STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345061	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Durham	3100 Erwin Road Durham, NC 27705

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234 Based on record reviews and interviews with staff, resident, and the Pharmacist, the facility failed to administer medications as ordered for 1 of 6 residents (Resident #64). Staff did not remove medication from the refrigerator believing the medication had not been received by the pharmacy, resulting in 11 missed doses of eyedrops for glaucoma. Findings included: Resident #64 was admitted to the facility on [DATE] with diagnoses including glaucoma. A physician's order dated 1/04/2025 noted Resident #64 was to receive timolol maleate 0.5 % eyedrops twice a day for glaucoma. Resident #64's February 2025 Medication Administration Record (MAR) noted she did not receive her timolol maleate eyedrops on 2/01/2025 at 9:00 AM, 2/01/2025 at 5:00 PM, 2/11/2025 at 5:00 PM, 2/12/2025 at 5:00 PM, 2/13/2025 9:00 AM, and on 2/14/2025 at 9:00 AM. The reasons noted by nursing staff were that the medication was unavailable, and they were awaiting delivery from the pharmacy. Resident #64's March 2025 MAR noted she did not receive her timolol maleate eyedrops on 3/01/2025 at 9:00 AM, 3/01/2025 at 5:00 PM, 3/17/2025 at 5:00 PM, 3/19/2025 at 9:00 AM, and 3/19/2025 at 5:00 PM. The reasons noted by nursing staff were that the medication was unavailable and they were awaiting delivery from the pharmacy. Resident #64's Minimum Data Set (MDS) dated [DATE] documented she was cognitively intact, had impaired vision, and was diagnosed with glaucoma. In an interview on 3/31/25 at 12:29 PM, Resident #64 said the nurses did not give her the eyedrops for her glaucoma. She said the nurses told her it was because it had to be reordered and the pharmacy had not delivered it. In an interview on 4/03/25 at 9:48 AM, Nurse #9 said she was one of the nurses who administered medications during that time. She said if the medication was not available on the cart, a nurse could easily reorder the medication from the MAR computer program. She said she did not remember the specific days she documented she was unable to give the medication or if she reordered the medication on that day. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/03/25 at 2:12 PM, Nurse #7 said she administered medications to Resident #64 on several of the days in February and March 2025 which noted the medication was not available. She said the medication was not on the medication cart and she was told by other nurses (names not recalled) that the medication had been reordered from the pharmacy. She said on one shift she worked (date not recalled), she was about to call the pharmacy to order the medication again, but then remembered that timolol maleate eyedrops were stored in the refrigerator when they were delivered from the pharmacy. She said she went and looked in the medication refrigerator and the medication was there. She said she put the medication on the cart and had not had a problem since. In an interview on 4/03/25 at 2:05 PM, the Pharmacy Consultant said the timolol maleate was sent as an automatic refill and was delivered to facility on 1/24/25, 2/11/25, 3/1/25, and 3/19/25. He said he checked the notes in pharmacy system and there were no notes regarding any insurance or delivery issues of the medication with no gap in delivery from the pharmacy records. He said the timolol maleate eyedrops were used to regulate the pressure in the resident's eye to treat glaucoma. In an interview on 4/03/25 at 3:27 PM, the Assistant Director of Health Services said she was the Director of Health Services at the time of the missed doses. She said she received complaints from Resident #64 and her family member (dates not recalled) that Resident #64 had missed several doses of the timolol maleate eyedrops because staff reported the medication was not available. She said she went to the medication refrigerator, where the eyedrops were stored when delivered from the pharmacy, and found the medication. She said she in-serviced the nurses on where to look for the medication and to look for them before ordering from the pharmacy. She said if there was a problem obtaining medications from the pharmacy, the facility had a back-up pharmacy that should have been called so the resident did not miss a dose of the medication.