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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/31/2024 |
| NAME OF PROVIDER OR SUPPLIER Durham Nursing & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 411 S Lasalle Street 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) |
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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>31146</p> <p>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).</p> <p>The findings included:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>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 the resident does not run out.</p> <p>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.</p> <p>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.</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31146</p> <p>Based on record review, staff interview and physician interview the facility failed to follow physician order for 1 of 3 residents reviewed for pharmaceutical services (Resident #2).</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on [DATE] with a diagnosis that included type 2 diabetes (DM) and kidney failure with tubular necrosis.</p> <p>Review of Resident #2's annual Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact, had a diagnosis of diabetes and received insulin during the look back period.</p> <p>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.</p> <p>A. Resident #2's physician order dated 5/4/24 stated administer Tresiba FlexTouch subcutaneous pen-injector 100 unit/milliliter (ml) (insulin Degludec). The order stated inject 30 units subcutaneously one time a day for DM.</p> <p>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.</p> <p>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.</p> <p>Medication Administration note dated 7/1/24 at 12:09 pm written by Nurse #2 stated Tresiba 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>Interview with Nurse #1 on 7/31/24 at 10:40 am 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> | | |