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F 000	INITIAL COMMENTS The survey team entered the facility on 10/28/24 to conduct a complaint investigation and exited on 10/29/24. Additional information was obtained offsite on 10/30/24. Therefore, the exit date was changed to 10/30/24. Event ID# R4W711. The following intakes were investigated NC002222966, NC00221461, NC00219068, NC00222617, NC00220669, NC00219624, NC00216212, NC00220619, NC00217310. 4 of the 15 complaint allegations resulted in a deficiency. On 11/20/24 the 2567 was amended to reflect a change to F689-D to PNC.	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, observation, and interviews with staff, the facility failed to protect the resident's right to be free from misappropriation of controlled medications for 1 of 3 residents reviewed for misappropriation of a resident's property (Resident #3). The resident received her pain medication as scheduled. Findings included:	F 602	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/20/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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The facility's Abuse, Neglect, and Exploitation Policy, last updated on 3/20/23, was reviewed and it included misappropriation in part was the protection of resident property "the deliberate misplacement, exploitation, or wrongful, temporary or permanent of a resident's belongings or money without the resident's consent."

Resident #3 was admitted to the facility on 5/12/22 with the diagnosis of arthritis.

A review of the facility record revealed Resident #3 had an order for Oxycodone 5 mg three times a day for pain dated 7/10/24.

A review of the facility record revealed Resident #3 had an order for Hydrocodone 10-325 mg every 6 hours as needed for pain dated 7/10/24.

A review of the facility pharmacy record revealed Resident #3 had an order dated and received from pharmacy on 7/10/24 for 26 hydrocodone (opiate for pain)/Tylenol 10-325 milligram (mg) tablets every 6 hours as needed for pain. The pharmacy record documented the pharmacy had dispensed 2 cards of 10 hydrocodone/Tylenol tablets each, 1 card of 5 hydrocodone/Tylenol tablets, and 1 card of 1 hydrocodone/Tylenol tablet.

The declining count sheet for Resident #3's hydrocodone/Tylenol 10-325 mg tablets dated 7/10/24 had no documented administration of the medication indicating there 26 tablets remaining.

Resident #3's significant change Minimum Data Set dated 9/20/24 documented she usually

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F 602 Continued From page 2
understands/understood and had a memory deficit. The resident had a cancer diagnosis, was receiving scheduled pain medication, and receiving hospice services.

The care plan for Resident #3 dated 9/20/24 included cancer with pain treatment/control and hospice services.

Resident #3's documented pain level on her Medication Administration Record (MAR) for August of 2024 was 0 (pain scale 0 to 10, with 0 no pain). The MAR documented scheduled Oxycodone was given as scheduled and as needed hydrocodone was not given.

A review of a facility misappropriation investigation revealed an investigation regarding 26 missing hydrocodone tablets which had been dispensed from the pharmacy for Resident #3. The investigation was completed by the Interim Director of Nursing (DON) and review of the investigation revealed there were 4 nurses that had access to the medication cart prior to when the hydrocodone was reported missing, and the medication was never found. Nurse #2 was a witness that the hydrocodone was present on 8/28/24. Nurse #3 at the end of day shift on 8/29/24 at 7:00 pm counted with Nurse #4 and observed all 26 tablets of hydrocodone locked in the medication cart. Both nurses signed for narcotic medication reconciliation. On 8/30/24 the narcotic count took place between night Nurse #4 and day Nurse #1 at 7:00 am. All 26 tablets of hydrocodone were noted to no longer be in the locked medication cart drawer and none were documented as dispensed. Nurse #1 thought the hydrocodone was returned to the pharmacy because it was not being used and

F 602

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F 602	Continued From page 3 Nurse #4 had not known where the medication was. All 4 nurses were tested and found to be negative for opiates. Nurses #1, Nurse #2, and Nurse #4 made statements that they had not diverted/taken the narcotic medication hydrocodone. All nursing staff that were responsible for narcotic administration and storage participated in education and QAPI (Quality Assurance/Performance Improvement) was informed. Ongoing audits were in place for controlled substance count and storage. The 26 hydrocodone tablets were never found. The local Police and Drug Enforcement Administration were notified. The facility initiated a new process that when medication was not used after 14 days it would be sent back to the pharmacy. The hydrocodone was sitting in the medication cart for a long time not being used and should have been returned to the pharmacy. Resident #3 had scheduled Oxycodone, and her pain was under control. On 10/29/24 an attempt was made to interview the investigating officer at the local police department without success. The facility submitted the required Federal Drug Administration Form 106 report of loss or theft of controlled substance dated 8/30/24. A review revealed it was completed with the list of the controlled substance and how the corrective actions will be accomplished for those residents to have been affected by the deficient practice. On 10/28/24 at 11:30 am an interview was conducted with the Interim Director of Nursing (DON). The DON stated she completed the misappropriation investigation of Resident #3's hydrocodone. There were 4 nurses that had	F 602		

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F 602	Continued From page 4 access to the cart when the 26 tablets of hydrocodone 10-325 mg went missing, and the medication was never found. All 4 nurses were tested and found to be negative. All nurses involved made a statement that they had not diverted the narcotic medication (hydrocodone). All nursing staff that were responsible for narcotic administration and count/storage participated in education and QAPI was informed. Ongoing audits were in place for all narcotic count and storage. The police were notified. There was a new process put in place that when medication was not used after 14 days it would be sent back to the pharmacy. The hydrocodone which was found to be missing was stored in the medication cart for a month and was not being used. The resident had received scheduled Oxycodone, and her pain was under control and the hydrocodone was not being used. On 8/30/24 Nurse #1 documented a statement as part of the investigation regarding Resident #3's missing hydrocodone. The review revealed "When I was counting narcotics at the beginning of shift this morning (8/30/24), I noticed that the bag of 26 Norco (hydrocodone) was missing. It was last here on Tuesday, August 27, but we have had that bag of 26 Norco in the drawer for a month, so I'm accustomed to seeing it. I asked where it was and was told by the night shift nurse (Nurse #4) that she didn't know." Nurse #2 was then involved in the conversation and texted Nurse #3 who worked 8/29/24 day shift until 7:00 pm and counted narcotics with Nurse #4. Nurse #3 texted back that the hydrocodone was accounted for. On 10/29/24 at 1:56 pm an interview was conducted with Nurse #1. Nurse #1 stated she	F 602		

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counted the controlled substances with Nurse #4 on 8/30/24 at 7:00 am and noticed that the hydrocodone 26 tablets for Resident #3 that had been in a plastic bag was missing. The tablets were sealed in cards, 2 cards of 10, 1 card of 5, and 1 card of 1. Nurse #4 was unable to state to Nurse #1 what happened to the medication. Nurse #1, #2 and #4 looked for the medication and it was not found. Nurse #1 stated she assumed the medication was sent back to pharmacy because it was stored and not used for months. Nurse #1 stated that management was not in yet and Nurse #4 went home. When management arrived, they were informed of the missing medication and staff searched again and determined that it was not present. The pharmacy was contacted and had not received the hydrocodone back. Nurse #1 stated that the hydrocodone was present the day before during count at the end of day shift 7:00 pm according to her conversation with Nurse #3 and what was documented. Nurse #1 stated she had not taken the medication and had not known what happened to it.

There was no statement for Nurse #3.

According to the facility record reviewed, Nurse #3 worked on day shift until 7:00 pm on 8/29/24 and counted controlled substances with Nurse #4 and all medication was reconciled.

On 10/30/24 at 4:50 pm an interview was conducted with Nurse #3. Nurse #3 stated she was assigned to Resident #3 on 8/29/24 day shift from 7:00 am to 7:00 pm. Nurse #3 had contacted hospice to talk about the resident's pain control and the hydrocodone was reviewed and checked for usage and tablets remaining.

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Nurse #3 stated she double checked the hydrocodone was available in the locked narcotic drawer. There were 26 tablets in cards inside of a plastic bag. Nurse #3 stated she counted the narcotics at the end of her shift with Nurse #4. All medications were accounted for and both nurses signed accordingly. Nurse #3 stated she was notified on 8/30/24 that the resident's hydrocodone tablets were missing at narcotic count 8/30/24 at 7:00 am. Nurse #3 further explained nurses do not share medication cart keys, nobody asked her for the keys on the day shift 8/29/24. Nurse #3 stated she was drug tested for opiate presence in her system and was negative.

A review of an investigation statement dated 8/30/24 written by Nurse #2 documented that she worked on 8/28/24 and Resident #3's hydrocodone was in a bag and accounted for. On 8/29/24 day shift, Nurse #3 was scheduled and counted with Nurse #4 at 7:00 pm and documented on the count sheets. The count sheets documented that the hydrocodone was present. Nurse #2 heard on 8/30/24 during morning shift change Nurse #4 inform Nurse #1 she "did not know what she (Nurse #4) was talking about," when questioned about the hydrocodone.

On 10/29/24 at 2:11 pm an interview was conducted with Nurse #2. Nurse #2 stated she worked day shift until 7:00 pm on 8/28/24 and counted the controlled substances and Resident #3's hydrocodone 26 tablets were all present in a plastic bag. Nurse #2 stated she was informed the morning of 8/30/24 by Nurse #1 that the hydrocodone was not there when Nurse #1 and Nurse #4 counted at shift change. Nurse #2

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stated Nurse #1 informed her she had not asked Nurse #4 to remain until the medication was found or management was notified. Nurse #2 stated Nurse #1 commented to her she thought the medication was returned to pharmacy and was aware the medication was documented as being there the night before. Management was notified and the 4 nurses were required to take a drug test. The medication was never found. "I had not taken the hydrocodone," Nurse #2 stated, and she explained she had not shared her key for locked medication to other nurses.

On 10/30/24 at 1:12 pm Nurse #4 was called, a message was left, and the nurse did not return the call.

On 10/28/24 at 5:01 pm an interview was conducted with the Administrator. She stated the investigation for misappropriation of Resident #3's hydrocodone could not prove which nurse took the medication. There was education and a new process to return to pharmacy medication that was prescribed but not used after 14 consecutive days. All other shift-change controlled substance count sheets were accurate and accounted for.
The facility provided the following corrective action plan with a completion date of 9/9/24:

F602
1. Corrective action for resident(s) affected by the alleged deficient practice:
Resident #3 was affected by misappropriation of her hydrocodone pain medication as needed. The resident received her scheduled pain medication of Oxycodone as ordered and had no requirement for as needed hydrocodone and pain management was not affected.

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F 602	Continued From page 8 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents with a narcotic order for pain had potential to be affected. The Unit Manager and Director of Nursing completed an audit of all medication carts with narcotics to verify that all narcotics and narcotic sheets were accounted for with no other concerns identified. The audit was completed on 8/30/24. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 9/2/24 training on the following topics for all licensed nurses and medication aides regarding misappropriation of personal property that focused on storing, maintaining and returning of controlled medications to the pharmacy was completed. This in-service included the process for shift-to-shift count, verifying medications on hand, and returning discharged residents' or discontinued medications to the pharmacy. The Director of Nursing and/or designee would continue to maintain and monitor controlled medication records to ensure consistency and accountability. Education was completed by 9/6/24 for all nursing staff, including agency staff. All nursing staff would not be allowed to work after 9/6/24 until education is completed. Education would be added to the new hire packet to be reviewed with all new employees during orientation. 4. Monitoring procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing, Unit Managers and/or	F 602		

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designee will audit all medication. They began auditing medication carts 5 times a week for 4 weeks on 9/6/24 then weekly for 4 weeks to verify the narcotic count was correct for each cart, shift-to-shift count was completed appropriately, and discontinued controlled medications were removed from the medication cart and returned to the pharmacy in a timely manner. Findings would be reported to the QAPI (Quality Assurance/Performance Improvement) Committee monthly for 3 months for suggestions and recommendations until substantial compliance was achieved. An Ad hoc QAPI was held with the Medical Director, Director of Nursing, Executive Director, Regional Director of Operations, and Regional Clinical Consultant via teams after the incident.

Compliance Date: 9/7/24

Validation of the corrective action plan was completed on 10/30/24.

Review of documentation/staff roster of education that was completed with 27 nurses and medication aides who had responsibility to administer narcotic medication and had access to controlled substances covered drug loss or theft, drug storage, administration, return to pharmacy, and shift-to-shift drug count was completed. The education took place between 8/30/24 through 9/6/24.

On 10/28/24 at 1:40 pm an interview was conducted with the Unit Coordinator. She stated she participated in education for narcotic misappropriation, storage, reporting, and a new process to return unused medication after 14 days.

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F 602	Continued From page 10 On 10/28/24 at an interview was conducted individually with Nurse #s 1, 2, 3, and 5. The Nurses stated they participated in education for narcotic misappropriation, storage, reporting, count, keys, signature book, and a new process to return unused medication after 14 days. The completion date of 9/7/24 was validated.	F 602		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, the facility failed to care for a resident in a safely manner for 1 of 3 residents were reviewed for accidents (Resident #5). Resident #1 was assisted by Hospice Aide #1 during a bed bath and the resident fell to the floor. The findings included: Resident #5 was admitted to the facility on 02/17/23 with diagnoses including hypertension, dementia, muscle weakness, and osteoporosis. Review of Resident #5's significant change Minimum Dat Set (MDS) dated 05/30/24 revealed the resident was moderately cognitively impaired	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 11	F 689		

and required extensive assistance of two staff for bed mobility.

Review of Resident #5's care plan revised 02/21/23 revealed Resident #5 required assistance with activities of daily living (ADL). The goal was for Resident #5 to remain a current level of function through the next review date. Interventions included two people assist with bed mobility and transfers.

Review of Resident #5's care guide not dated revealed nursing staff to educate hospice that the resident was a two person assist with bed mobility

Review of progress note dated 7/18/24 by Nurse #5 revealed it was reported at 7:12 AM that Resident #5 had fallen from her bed while Hospice Aide #1 gave her a bed bath. The note further revealed Resident #5 fell approximately three and a half feet from her bed landing on her right side.

Review of incident report dated 07/18/24 was completed by Nurse #5 and revealed Hospice Aide #1 gave Resident #5 a bed bath and called Nurse #5 to the resident's room. The report further revealed Nurse #5 found Resident #5 laying in the floor on her right side with head towards the nightstand. It was noted Resident #5 was unable to give description of incident and obtained a skin tear to her face.

A phone interview conducted with Hospice Aide #1 on 10/28/24 at 3:30 PM revealed she gave Resident #5 a bed bath early in the morning on 07/18/24. Hospice Aide #1 stated Resident #5 was normally a two person assist for bed mobility and bed baths but she had not been using a

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F 689	Continued From page 12 second person for assistance and thought it would be fine. Hospice Aide #1 indicated she had washed Resident #5 and had set her back to the middle of the bed and Resident #5's placed her foot on the side of the bed which caused the residents foot to fall and she rolled off the left side of the bed landing on her right side. Hospice Aide #1 revealed she observed a small cut on the residents' face, but the resident did not show any signs of pain. It was further revealed Nurse #5 assessed Resident #5. A phone interview conducted with Nurse #5 on 10/29/24 at 11:25 PM revealed on 07/18/24 at the end of 3rd shift she heard staff calling for assistance from Resident #5's room and found the resident laying on the floor on her right side. Nurse #5 further revealed she observed Resident #5's bed high off the floor. Nurse #5 indicated Resident #5 did not show signs of pain but the residents' bed was high when she fell and Resident #5 was fragile. Nurse #5 stated Resident #5 had been a two person assist and was unsure why Hospice Aide #1 did not have a second aide or a facility staff member to assist. An interview conducted with Unit Manager (UM) #1 on 10/28/24 at 2:50 PM revealed she was not present for the incident that occurred on 07/18/24. UM #1 further revealed she was notified Resident #5 had fallen from her bed during a bed bath. UM #1 indicated Resident #5 required a two person assist with bed mobility and bathing. UM #1 stated hospice had been educated on Residents #5's activities of daily living (ADL) and was unsure why another staff was not present during care. The facility implemented the follow corrective	F 689		

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	345419	A. BUILDING ______ B. WING ______	C 10/30/2024

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F 689	Continued From page 13 action plan: · Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 07/18/24 a Hospice Certified Nursing Assistant (CNA) was providing incontinence care to Resident #5, Resident #5 rolled off the bed and fell onto the floor. The resident did not complain of the pain to the nurse. Resident #5 was assessed by a Nurse and was transported to the Emergency Department (ED) for further evaluation and treatment to rule out any new factures due to the odd positioning in which she was found on the floor. The guardian, the Nurse Practitioner (NP), and the Hospice provider were all notified. The resident was sent to the hospital for further evaluation to conclude no new injury was sustained from this current fall. The resident was diagnosed with a subacute fracture which was not new, or acute, and age was undetermined by the hospitalist. The resident returned to the facility on 07/19/24 and resumed her care plan as written. This requirement for these services was the direct result of a Hospice CNA providing care alone for bed mobility instead of with an additional licensed staff member (two person assist) as documented in the resident care plan guide/Kardex (a guide to provide information about different aspects of care). As a result of not following the care plan guide/ Kardex the resident was rolled off the bed and fell onto the floor during incontinence care. · Address how the facility will identify other residents having the potential to be affected by the same deficient practice;/ 07/18/24 Unit Managers and/or designee	F 689		

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F 689	Continued From page 14 conducted a 100% audit of all residents to ensure each person in need of a two person assist for bed mobility and incontinence care was identified and correctly document in his or her Kardex/Care Plan. The audit was completed 07/20/24. The results of the interview revealed Hospice staff do not check in with the nurses or nurse aides because the Hospice agency usually provides ADL information including which service to provide during the visit. The cause of the incident for resident #5 was the decision of the Hospice staff to not review the Kardex as is our usual practice to determine resident needs. The Minimum Data Set (MDS) nurse interviewed alert and oriented residents with a BIMS of 13 or greater to ensure residents in need of two person assist with bed mobility were identified and correctly care planned. Residents with a BIMs score of less than 13 received head-to-toe assessments and care plan reviews to determine if there was a need to update the care plan with and require two-person assist with bed mobility. Hospice staff will see the nurse at each visit to ensure Kardex is reviewed/followed. If more than one staff member is required for care our staff will assist Hospice staff with care. Direct care staff and Hospice staff are randomly interviewed regarding providing ADLS including two-person assist, proper body mechanics, the usage of gait belts and the usage of lifts. Also, during huddles staff are reminded to provide care based as written in the electronic Kardex. Hospice staff is also part of the care plan meeting to ensure the hospice agency and our facility care plans match. During the investigation in July 2024 interviews were conducted with hospice agency NAs. The results of the interview revealed Hospice staff do not check in with the nurses or nurse aides because the Hospice agency usually provides	F 689		

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F 689	Continued From page 15 ADL information including which service to provide during the visit. · Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; 07/22/24 The Staff Development Coordinator (SDC) and Unit A Manager began educating the nursing staff and Hospice agency staff on the requirement of asking for assistance during two persons assist for bed mobility and incontinence care. The Unit A and Unit B Manager assisted with educating nursing staff during different shifts and during huddles to ensure all clinical staff were aware of this process to prevent future falls. Hospice staff was trained by our Unit Mangers or Charge Nurse during their initial visit, then if or when the care plan is changed to ensure the new care plan/ guide is being followed during care at the facility after this incident. New hospice aides are trained by SDC or the Unit-A manager during the initial hospice visit to our facility by either SDC or the Unit A Manager during the initial hospice visit. During orientation new clinical staff are trained to review resident care plan/guide the importance and requirements for assistance during two persons assist for bed mobility and incontinence care. Our facility does not have agency staff. Training was completed 07/26/24. We have a total of three hospice agencies in which education is provided during visits. All training for hospice agency staff was completed during the same time frame as the facility staff. · Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and The Minimum Data Set (MDS) nurse and/or Unit Managers have been assigned Observations/	F 689		

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F 689	Continued From page 16 Care Audits to be completed as follows: 5 times weekly for 4 weeks 3 times weekly for 4 weeks;1 time weekly for 4 weeks. The Director of Nursing (DON) will report the results to the monthly Quality Assurance Process Improvement (QAPI) committee meeting. This was reviewed in ADHOC Quality Assurance (QA) meeting on 07/22/24. Compliance Date The facility alleged date of compliance was 07/27/24 Validation of the implementation of the corrective action plan: On 10/29/24 the corrective action plan was validated by reviewing the following: Immediately after the incident that occurred on 07/18/24 the immediate response was the Resident #5 was assessed by a nurse and was transported to the Emergency Department for treatment and evaluation. The resident was found to have a right femur fracture of an undetermined age, not acute, and was discharged back to the facility on 07/19/24. On 07/18/24 the facility conducted a 100% audit for all residents that needed a two person assist for bed mobility were verified. The facility audit was reviewed and found to be completed on 07/20/24. Care plans and Kardex's were reviewed for residents who required the assistance of two people to ensure accurate assistance level needed for residents was accurate. Measures in place included when hospice care was being provided, hospice staff were to make facility staff aware they were in the building, the hospice staff must follow residents care guides, and ask facility staff for assistance. The Staff Development Coordinator on 07/22/23 educated all nursing staff to review residents care	F 689		

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F 689	Continued From page 17 guide for assistance needed and care expectations for all residents. Education will be provided for new hire and staff will not be permitted to work until education is completed. Interviews conducted with nursing staff indicated they had completed in-service training on bed mobility and to review residents care guides. Review of the education revealed education for staff was completed on 07/26/24. The Director of Nursing (DON) will report the results of monitoring to the monthly Quality Assurance Process Improvement (QAPI) committee meeting. The facility's alleged date of compliance of 07/27/24 was validated.	F 689		