STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Louisburg Healthcare & Rehabilitation Center	202 Smoketree Way Louisburg, NC 27549

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772 Based on record review, resident, staff, Pharmacist and Medical Director Interview, the facility failed to ensure medication was available as ordered for 1 of 3 residents reviewed for administration of medication to meet needs of the resident. (Resident #2) The findings included: Resident #2 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the left breast and bipolar schizoaffective disorder. a.Review of a physician ' s order dated 2/22/23 revealed Resident #2 was to receive Aripiprazole 5 MG (milligram): Give 1 tablet by mouth one time a day for schizophrenia. Review of Resident #2 ' s electronic Medication Administration Record (MAR) for July 2024 revealed she had not received Aripiprazole as ordered on the following dates: On 7/20/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate other/see nurses notes. A nurses note dated 7/20/24 revealed Resident #2 did not receive her Aripiprazole due to medication being on order. The note did not indicate the pharmacy or Director of Nursing was notified. An interview was conducted with Nurse #1 on 8/28/24 at 9:13 AM. Nurse #1 stated she had not received education on the process for missing medications. The nurse stated she had attempted to order the medication from the pharmacy and was made aware that the medication would be arriving that evening in the pharmacy delivery. Nurse #1 stated she did not notify the charge nurse or Director of Nursing that Resident #2 did not have the medication. On 7/21/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate other/see nurses notes. A nurses note dated 7/21/24 revealed Resident #2 did not receive her Aripiprazole due to medication being on order. The note did not indicate the pharmacy or Director of Nursing was notified. Multiple attempts to reach Nurse #2 were unsuccessful. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2 ' s electronic Medication Administration Record (MAR) for August 2024 revealed she had not received Aripiprazole as ordered on the following dates: On 8/12/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate other/see nurses notes. A nurses note dated 8/12/24 revealed Resident #2 did not receive her Aripiprazole due to medication being on order. The note did not indicate the pharmacy or Director of Nursing was notified. An interview was conducted with Nurse #3 on 8/27/24 at 3:13 PM. Nurse #3 stated she was able to reorder a medication through the electronic MAR. The nurse stated she did not follow up with the pharmacy to see when the medication would arrive. Nurse #3 stated she had not been made aware of the use of a backup pharmacy and she did not report the missing medication to the charge nurse or Director of Nursing. On 8/13/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate other/see nurses notes. A nurses note dated 8/13/24 revealed Resident #2 did not receive her Aripiprazole due to medication being on order. The note did not indicate the pharmacy or Director of Nursing was notified. Multiple attempts to reach Nurse #4 were unsuccessful. An interview was conducted with the Pharmacist on 8/27/24 at 4:14 PM. The Pharmacist stated the first medication request for Aripiprazole for Resident # 2 was entered into the electronic system on 7/19/24. A second request for Aripiprazole was entered on 7/22/24. The Pharmacist stated there was no documentation in the system stating anyone from the facility had called about the medication not being available. The Pharmacist reported that a 30-day supply of Aripiprazole was sent to the facility on [DATE]. Further interview with Pharmacist revealed there was a local backup pharmacy to aid in the administration of resident ' s medications. During an interview with the Medical Director on 8/27/24 at 4:18 PM, she stated there were no side effects if the resident missed doses of the medication Aripiprazole. b. Review of a physician ' s order dated 2/22/23 revealed Resident #2 was to receive Letrozole 2.5 MG (milligram) -Give 1 tablet by mouth one time a day for Breast CA. Review of Resident #2 ' s electronic Medication Administration Record (MAR) for August 2024 revealed she had not received Letrozole as ordered on the following date: On 8/12/24 at 9:00 AM, the MAR showed no dose of Letrozole was administered. A chart code of 9 was documented on the MAR to indicate other/see nurses notes. A nurses note dated 8/12/24 revealed Resident #2 did not receive her Aripiprazole due to medication being on order. An interview was conducted with the Pharmacist on 8/27/24 at 4:14 PM. The Pharmacist stated the medication request for Letrozole for Resident # 2 was entered into the electronic system on 8/12/24. The Pharmacist stated the request was filed too soon to be filled. The Pharmacist stated there was no other documentation of request for the medication. The Pharmacist reported that a 30-day supply of Letrozole was sent to the facility on [DATE]. Further interview with Pharmacist revealed there was a local backup pharmacy to aid in the administration of resident ' s medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Medical Director on 8/27/24 at 4:18 PM, she stated there were no side effects if the resident missed doses of the medication Letrozole. During an interview with the Director of Nursing on 8/27/24 at 3:40 PM. The DON stated she expected that the nurse assigned to a resident with missing medications would notify the charge nurse and DON. The DON explained the pharmacy should have been notified and the missing medication picked up from the backup pharmacy until the medication refill could be received at the facilit

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772 Based on record review, resident, staff, and Medical Director Interview, the facility failed to prevent a significant medication error by not following physicians order and failing to administer Aripiprazole (an antipsychotic medication used to treat schizophrenia and Letrozole (an antineoplastic medication used to treat breast cancer) for 1 of 3 residents (Resident #2) reviewed for significant medication error. The findings included: Resident #2 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the left breast and bipolar schizoaffective disorder. Review of Resident #2 ' s most recent quarterly Minimum Data Set (MDS) 6/6/24 revealed the resident was cognitively intact. The MDS also revealed the resident had received antipsychotics for 7 days of the lookback period. Review of Resident #2 ' s care plan dated 12/15/23 revealed the resident had a care plan for receiving antipsychotic medication related to her diagnosis of Schizophrenia. The interventions included in part administer medication as ordered by the physician. Review of the care plan also revealed a focus area of diagnosis of left breast cancer. The interventions included give medications as ordered. a. Review of a physician ' s order dated 2/22/23 revealed Resident #2 was to receive Aripiprazole 5 MG (milligram): Give 1 tablet by mouth one time a day for schizophrenia at 9:00 AM. An interview with Resident #2 on 8/27/24 at 2:36 PM revealed she had missed some medication for two days in July and two days in August due to the medication being out. Resident #2 stated she was concerned about missing this medication because it was important she take it daily. Review of Resident #2 ' s electronic Medication Administration Record (MAR) for July 2024 and August 2024 revealed she had not received Aripiprazole as ordered on the following dates: On 7/20/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate other/see nurses notes. A nurses note dated 7/20/24 written by Nurse #1 revealed Resident #2 did not receive her Aripiprazole due to medication being on order. An interview was conducted with Nurse #1 on 8/28/24 at 9:13 AM. Nurse #1 stated she had not received education on the process for missing medications. The nurse stated she had attempted to order the medication from the pharmacy and was made aware that the medication would be arriving that evening in the pharmacy delivery. On 7/21/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate other/see nurses notes. A nurses note dated 7/21/24 written by Nurse #2 revealed Resident #2 did not receive her Aripiprazole due to medication being on order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple attempts to reach Nurse #2 were unsuccessful. On 8/12/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate other/see nurses notes. A nurses note dated 8/12/24 written by Nurse #3 revealed Resident #2 did not receive her Aripiprazole due to medication being on order. An interview was conducted with Nurse #3 on 8/27/24 at 3:13 PM. Nurse #3 stated she was able to reorder a medication through the electronic MAR. The nurse stated she did not follow up with the pharmacy to see when the medication would arrive. Nurse #3 stated she had not been made aware of the use of a backup pharmacy. On 8/13/24 at 9:00 AM, the MAR showed no dose of Aripiprazole was administered. A chart code of 9 was documented on the MAR to indicate other/see nurses notes. A nurses note dated 8/13/24 written by Nurse #4 revealed Resident #2 did not receive her Aripiprazole due to medication being on order. Multiple attempts to reach Nurse #4 were unsuccessful. During an interview with the Medical Director on 8/27/24 at 4:18 PM, she stated there were no side effects if the resident missed doses of the medication Aripiprazole. b. Review of a physician ' s order dated 2/22/23 revealed Resident #2 was to receive Letrozole 2.5 MG (milligram) -Give 1 tablet by mouth one time a day for Breast Cancer at 9:00 AM. Review of Resident #2 ' s electronic Medication Administration Record (MAR) for August 2024 revealed she had not received Letrozole as ordered on the following date: On 8/12/24 at 9:00 AM, the MAR showed no dose of Letrozole was administered. A chart code of 9 was documented on the MAR to indicate other/see nurses notes. A nurses note dated 8/12/24 written by Nurse #3 revealed Resident #2 did not receive her Aripiprazole due to medication being on order. An interview was conducted with Nurse #3 on 8/27/24 at 3:13 PM. Nurse #3 stated she was able to reorder a medication through the electronic MAR. The nurse stated she did not follow up with the pharmacy to see when the medication would arrive. Nurse #3 stated she had not been made aware of the use of a backup pharmacy and she did not report the missing medication to the charge nurse or Director of Nursing. During an interview with the Medical Director on 8/27/24 at 4:18 PM, she stated there were no side effects if the resident missed doses of the medication Letrozole. During an interview with the Director of Nursing on 8/27/24 at 3:40 PM. The DON stated she expected that the nurse assigned to a resident with missing medications would notify the charge nurse and DON. The DON explained the pharmacy should have been notified and the missing medication picked up from the backup pharmacy until the medication refill could be received at the facility.