 755 | Continued From page | e 2 | F 75 | 55 | | | |
| | received education o | n the process for missing | | | notification and there were no new orc | lers. | |
| | medications. The nur | se stated she had attempted | | | No further corrective action was require | red. | |
| | | on from the pharmacy and | | | | | |
| | | t the medication would be | | | 2. Corrective action for residents wit | | |
| | | in the pharmacy delivery. | | | the potential to be affected by the alleg | ged | |
| | | did not notify the charge lursing that Resident #2 did | | | deficient practice: | | |
| | not have the medicat | - | | | On 09/03/2024, the Registered Nurse | | |
| | | | | | Supervisor (RN) initiated an audit of 1 | | |
| | On 7/21/24 at 9:00 A | M, the MAR showed no dose | | | of the Medication Administration Notes | | |
| | of Aripiprazole was a | dministered. A chart code of | | | the last 14 days from 08/21/2024 - | | |
| | - | n the MAR to indicate | | | 09/03/2024 for all current residents. T | | |
| | | tes". A nurses note dated | | | audit consisted of a review of the EMA | ٨R | |
| | | sident #2 did not receive her | | | progress notes to to identify any | d | |
| | | nedication being "on order". cate the pharmacy or | | | medications that were not administere due to not being available. This was | a | |
| | Director of Nursing w | | | | completed: 09/04/2024. The results | | |
| | | | | | included: There were residents identif | fied | |
| | Multiple attempts to r | each Nurse #2 were | | | as not receiving medications because | | |
| | unsuccessful. | | | | they were on order. On 09/04/2024 , 1 | | |
| | | | | | pharmacy was contacted for any | | |
| | | #2 's electronic Medication | | | medications that were identified as no | | |
| | | d (MAR) for August 2024 | | | being available and the medications w | /ere | |
| | | t received Aripiprazole as | | | delivered to the facility. | | |
| | ordered on the follow | ing dates. | | | On 09/05/2024 the Director of Nurses | | |
| | On 8/12/24 at 9:00 A | M, the MAR showed no dose | | | (DON) or designee will have ongoing | | |
| | | dministered. A chart code of | | | random review of the Medication | | |
| | | n the MAR to indicate | | | Administration Notes for current reside | ents | |
| | | tes". A nurses note dated | | | to identify any medications that were r | | |
| | | sident #2 did not receive her | | | administered due to not being availabl | e. | |
| | | nedication being "on order". | | | This random audit will be continued | | |
| | | cate the pharmacy or | | | through 09/17/2024. | | |
| | Director of Nursing w | สรามปแมยน. | | | Additionally, from 09/05/2024 to | | |
| | An interview was cor | nducted with Nurse #3 on | | | 09/16/2024 the DON initiated medicati | ion | |
| | | Nurse #3 stated she was | | | administration post tests and medicati | | |
| | able to reorder a med | | | | administration observations to audit | | |
| | | nurse stated she did not | | | compliance with medication availability | v | |

Facility ID: 923313

If continuation sheet Page 3 of 10

| | | | | | | NO. 0938-03 |
|--|-------------------------------|---|--------------------|--|----------------------------------|---------------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | TIPLE CONSTRUCTION | (X3) DATE SURVE COMPLETED | |
| | | 345358 | B. WING | | | C 08/28/2024 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | | 50,20,2024 |
| LOUISBURG HEALTHCARE & REHABILITATION CENTER | | | 202 SMOKETREE WAY | | | |
| | | | | LOUISBURG, NC 27549 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETIO DATE |
| F 755 | Continued From pag | e 3 | F | 755 | | |
| | | armacy to see when the | | | | |
| | | ive. Nurse #3 stated she had | | 3. Measures /Systemic cl | hanges to | |
| | | e of the use of a backup | | prevent reoccurrence of all | - | |
| | pharmacy and she d | id not report the missing | | practice: | - | |
| | | arge nurse or Director of | | On 09/05/2024, the Directo | r of Nurooo | |
| | Nursing. | | | (DON) began educating all | | |
| | On 8/13/24 at 9.00 A | M, the MAR showed no dose | | Nurses, RN⊡s, Licensed P | | |
| | | dministered. A chart code of | | (LPN s), Medication Aides | | |
| | | on the MAR to indicate | | time, including agency staff | | |
| | | tes". A nurses note dated | | needed) on the following to | | |
| | 8/13/24 revealed Res | sident #2 did not receive her | | , , | | |
| | Aripiprazole due to n | nedication being "on order". | | " How to obtain medicat | ions from the | |
| | The note did not indi | cate the pharmacy or | | back up pharmacy | | |
| | Director of Nursing w | /as notified. | | " The importance of ens | - | |
| | | | | medications are always ava | | |
| | Multiple attempts to I | reach Nurse #4 were | | given to the resident as ord | lered by the | |
| | unsuccessful. | | | Physician. | | |
| | | ducted with the Dhemeseist | | " Understand the steps i | | |
| | | nducted with the Pharmacist M. The Pharmacist stated the | | obtain medications from the | • | |
| | | | | during business hours and hours for all situations. | alter business | |
| | | est for Aripiprazole for tered into the electronic | | " Preventing medication | orrors | |
| | system on 7/19/24. | | | " 6 rights of medication | | |
| | Aripiprazole was ent | - | | | aaniniotration | |
| | | ere was no documentation in | | The DON or designee will b | oe responsible | |
| | | nyone from the facility had | | for ensuring Pharmacy Ser | | |
| | | lication not being available. | | Medication Error Prevention | n Education will | |
| | | orted that a 30-day supply of | | be integrated into the stand | lard orientation | |
| | | t to the facility on 7/23/24. | | training and in the required | | |
| | | h Pharmacist revealed there | | refresher courses for all Lic | | |
| | | harmacy to aid in the | | RN⊡s, Licensed Practical N | | |
| | administration of resi | ident ' s medications. | | (LPN□s), Medication Aides | | |
| | During on interview | with the Medical Director or | | time, including agency staff | | |
| | - | with the Medical Director on | | staff and will be reviewed b | • • | |
| | | she stated there were no ident missed doses of the | | Assurance process to verify change has been sustained | | |
| | medication Aripipraz | | | LPN, Medication Aides who | - | |
| | | | | LI IN, MEUICALIULI AIUES WILL | | |

Event ID: SOU911

Facility ID: 923313

If continuation sheet Page 4 of 10

| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | CONSTRUCTION | · / | SURVEY PLETED |
|--------------------------|------------------------------|---|---------------------|---|--|-----------------|----------------------------|
| | 001112011011 | | A. BUILDING | ; <u> </u> | | C 08/28/2024 | |
| | | 345358 | B. WING | | | | |
| NAME OF PF | OVIDER OR SUPPLIER | • | | REET ADDRESS, CITY, STATE, ZIP CODE | 00/20/2024 | | |
| LOUISBUF | G HEALTHCARE & REI | ABILITATION CENTER | | | 2 SMOKETREE WAY DUISBURG, NC 27549 | | |
| (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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 755 | Continued From page | e 4 | F 75 | 5 | | | |
| | | | | | 09/16/2024 will not be allowed to work until training has been completed. | | |
| | | ian ' s order dated 2/22/23 was to receive Letrozole | | | 4. Monitoring Procedure to ensure the | at | |
| | | Give 1 tablet by mouth one | | | the plan of correction is effective and the | | |
| | time a day for Breast | | | specific deficiency cited remains correct | | | |
| | · | | | | and/or in compliance with | | |
| | | 2 's electronic Medication | | | regulatory/requirements. | | |
| | | d (MAR) for August 2024 | | | | | |
| | ordered on the follow | received Letrozole as | | | The Director of Nurses, or designee wil monitor compliance utilizing the F755 | 1 | |
| | | ing date. | | | Monitoring Tools weekly x 3 weeks the | n | |
| | On 8/12/24 at 9:00 Al | | | monthly x 2 months. The monitoring w | | | |
| | | inistered. A chart code of 9 | | | review Pharmacy Services and | | |
| | was documented on t | | | | Medication availability procedures to | | |
| | | tes". A nurses note dated | | | ensure medications are available and | | |
| | | ident #2 did not receive her | | | administered as ordered to meet needs | s of | |
| | Aripiprazole due to m | edication being "on order". | | | the resident. The facility will monitor 5 random residents EMAR progress note | S | |
| | An interview was con | ducted with the Pharmacist | | | on different days, shifts to ensure | | |
| | on 8/27/24 at 4:14 PM | И. The Pharmacist stated the | | | compliance with medication availability | | |
| | medication request for | or Letrozole for Resident # 2 | | | and complete 4 random medication | | |
| | was entered into the | - | | | administration observations. Reports w | ill | |
| | | acist stated the request was | | | be presented to the monthly Quality | £ | |
| | | led. The Pharmacist stated ocumentation of request for | | | Assurance committee by the Director o Nursing to ensure corrective action is | 1 | |
| | | Pharmacist reported that a | | | initiated as appropriate. Compliance w | ill | |
| | | ozole was sent to the facility | | | be monitored and the ongoing auditing | | |
| | | terview with Pharmacist | | | program reviewed at the monthly Quali | ty | |
| | | local backup pharmacy to | | | Assurance Meeting. The monthly QA | | |
| | aid in the administration | ion of resident ' s | | | Meeting is attended by the Administrate | | |
| | medications. | | | | Director of Nursing, Minimum Data Set Coordinator, Unit Support Nurses, | | |
| | During an interview w | vith the Medical Director on | | | Therapy Manager, Health Information | | |
| | - | she stated there were no | | | Manager, Social Worker, Maintenance | | |
| | | dent missed doses of the | | | Director, Business Office Manager, and | ł | |
| | medication Letrozole | | | | the Dietary Manager. | | |
| | | | | | | | |

Facility ID: 923313

If continuation sheet Page 5 of 10

| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NC | 0. 0938-039 |
|--------------------------|------------------------------|---|--------------------|--|--|-----------------|----------------------------|
| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , í | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY PLETED |
| | | 345358 | B. WING | | | C 08/28/2024 | |
| NAME OF PF | ROVIDER OR SUPPLIER | | • | SI | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | RG HEALTHCARE & RE | HABILITATION CENTER | | 20 | 02 SMOKETREE WAY | | |
| 200.0201 | | | | L | OUISBURG, NC 27549 | | |
| (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) COMPLETION DATE |
| F 755 | Continued From page | e 5 | F | 755 | | | |
| 1 / 00 | | M. The DON stated she | | 155 | | | |
| | | rse assigned to a resident | | | | | |
| | • | ions would notify the charge | | | | | |
| | nurse and DON. The | | | | | | |
| | pharmacy should have | e been notified and the | | | | | |
| | U | icked up from the backup | | | | | |
| | • | edication refill could be | | | | | |
| | received at the facilit | | _ | | | | |
| I | | f Significant Med Errors | F | 760 | | | 9/17/24 |
| SS=D | CFR(s): 483.45(f)(2) | | | | | | |
| | The facility must ensu | ure that its- | | | | | |
| | - | nts are free of any significant | | | | | |
| | medication errors. | | | | | | |
| | This REQUIREMENT by: | Γ is not met as evidenced | | | | | |
| | | iew, resident, staff, and | | | The statements made on this plan of | | |
| | | rview, the facility failed to | | | correction are not an admission to and | do | |
| | | medication error by not | | | not constitute an agreement with the | | |
| | following physicians | 5 | | | alleged deficiencies. | | |
| | administer Aripiprazo | | | | To remain in compliance with all federal | | |
| | | eat schizophrenia and plastic medication used to | | | and state regulations the facility has tak or will take the actions set forth in this | ken | |
| | - | or 1 of 3 residents (Resident | | | plan of correction. The plan of correctio | n | |
| | | ificant medication error. | | | constitutes the facility s allegation of | | |
| | ··· / | | | | compliance such that all alleged | | |
| | The findings included | l: | | | deficiencies cited have been or will be corrected by the dates indicated. | | |
| | Resident #2 was adn | nitted to the facility on | | | F760 | | |
| | | es that included malignant | | | 1. Corrective action for resident(s) | | |
| | neoplasm of the left t | • | | | affected by the alleged deficient practic | e: | |
| | schizoaffective disord | der. | | | A. Corrective action was received for | | |
| | Deview of Devide 11 | 40 La maat na aant muut du | | | resident # 2 on 08/16/2024 when the | | |
| | | #2 's most recent quarterly #DS) 6/6/24 revealed the | | | facility received a replenishment of residents Aripiprazole from the pharmad | 21/ | |
| | | ely intact. The MDS also | | | and resident has received the dose as | у | |
| | | t had received antipsychotics | | | ordered. On 08/28/2024, the Medical | | |
| | | | 1 | | | | 1 |

Event ID: SOU911

Facility ID: 923313

If continuation sheet Page 6 of 10

| | OF DEFICIENCIES | MEDICAID SERVICES | | LE CONSTRUCTION | | <u>8 NO. 0938-03</u> DATE SURVEY | |
|--|-----------------------|--|-------------------|--|----------------|-------------------------------------|--|
| | CORRECTION | IDENTIFICATION NUMBER: | . , | | · · · · | COMPLETED | |
| | | | | | | с | |
| | | 345358 | B. WING | | | 08/28/2024 | |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CC | DE | | |
| | | | 202 SMOKETREE WAY | | | | |
| LOUISBURG HEALTHCARE & REHABILITATION CENTER | | | | LOUISBURG, NC 27549 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF C | | (X5) | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | IE APPROPRIATE | COMPLETIO | |
| F 760 | Continued From page | e 6 | F 76 | - | | | |
| | | | | medication not being admini | | | |
| | Review of Resident # | - | | 08/28/2024, the resident wa | | | |
| | | e resident had a care plan hotic medication related to | | for any change in condition medication error, there were | | | |
| | | zophrenia. The interventions | | adverse effects as evidence | | | |
| | - | nister medication as ordered | | changes in resident #2 s cl | - | | |
| | - | view of the care plan also | | condition. No further correc | | | |
| | | a of diagnosis of left breast | | was required. | | | |
| | cancer. The intervent | tions included give | | | | | |
| | medications as order | ed. | | B. Corrective action was re- | | | |
| | | | | resident # 2 on 08/21/2024 | | | |
| | | cian 's order dated 2/22/23 | | facility received a replenishr | | | |
| | | e was to receive Aripiprazole we 1 tablet by mouth one time | | residents Letrozole from the and resident has received th | | | |
| | a day for schizophrer | | | ordered. On 08/28/2024, the | | | |
| | | | | Director (MD) was notified o | | | |
| | An interview with Res | sident #2 on 8/27/24 at 2:36 | | medication not being admini | istered. On | | |
| | | I missed some medication | | 08/28/2024, the resident wa | | | |
| | | nd two days in August due to | | for any change in condition | | | |
| | - | out. Resident #2 stated she | | medication error, there were | | | |
| | because it was impor | t missing this medication | | adverse effects as evidence changes in resident #2□s cl | - | | |
| | | tant she take it daily. | | condition. No further correc | | | |
| | Review of Resident # | 2 's electronic Medication | | was required. | | | |
| | | d (MAR) for July 2024 and | | 2. Corrective action for resid | dents with the | | |
| | | d she had not received | | potential to be affected by th | ne alleged | | |
| | Aripiprazole as order | ed on the following dates: | | deficient practice. | | | |
| | | | | On 09/03/2024, the Register | | | |
| | | M, the MAR showed no dose | | Supervisor (RN) initiated an | | | |
| | | dministered. A chart code of n the MAR to indicate | | of the Medication Administrative the last 14 days from 08/21 | | | |
| | | tes". A nurses note dated | | 09/03/2024 for all current res | | | |
| | | Irse #1 revealed Resident #2 | | audit consisted of a review of | | | |
| | - | ripiprazole due to medication | | progress notes to identify an | | | |
| | being "on order". | | | that were not administered a | | | |
| | | | | physicians order wasn⊡t fol | | | |
| | | ducted with Nurse #1 on | | was completed: 09/04/2024 | | | |
| | | Nurse #1 stated she had not | | included: There were reside | | | |
| | received education of | n the process for missing | | with medications not admini | stered and | | |

Facility ID: 923313

If continuation sheet Page 7 of 10

| | | MEDICAID SERVICES | | | OMB NO. 0938-03 | |
|--------------------------|-----------------------------------|---|---------------------|---|-------------------------------|--|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | (X3) DATE SURVEY COMPLETED | |
| | | | A. BUILDING | j | C 08/28/2024 | |
| | | 345358 | B. WING | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 202 SMOKETREE WAY | | |
| LOUISBU | RG HEALTHCARE & RE | HABILITATION CENTER | | LOUISBURG, NC 27549 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | DULD BE COMPLETIC | |
| F 760 | Continued From pag | ne 7 | F 76 | 0 | | |
| 1 700 | · · · · · · · · · · · · · · · · · | rse stated she had attempted | | where physicians orders weren | □ + | |
| | | ion from the pharmacy and | | followed. On 09/04/2024, the ph | | |
| | | at the medication would be | | was contacted for any medication | - | |
| | arriving that evening | in the pharmacy delivery. | | were identified as not being avail | | |
| | | | | the medications were delivered to | o the | |
| | | | | facility for administration. | | |
| | On 7/21/24 at 9:00 A | AM, the MAR showed no dose | | Additionally, from 09/05/2024 to | | |
| | | administered. A chart code of | | 09/16/2024 the DON initiated me | | |
| | - | on the MAR to indicate | | administration post tests and med | | |
| | | otes". A nurses note dated | | administration observations to au | | |
| | - | urse #2 revealed Resident #2 ripiprazole due to medication | | compliance with following physici orders and administering medica | | |
| | being "on order". | | | 3. Measures/Systemic changes | | |
| | | | | prevent reoccurrence of alleged of | | |
| | Multiple attempts to | reach Nurse #2 were | | practice: | | |
| | unsuccessful. | | | Education: | | |
| | | | | On 09/05/2024, the Director of N | | |
| | | AM, the MAR showed no dose | | began education of All Full Time, | | |
| | | administered. A chart code of on the MAR to indicate | | Time, and as needed (PRN) Nurs Licensed Practical Nurses (LPNs | | |
| | | otes". A nurses note dated | | Medication Aides on the following | - | |
| | | urse #3 revealed Resident #2 | | | ,. | |
| | | ripiprazole due to medication | | " How to obtain medications fr | om the | |
| | being "on order". | | | back up pharmacy | | |
| | | | | " The importance of ensuring | | |
| | | nducted with Nurse #3 on | | medications are always available | | |
| | | Nurse #3 stated she was | | given to the resident as ordered b | by the | |
| | able to reorder a me | nurse stated she did not | | Physician. " Understand the steps necess | sarv to | |
| | | armacy to see when the | | obtain medications from the Phar | - | |
| | | rive. Nurse #3 stated she had | | during business hours and after b | | |
| | not been made awar | re of the use of a backup | | hours for all situations. | | |
| | pharmacy. | | | Preventing medication errors6 rights of medication admin | | |
| | On 8/13/24 at 9:00 A | AM, the MAR showed no dose | | | | |
| | | administered. A chart code of | | On 09/05/2024, the DON initiated | 1 | |
| | | on the MAR to indicate | | Medication administration post te | | |
| | other/see nurses no | otes". A nurses note dated | | medication administration observ | ations to | |

Facility ID: 923313

| | | MEDICAID SERVICES | | | | | <u>0. 0938-039</u> |
|---------------|-------------------------------|--|---------------------------------------|--------------------------------------|---|-------------------------------|--------------------|
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | | A. BUILDING | | | с | |
| | | 345358 | 345358 B. WING | | | | /28/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | | REET ADDRESS, CITY, STATE, ZIP CODE | 1 00 | 20/2024 |
| | | | | | 2 SMOKETREE WAY | | |
| LOUISBU | RG HEALTHCARE & RE | HABILITATION CENTER | | LO | DUISBURG, NC 27549 | | |
| (X4) ID | | 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 ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | COMPLETION |
| F 760 | Continued From page | e 8 | F 76 | 50 | | | |
| | | Irse #4 revealed Resident #2 | _ | | audit compliance with following | | |
| | | ripiprazole due to medication | | | physicians□ orders. | | |
| | being "on order". | | | | | | |
| | Multiple attempts to r | | | The DON or designee will be responsi | ble | | |
| | unsuccessful. | | | | for ensuring Pharmacy Service & | | |
| | Duning on interview | | | | Medication Error Prevention Education | | |
| | - | vith the Medical Director on she stated there were no | | | be integrated into the standard orienta training and in the required in-service | tion | |
| | | ident missed doses of the | | | refresher courses for all Licensed Nurs | 8 6 5 | |
| | medication Aripiprazo | | | | RN s, Licensed Practical Nurses | | |
| | | | | | (LPN s), Medication Aides, full time, p | oart | |
| | | | | | time, including agency staff, and PRN | | |
| | | | | | staff and will be reviewed by the Quality | ty | |
| | | cian ' s order dated 2/22/23 | | | Assurance process to verify that the | | |
| | | 2 was to receive Letrozole | | | change has been sustained. Any RN, | | |
| | , , , | Give 1 tablet by mouth one | | | LPN, Medication Aides who does not | | |
| | time a day for Breast | Cancer at 9:00 AM. | | | receive scheduled in-service training b | • | |
| | Review of Resident t | 2 's electronic Medication | | | 09/16/2024 will not be allowed to work until training has been completed. | | |
| | | d (MAR) for August 2024 | | | 4. Monitoring Procedure to ensure that | nt | |
| | | received Letrozole as | | | the plan of correction is effective and t | | |
| | ordered on the follow | | | | specific deficiency cited remains corre | | |
| | | - | | | and/or in compliance with regulatory | | |
| | On 8/12/24 at 9:00 A | M, the MAR showed no dose | | | requirements. | | |
| | | ninistered. A chart code of 9 | | | The DON or designee will monitor | | |
| | was documented on | | | | compliance utilizing F760 Quality | | |
| | | tes". A nurses note dated | | | Assurance Tool s weekly x 3 weeks th | nen | |
| | - | Irse #3 revealed Resident #2 | | | monthly x 2 months. Monitoring tools completed by the DON or designee wi | ш | |
| | being "on order". | | | | monitor 4 RN \Box s, LPN \Box s, or Medicatio | | |
| | | | | | Aides for compliance with following | | |
| | An interview was con | ducted with Nurse #3 on | | | physicians order completing medicatio | n | |
| | 8/27/24 at 3:13 PM. | Nurse #3 stated she was | | | administration post tests and medication | | |
| | able to reorder a med | | | | administration observations. Reports | will | |
| | | nurse stated she did not | | | be presented to the monthly Quality | | |
| | | armacy to see when the | | | Assurance committee by the DON to | | |
| | | ive. Nurse #3 stated she had | | | ensure corrective action is initiated as | | |
| | not been made aware | e of the use of a backup | | | appropriate. Compliance will be monitor | ored | 1 |

Facility ID: 923313

If continuation sheet Page 9 of 10

| TATEMENT (| OF DEFICIENCIES CORRECTION | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | ECONSTRUCTION | (X3) DATE |) <u>. 0938-039</u> SURVEY LETED |
|--------------------------|---|---|---------------------|--|--|--|
| | | 345358 | | | C 08/28/2024 | |
| | ROVIDER OR SUPPLIER | 545550 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 08/ | 28/2024 |
| | | HABILITATION CENTER | 2 | 202 SMOKETREE WAY LOUISBURG, NC 27549 | | |
| (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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| F 760 | Continued From pag | e 9 | F 760 | | | |
| F 760 | Continued From page 9 pharmacy and she did not report the missing medication to the charge nurse or Director of Nursing. During an interview with the Medical Director on 8/27/24 at 4:18 PM, she stated there were no side effects if the resident missed doses of the medication Letrozole. During an interview with the Director of Nursing on 8/27/24 at 3:40 PM. The DON stated she expected that the nurse assigned to a resident with missing medications would notify the charge nurse and DON. The DON explained the pharmacy should have been notified and the missing medication picked up from the backup pharmacy until the medication refill could be received at the facility. | | | and the ongoing auditing progra reviewed at the monthly Quality Assurance Meeting. The monthl Meeting is attended by the Adm Director of Nursing, MDS Coord Therapy Manager, Unit Support Health Information Manager, an Dietary Manager. Date of Compliance: 09/17/2024 | the monthly Quality Meeting. The monthly QA attended by the Administrator, Nursing, MDS Coordinator, anager, Unit Support Nurses, mation Manager, and the nager. | |
| | | | | | | |

If continuation sheet Page 10 of 10