

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 11/05/2024
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)
<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48916</p> <p>Based on record reviews, and staff, Nurse Practitioner (NP), responsible party, and Resident interviews, the facility failed to notify the physician and responsible party of changes in condition for of 1 of 1 resident (Resident #7). Resident #7 had intact cognition and a history of stroke and on 10/21/24 at approximately 9:00 PM he reported to a nurse aide (NA) he had pain and numbness in his left arm and leg. The NA aide reported this to the nurse. On the next shift at approximately 6:00 AM Resident #7 informed another NA he could not feel his left side. The NA reported this to the nurse. On 10/22/24 between 7:00 and 7:15 AM Unit Manager (UM) #1 was called to the room by an NA and assessed Resident #7 and found his speech was slurred, his left arm and leg did not have any feeling, and they did not have any muscle tone. The Nurse Practitioner was in the facility and assessed Resident #7 and had him transferred to the Emergency Department (ED) for evaluation of stroke symptoms. There were no nursing progress notes entered on 10/21/24 or 10/22/24 regarding notification of the physician or responsible party regarding the change in Resident #7's condition until the note entered by UM #1 on 10/22/24 at 8:25 AM. Resident #7 presented to the Emergency Department (ED) with new onset vision changes and inability to use his left upper and lower extremities. Diagnoses included cerebral vascular accident (CVA- ischemic stroke) with following cognitive deficits and dysphagia (difficulty swallowing) post CVA. It was noted Resident #7 was outside of the window for the administration of Alteplase (tPA) which is a medicine that dissolves blood clots used to treat ischemic strokes. Resident #7 was admitted to the critical care stroke unit and was discharged on [DATE].</p> <p>Immediate jeopardy began on 10/21/24 for Resident #7 he reported his left arm and leg were numb and a medical provider and responsible party were not notified. Immediate jeopardy was removed on 11/02/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective.</p> <p>Findings included:</p> <p>Resident #7 was admitted to the facility on [DATE], with diagnoses of history of right hemiparesis/hemiplegia (partial or complete paralysis of one side) with right side weakness related to a stroke and Type 1 diabetes mellitus.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #7's cognition was intact.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview with NA # 5 at 10/29/24 4:33 PM revealed she worked the 3:00 pm to 11:00 PM shift on 10/21/24 and did first rounds with Resident #7 at 6:30 PM and he did not have any concerns. When she did her second round at 9:00 PM, the resident told her he had pain and numbness in his left arm and leg. NA #5 indicated she went to tell Nurse #5 Resident #7 had numbness and pain, and Nurse #5 nodded to NA #5. NA #5 stated Nurse #5 did not go in to check on Resident #7, that she was aware of.</p> <p>An interview with Nurse # 5 on 10/29/24 at 6:06 PM revealed she worked the 3:00 PM to 11:00 PM shift on 10/21/24. Nurse #5 went to Resident #7's bedside to take his blood sugar at 5:00 PM. The Resident did not mention he was having any issues. Nurse #5 did not recall NA #5 telling her Resident #7 was having any change in condition.</p> <p>An interview with NA #4 on 10/29/24 at 5:05 pm revealed at 6:00 AM (on 10/22/24) Resident #7 stated, I can't feel my left side. NA #4 went to tell Nurse #6 and Nurse #6 wrote something down but did not come with NA #4. NA #4 further stated she went back to the room and told Resident #7 she reported his symptoms to Nurse #6 and went on with her assignment.</p> <p>An interview with Nurse #6 on 10/30/24 at 12:47 PM revealed on 10/21/24 at around 6:00 AM NA #4 reported to her that Resident #7's left side wasn't feeling right. Nurse #6 stated that she did an assessment when she gave Resident #7 his medication and checked his blood sugar at around 6:00 AM. She stated she briefly spoke with him while doing the blood sugar and Resident #7 did not indicate anything was wrong at that time. Nurse #7 stated she had not been given any kind of report from the prior shift that anything was going on with Resident #7.</p> <p>An interview with NA #8 on 10/29/24 at 4:25 PM revealed she worked the 7:00 AM to 3:00 PM shift on 10/22/24 and had taken breakfast to the resident around 7:15 am and asked Resident #7 how he was doing. He said, I am not well and I haven't felt well since last night and he couldn't feel his left side, and this had started after dinner. Resident #7 further revealed that his vision was blurred on the left side, and he was numb and could not feel anything on the left side. NA #8 stated she noticed his speech was slurred too.</p> <p>A review of the medical record revealed there were no nursing progress notes entered on 10/21/24 notification to the family or physician regarding a change in Resident #7's change in condition.</p> <p>An interview with Unit Manager (UM) #1 on 10/29/24 at 11:40 AM revealed she was requested by NA #8 to come to Resident #7's room as soon as possible at 7:15 AM (on 10/22/24). Upon arrival, she found Resident #7 with left-sided paralysis, including the left arm and left leg. UM #1 further revealed Resident #7 stated he had been unable to move his left side since last night after dinner. UM #1 stated she began her assessment and called for the Nurse Practitioner (NP). UM #1 stated Resident #7's left arm and leg were flaccid, dropping to the bed when she raised them up. The NP arrived, assessed Resident #7 and asked for EMS to be called because Resident #7 had had a stroke.</p> <p>A phone interview on 10/29/24 at 4:48 PM with the family member/responsible party revealed she was called by NA #8 around 8:15 AM (on 10/22/24) and was told that Resident #7 had been sent to the hospital for a stroke.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A phone interview with Resident #7 on 10/30/24 at 5:30 PM revealed after dinner on 10/21/24 he could not feel his left arm and left side when the nurse aide was trying to change him. He could not help due to the lack of movement. NA #5 and NA #9 (3:00 pm to 11:00 pm shift) helped him because one person couldn't do it. He further stated he usually could position himself on his side with the use of the bed rails and a push on his hip to the turning side. This was when he noticed he couldn't move his left side. Nurse #5 came in and he told her he couldn't move his left arm or left leg, and he did not know what was going on. Resident #7 further stated Nurse #5 did not respond. Resident #7 indicated Nurse #5 should have checked him and called the doctor. Resident #7 explained his condition stayed the same until NA #4 came in on third shift and he told NA #4 he could not feel his left side and she went and told Nurse #6. Nurse #6 came into his room around 6:00 am or so and gave him his medicine. Resident #7 indicated Nurse #6 did not assess him or ask if anything was wrong. When the first shift NA (NA #8) came in with breakfast at 7:15 AM, Resident #7 told her he was not himself and she asked what was going on. Resident #7 told her he could not move his left side, and NA #8 immediately called Unit Manager #1. NP #1 came in and assessed him then sent him to the local hospital.</p> <p>An interview with the NP on 10/29/24 at 4:40 pm revealed she was called by the Unit Manager #1 on 10/22/24 because Unit Manager #1 thought Resident #7 had a stroke, and that UM #1 called EMS. NP #1 stated neuro-checks should have been done when his symptoms started on the evening of 10/21/24 and he should have been sent out to the ED on 10/21/24. She further indicated if Resident #7 had been assessed when he first was having numbness (after dinner), and nursing staff had called our on-call provider, we would have instructed them to send Resident #7 to the hospital where his condition could have been managed. NP #1 confirmed Resident #7 had been admitted to the local hospital with a left side stroke.</p> <p>An interview with DON 10/29/24 4:07 PM revealed that when the NA tells the nurse that something was wrong with a Resident, the nurse goes in and does an assessment and notifies the provider, she then notifies the party responsible.</p> <p>The Emergency Department (ED) note dated 10/22/24 indicated Resident #7 had a medical history significant for congested heart failure, chronic renal insufficiency, coronary artery disease, and prior stroke with left-sided deficits. Resident #7 presented to the Emergency Department with new onset vision changes and inability to use his left upper and lower extremities. Stroke code was called upon arrival. A National Institute of Health Stroke Scale (NIH) was documented as an 8 which indicated a mild to moderately severe stroke. Resident #7 reported he was unable to move his arm or leg at 6:00 PM on 10/21/24, which was new for him. The computed tomography (CT) scan showed a right posterior frontal lobe hypodensity concerning edema which could be related to an acute/subacute infarct. It was noted Resident #7 was outside of the window for the administration of Alteplase (tPA) which is a medicine that dissolves blood clots used to treat ischemic strokes. Resident #7 was admitted to neurology stroke service. Resident #7's vitals were blood pressure 162/59, pulse rate 60, temperature 98.5, and oxygen saturation 90%. The clinical impression after evaluation findings were Cerebral vascular accident (CVA) with following cognitive deficits and dysphagia (oropharyngeal phase) post CVA.</p> <p>Resident #7 was released to a skilled nursing facility on 10/29/24.</p> <p>The Administrator was notified of the immediate jeopardy 10/29/24 at 2:15 PM.</p> <p>The facility provided the following credible allegation of IJ removal:</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>(1) Identify those recipients who have suffered, or are likely to suffer a serious adverse outcome as a result of the noncompliance:</p> <p>Resident #7, who has a history of a prior stroke with left sided weakness, reported to Nursing Assistant (NA) #7 on 10/21/24 at 9:00 PM he was experiencing pain and numbness to his left side. Nursing assistant #7 reported to the nurse who did not identify any acute changes, did not complete a neurological assessment, obtain vital signs, did not notify healthcare provider or, initiate emergency medical services. On 10/21/24 at 11:30 PM the resident reported to NA #4 he was moving slowly and could not move his left arm. Nursing assistant #4 reported to the nurse who did not identify any acute changes, did not complete a neurological assessment, obtain vital signs, did not notify healthcare provider, or initiate emergency medical services. The resident reported further symptoms to NA #4 on 10/22/24 at 6:00 AM about being unable to move his left side who then reported to the nurse who did not identify any acute changes, did not complete a neurological assessment, obtain vital signs, did not notify healthcare provider, or initiate emergency medical services.</p> <p>NA took Resident #7 his breakfast tray on 10/22/24 between 7 and 7:15 AM, the resident had slurred speech and was unable to move his left side. The CNA immediately reported the change in condition to Unit Manager #1. Unit Manager #1 assessed the resident and found his left side to be flaccid. The Resident was also complaining of blurry vision. Resident stated that he had been able to move his left side since last night after dinner. The Nurse Practitioner then assessed the resident and directed the resident to be sent out to the hospital via Emergency Medical Services because he had had a stroke. The resident was admitted to the hospital with an acute stroke on 10/22/24.</p> <p>An audit to determine if any residents had reported any new change in condition that was not reported to the healthcare provider by a licensed nurse of residents with a brief interview for mental status (BIMS) score of 13 or higher was completed by the Administrator on 10/25/2024. The Audit revealed that no other residents were noted to be affected.</p> <p>An audit was completed on 10/25/24 by the Director of Nursing of progress notes for the past 7 days to ensure that anyone reporting a change of condition had provider notification. The audit revealed that no one else was affected.</p> <p>As part of the staff education from 10/25/24-10/28/24, the Director of Nursing also questioned all of the licensed nurses regarding knowledge of any residents having had a change in condition that deviated from their baseline and did not have healthcare provider notification. Signatures accounted for both the education and the questionnaire. No residents were noted to be affected.</p> <p>From 10/31/24-11/1/24 the Director of Nursing or Staff Development Coordinator interviewed all nursing assistants regarding knowledge of any residents having change of conditions in the last 7 days that were not reported to the healthcare provider. No negative findings were noted.</p> <p>(2) Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/25/2024 the Director of Nursing initiated education to all licensed nurses to complete a clinical assessment of a minimum vital signs and pertinent body systems once notified of a change in condition to include accident or incident, injuries of unknown source, significant change in residents physical, emotional, or mental condition which can include elevated vital signs, altered mental status, blurred vision, headaches, numbness or tingling to body parts, uncontrolled pain, etc., to notify the healthcare provider immediately of findings once the assessment is complete. Education also included any changes reported by nursing assistants. Any licensed nurse that has not been educated by 10/28/2024 will be taken off the schedule until the educated has been received. All new hires will be educated by the Director of Nursing during orientation. The Director of Nursing will ensure all licensed nurses are in-serviced.</p> <p>On 11/1/2024, the Regional Director of Clinical Services educated the Administrator, The Director of Nursing, Staff Development Coordinator, and The Human Resource Director on the orientation process for nursing staff that will include education on recognizing change in condition, timely assessment and monitoring of change in condition, effective communication during a medical emergency, importance of notifying the healthcare provider, and effective communication during a medical emergency.</p> <p>On 11/1/2024, the Director of Nursing/Staff Development Coordinator re-educated all nursing assistants on change in condition of residents to include recognizing signs and symptoms of a stroke such as blurred vision, slurred speech, weakness to one side of the body, and facial drooping. Education also included the importance of reporting any change in condition or any of these symptoms to their nurse Any nursing assistant that has not received the education on 11/1/2024 will be taken off the schedule until the education has been received. The Director of Nursing will ensure all nursing assistant educated.</p> <p>The facility alleges removal of immediate jeopardy on 11/02/2024.</p> <p>An on-site validation of the facility's implementation of their credible allegation of immediate jeopardy removal was conducted on 11/4/24. Review of the completed facility audits included daily 24-hour resident report, resident clinical assessments to include neurological, pain and vital signs were documented in the record. Multiple interviews were conducted with nurse aides and licensed nurses to ensure the in-service/ education was provided prior to working their shift. The nurse aides and licensed nurses consistently reported they received in-service education, which included ensuring the medical team and Resident Representative was notified of the resident's change of condition assessment and verifying any new orders with a facility provider prior to initiating the orders. All nursing staff were educated on the reporting and documentation process of any signs of change of condition on the daily 24-hour report and in the resident record.</p> <p>An interview with the Director of Nursing and Staff Development Coordinator on 11/4/24 at 3:00 PM confirmed that re-education was done for all nurse aides and licensed nurses on the change of condition of residents including signs/symptoms of stroke, the importance of reporting any change of condition and documentation of notifying healthcare providers of a medical emergency. The Director of Nursing stated daily record reviews and monthly monitoring will be done to ensure the assessments and notification process was maintained.</p> <p>The immediate jeopardy removal date of 11/02/24 was validated.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>51464</p> <p>Based on observations and staff interviews, the facility failed to maintain the privacy of a resident's record by leaving a medication cart laptop unattended, with resident health information exposed in an area accessible and visible to the public, for 1 of 4 medication carts (Zone 1 medication cart).</p> <p>The findings included:</p> <p>An observation of the Zone 1 medication cart was completed on 10/23/24 at 9:57 AM, inclusive of the medication cart laptop which was unattended. The laptop displayed resident personal health information including name, medications and diagnoses. Staff and residents were observed to pass by the medication cart during this time.</p> <p>An interview with Nurse #4 was completed on 10/23/24 at 9:59 AM. Nurse #4 stated her medication cart was locked but she should have closed or locked her laptop screen so that resident personal health information was not displayed.</p> <p>An interview with the Director of Nursing (DON) was completed on 10/23/24 at 12:22 PM. The DON verbalized that Nurse #4 should have locked her laptop screen with the lock button prior to moving away from the medication cart.</p> <p>An interview with the Administrator was completed on 10/23/24 at 12:31 PM. He indicated staff should lock the laptop screen prior to leaving the medication cart unattended.</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920</p> <p>Based on observation, record review, resident, family member, staff, Emergency Medical Technician (EMT), Physician, and Nurse Practitioner (NP) interviews, the facility failed to comprehensively assess a resident (Resident #1) who had untreated obstructive sleep apnea (a condition that causes the upper airway to become blocked during sleep, reducing or stopping airflow) to determine the root cause of periodic abdominal pain, change in mental status, and migraines that occurred intermittently over the last 6 months in conjunction with Carbon Dioxide (CO2) levels near the upper limit of the reference range (a set of numbers that are the high and low ends of the range of results that's considered to be normal) in August 2024 and October 2024. When breathing is reduced due to sleep apnea it can lead to a decrease in oxygen and an increase in CO2 in the blood. The facility also failed to implement Physician's orders for Resident #1 for a Continuous positive Airway Pressure (CPAP) machine (used to treat sleep apnea by keeping the airways open while sleeping) ordered on 4/13/24, pulmonary consultation (insurance requirement for obtaining the CPAP) ordered on 5/10/24, neurology consultation (ordered for constant migraines) ordered on 8/24/24, and an x-ray (ordered for abdominal pain) ordered on 8/24/24. On 10/6/24 Resident #1 was excessively sleeping, difficult to rouse, and had no oral intake. On 10/7/24 Emergency Medical Service (EMS) were contacted for altered mental status changes and upon EMS assessment Resident #1 was confused and hypoxic (low oxygen saturation) with an oxygen (O2) saturation of 60% (normal 90-100%) and a CO2 level in the 90's (normal 22-31). The resident's Glasgow Coma Scale (scale used to measure a person's level of consciousness) showed she was in a comatose state, and she was assessed at the hospital with hypercapnia (CO2 retention with elevated CO2 levels), prolonged systemic hypoxemia/severe respiratory failure, acute kidney injury, and transaminitis (high level of liver enzymes in the blood) suspected due to the prolonged systemic hypoxemia/severe respiratory failure. The contributing factors included untreated obstructive sleep apnea. Resident #1 was admitted to the Intensive Care Unit (ICU) on 10/7/24 and spent 10 days in the hospital.</p> <p>In addition, the facility failed to identify the seriousness of a change in condition, complete ongoing comprehensive assessments and identify the urgent need for medical attention for a resident with a history of a stroke. Resident #7 had intact cognition and on 10/21/24 at approximately 9:00 PM he reported to a nurse aide (NA) he had pain and numbness in his left arm and leg. The NA aide reported this to the nurse. On the next shift at approximately 6:00 AM Resident #7 informed another NA he could not feel his left side. The NA reported this to the nurse. There were no documented comprehensive assessments for Resident #7 by either nurse. On 10/22/24 between 7:00 and 7:15 AM a NA took Resident #7 his breakfast and Resident #7 stated he was not well, couldn't feel his left side, and his vision was blurred on the left side, and this had all started after dinner (on 10/21/24). Unit Manager #1 was called to the room and assessed Resident #7 and found his speech was slurred, his left arm and leg did not have any feeling, and they did not have any muscle tone. The Nurse Practitioner was in the facility and assessed Resident #7 and had him transferred to the Emergency Department (ED) for evaluation of stroke symptoms. Resident #7 presented to the ED with new onset vision changes and inability to use his left upper and lower extremities. Diagnoses included cerebral vascular accident (CVA- ischemic stroke) with following cognitive deficits and dysphagia (difficulty swallowing) post CVA. It was noted Resident #7 was outside of the window for the administration of Alteplase (tPA) which is a medicine that dissolves blood clots used to treat ischemic strokes. Resident #7 was admitted to the critical care stroke unit and was discharged on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>This deficient practice occurred for 2 of 3 residents reviewed for professional standards of care.</p> <p>Immediate jeopardy for Resident #1 began on 10/7/24 when Resident #1 had a significant change in condition and was assessed by EMS with an O2 saturation of 60% and a CO2 level in the 90s and immediate jeopardy ended on 10/25/24. Immediate jeopardy began on 10/21/24 for Resident #7 when he reported his left arm and leg were numb and a comprehensive assessment was not completed to determine if medical interventions were necessary. Immediate jeopardy ended for Resident #7 on 11/02/24. Immediate jeopardy was removed on 11/02/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included tachycardia (increased heart rate), asthma, and obstructive sleep apnea. The resident did not have a diagnosis of migraines on admission.</p> <p>A Physician order dated 3/28/23 revealed Resident #1 was to receive Fioricet 50-300-40 milligrams (mg) every 6 hours as needed for headache.</p> <p>A Physician order for Resident #1 dated 7/11/23 indicated Protonix (acid reflux medication) 40 milligrams (mg) twice a day.</p> <p>A Physician order for Resident #1 dated 11/8/23 indicated Propranolol (beta blocker) 20mg three times a day for headaches and migraines.</p> <p>A Physician order for Resident #1 dated 1/6/24 indicated Topamax 25mg daily for migraine headache.</p> <p>A Physician order dated 4/13/24 revealed an order for Resident #1 to receive a CPAP machine for obstructive sleep apnea.</p> <p>Another Physician order dated 5/10/24 revealed Resident #1 was to receive a pulmonology consult for her obstructive sleep apnea and CPAP machine.</p> <p>The Physician order dated 4/12/24 revealed an order for Acetaminophen 325mg give 2 tablets 3 times a day for pain.</p> <p>A phone interview occurred with Physician #1 on 10/22/24 at 3:52pm. Physician #1 verified he had written the order for Resident #1 to receive a CPAP machine and a Pulmonology consultation. He stated he had ordered the CPAP machine in April 2024 first because he understood Resident #1 already had a CPAP machine. Physician #1 stated Resident #1 required a CPAP machine for her obstructive sleep apnea. The Physician stated about a month later he learned (could not remember from who) that Resident #1 did not have a CPAP machine and needed a Pulmonology appointment to obtain a CPAP machine, so he wrote an order for a Pulmonology consultation in May 2024. He stated he did not know if Resident #1 ever attended the Pulmonology consultation but said he knew Resident #1 never had a CPAP machine.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview with Physician #2 on 10/22/24 at 3:36pm, the Physician stated Resident #1 was required by insurance to receive a Pulmonary consultation prior to receiving a CPAP machine. He explained that the insurance company needed proof and severity of Resident #1's obstructive sleep apnea before they would approve Resident #1 for a CPAP machine. The Physician stated Resident #1 required a CPAP machine due to her obstructive sleep apnea. Physician #2 stated Resident #1 was never able to receive the consultation due to transportation difficulties.</p> <p>An interview with Transport Staff occurred on 10/22/24 at 4:54pm. Transport Staff confirmed she was responsible for making residents' appointments. She also discussed being responsible for securing alternate transportation if a resident did not fit in the facility's van. Transport Staff discussed Resident #1 being too large to transport in a wheelchair van and would need non-emergency stretcher transport. She stated the facility had a contract with a non-emergency transport company but said they are always booked up. Transport Staff discussed not receiving the consultation request for Pulmonology until 7/30/24. She stated since 7/30/24 she had been periodically trying to schedule the appointment with Pulmonology that would also meet the non-emergency transportation schedule. She stated she had been unsuccessful in getting Resident #1 to the Pulmonologist.</p> <p>A review of a Physicians note dated 6/19/24 written by Physician #1 revealed Resident #1 had episodic altered awareness, ongoing chronic headaches that were being treated with Topamax (migraine medication) daily and Fioricet (migraine medication) as needed, and insomnia with tiredness during the day which was documented as being treated with a CPAP machine and follow up with a Pulmonologist.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was cognitively intact, no rejection of care, and no shortness of breath. The MDS also documented Resident #1 did not have a CPAP machine. Resident #1 was documented as having a weight of 430 pounds. The MDS documented the resident also had pain that occasionally interfered with her daily routine and that she received pain medication.</p> <p>The physician order dated 8/18/24 revealed an order for lab work that included a complete blood count (CBC), comprehensive metabolic panel (CMP), lipid panel (for cholesterol), and an A1C (for diabetes).</p> <p>Resident #1's lab work dated 8/20/24 revealed her CO2 level was 30.</p> <p>On 8/24/24 there was a physician order for Resident #1 to receive a neurology consultation for constant migraines.</p> <p>There was an order on 8/24/24 for Resident #1 to receive an x-ray for abdominal pain.</p> <p>A nurses note dated 8/25/24 written by Nurse #3 revealed the x-ray technician told her the x-ray was unable to be performed because Resident #1 weighed more than the machine can hold.</p> <p>The care plan dated 8/26/24 for Resident #1 revealed no goals or interventions related to her diagnosis of sleep apnea. The resident's care plan also did not include information on migraines, abdominal pain, or refusals of care.</p> <p>A Physician's order revealed Resident #1's Fioricet 50-300-40 milligrams (mg) every 6 hours as needed for headache was discontinued on 9/8/24.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Nursing documentation on 9/11/24 written by Unit Manager #1 revealed Resident #1 did not want to get out of bed due to not feeling well and having a headache.</p> <p>A Physician order for Resident #1 dated 9/14/24 indicated Fioricet 50-300-40 milligrams (mg) every 6 hours as needed for headache.</p> <p>On 9/14/24 a nursing note written by the Director of Nursing (DON) revealed Resident #1 requested Fioricet be re-started as needed for the resident's headaches.</p> <p>Review of Resident #1's Medication Administration Record (MAR) from October 2023 through August 2024 revealed Resident #1 received as needed (PRN) Fioricet 39 times and in September 2024 Resident #1 received Fioricet on 9/3, 9/7, 9/25, 9/26, and 9/30/24 for complaints of a headache.</p> <p>The resident's medical record revealed no evidence the orders were implemented for the CPAP ordered on 4/13/24, pulmonology consultation ordered on 5/10/24, or the neurology consultation and x-ray ordered on 8/24/24.</p> <p>On 10/1/24 Resident #1 was administered PRN Fioricet for complaints of a headache.</p> <p>A Physician order dated 10/4/24 for Resident #1 indicated Protonix 40mg once a day. This Protonix order indicated Resident #1's medication was lowered from the initial order dated 7/11/23 of Protonix 40mg twice a day.</p> <p>The Nurse Practitioner (NP) note dated 10/4/24 revealed Resident #1 had continued to complain of headaches that were not responding to the current treatment. The NP documented she was seeing Resident #1 today (10/4/24) for complaints of stomach pain rating a 9 out of 10 (10 being the worst pain). She documented due to the resident's size, imaging such as x-rays could not be completed, so no imaging had been done. The NP noted that Resident #1 had refused to go to the emergency room but that the resident told her she would go if the pain became intolerable. She documented Resident #1's stomach pain was due to eating but then documented Resident #1 has stomach pain when she is not eating. The NP noted that Resident #1 expressed that her migraines were returning daily without other neurological deficits. The NP's plan for stomach pain was to order lab work. There was no documented plan for Resident #1's increased migraines.</p> <p>The NP was interviewed on 10/23/24 at 8:18am. The NP discussed 10/4/24 was the first time she had ever seen Resident #1. She stated she saw Resident #1 on 10/4/24 for complaints of abdominal pain. The NP explained that was why she had ordered the lab work. She explained by doing lab work it would let her know if Resident #1 had an abdominal infection that maybe caused her pain. She stated Resident #1 had told her that x-rays had been ordered for her abdominal pain but had not been completed. The NP said when she asked Unit Manager #1 why the x-ray had not been completed, the nursing supervisor told her it was because Resident #1 did not fit into the facility van. She stated she offered to send Resident #1 to the hospital to have the x-rays completed on 10/4/24 but the resident refused. The NP discussed being aware that Resident #1's CO2 levels had been in the high range since August 2024 but stated Resident #1 did not show any signs of respiratory distress.</p> <p>Resident #1's lab work dated 10/5/24 revealed her CO2 level was 31.</p> <p>On 10/5/24 Resident #1 was provided with PRN Fioricet for complaints of a headache.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's intake for 10/6/24 revealed she did not have any intake.</p> <p>Review of Resident #1's medical record revealed no nursing documentation for 10/6/24.</p> <p>Nursing Assistant (NA) #1 was interviewed on 10/23/24 at 8:55am. NA #1 stated she worked 11:00pm to 7:00am the night of 10/6/24 to the morning of 10/7/24 with Resident #1. She explained at the start of her shift Resident #1 was talkative and oriented, which NA #1 stated was Resident #1's baseline, but then said Resident #1 usually asked for food to be warmed between 1:00-2:00am and stated the resident did not request for any food to be warmed up. NA #1 stated the next time she saw Resident #1 was between 5:00-6:00am. She said at that time the resident was a little groggy but interacting with the NA. The NA stated she did not notice anything alarming or she would have told the nurse.</p> <p>During a telephone interview with Nurse #1 on 10/23/24 at 10:40am, the nurse discussed being familiar with Resident #1 and confirmed she worked with the resident on 10/6/24 from 7:00am to 3:00pm shift. Nurse #1 stated on 10/6/24 Resident #1 was talkative, but her speech was quiet and slow. She stated she could not remember if the resident ate or appeared sleepy but said Resident #1 took all her medications.</p> <p>NA #2 was interviewed on 10/23/24 at 11:35am. The NA confirmed she worked with Resident #1 on 10/6/24 on the 3:00pm to 11:00pm shift and stated she had been familiar with the resident. NA #2 discussed resident being usually very talkative, alert, and oriented but said on 10/6/24 Resident #1 was very sleepy and difficult to wake up. The NA stated she had to shake the resident to arouse her and then the resident would say I'm awake but the NA stated Resident #1 would fall right back to sleep. She discussed telling the nurse on shift (could not remember the nurses name) and the nurse performing vital signs then telling her Resident #1 was ok and I just gave her an Ativan. NA #2 stated Resident #1 would become very sleepy after receiving medication, so she stated she did not think anything was wrong. The NA stated Resident #1 did not eat or drink anything during her shift.</p> <p>Review of Resident #1's MAR for 10/6/24 revealed, the resident had not received any Ativan (antianxiety medication).</p> <p>There were no vital signs documented for Resident #1 on 10/6/24.</p> <p>During an interview with NA #3 on 10/23/24 at 11:45am, the NA confirmed she had worked with Resident #1 on 10/6/24 and 10/7/24 during the 7:00am to 3:00pm shift. NA #3 discussed not being very familiar with Resident #1 but said she had been assigned to her a few times before 10/6/24. She stated on 10/7/24 Resident #1 was very sleepy and had refused care which the NA stated had not happened before when she was assigned to her. The NA said she could not remember if Resident #1 had anything to eat or drink. NA #3 stated she informed Nurse #1 of Resident #1 refusing care.</p> <p>Review of Resident #1's intake for 10/7/24 revealed she did not have any intake.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The NP note dated 10/7/24 documented Resident #1 was sleeping, would open her eyes, and respond to questions but remained very sleepy. She documented that Resident #1 was still reporting abdominal pain and that she checked with nursing to ensure Resident #1 was still receiving medication for her continued headaches. The NP documented her plan for the continued abdominal pain was to order further testing to rule out an infection. There was no plan noted related to Resident #1's headaches or documentation/plan for the resident's increased CO2 level. There was no documentation that the NP offered for Resident #1 to go to the hospital.</p> <p>A nursing progress note written by Nurse #1 dated 10/7/24 documented at 2:16pm revealed that Resident #1 was alert and able to answer, simple questions. The note documented Resident #1 was hard to arouse and the Medical Doctor (MD) was at the bedside. Nurse #1 documented Resident #1 refused care and refused her 2:00pm medication.</p> <p>During a telephone interview with Nurse #1 on 10/23/24 at 10:40am the Nurse discussed when she returned to work at 7:00am on 10/7/24, she saw a difference in Resident #1. She explained the resident was not talking, excessively sleepy, and difficult to arouse. The nurse stated she went and got the NP to assess Resident #1, and that the NP offered Resident #1 to go to the hospital, but the resident refused. Questioned Nurse #1 about her documentation and what she met by would only answer simple questions. Nurse #1 explained Resident #1 would usually provide long answers but on 10/7/24 Resident #1 would only provide 1-2-word answers. Nurse #1 stated Resident #1 remained sleepy, and it was difficult to arouse her whole shift and late in the shift Resident #1 started complaining of her stomach hurting and not feeling well. The nurse stated she offered to send the resident to the hospital, but the resident refused. Nurse #1 discussed Resident #1 having symptoms of a headache, abdominal pain, and sleepiness often but could not remember for how long the resident had the symptoms.</p> <p>Unit Manager #1 was interviewed on 10/22/24 at 5:47pm. The Unit Manager discussed Resident #1 being off in her demeanor on 10/7/24 in the morning. She explained Resident #1's speech was quiet, and that the resident told her she did not feel well. The Unit Manager stated she offered to send Resident #1 to the hospital on 10/7/24 in the morning but the resident refused. She said the morning of 10/7/24 there were no prominent noticeable issues but by the afternoon when she stopped in to see Resident #1, she noticed the resident had right side facial drooping and thought Resident #1 may be having a stroke. The Unit Manager stated that was when she asked Nurse #2 to assess the resident. She discussed not being aware Resident #1 had sleep apnea but said she remembered at some point it was mentioned that Resident #1 needed a CPAP machine. The Unit Manager also discussed Resident #1 having periods of headaches, abdominal pain, and sleepiness for at least 6 months. The Unit Manager stated she was not aware</p> <p>Resident #1 had no oral intake on 10/6/24 or 10/7/24.</p> <p>Nurse #2 wrote a progress note on 10/7/24 documented at 4:08pm. Nurse #2 documented Resident #1 was observed with the right side of her mouth drooping, right eye drooping, unable to use right hand, and was unable to answer questions. The note showed 911 was contacted and the resident was transferred to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with Nurse #2 (the facility's skills development coordinator) on 10/22/24 at 5:32pm, the nurse clarified that an MD did not see Resident #1 on 10/7/24 but that it was the NP. Nurse #2 explained she saw Resident #1 on 10/7/24 after being asked to assess the resident by Unit Manager #1. When asked what time she saw Resident #1 she stated it was the time documented on her note which was 4:08pm. Nurse #2 described Resident #1 on 10/7/24 with drooping to the right side of her mouth, right eye drooping, unable to squeeze her hands, and unable to answer questions. Nurse #2 stated Resident #1 was normally alert and oriented x4 (person, place, time, and situation) and talkative. Nurse #2 explained as soon as she saw Resident #1 on 10/7/24 she immediately called EMS. She stated she did not know the resident well enough to say how long Resident #1 had been complaining of headaches, sleepiness, or abdominal pain. Nurse #2 stated she was not aware Resident #1 did not have any oral intake on 10/6/24 or 10/7/24.</p> <p>The Emergency Medical Service (EMS) report dated 10/7/24 revealed a call was placed to 911 at 3:56pm, dispatch was notified at 4:00pm, EMS arrived at the facility at 4:07pm and was at Resident #1's bedside at 4:09pm. EMS documented upon their arrival Resident #1 was sitting on her bed confused and repeating take me to the hospital. EMS noted Resident #1 was altered and could not tell the EMS staff who she was, where she was, or what was going on. Resident #1's skin was cold and sweaty, pupils constricted, oxygen sats were 60% (normal 90-100%) and her CO2 was 90. The EMS staff documented they placed Resident #1 on high flow oxygen with improvement and provided 2 milligrams (mg) of Narcan (medication used to reverse opioid effects) due to Resident #1's pupils being constricted (sign of possible overdose) with improvement. Resident #1 would show improvement but then the resident would become confused again and her sats would drop.</p> <p>A telephone interview occurred with Emergency Medical Technician (EMT) #1 on 10/29/24 at 5:17pm. The EMT discussed they arrived at the facility shortly after 4:00pm on 10/7/24. He stated he was escorted to Resident #1's room by the facility's receptionist. EMT #1 said when he arrived at Resident #1's room she was by herself in bed with the head of the bed in a full upright position and Resident #1 was slumped over. He explained the resident was not conscious and only responded to painful stimuli. EMT #1 stated when she did open her eyes and try to speak, Resident #1's speech was incoherent and that she would only stay awake for a few seconds. He stated approximately 5 minutes of being in Resident #1's room, an older nurse entered and told him EMS was called because of abnormal vital signs but the EMT stated the vital signs the nurse provided were within normal range. EMT #1 stated upon his assessment Resident #1 had decreased respirations, altered mental status, and was hypoxic. He explained Narcan was given due to Resident #1 having constricted pupils which he stated could occur if there was an opioid overdose. EMT #1 also explained the overdose may not have been intentional but said if Resident #1 had not been fully conscious when given her medication or if she had an infection, this could impede the resident being able to fully process her medications through her system causing an overdose. He stated Resident #1's high CO2 levels would not have caused constricted pupils but would have caused the altered mental status. The EMT said upon leaving the facility Resident was unconscious and not talking.</p> <p>Review of Resident #1's medical record revealed no documentation of vital signs on 10/7/24.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's hospital records revealed the resident was admitted on [DATE] and discharged on [DATE]. Upon admission, Resident #1's CO2 level was 90.5 and her oxygen level was 73%. The resident was assessed at the hospital with hypercapnia (CO2 retention with elevated CO2 levels), prolonged systemic hypoxemia/severe respiratory failure, acute kidney injury, and transaminitis (high level of liver enzymes in the blood) suspected due to the prolonged systemic hypoxemia/severe respiratory failure. The contributing factors included untreated obstructive sleep apnea. The resident had a Glasgow Coma Scale completed which showed Resident #1 was in a comatose state. She was transferred to intensive care where Resident #1 was treated with a BiPAP machine (a machine that helps to provide oxygen and remove CO2 from the lungs) for her hypercapnia. The hospital records documented Resident #1's migraines exacerbated due to untreated sleep apnea and the resident was given medication.</p> <p>An interview with Resident #1 occurred on 10/22/24 at 12:08pm. Resident #1 discussed her change in condition that started on 10/6/24. She explained she slept all day on 10/6/24 and 10/7/24 then woke up in intensive care at the hospital on 10/8/24. Resident #1 stated she did not remember having any conversations with staff, taking any medications or having anything to eat on 10/6/24 or 10/7/24. Resident #1 stated she never had a CPAP machine since she has been in the facility. She explained that the Physician (Physician #1) had discussed with her needing to see a Pulmonologist several months ago and explained to her the appointment was needed so she could obtain a CPAP machine but stated she never saw a Pulmonologist or received a CPAP machine. Resident #1 also explained another Physician (Physician #2) had also told her he wanted her to see a Pulmonologist a few months ago and have a CPAP machine but she was told by the facility (could not remember who) that the facility could not find transportation to get her to the pulmonologist so she could receive the CPAP machine. Resident #1 stated she was told there was no transportation available for someone her size. The resident discussed periods of excessive sleepiness, trouble remembering, headaches, and abdominal pain for at least the past 6 months. She stated one of the Physician's had ordered her to see a Neurologist for her headaches and to have an x-ray of her abdomen but said none of the appointments happened. Resident #1 discussed remembering a mobile x-ray coming to the facility but said she was told by the x-ray technician that she was too large for the mobile x-ray machine. Discussed with Resident #1 her refusal to go to the hospital. Resident #1 stated on 10/4/24 when the NP offered to send her to the hospital, she did not think she needed to go to the hospital and on 10/7/24 she said she had no recollection of talking to the NP or saying she did not want to go to the hospital. The resident stated no one explained to her that she would have been able to see a Pulmonologist and/or a Neurologist and have an x-ray at the hospital. She also stated no one explained to her that some of her symptoms could have been caused by increased CO2 levels. Resident #1 stated if she had known the information, she would have agreed to go to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The NP stated she saw Resident #1 again in the early morning of 10/7/24 and the resident was sleeping. She explained Resident #1 needed to be shaken to wake up but said she felt this was due to it being so early in the morning and the resident told her I am catching up on my sleep. The NP commented Resident #1 appeared sleepy. She stated she was unaware Resident #1 did not have any oral intake from 10/6/24 to 10/7/24. The NP stated she did not see Resident #1 again on 10/7/24. She stated she was not aware Resident #1 was ordered a CPAP machine back in April 2024 or that Resident #1 had an order to see a Pulmonologist in May 2024. She also stated she was not aware there had been a Neurology consultation order in August 2024 or that Resident #1 had not attended any of these appointments due to transportation issues. Discussed with the NP Resident #1's periodic symptoms of headaches, altered mental status, and abdominal pain. The NP confirmed all of Resident #1's symptoms could have been caused by her increased CO2 levels. She stated since Resident #1's CO2 levels were not considered out of range she did not inform Resident #1 that her symptoms could be caused by her increased CO2 levels. The NP commented that the only way to assess CO2 levels was to conduct an arterial blood gas test which she stated was normally completed in the hospital. She explained the arterial blood gas test would draw blood directly from the arteries which would show higher oxygen levels. She stated she had offered on 10/4/24 and 10/7/24 to send Resident #1 to the hospital but the resident refused. The NP stated she did not know if Resident #1 understood why going to the hospital was important.</p> <p>The Director of Nursing (DON) was interviewed by telephone on 10/29/24 at 10:09am. The DON explained she had not had much contact with Resident #1 and that the resident never voiced any concerns to her. She stated she was aware Resident #1 was not able to attend any of her scheduled appointments due to transportation issues and explained the need for non-emergency transportation company required a month in advance notice and the facility could not coordinate transportation with the time of the appointments. The DON discussed not being aware of Resident #1's increased CO2 levels or that Resident #1 did not have any intake on 10/6/24 or 10/7/24. She stated she did see Resident #1 on 10/7/24 right before the resident left the facility. The DON stated Resident #1 was awake but looked drowsy.</p> <p>The Administrator was interviewed on 10/23/24 at 3:20pm. The Administrator discussed being aware Resident #1 was unable to attend her scheduled appointments due to transportation issues. He had no comments related to Resident #1's hospitalization or how the lack of follow-through with Resident #1's appointments correlated to her hospitalization .</p> <p>The Administrator was notified of immediate jeopardy on 10/23/24 at 3:20pm.</p> <p>The facility provided the following credible allegation of immediate jeopardy removal:</p> <p>(1) Identify those recipients who have suffered, or are likely to suffer a serious adverse outcome because of the noncompliance:</p> <p>The facility failed to comprehensively assess a resident (Resident #1) who had untreated obstructive sleep apnea to determine the root cause of periodic abdominal pain, change in mental status, and migraines that occurred intermittently over the last 6 months in conjunction with elevated CO2 levels on labs completed in August and October 2024. The facility also failed to implement physician's orders for Resident #1 for a CPAP ordered on 4/13/24, pulmonology consultation (insurance requirement for obtaining CPAP) ordered on 5/10/24, neurology consultation ordered on 8-24-24 (ordered for constant migraines), x-rays and ultrasound ordered on 8/24/24 (ordered for abdominal pain). Resident #1 was identified as being affected by the noncompliance.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The nurse practitioner performed a comprehensive assessment on 10/4/2024 and 10/7/2024 and it was recommended that she be transferred to hospital on both dates. Resident #1 refused to go to the hospital on 10/4/2024. On 10/7/2024 at 2:36 PM a note was documented at this time; Resident #1 was comprehensively assessed by the nurse practitioner who recommended she go to the hospital. However, Resident # 1 refused to go.</p> <p>On 10/7/2024 at 4:08 PM, Resident #1 had an acute change in status and was unable to answer questions and was sent to the hospital. Resident #1 was diagnosed in the hospital with altered mental status, acute respiratory failure, acute kidney injury, transaminitis, and migraines. Resident #1 was placed on a BIPAP and admitted to an intensive care unit. She received IV Lasix and supplemental oxygen. An Ultrasound was done due to transaminitis which demonstrated steatosis. In addition, Resident #1 received an order for Fioricet for migraines.</p> <p>Resident # 1's pulmonary and neurology consultations were discontinued on 10/7/2024 upon discharge to hospital. Upon return to the facility on [DATE], Resident #1 did not have any new orders for pulmonology consultation or follow up as she currently has BIPAP in place.</p> <p>Upon review, Resident [TRUNCATED]</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>20906</p> <p>Based on record reviews and staff interviews, the facility failed to complete a performance review every 12 months for 5 of 5 nurse aides (NAs) reviewed (NA # 4, #5, NA 7, NA #9 and NA #10).</p> <p>The findings included:</p> <p>a. Review of Nurse Aide #4's employee file revealed a date of hire of 4/10/23. The employee file for NA #4 did not include annual performance review documents based on the date of hire including April 2024.</p> <p>b. Review of NA #5's employee file revealed a date of hire of 3/28/23 . The employee file for NA #5 did not include annual performance review documents based on the date of hire including March 2024.</p> <p>c. Review of NA #7's employee file revealed a date of hire of 10/18/22. The employee file for NA #7 did not include annual performance review documents based on the date of hire including October 2023 and October 2024.</p> <p>d. Review of Nurse Aide #9's employee file revealed the date of hire of 11/9/22. The employee file for NA #9 did not include annual performance review documents based on the date of hire including November 2023.</p> <p>e. Review of NA #10's employee file revealed the date of hire of 1/31/23. The employee file for NA #10 did not include annual performance review documents based on the date of hire including January 2023 and January 2024.</p> <p>An interview was conducted 11/4/24 at 3:15 PM with the Director of Nursing who stated she was hired in May 2024 and was unaware of the facility's process for maintaining nurse aide competency skills training and performance reviews. She was unaware the mandatory requirements for nurse aide training/competency performance reviews had not been done for 2023 and 2024 for several employees. She stated she was unable to provide any evidence of any training done prior to her employment. She stated she began restructuring the documentation and records of staff training with the initiation of a new system developed with the Staff Development Coordinator that started with the new hires on 9/25/24 when the facility's skill fair was started to educate and provide nurse aide training to reinforce skills and best practices to practice skills used daily for the care of residents in a long term care setting in accordance with the healthcare regulations.</p> <p>An interview was conducted on 11/4/24 at 3:30 PM with the Staff Development Coordinator (SDC) who stated she was hired on 8/26/24 and was not aware of the facility's process for maintaining nurse aide competency skills training and performance reviews. She indicated after reviewing the employee files it was discovered the nurse aide competency skills and performance reviews had not been done for 2023 and 2024. She indicated she was currently doing new employee orientation in-services and competencies. She stated she had not been in the role of SDC for very long and she had not started to review employee training files or training nursing staff in order to complete annual performance evaluations or review.</p> <p>(continued on next page)</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/4/24 at 4:00 PM the Administrator stated Nurse Aides' skills assessment /competencies should be completed at hire and annually. The facility should also have a performance review completed annually to address the needs of staff. The Administrator stated at this time the facility was unable to provide documentation to indicate Nurse Aides' annual performance reviews were completed. The Administrator indicated the skill competencies evaluation and annual performance review should be completed and signed by Staff Development Coordinator (SDC) or her designee. The Administrator stated the facility had some turnover in the SDC position, resulting in no evidence that the training/education was completed and documented.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920</p> <p>Based on record review, resident, staff, Physician, and Nurse Practitioner (NP) interviews the facility failed to ensure a resident (Resident #1) had a Pulmonary consultation appointment ordered once on 4/13/24 and again on 5/10/24. Resident #1 was diagnosed with obstructive sleep apnea and the appointment was required so Resident #1 could obtain a continuous positive airway pressure (CPAP) machine (used to treat sleep apnea by keeping the airways open while sleeping) that was ordered on 4/13/24. The facility also failed to ensure Resident #1 attended a Neurology consultation appointment ordered on 8/24/24 which was made due to Resident #1 complaining of constant migraines/headaches. This occurred for 1 of 3 residents reviewed for medically related social services.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included tachycardia (increased heart rate), asthma, morbid obesity, and obstructive sleep apnea. The resident did not have a diagnosis of migraines on admission.</p> <p>Physician #1 order dated 4/13/24 revealed an order for Resident #1 to receive a Pulmonary consultation and a CPAP machine for obstructive sleep apnea.</p> <p>Another Physician #1 order dated 5/10/24 revealed Resident #1 was to receive a pulmonology consult for her obstructive sleep apnea and CPAP machine.</p> <p>A phone interview occurred with Physician #1 on 10/22/24 at 3:52pm. Physician #1 verified he had written the order for Resident #1 to receive a CPAP machine and a pulmonology consultation. He stated he had ordered the pulmonology consultation and CPAP machine in April 2024 because he understood Resident #1 already had a CPAP machine, but it was not present at the facility. Physician #1 stated Resident #1 required a CPAP machine for her obstructive sleep apnea. The Physician stated about a month later he learned (could not remember from who) that Resident #1 did not have a CPAP machine and needed a Pulmonology appointment to obtain a CPAP machine, so he wrote an order for a Pulmonology consultation in May 2024. Physician #1 explained he did not remember writing the pulmonology consultation in April 2024 when he re-wrote the order in May 2024. He stated he did not know if Resident #1 ever attended the pulmonology consultation but said he knew Resident #1 never had a CPAP machine.</p> <p>A follow-up telephone interview with Physician #1 occurred on 11/4/24 at 11:03am. Physician #1 discussed due to Resident #1's weight, the lack of follow-through with her Pulmonology consultation, Neurology consultation, and lack of obtaining a CPAP machine could not have caused her hospitalization on [DATE]. He explained Resident #1 had been stable without her CPAP prior to her hospitalization s.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview with Physician #2 on 10/22/24 at 3:36pm, Physician #2 explained he began seeing Resident #1 after Physician #1 had left the facility. The Physician stated Resident #1 was required by insurance to receive a pulmonary consultation prior to receiving a CPAP machine. He explained that the insurance company needed proof and severity of Resident #1's obstructive sleep apnea before they would approve Resident #1 for a CPAP machine. The Physician stated Resident #1 required a CPAP machine due to her obstructive sleep apnea. Physician #2 stated Resident #1 was never able to receive the consultation due to transportation difficulties.</p> <p>An interview with Transport Staff occurred on 10/22/24 at 4:54pm. Transport Staff confirmed she was responsible for making residents' appointments. She also discussed being responsible for securing alternate transportation if a resident did not fit in the facility's van. Transport Staff discussed Resident #1 being too large to transport in a wheelchair van and would need non-emergency stretcher transport. She stated the facility had a contract with a non-emergency transport company but said they are always booked up. Transport Staff discussed not receiving the consultation request for Pulmonology until 7/30/24. She stated since 7/30/24 she had been periodically trying to schedule the appointment with Pulmonology and Neurology that would also meet the non-emergency transportation schedule. The Transport staff explained periodically met she would try to call both the Pulmonology office and the Neurology office plus the transportation company every 2-3 weeks to try to arrange the schedules. She stated she had been unsuccessful in getting Resident #1 to the Pulmonologist. The Transport Staff also discussed her neurology consultation. She stated Resident #1 was not able to attend the consultations due to not being able to arrange transportation with the non-emergency transportation company. She stated she kept Unit Manager #1 and the DON up to date in her failed attempts to arrange the appointments.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was cognitively intact, no rejection of care, and no shortness of breath. The MDS also documented Resident #1 did not have a CPAP machine. Resident #1 was documented as having a weight of 430 pounds. Resident #1 was documented as having impairment on one side for her upper and lower extremities, dependent on toileting, bathing, upper and lower dressing, substantial/max assist with bed mobility, and dependent with transfers.</p> <p>On 8/24/24 there was a physician order from Physician #3 for Resident #1 to receive a neurology consultation for constant migraines.</p> <p>The resident's medical record revealed no evidence was documented that Resident #1 received her CPAP. The medical record also revealed Resident #1 never attended her pulmonology consultation, or the neurology consultation.</p> <p>Unit Manager #1 was interviewed on 10/22/24 at 5:47pm. She discussed not being aware Resident #1 had sleep apnea but said she remembered at some point it was mentioned that Resident #1 needed a CPAP machine. She also stated she was aware Resident #1 was unable to attend her Neurology consultation and Pulmonary consultation due to transportation issues.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Resident #1 occurred on 10/22/24 at 12:08pm. Resident #1 stated she never had a CPAP machine since she had been in the facility. She explained that the Physician (Physician #1) had discussed with her needing to see a Pulmonologist several months ago and explained to her the appointment was needed so she could obtain a CPAP machine but stated she never saw a Pulmonologist or received a CPAP machine. Resident #1 also explained another Physician (Physician #2) had also told her he wanted her to see a Pulmonologist a few months ago and have a CPAP machine but she was told by the facility (could not remember who) that the facility could not find transportation to get her to the pulmonologist so she could receive the CPAP machine. Resident #1 stated she was told there was no transportation available for someone her size. The resident discussed periods of excessive sleepiness, trouble remembering, headaches, and abdominal pain for at least the past 6 months. She stated one of the Physician's had ordered her to see a Neurologist for her headaches but said none of the appointments happened. The resident stated no one explained to her that she would have been able to see a Pulmonologist and/or a Neurologist.</p> <p>The NP was interviewed on 10/23/24 at 8:18am. She stated she was not aware Resident #1 was ordered a CPAP machine or to see a Pulmonologist back in April 2024 or that Resident #1 had an order to see a Pulmonologist in May 2024. She also stated she was not aware there had been a Neurology consultation order in August 2024 or that Resident #1 had not attended any of these appointments due to transportation issues.</p> <p>The Director of Nursing (DON) was interviewed by telephone on 10/29/24 at 10:09am. The DON explained she had not had much contact with Resident #1 and that the resident never voiced any concerns to her. She stated she was aware Resident #1 was not able to attend any of her scheduled appointments due to transportation issues and explained the need for non-emergency transportation company required a month in advance notice and the facility could not coordinate transportation with the time of the appointments.</p> <p>The Administrator was interviewed on 10/23/24 at 3:20pm. The Administrator discussed being aware Resident #1 was unable to attend her scheduled appointments due to transportation issues. He had no comments related to the lack of follow-through with Resident #1's appointments.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>51464</p> <p>Based on observations and staff interviews, the facility failed to secure resident medications left in an unattended medication cart for 1 of 4 medication carts (Zone 1 medication cart).</p> <p>The findings included:</p> <p>An observation of the Zone 1 medication cart on 10/22/24 at 5:20 PM revealed the medication cart was unlocked and unattended. The locking mechanism on the right front of the medication cart was observed to be popped out in the unlocked position. Staff and residents were observed to pass by the unlocked medication cart during this time.</p> <p>On 10/22/24 at 5:23 PM Nurse #3 was observed approaching the medication cart from a resident's room. Nurse #3 was observed to lock the cart and proceed to gather items on the top of the cart. An interview was completed with Nurse #3, she stated she was giving evening medications to a resident in the resident's room. Nurse #3 stated the medication cart should have been locked when she was not in attendance of the cart. Observation of the medication cart contained resident medications, insulin pens, medicated ointments and medicated eye drops.</p> <p>An interview was completed with the Director of Nursing (DON) on 10/23/24 at 12:22 PM. The DON stated nurses should lock their medication cart when not in attendance.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51464</p> <p>Based on observations, record review, and staff and service technician interviews the facility failed to cover facial hair and wear gloves during food preparation; keep food service equipment clean and free from debris and maintain a clean kitchen environment; label and date open food items in 1 of 1 walk in coolers; maintain and monitor the kitchen's dish machine that was utilized to clean the dishware and eating utensils to ensure the machine's wash cycle and rinse cycle temperature reached a minimum temperature of 120 degrees Fahrenheit (F); and insulated dome lids and bases were dry before they were stacked for use.</p> <p>The findings included:</p> <p>1. On [DATE] at 4:11 PM Dietary Aide #2 was observed placing lids on insulated mugs full of liquid for meal service with no gloves or facial covering in place. Dietary Aide #2 was observed to have facial hair (beard). Dietary Aide #2 observed surveyors in the kitchen and placed gloves at 4:13 PM on but no facial hair covering and continued placing lids on the insulated mugs full of liquid for meal service.</p> <p>A continuous observation on [DATE] from 10:16 AM to 10:18 AM revealed [NAME] #2 used a spatula to remove cooked fish filets from a large pan to a smaller holding container while not wearing gloves.</p> <p>During an interview with the Dietary Supervisor on [DATE] at 4:26 PM she indicated facial hair coverings should be in place while in the kitchen. She stated she had facial hair coverings available for staff in her office. The Dietary Supervisor also stated gloves should be worn during food preparation.</p> <p>An interview with [NAME] #2 on [DATE] at 10:18 AM indicated she should have been wearing gloves when handling the food but thought it was alright not to because she was using a spatula.</p> <p>An interview with the Administrator on [DATE] at 12:35 PM revealed staff should have facial hair coverings in place while in the kitchen and should wear gloves for food preparation.</p> <p>2. Further observation of the kitchen revealed the following.</p> <p>-Continuous observation of the kitchen on [DATE] from 4:11 PM to 4:26 PM revealed the 3-compartment sink heavily soiled in all 3 compartments with food debris, a greasy jelly-like light brown substance and a deceased insect stuck to the inside wall of the right end sink. The sink was observed at 4:15 PM.</p> <p>An interview on [DATE] at 4:26 PM with the Dietary Supervisor revealed the kitchen was deep cleaned every Thursday.</p> <p>-Observation of the dish washing area on [DATE] at 8:00 AM revealed wooden material surrounding the garbage disposal electrical control box attached to the wall in the corner of the dish washing area. The wooden material was decaying, chipped, and covered with black matter/ growth.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview completed with Maintenance Director on [DATE] at 8:03 AM. The Maintenance Director discussed knowing the garbage disposal electrical control box wooded area needed repair. He stated the wooden area around the garbage disposal electrical control box was decaying, chipped and covered with black matter/growth prior to his employment.</p> <p>3. An observation of the walk-in cooler on [DATE] at 4:23 PM revealed 9 unshelled hard-cooked eggs in a plastic storage bag that was undated. An opened 4 pound jar of grape jelly was also observed to be undated. The Dietary Supervisor was present for the observation.</p> <p>An interview with the Dietary Supervisor on [DATE] at 4:26 PM revealed she was responsible for completing a walk-through of the cooler each morning and checked that each item in the cooler that was open had a date when it was opened and an expiration date. The Dietary Supervisor did not recall seeing these items in the cooler this morning.</p> <p>An interview with the Administrator on [DATE] at 12:35 PM revealed food items in the walk-in cooler should be properly dated.</p> <p>4. A continuous observation of the low temperature dish machine in use on [DATE] from 9:39 AM to 9:48 AM showed the dish machine temperature gauge reading at 102 degrees Fahrenheit (F) for both the wash and rinse cycle with a load of dishes in the compartment. The dish machine was then observed for three more wash and rinse cycles including one cycle each for 20 plastic drinking cups, 32 fruit bowls and 26 dinner plates with the temperature gauge remaining at 102 degrees F. Dietary Aide #1 was noted to be operating the machine during the observations.</p> <p>Review of the manufacturers' recommended temperatures affixed to the front of the dish machine for wash specified the dish machine should reach a minimum temperature of 120 degrees F with a recommended temperature of 140 degrees F. The manufacturers recommended temperatures for rinse revealed the dish machine should reach a minimum temperature of 120 degrees F with a recommended temperature of 140 degrees F.</p> <p>An interview on [DATE] at 9:42 AM with Dietary Aide #1 indicated he spot checked the dish machine temperature at the beginning of his shift prior to starting the dish washing process. He indicated once his initial temperature check was completed, he did not recheck the temperature gauge to make sure the dish machine was maintaining the minimum temperature of 120 degrees F.</p> <p>An observation and interview were conducted on [DATE] at 9:45 AM with the Dietary Supervisor regarding the dish machine which revealed the temperature gauge remaining at 102 degrees F. The Dietary Supervisor stated she would contact the vendor immediately for a service call. The Dietary Supervisor voiced that the Dietary Aides would initially complete several wash and rinse cycles to make sure the dish machine was reaching temperature prior to starting the dish cleaning process. The Dietary Supervisor explained that staff completed the initial check, but the temperature was not checked throughout the dish cleaning process.</p> <p>An observation and interview were conducted on [DATE] at 10:08 AM with the Maintenance Director regarding the dish machine. He stated the dish machine was leased and that he could not complete repairs. The temperature gauge remained at 102 degrees F and he stated the temperature gauge was probably not properly reading the water temperatures cycling through the dish machine.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 10:18 AM a telephone interview was conducted with the Service Manager for the dish machine service company. He stated the dish machine was a low temperature dish machine and water temperature readings for wash and rinse cycle should be a minimum of 120 degrees F but the recommended temperature should be at least 140 degrees F. The service manager explained the dish machine temperature gauges would become faulty over time and not read the correct water temperature or stay fixed on a certain temperature and need to be replaced. He stated the dish machine at the facility was installed in February of 2023. He further explained the dish machine was last serviced 8 weeks ago (no date given). The Service Manager voiced the service technician was in route to the facility to assess the dish machine.</p> <p>Review of the dish machine service company service report for the dish machine dated [DATE] revealed the dish machine had a water temperature reading of 128 degrees F during this service call. No other concerns or recommendations noted.</p> <p>Review of the dish machine service company service report for the dish machine dated [DATE] revealed the dish machine had a water temperature reading of 115 degrees F. Remarks from the service technician noted the temperature gauge was replaced with a new temperature gauge. No other concerns or recommendations noted.</p> <p>A continuous observation of the dish machine on [DATE] from 11:45 AM to 11:51 AM and an interview with the dish machine service company Service Technician was conducted at 11:45 AM. The observation revealed that a new gauge was installed, and the old gauge had been disconnected. The Service Technician stated the old gauge was not working properly and did not show the actual dish machine water temperatures for washing and rinsing. The Service Technician completed several wash and rinse cycles and indicated the temperature gauge was working properly at this time with the temperature gauge reading showing above 120 degrees F. The temperature gauge was observed to read 128 degrees F.</p> <p>An interview with the Administrator on [DATE] at 12:35 PM revealed when staff notice the temperature gauge not working properly, they should notify the vendor so the issues could be corrected.</p> <p>5. On [DATE] at 10:03 AM an observation of the light brown 4-compartment trolley holding insulated dome lids and bases revealed a stack of wet insulated dome lids and bases in 1 compartment. The compartment held a total of 31 insulated dome lids and bases.</p> <p>During an interview on [DATE] at 10:16 AM Dietary Aide #3 stated he forgot to let the insulated dome lids and bases dry prior to placing the items in the 4-compartment trolley. He stated he was rushing.</p> <p>An interview on [DATE] at 10:17 AM with the Dietary Supervisor revealed staff should make sure the insulated dome lids and bases are dry before storing them in the trolley.</p> <p>During an interview on [DATE] at 12:35 PM with the Administrator he indicated items should be properly dried and then stored.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920</p> <p>Based on record review, resident, staff, and Physician interviews, the facility failed to maintain an accurate medical record regarding the use of a Continuous Positive Airway Pressure (CPAP) machine for 1 of 1 resident (Resident #1) reviewed for professional standards.</p> <p>The findings included</p> <p>Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included obstructive sleep apnea (a condition that causes the upper airway to become blocked during sleep, reducing or stopping airflow).</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was cognitively intact with no rejection of care. The MDS also documented that Resident #1 did not have a Continuous positive Airway Pressure (CPAP) machine (used to treat sleep apnea by keeping the airways open while sleeping).</p> <p>Review of a Physician note dated 6/19/24 written by Physician #1 revealed documentation to initiate Resident #1 on CPAP 5/10 settings and follow up with outpatient Pulmonology. Also documented was that Resident #1 was stable and to continue the use of the CPAP machine at night.</p> <p>A phone interview occurred with Physician #1 on 10/22/24 at 3:52pm. Physician #1 verified he had written the note on 6/19/24. He explained he thought Resident #1 had received her CPAP machine for her obstructive sleep apnea and was not aware Resident #1 did not have the CPAP machine or the inability to follow up with the Pulmonologist.</p> <p>An interview with Resident #1 occurred on 10/22/24 at 12:08pm. Resident #1 stated she never had a CPAP machine since she had been in the facility. She explained that the Physician (Physician #1) had discussed with her needing to see a Pulmonologist several months ago and explained to her the appointment was needed so she could obtain a CPAP machine but stated she never saw a Pulmonologist or received a CPAP machine.</p> <p>The Director of Nursing (DON) was interviewed by telephone on 11/1/24 at 9:53am. The DON stated the facility did not review or monitor the Physician's documentation. She confirmed Resident #1 never had a CPAP machine prior to her hospitalization . The DON stated she was unaware Physician #1 was documenting that Resident #1 already had her CPAP machine.</p>		

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 11/05/2024
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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>51464</p> <p>Based on observations and staff interviews the facility failed to maintain a clean and sanitary environment as evidenced by the presence of a growth buildup in and on 1 of 2 ice machines observed and various colored growths on the floor for 1 of 2 observations that were conducted for clean and sanitary environment.</p> <p>The findings included:</p> <p>On 10/22/24 at 4:11 PM the following observations were made.</p> <p>1. The ice machine located in a room with electronic equipment on Zone/hall 3 revealed blackish brown spots of matter on the external facing of the ice machine between the top portion of the ice machine and the ice machine door. The inside of the ice machine revealed pinkish/ black colored matter on the internal ceiling of the ice machine and small brownish-black spots on the internal ceiling front metal lip.</p> <p>2. The floor and corner molding in the right corner behind the ice machine revealed blackish matter along the molding and underneath the exposed and decayed wood, light beige colored puffy growths among the blackish matter on the floor and corner molding. Yellow matted stringy material was also observed on the floor and among the blackish matter and light beige colored growths.</p> <p>An interview and observation on 10/22/24 at 5:26 PM with the Maintenance Director revealed he was not aware of the ice machine being in this condition. He explained that the ice machine was used by staff, and he had not received any concerns related to mold in the ice machine from staff. The Maintenance Director stated he cleaned the ice machines in the building quarterly. He verbalized he was not certain what the blackish or light beige or yellow colored matter was on the floor or the corner molding. He suspected that it was mold but not 100% certain. The Maintenance Director explained that he would shut down the ice machine, empty the ice machine out, complete a chemical clean, and repair the flooring around the ice machine.</p> <p>An interview with the Administrator on 10/23/24 at 12:35 PM revealed ice machines were checked weekly by staff and maintenance. The Administrator stated he was not certain of the deep clean schedule for the ice machines.</p>		