STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 06/05/2024

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INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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E 000	Initial Comments An unannounced recertification survey and complaint investigation were conducted 5/28/24 through 6/5//24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# AL9511.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility to conduct a recertification and complaint investigation survey on 5/28/24 and exited on 5/30/24. Additional information was obtained on 6/5/24. Therefore, the exit date was changed to 6/5/24. Event ID# AL9511. The following intakes were investigated: NC00212610, NC00212587, NC00202191, NC00206314, NC00210083 and NC00212027. 1 of the 12 complaint allegations resulted in deficiency.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to protect the residents ' right to be free from misappropriation of a narcotic medication (oxycodone/acetaminophen) prescribed to treat pain for Resident #250. This was for 1 of 1	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 06/17/2024

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F 602	Continued From page 1	F 602		

residents reviewed for misappropriation.

The findings included:

Resident #250 was admitted to the facility on 10/25/23 and discharged home on 11/14/23. His admitting diagnosis included cellulitis of both lower extremities, urinary tract infection due to proteus (gram-negative bacterium-type of bacteria), and lymphedema of both lower extremities.

An admission Minimum Data Set (MDS) assessment dated 11/01/23 indicated Resident #250 was cognitively intact.

Review of Resident #250 ' s medication orders revealed the following orders:

Oxycodone/acetaminophen oral tablet 5/325mg. Give 1 tablet by mouth every 6 hours as needed for pain for 5 days. Order start date was 10/25/23 with a stop date of 10/30/23.

Oxycodone/acetaminophen oral tablet 5/325mg. Give 1 tablet by mouth every 6 hours as needed for pain. Start date 11/01/23.

Review of the Medication Administration Record (MAR) the Oxycodone/acetaminophen oral tablet 5/325mg was given 9 times during his stay. The MAR was signed on the following dates and times:

- 10/25/23 at 11:41 PM

- 10/26/23 at 5:30 AM

- 10/28/23 at 11:16 AM

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F 602	Continued From page 2	F 602		

- 10/29/23 at 10:23 AM

- 11/01/23 at 9:00 PM

- 11/04/23 at 9:47 PM

- 11/05/23 at 930 PM

- 11/07/23 at 9:37 PM

- 11/12/23 at 9:01 PM

Nurse #2 signed the MAR for administering the oxycodone/acetaminophen 7 out of 9 times: 10/25/23 at 11:41 PM, 10/26/23 at 5:30 AM, 11/01/23 at 9:00 PM, 11/04/23 at 9:47 PM, 11/05/23 at 9;30 PM, 11/07/23 at 9:37 PM, and on 11/12/23 at 9:01 PM. A total of 9 administrations were given from a card of 20 tablets leaving 11 tablets.

Record review did not reveal any evidence of uncontrolled pain.

An initial report was submitted to the North Carolina Department of Health Human Services Division of Health Service Regulation on 11/17/23 by the Director of Nursing (DON). The allegation of misappropriation of property was made on 11/14/23 after a card of narcotic medication, oxycodone/acetaminophen 5/325mg tablets, and declining inventory sheet (used to record the reduction of an inventory's amount on hand) were missing from the medication cart. Resident #250 was being discharged home on 11/14/23 with all medications when Nurse # 1, the discharging nurse, was unable to locate his pain medication. She contacted the Director of Nursing (DON),

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F 602	Continued From page 3	F 602		

and an investigation was initiated. The DON was unable to locate the narcotic medication or the declining inventory sheet.

Review of facility investigation completed by the Director of Nursing (DON) on 11/21/23 revealed a card of 20 oxycodone/acetaminophen 5/325mg tablets were delivered to the facility on 10/25/23. A review of the medication administration record (MAR) showed Resident #250 received his narcotic medication 9 times on the following dates: 10/25/23, 10/26/23, 10/28/23, 10/29/23, 11/01/23, 11/04/23, 11/05/23, 11/07/23, and 11/12/23. The MAR also revealed 7 of the 9 administrations were given by Nurse #2 which were 10/25/23, 10/26/23, 11/01/23, 11/04/23, 11/05/23, 11/07/23, and 11/12/23. Nurse #2 was interviewed on 11/14/23 and stated that she administered the last dose of the narcotic medication on 11/12/23. This 11/12/23 dose was not signed out on the Medication Administration Record (MAR). Nurse #2 later signed a late entry for 11/12/23 dose. This would have made the total administration 9, leaving 11 narcotic pills in the bubble pack. Nurse #2 then stated she put the declining inventory sheet in the Director of Nursing ' s (DON ' s) box (a box where staff can put documents that the DON needs to review/file). On the evening of 11/14/23 Nurse #2 sent the Director of Nursing (DON) a picture of the top portion of the narcotic card that had the resident ' s name and the name of the medication on it stating she located it in her book bag with other papers. The Administrator and DON reviewed camera footage on 11/15/23 and 11/16/23, which revealed Nurse #2 did not enter Resident #250 ' s room on 11/07/23 or 11/12/23 for several hours before or after the times the administration record (MAR) showed the narcotic

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F 602	Continued From page 4	F 602		

had been signed as being given. Nurse #2 was interviewed again on 11/17/23 and was unable to explain the discrepancies noted. The investigation report did not indicate what time Nurse #2 had entered Resident #250 ' s room on 11/07/23 or 11/12/23. The investigation was substantiated by the DON and Administrator.

Unsuccessful attempts were made to contact Resident #250.

Review of a statement written by Nurse #1 dated 11/20/23 revealed on 11/14/23 she was gathering Resident #250 ' s medications and noted his narcotic medication, oxycodone/acetaminophen 5/325mg tablets, were not in the locked narcotic drawer. She also noted that the declining inventory sheet was also not on the medication cart. She notified the Director of Nursing (DON).

Attempts were made to contact Nurse #1 by phone, but they were unsuccessful.

Review of a statement written by Nurse #2 dated 11/14/23 indicated she worked on 11/12/23 and administered the last dose of the narcotic medication to Resident #250. She then put the declining inventory sheet, which read 0 tabs were left, in the Director of Nursing (DON) box.

Multiple unsuccessful attempts were made to contact Nurse #2.

An interview was conducted on 05/30/24 at 11:01 AM with the Director of Nursing (DON). She stated she was notified on 11/14/23 by Nurse #1 that Resident #250 ' s medications were supposed to be in the medication locked narcotic box, however when the nurse discharged him the

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F 602	Continued From page 5	F 602		

narcotic pain medication was not in the drawer and the declining inventory flow sheet was missing as well. She stated she then began a full investigation. She stated nurses count the narcotics on the medication carts compared to the declining inventory sheets during shift change. The nurses did not realize the medication was missing. During the investigation copies were made of the Medication Administration Record (MAR) which revealed 8 doses of the narcotic medication were given. During the investigation Nurse #2 stated she administered the medication on 11/12/23 but she forgot to sign the MAR. This would have made the total administration 9, leaving 11 narcotic pills in the bubble pack.

An interview was conducted on 05/30/24 at 12:45 PM with the Director of Nursing (DON) and the Administrator. They stated the narcotic medication or declining inventory sheets were never located. The DON stated she expected all nurses to administer medications per order and not to remove or take medications from the residents or facility for personal purposes. Nurse #2 was suspended then terminated following the completion of the investigation.

The facility provided the following corrective action plan:

Corrective action for the involved resident dated 11/22/23 read as follows: Resident #250 was discharged home on 11/14/23. The day the card was noted missing. Resident #250 was given a prescription for oxycodone/ acetaminophen 5/325mg and his family member verified they could pick the narcotic medication up. Investigation initiated, and drug tests initiated.

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F 602	Continued From page 6	F 602		

Drug tests were given to the 3 nurses that were working on the medication cart, all were negative. On 11/15/23 the

nurse in question was suspended until investigation complete. On 11/17/23 a 24 hour report was submitted; the North Carolina Board of Nursing (NCBON) was notified, and the police department notified of open investigation.

Corrective action for other potentially affected residents dated 11/22/23 read as follows: On 11/17/23, the current residents that were able to be interviewed, were interviewed using the Audit Medication Concerns/Misappropriation. This was completed by the Social Worker and Director of Nursing (DON). Results included: no concerns voiced. Additionally, pain assessments were completed by DON on current residents that were not interviewed. These residents were assessed to identify verbal or nonverbal untreated pain cues or concerns. Results included: no concerns noted. On 11/15/23 the Staff Development Coordinator and DON initiated and implemented corrective action for those residents which includes education for all nursing staff.

Systemic Changes and Education initiated on 11/15/23 read as follows: On 11/15/23 the Director of Nursing (DON) initiated education for all nurses on Controlled Substance Process and Abuse policy. This education will include all current staff. DON will ensure that any of the above identified staff who do not complete the in-service training by 11/21/23 will not be allowed to work until the training is complete.

Quality Assurance (QA) Plan initiated on 11/15/23 read as follows: The Director of Nursing (DON)

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F 602	Continued From page 7 will monitor five residents using the Medication Concerns or Misappropriation Audit weekly for 2 weeks and monthly for 3 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored, and an ongoing auditing program reviewed at the weekly QA meeting. The weekly QA meeting is attended by the Administrator, DON, Minimum Data Set (MDS) Coordinator, therapy, Health Information Manager (HIM), and the Dietary Manager. The plan alleged compliance on 11/21/23. Review of the facility plan of correction revealed evidence of 100% auditing of medication concerns or misappropriation, including pain assessments. The facility provided evidence of 100% staff education on Controlled Substance Process and Abuse policy completed on 11/21/23. Reports were presented to the QA committee by the DON to ensure corrective action was appropriate. Compliance was monitored, and the ongoing auditing program was reviewed at weekly QA meetings for the timeframe of the monitoring period. The facility ' s date of compliance was validated as 11/21/23. The facility ' s date of compliance was validated on 05/30/24.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		6/13/24

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F 609	Continued From page 8 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit an initial report to the state regulatory agency and to report to Law Enforcement within 24 hours of discovery of misappropriation of resident property. They further failed to notify Adult Protective Services (APS) regarding an allegation of misappropriation of resident property. This was for 1 of 1 residents (Resident #250) reviewed. The findings included: A review of the facility's Abuse policy, last revised 01/2023, revealed the facility would report a 24-hour investigation into misappropriation of	F 609	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F609 For the resident involved, corrective action has been accomplished by:	

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F 609	Continued From page 9 resident property and the report must be completed and faxed into Healthcare Personnel Registry. All alleged violations must be reported no later than 24-hours if the alleged violation involves misappropriation of resident property and does not result in serious bodily injury. An interview with the Director of Nursing (DON) was conducted on 05/30/24 at 11:01 AM revealed she was notified on 11/14/23 by Nurse #1 that Resident #250 ' s narcotic medication was supposed to be in the medication locked narcotic box, however when the nurse was discharging him the narcotic pain medication was not in the drawer and the declining inventory flow sheet was missing as well. The DON indicated she started her investigation on 11/14/23 after being notified of the missing narcotic medication. A phone interview with the Director of Nursing (DON) and the Administrator was conducted on 06/05/24 at 9:04 AM. They both stated they did not send an initial report to the state regulatory agency or notify law enforcement within 24 hours because they were not sure if this was a diversion of facility drugs issue or not. They both clarified that they were unsure if the resident had received all the narcotic medications or if they were in fact missing. They indicated on 11/15/23 as a confirmatory measure the Administrator began reviewing camera footage but there was no evidence that implied diversion until late in the evening of 11/16/23. The DON stated she filed the 24-hour report to the state regulatory agency and reported it to Law Enforcement on 11/17/23.	F 609	At the time of survey, no current residents were affected by this practice. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On June 12, 2024 the Director of nursing (DON) utilized the Reporting Compliance Audit Tool to audit 12 month of 24 hour / 5 day reports at 100%. This is to ensure that initial reporting of allegations were submitted per DHSR guidelines. (Exhibit 1) Measures put in place or systematic changes made to ensure the alleged deficient practice does not occur: On June 13, 2024 Liberty Health Care's Regional consultant educated the Administrator and the Director of Nursing on the following: (Exhibit 2) • NC-DHSR Reporting Allegations to N.C. Health Care Personnel Investigations Branch education packet. • Policy: Reporting Suspected Crimes Under the Federal Elder Justice Act. The facility has implemented a Quality Assurance Monitor: The Reporting Compliance Audit Tool will be completed by the DON monthly for 3 months to ensure compliance with reporting guidelines. The audit findings will be reported to the Monthly Quality of Life Team at the Monthly Quality of Life Meetings. For any month with less than 100% compliance, the monitor will be extended an additional month and	

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F 609	Continued From page 10	F 609	corrective action will be implemented by the Monthly Quality of Life Team at that time.	