

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345551	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Carolina Point		STREET ADDRESS, CITY, STATE, ZIP CODE 5935 Mount Sinai Road Durham, NC 27705	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with the Medical Director, Nurse Practitioner (NP), Assistant Manager of Pharmacy Operations, residents and staff, the facility failed to have effective systems in place to ensure a twice a day dose of an antiseizure oral medication prescribed for the treatment of seizure was administered resulting in a seven-day delay of it being administered. Resident #1 did not change his condition. This occurred for 1 of 1 resident reviewed for significant medication error (Resident #1).</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses including seizure disorder and traumatic brain injury.</p> <p>Review of Resident 1's plan of care, dated [DATE], revealed he had a seizure disorder. The interventions included receiving medications as ordered.</p> <p>Record review of the physician's orders for Resident #1 revealed:</p> <p>[DATE] - Lacosamide (seizure medication), 200 mg (milligram), by mouth every 12 hours,</p> <p>Lacosamide 50 mg, by mouth every 12 hours,</p> <p>Levetiracetam (seizure medication), oral solution, 100 mg in mL (milliliter), to take 17.5 mL twice a day,</p> <p>[DATE] - Depakote (Anticonvulsant), tablets, 500 mg, to take 1 tablet daily.</p> <p>Review of the Medication Administration Record (MAR) for Resident #1 for [DATE] revealed that Lacosamide 50 mg, was not administered, because it was not available on [DATE] at 9 AM and 9PM, [DATE] at 9 AM and 9PM.</p> <p>Record review of the communication to NP book revealed the note, dated [DATE], documented by Nurse #5, indicated the new prescription request for Lacosamide 50 mg for Resident #1.</p> <p>Record review of the Nurse Practitioner's (NP #1) notes, dated [DATE], revealed that it was a routine regulatory visit of Resident #1. NP #1 reviewed Resident 1's medications and did not place new orders. There was no documentation of the missing dose of Lacosamide 50 mg in NP 1's notes.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the nurses' notes, dated [DATE] at 7:15 AM, revealed that Nurse #7 was noted Resident #1 was out of refills for Lacosamide 50mg tablet. Nurse #7 confirmed no refills with the pharmacy, communicated with the Medical Director and informed him of the missed doses of Lacosamide. The Medical Director sent a new prescription to the pharmacy and ordered blood tests. The family was notified about the delay in medication administration. Resident #1 did not have symptoms of seizure, maintained normal vital signs and attended activity alone with his family member.</p> <p>Record review of the nurses' notes, dated [DATE] at 11:30 AM, documented by Assistant Director of Nursing (ADON), indicated that Lacosamide 50mg tablets arrived at the facility on [DATE] at 11:00 AM.</p> <p>On [DATE] at 7:45 AM, during an interview, Nurse #1 indicated that she was assigned for Resident #1 on [DATE], 7 PM - 7 AM shift. At 9 PM, Nurse #1 administered 200 mg of Lacosamide, but did not have Lacosamide 50 mg tablet. Nurse #1 called the pharmacy and on-call physician, left messages about missing 50 mg of Lacosamide tablets. Nobody called her back during the shift. Nurse #1 documented in the MAR that 50 mg of Lacosamide was not available. Resident #1 was at his baseline, with no signs of seizure or agitation.</p> <p>On [DATE] at 7:55 AM, during the observation/interview, Resident #1 was in bed. He indicated that the last seizure episode occurred for him a few months ago. The resident did not recall if he recently missed his antiseizure medications.</p> <p>On [DATE] at 8:55 AM, during an interview, Nurse #2 indicated that on [DATE], Saturday, she was assigned for Resident #1 on 7 AM-7 PM shift. There were two separate orders for Lacosamide 200 mg and Lacosamide 50 mg twice a day for the resident. At 9 AM, Nurse #2 administered 200 mg of Lacosamide, but did not have 50 mg of Lacosamide available. She called the pharmacy and left a message. Nobody called her back. Nurse #2 could not recall if she notified the physician or family. Nurse #2 did not receive from the pharmacy a 50 mg dose of Lacosamide during her shift and notified the upcoming nurse. On [DATE] and [DATE], Nurse #2 was assigned for Resident #1 on the 7 AM-7 PM shifts, and 50 mg dose of Lacosamide was not available. Nurse #2 documented in the MAR that 50 mg of Lacosamide was not available. The resident was at his baseline, presenting no signs of seizure or agitation.</p> <p>On [DATE] at 10:00 AM, during an interview, Nurse #8 indicated he was assigned for Resident #1 on [DATE] and [DATE], on 7 AM to 7 PM shifts. The previous shift nurses reported that it was no 50 mg of Lacosamide available to administer. Nurse #8 administered 200 mg of Lacosamide per order and documented in the MAR that 50 mg of Lacosamide was not available. He did not notify the pharmacy or physician because he read the notes in the NP book about a new prescription request for 50 mg of Lacosamide. The resident did not have agitation, seizure activity or abnormal vital signs.</p> <p>On [DATE] at 12:45 PM, during the phone interview, Nurse #7 indicated that on [DATE] she was assigned for Resident #1 at 7 AM to 7 PM shift. At 9:30 AM, during the medication administration, Nurse #7 did not have 50 mg dose of Lacosamide for Resident #1. At 10 AM, the resident's family member came to visit and Nurse #7 notified her about the not available medication. Nurse #7 reported it to the Director of Nursing (DON), called the pharmacy and found that the new prescription for Lacosamide 50 mg was required. Nurse #7 contacted the provider on call, who sent the new prescription for Lacosamide 50 mg to the pharmacy. The 50 mg Lacosamide tablets arrived at the facility in the morning of [DATE]. Resident #1 remained at his baseline, did not have signs of agitation or seizure activity.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 3:45 PM, during the phone interview, Nurse #3 indicated that on [DATE], he was assigned for Resident #1 on 7 PM - 7 AM shift. During the shift change report at 7 PM, he learned that 50 mg dose of Lacosamide was not available for Resident #1, and thought the previous shift staff already communicated the issue with the pharmacy and physician. On [DATE], Nurse #3 was assigned for Resident #1 on 7 PM - 7 AM shift, did not have 50 mg dose of Lacosamide and put the request for new prescription to the communication with NP book. On [DATE], he was assigned for Resident #1 on 7 PM - 7 AM shift, and the 50 mg dose of Lacosamide was not available for Resident #1. The resident did not show signs of seizure, interacted with his family over the phone and was showed normal vital signs.</p> <p>On [DATE] at 9:00 AM, during the phone interview, the Medical Director indicated that he has known Resident 1 for about twenty years and was very familiar with his medication regimen. On [DATE], the staff informed him that the 50 mg of Lacosamide was missing for several days due to an expired prescription. The Medical Director immediately sent the new prescription for Lacosamide 50 mg to the pharmacy. The staff reported no negative changes in Resident 1's condition, behavior or seizure activity. Resident #1 did not have the negative outcome from missing 50 mg doses of Lacosamide, because he received the higher doses of Lacosamide (200 mg) and other antiseizure medications (Levetiracetam and Depakote). The Medical Director expected the staff to follow physician's order and communicate the delayed or missed medications administration to the provider on call.</p> <p>On [DATE] at 9:40 AM, during the phone interview, the Assistant Manager Pharmacy Operations indicated that the prescription for Lacosamide 50 mg, ordered in [DATE] was expired on [DATE]. Considering that, the pharmacy sent the multiple requests for new Lacosamide 50 mg tablets prescription to the provider on [DATE], [DATE] and [DATE]. The pharmacy received a new prescription for Lacosamide 50 mg tablets on the evening (after business hours) of [DATE] and dispensed the medication to the facility on [DATE].</p> <p>On [DATE] at 10:00 AM, during an interview, the Director of Nursing (DON) expected the staff to implement a working system to make sure all the residents would have medications as ordered. On [DATE], when the 50 mg of Lacosamide was not available for the administration for Resident #1, the floor nurses should follow the Medication Administration policy, which requires to call the pharmacy, request the medication, and notify the provider and family. On [DATE], when the administration became aware of the missing doses of 50 mg of Lacosamide, the new prescription was immediately obtained, sent to the pharmacy and medication arrived at the facility on [DATE]. During the seven days of missing Lacosamide 50 mg doses, the staff closely monitored Resident #1, who remained at his baseline.</p> <p>On [DATE] at 10:20 AM, during an interview, the NP #1 indicated that she conducted the routine visit for Resident #1 on [DATE]. Upon assessment, the resident did not show agitation or signs of seizure activity. NP #1 did not recall reports from the staff or the notes in the NP communication book about the need for a new prescription for Lacosamide 50 mg. She was not aware of missing doses of Lacosamide 50 mg until [DATE].</p> <p>The administrator provided the following Corrective Action Plan.</p> <p>Plan of Correction for Medication Administration, notification to physician/extender when medications are unavailable.</p> <p>o</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>What corrective action will be accomplished for those residents found to have been affected by practice:</p> <p>Resident ordered to receive 200 mg (milligrams) and 50 mg (milligrams) Lacosamide at 9:00am and 9:00pm. Resident's 50mg Lacosamide was not noted to be in the medication cart on [DATE]. On [DATE] the nurse placed in the provider notebook that we needed a script for 50mg Vimpat. The different nurse contacted the provider extender on [DATE] to reorder the medication and the medication was received on [DATE]. The Medical Director was notified on [DATE] and ordered CMP and CBC which resulted on [DATE].</p> <p>o</p> <p>How will the facility identify other residents having the potential to be affected by the same practice:</p> <p>On [DATE] the Director of Health Services and Nurse Managers reviewed all residents with anti-seizure medications to validate availability of medications. The timeframe for the review was from [DATE] thru [DATE], all medications were found to be available.</p> <p>o</p> <p>What measures will be put in place or systemic changes will be made to ensure that the deficient practice will not recur:</p> <p>On [DATE] the Assistant Director of Health Services and Nurse Managers began education to Nurses regarding, following the Six Rights of Medication Administration (right patient, right medication, right dose, right time, right route, right indication), notification to pharmacy, the physician, resident, and family when a medication is not available for prescribed administration and the six rights of medication administration. Any nurse scheduled to work a medication cart will be educated by [DATE] or prior to their next scheduled medication pass time. This education will be added to the general orientation for all newly hired Nurses.</p> <p>The Director of Health Services and/or nurse managers began education of nurses on [DATE] related to medication administration guidelines protocol, any nurse working a medication cart not educated by [DATE] will be educated prior to their next schedule medication pass. This education has been added to the general orientation for all newly hired nurses.</p> <p>On [DATE] The Director of Health Services and Nurse Management began the review of anti-seizure medication reviews to validate the availability and the administration of the medications to the resident per physician orders. This process will be completed weekly for four weeks then monthly until three months of sustained compliance is maintained quarterly thereafter.</p> <p>o</p> <p>How will the facility monitor its performance to make sure the solutions are sustained:</p> <p>(continued on next page)</p>		

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