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	345305	A. BUILDING _____ B. WING _____	C 03/20/2025

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 03/17/25 through 03/20/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #T5RE11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/17/25 through 03/20/25. Event ID#T5RE11. The following intakes were investigated NC00218389, NC00222422, NC00224954, NC00226593, NC00227562, and NC00227938. 2 of the 7 complaint allegations resulted in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		4/14/25

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

Electronically Signed | 04/10/2025

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F 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate advance directive information throughout the electronic and paper medical records for 1 of 3 residents reviewed for advance directive (Resident #73). Findings included: Resident #73 was admitted to the facility on 02/06/25 with diagnoses including chronic obstructive pulmonary disease and history of pulmonary embolism (blood clot blocking blood flow to the lungs). The admission Minimum Data (MDS) assessment indicated Resident #73's cognition	F 578	The following Plan of Correction is Date Certain for F 578 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #73 was admitted to the facility on 2/6/25. The admission Minimum Data Assessment (MDS) indicated resident #73 cognition was intact and made own medical decisions. The MOST (Medical Orders for Scope of Treatment) form was completed on 2/6/25 with resident #73 by the social worker. Resident #73 expressed desire for Cardiopulmonary Resuscitation, attempt (CPR) and the	

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F 578	Continued From page 2 was intact. A review of the paper medical records revealed on 02/06/25 Resident #73 signed a Medical Scope of Treatment (MOST) form and checked if no pulse and not breathing attempt cardiopulmonary resuscitation (CPR). A review of Resident #73's electronic medical record revealed a physician's order dated 02/08/25 for code status Do Not Resuscitate (DNR) created by the Unit Manager. During an interview on 03/20/25 at 1:05 PM Nurse #9 revealed she was Resident #73's assigned nurse and in an emergency she followed the advance directive kept in the resident's paper medical records. After review of Resident #73's electronic and paper medical records Nurse #9 confirmed the electronic records showed Resident #73's code status as a DNR but the paper records contained a MOST form signed by Resident #73 indicating his code status was to receive CPR. During an interview on 03/20/25 at 4:54 PM the Social Worker (SW) revealed she reviewed the MOST form dated 02/06/25 with Resident #73 and at that time he wanted to receive CPR. The SW revealed she clarified the advance directive with Resident #73 today (03/20/25) and he wanted to receive CPR and remain a full code. The SW revealed she reviewed the MOST form with newly admitted residents and those were updated annually or as needed and any changes in a resident's code status she communicated to the Unit Manager. During an interview 03/20/25 at 5:00 PM the Unit	F 578	MOST form was placed and located in the resident's medical record chart. On 2/8/25 in review of resident admission paperwork, the unit manager input an order into resident #73's electronic medical record indicating DNR (Do Not Resuscitate) in physician order set resulting in failure to maintain accurate advance directive information throughout the electronic and paper medical record for 1 of 3 residents reviewed for advanced directive. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 3/20/25 Director of Nursing/designee conducted 100% audit of code status, verifying in Electronic Medical Record (EMR) residents code status and validating corresponding Advance Directives documentation no other issues were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Director of Nursing provided education on 03/20/2025 to Social Worker and Nursing Supervisor regarding expectation completion for Advanced Directives for residents. A process was developed and put in place for nurses to start the determination process of Advance Directives, utilizing the MOST form, on admission. If a physician is not in the facility, nurses would obtain a verbal order. The Social Worker is to follow up the day or next day of admission to initiate, and or verify MOST form with	

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F 578	Continued From page 3 Manager revealed she checked newly admitted residents' admission paperwork to ensure everything was completed and part of her check included the advance directive. The Unit Manager revealed the discrepancy in Resident #73's electronic and paper medical records was a mistake on her part and should have been entered to reflect he was a full code and wanted to receive CPR. An interview was conducted on 03/20/25 at 5:25 PM with the Administrator and Director of Nursing (DON). Both the Administrator and DON stated the advanced directive in the electronic and paper medical records should match and reflect Resident #73 wished to receive CPR.	F 578	facility resident and or responsible parties. Staff Development Coordinator provided in-services to nurses on the new process on 04/03/25. On 04/10/25 Assistant Director of Nursing notified agency entity of onboarding educational requirement regarding Advanced Directives for any upcoming shifts. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. Nursing Supervisor and Social Worker are to review 100% of new admission and readmission residents EMR for code status and validate corresponding Advance Directives documentation 5x week for 2 weeks, then 3x week for 2 weeks, then 2 x week for 2 weeks then weekly thereafter. Any identified issues will be corrected at that time. Results of the monitoring tool results will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee to determine substantial compliance.	

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F 578	Continued From page 4	F 578	Date of compliance 04/14/25	
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 interviews with staff, the facility failed to protect a resident's right to be free from misappropriation of a controlled narcotic pain medication for 1 of 10 residents reviewed for abuse (Resident #93). Findings included: The facility's Abuse, Neglect, and Exploitation policy dated 09/01/24 revealed the policy and procedures was created to protect residents against abuse that included misappropriation of resident property defined in part as the deliberate misplacement, exploitation, or permanent use of resident's belongings without consent. Resident #93 was admitted to the facility on 04/16/24. The physician orders for Resident #93 included to administer hydrocodone-acetaminophen 5-325 milligrams (mg) with directions to give two tablets every six hours for pain started on 11/19/24.	F 602	Past noncompliance: no plan of correction required.	

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A review of the Resident #93's medical record revealed the resident resided on the 400 Hall on 12/05/24 and 12/06/24.

A review of the Medication Administration Records (MAR) for Resident #93 revealed the physician's order for hydrocodone-acetaminophen 5-325 mg give two tablets every six hours (4 times a day) for pain was scheduled to be administered at 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 AM. On 12/05/24 at 6:00 PM Nurse #8 initialed the MAR to indicate hydrocodone-acetaminophen 5-325 milligrams was administered. On 12/06/24 at 12:00 AM (midnight) Nurse #4 initialed the MAR to indicate hydrocodone-acetaminophen 5-325 mg was administered.

A review of Resident #93's controlled medication declining record for hydrocodone-acetaminophen 5-325 mg give two tablets every six hours revealed on 12/06/24 at 12:00 AM Nurse #8 signed one dose (2 tablets) was given and one dose (2 tablets) was "popped in error." There was no second nurse initials to verify Nurse #8 wasted two tablets of hydrocodone-acetaminophen that were "popped in error." Both doses (4 tablets) were subtracted from the amount remaining. On 12/06/24 at 12:00 AM Nurse #4 signed one dose (2 tablets) of hydrocodone-acetaminophen 5-325 mg was given and subtracted the dose from the amount remaining. In total 6 tablets of hydrocodone-acetaminophen 5-325 mg were subtracted from the amount remaining on 12/06/24 at 12:00 AM.

A review of the facility's 24-hour initial report revealed on 12/06/24 at 8:00 AM the facility

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became aware of an alleged diversion of Resident #93's narcotic pain medication when a staff member reported Nurse #8 signed out a dose of hydrocodone and indicated it was wasted without a second signature for verification. The report indicated Nurse #8 was suspended pending an investigation, staff education was initiated related to two signatures were needed for wasting, and the local police department was notified. The person listed as preparing the report was the Director of Nursing (DON).

A review of the facility's 5-day investigation revealed Nurse #8 tested positive for opioids and did not provide documentation or a prescription for the use of medications she was taking. Nurse #8 was unable to provide documentation or reason why a second nurse signature was not obtained when wasting Resident #93's opioid hydrocodone-acetaminophen medication. The facility substantiated misappropriation of property for two unaccounted tablets of Resident #93's hydrocodone-acetaminophen and terminated Nurse #8 on 12/11/24. The investigation included written statements from nursing staff and notification to the State Agency, Board of Nursing, and Drug Enforcement Administration (DEA). The person listed as preparing the report was the DON.

A review of the time clock record revealed Nurse #8 signed in at 2:03 PM and out at 11:24 PM on 12/05/24.

A review of the nursing staff schedule revealed Nurse #8 was assigned to Hall 400 from 3:00 PM through 11:00 PM on 12/05/24.

A review of Nurse #8's written statement dated

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12/06/24 revealed she understood a second signature was needed for verification when wasting medication and named Medication Aide #1 as the person she had asked but was told no indicating that as the reason there was no second signature to verify she had wasted the narcotic medication. Nurse #8's statement named Nurse #4 as the person she asked and had agreed Nurse #8 could administer the 12:00 AM (midnight) dose of hydrocodone-acetaminophen to Resident #93 on 12/06/24 and indicated the controlled medication declining record was shown to Nurse #4 to show it was given.

A review of the oral drug test dated 12/06/24 revealed Nurse #8's results were positive for oxycodone.

During a telephone interview on 03/20/25 at 9:38 AM Nurse #8 revealed she was the nurse assigned to administer medication on Hall 400 where Resident #93 resided and described it was busy night, and she did not recall asking the nurse if she wanted her to administer the 12:00 AM dose of hydrocodone-acetaminophen on 12/06/24. Nurse #8 revealed she administered a dose of hydrocodone-acetaminophen 5-325 mg due at 12:00 AM (midnight) on 12/06/24 and stated Resident #93 "always made sure he got his pain medication." Nurse #8 revealed she was told the expectation was to administer the medications up to the end of the shift meaning if she was scheduled from 3:00 PM through 11:00 PM on 12/05/24 she was expected to administer the medications due at midnight on 12/06/24 as the reason why she had administered Resident #93's hydrocodone-acetaminophen. Nurse #8 revealed if her initials were not on the MAR that meant she did not give the medication and if her

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initials were on the MAR that meant she gave the medication. When asked why she signed the controlled declining record for Resident #93's hydrocodone-acetaminophen 5-325mg on 12/6/24 at 12:00 AM and not the MAR, Nurse #8 revealed she did not sign the MAR but did give the medication and had signed the declining record. When asked about the hydrocodone-acetaminophen "popped in error" Nurse #8 stated she asked the nurse to waste it with her, but the nurse told her "No, she was too busy" and could not recall the person she asked. Nurse #8 confirmed she was drug tested at the facility on 12/06/24 and told she was positive for clonazepam. When asked if she provided her prescription for the medications she took Nurse #8 stated "I had some teeth pulled and had a prescription for clonazepam but had taken the last one and thrown the bottle away" and confirmed she did not provide the facility any prescriptions for medications she had taken.

A review of the time clock record revealed Medication Aide #1 signed in at 1:59 PM and out at 11:08 PM on 12/05/24.

A review of the nursing staff schedule revealed Medication Aide #1 was assigned to Hall 300 from 3:00 PM through 11:00 PM on 12/05/24.

A review Medication Aide #1's written statement dated 12/06/24 revealed she was not asked by Nurse #8 to waste a narcotic for Resident #93 and did not hear or recall being asked to assist in wasting a narcotic during her shift.

During an interview on 03/19/25 at 4:14 PM Medication Aide #1 revealed on 12/06/24 she was not asked to waste anything and was interviewed

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by the DON when Nurse #8 named her as the person she asked her to waste Resident #93's hydrocodone/acetaminophen. Medication Aide #1 stated she told the DON during their interview she did not witness Nurse #8 waste Resident #93's hydrocodone/acetaminophen and that's when Nurse #8 tried to say she forgot to sign the declining record. Medication Aide #1 revealed if she had to waste a controlled medication she got either her supervisor or charge nurse to witness and received education about the policy for wasting controlled medication was to verify it was the right medication you observed being wasted and ensure two signatures were included on the declining record and verify the count was correct.

A review of the time clock record revealed Nurse #4 signed in at 6:07 PM on 12/05/24 and out at 6:18 AM on 12/06/24.

A review of the nursing staff schedule revealed Nurse #4 was assigned to Hall 400 from 11:00 PM on 12/05/24 through 7:00 AM on 12/06/24.

A review of Nurse #4's written statement dated 12/06/24 revealed she was not told in report Nurse #8 had already given the scheduled dose and noted in her statement Nurse #8 was not in the building at 12:00 AM (midnight) when the dose of hydrocodone/acetaminophen was due to be administered. On 12/05/24 for 12:00 AM (midnight) Nurse #4's statement revealed she went to give 2 tablets of hydrocodone/acetaminophen to Resident #93.

During a telephone interview on 03/19/25 at 7:01 PM Nurse #4 revealed she was scheduled to work a 12 hour shift on 12/05/24 and came in at 6:00 PM and left the next morning on 12/06/24

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and based on the nursing schedule she was the assigned nurse on Hall 400 and Hall 500. She revealed when she arrived Nurse #8 was at the facility and assigned the Hall 400 and had the med cart keys and together they completed the controlled medication count, and it was correct. Nurse #4 revealed Nurse Aide #1 was in the room with Resident #93 when he asked for his pain medication and reported that to her around 12:00 AM midnight. Nurse #4 stated Resident #93 specifically told her he did not get his scheduled midnight dose of pain medication on 12/06/24 and that was the reason she administer hydrocodone/acetaminophen and signed the controlled declining record and the MAR she gave it at 12:00 AM. Nurse #4 revealed she did not notice Nurse #8 had signed 2 doses of hydrocodone/acetaminophen on the declining record for the same date and time on 12/06/24 at 12:00 AM (midnight) until the next morning when completing the count of controlled medications with the oncoming nurse. Nurse #4 further revealed Nurse #8 did not ask about administering the 12:00 AM dose of hydrocodone/acetaminophen and did not say she had and when she noticed Nurse #8's signatures on the declining record she informed the DON that same morning on 12/06/24. Nurse #4 revealed she received education if wasting a controlled medication, the policy was to have a witness sign to verify the medication was being wasted and both signatures must be included on controlled medication declining record and to report any discrepancy immediately to the DON. Nurse #4 revealed no other resident had shared with her they did not get their pain medication and when checked it was already signed as given.

A review of Resident #93's medical records

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revealed the following numerical pain levels were documented:
12/5/24 at 9:13 PM the pain level was 0,
12/6/24 at 12:11 AM and at 9:57 AM the pain level was 0,
12/7/24 at 7:05 AM and at 11:18 PM the pain level was 0,
12/8/24 at 10:27 AM the pain level was 0.

Attempts to interview Resident #93 by phone on 03/20/25 were unsuccessful.

During an interview on 03/19/25 at 11:12 AM the DON revealed she was notified by Nurse #4 on 12/06/24 early in the morning there was a concern with Resident #93's controlled medication declining record for hydrocodone-acetaminophen 5-325mg. After review the DON revealed Nurse #8 signed she removed two doses (4 tablets) for the same date and time on 12/06/24 at 12:00 AM and one dose (2 tablets) was "popped in error" without a second nurse signature to witness the medication was wasted. The DON revealed Nurse #8 was asked why she signed the medication out for the midnight (12:00 AM) dose she was not supposed give and scheduled to work from 3:00 PM through 11:00 PM on 12/06/24. The DON revealed Nurse #8 stated Nurse #4 asked for help, and she was still in building and gave the hydrocodone-acetaminophen 5-325mg midnight dose to Resident #93. The DON revealed Nurse #8 could not account or provide a reason why one dose was "popped in error" and reminded it was the facility's policy to have a second witness for wasting controlled medication. After Nurse #8's drug test resulted positive for oxycodone the DON revealed Nurse #8 was adamant about being allergic to oxycodone but did not provide

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information to support that. The DON revealed during Nurse #4's interview she stated she did not ask Nurse #8 for help or agree for her to administer Resident #93's hydrocodone-acetaminophen 5-325mg due on 12/06/24 at 12:00 AM and Nurse #4 notified her the morning of 12/06/24 after she noticed the medication was signed out by Nurse #8. The DON revealed during her interview with Medication Aide #1 she was asked about being a witness for Nurse #8 to waste hydrocodone-acetaminophen 5-325mg and stated she never heard Nurse #8 ask for a witness and wrote her statement. The DON revealed after identification of possible drug diversion Resident #93 was evaluated for pain and stated he did get the 12:00 AM dose of pain medication from Nurse #8. The DON revealed other residents controlled medication declining records were reviewed with no other issues identified, nursing staff were provided education related to facility policy to have a second nurse witness when wasting controlled medications and included abuse/misappropriation of resident property. The DON revealed weekly audits of controlled medication declining records were completed to ensure signatures were in place, the off-going nurse and oncoming nurse matched the medication cards to each controlled declining record to ensure the count was correct. The DON revealed the controlled medication declining records were kept and reviewed when all the medication was given or returned to pharmacy and compared to amounts initially received from the pharmacy to ensure count was correct. The DON confirmed Nurse #8 completed her shift on 12/05/24 and after their interview on 12/06/24 did not return and was terminated on 12/11/24. The DON revealed she reported Nurse #8 to the

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Board of Nursing and DEA and the total amount of hydrocodone-acetaminophen 5-325mg suspected to be diverted was 2 pills based on the interview with Resident #93 who reported he had received the scheduled dose at 12:00 AM on 12/06/24. The DON revealed all residents in the facility were evaluated for pain daily including residents that do not receive pain medications.

During an interview on 03/20/25 at 10:32 AM the Staff Development Coordinator revealed on 12/06/24 she asked Resident #93 if he got his pain medicine early and he said yes I think Nurse #8 gave it to me. The Staff Development Coordinator stated she asked Resident #93 if he had a good night and he said "yes" and described the resident as cognitively at his baseline. The Staff Development Coordinator revealed she provided staff education and discussed verifying the controlled medication counts on declining record and reporting any discrepancy or suspicious activity of diversion.

An interview was conducted on 03/20/25 at 5:17 PM with Administrator and DON. The DON revealed the number of unaccounted tablets of hydrocodone-acetaminophen 5-325mg was two and based on Resident#93's interview he did get his midnight dose from Nurse #8. The Administrator revealed the audits were reviewed during quality assurance performance improvement (QAPI) and there were no issues except the incident on 12/06/24 and that was reported to her.

The facility provided the following corrective action plan with a compliance date of 12/12/24.

Address how corrective action will be

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accomplished for resident(s) found to have been affected by the deficient practice:

On 12/6/24. the Director of Nursing reviewed the narcotic requisition sheets for resident #93, comparing it to the Electronic Medical Administration Record (EMAR). The Director of Nursing identified during the review discrepancies between the medications given, wasted, and signed out on the EMAR vs Narcotic requisition sheet.

The Director of Nursing identified that the following issues with documentation involved Nurse #8 during the review conducted on 12/6/24. Nurse #8 was notified of the investigation and suspended pending outcome of findings on 12/6/24 by the Administrator and Director of Nursing.
12/6/2024 (Nurse #8)

Resident #93- hydrocodone/acetaminophen 5-325mg- What was noted was that on the narcotic requisition form a notation of Nurse #8 signing out a hydrocodone/acetaminophen 5-325mg tab at 12:00 AM on 12/06/24, another signed out hydrocodone/acetaminophen 5-325mg at 12:00 AM and written beside it (popped in error) with no nurse witness signature verification for the waste of the mediation popped in error. Upon initiation of investigation, Resident #93 did verify that he received a midnight dose from Nurse #8 resulting in no notation or location of the popped in error tablet.

Upon interview with Nurse #8, she stated that she had asked oncoming night shift nurse # 4 if she wanted her to administer Resident #93's scheduled 12:00 AM dose of

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hydrocodone/acetaminophen 5-325mg, to which she understand Nurse #4 to agree to. Resident #93 did verify he received a dose from Nurse #8 for his nighttime dose. Nurse #8 stated that she asked another staff member to waste the accidentally popped medication with her but was unable to get a second staff member to validate and waste the popped medication. Therefore, there was no account for one blister containing 2 tablets of hydrocodone/acetaminophen 5-325mg. In review of medication administration record, it is noted that Nurse #8 signed out the 6:00 PM dose. Nurse # 8 was notified immediately that she would be suspended pending the results of the investigation and was removed from the schedule until the investigation conclusion by the Administrator and Director of Nursing.

Drug screening was completed for nurse # 8 due to potential narcotic discrepancy. Employee tested positive for oxycodone with completion of iScreen Oral Fluid Test Drug Screen Cube on 12/6/2024. Nurse #8 stated that she was allergic to oxycodone and was adamant that she did not take any medications. Provided oral confirmation that she was taking gabapentin and Wellbutrin. Nurse #8 stated she had just finished her medications and did not currently have a script. Nurse #8 advised by the Administrator to provide documentation of allergies and type and scripts for current medications. As of 12/11/24, Nurse #8 failed to provide any documentation for medications or allergies.

The Administrator and Director of Nursing spoke with Nurse #8 on 12/11/24 at approximately 12:30 PM. Nurse #8 stated she did not have documentation providing medication scripts and/or allergies and stated she understood the

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consequences.

Nurse #8 was terminated on 12/11/24.

Upon investigation findings a report was filed by the Director of Nursing to the Board of Nursing in the state of which the licensure was held on 12/11/24.

No negative outcomes were identified by Resident #93's assigned nurses on 12/5/24 day and evening shift and no complaints of pain were verbalized by Resident #93 on 12/5/24 to his assigned nurses on day, evening and night shift, which was documented on his Medication Administration Record.

On 12/11/24, the Director of Nursing notified the pharmacy of the medications and Resident #93 involved and the need for the medication requiring replacement and that the cost of the medications would be billed to the facility. The facility has additional medication available for the resident in the pharmacy provided CUBEX medication dispensing system.

Director of Nursing completed the 24-hour report to the Division of Health and Human Services (DHHS) on 12/6/2024 and will submit the five-day report upon completion of investigation on 12/11/2024 to DHHS.

The local police department was notified on 12/6/2024 upon the discovery of the missing narcotic by the Director of Nursing.

The Director of Nursing notified the rounding Nurse Practitioner (NP) of the alleged narcotic discrepancies and the residents involved on

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12/6/24. Resident #93 was assessed on 12/6/24 by the Nurse Practitioner with no adverse effects noted and medications were available for Resident #93 when scheduled and/or needed.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 12/6/24, the Staff Development Coordinator and Director of Nursing reviewed the pharmacy requisitions for all residents receiving narcotics within the facility for the presence and accuracy of declining narcotic count sheet to ensure all medications were signed out correctly and any wastes had documentation for reason and a second nurse witness signature.

All residents residing in the facility were evaluated for pain by their assigned nurse 7:00 AM-3:00 PM shift on 12/6/24. No issues or complaints were identified.

100% audit was conducted 12/6/24 by the Director of Nursing, Staff Development Coordinator and Nursing Supervisor of the control sheets and each medication on all medication carts to verify that all narcotic medication and control sheets were present. No other discrepancies were identified with all as needed and scheduled narcotics accounted for.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Education was initiated 12/6/24 in person and via phone for all licensed nursing staff and Medication Aides by the Director of Nursing or

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Staff Development Coordinator on the facility policy related to maintaining narcotics on the medication carts and signing of shift-to-shift count sheets, counting and verifying the narcotic count is correct. Education included expectations and requirement regarding a second witness for all wasted controlled substances. Additional education topics provided included abuse, neglect, and exploitation regarding controlled substance administration and accountability, diversion, misappropriation of facility and or resident property with the education to be completed by 12/11/24. Clinical nurses and Med Aides, including agency clinical staff will not be permitted to work until education completed after 12/11/2024. Education will be a part of the orientation process for all new hire and agency licensed staff prior to working their first shift.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

On 12/06/24 the Director of Nursing and/or Designee will audit medication carts related to the narcotic count being correct to ensure the medication cards matches the control sheets and the shift-to-shift count sheets are being signed at the start and at the end of the shift. The audit will also include review of narcotic declining sheets to ensure that wasted narcotics have 2 signatures. Auditing will be completed 5 X Per week Monday through Friday for 1 week then 3x week Monday through Friday for 1 week, then 2 x weekly Monday through Friday for 1 week, then 1x weekly for 1 week and then weekly thereafter until compliance established or no other issues are identified.
The Director of Nursing will report all the findings

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of audits to the Quality Assurance Performance Improvement committee monthly for 3 months for any needed improvement.

Date of Compliance 12/12/2024.

The facility's corrective action plan with a correction date of 12/12/24 was validated onsite by record review, observations, and interviews.

A review of the audit tool revealed the narcotic books on Halls 200, 300, 400, and 500 were checked for accuracy of the controlled medication declining record to ensure 2 nurse signatures for verification witnessed wasting of controlled medications. The audit tool included checks for any changes made to the controlled medication declining records and validation of the witness signature to ensure the nurse had worked the shift for the date and time they signed the controlled declining record. The audit tool dated 12/06/24 noted Nurse #8 had no nurse second witness signature for wasting a dose of hydrocodone/acetaminophen.

Staff education sign in record dated 12/06/24 included the summary of topics covered as follows: med pass policy and procedure related to signing out and wasting narcotics; two nurse signatures were required and verifying meds. The record was signed by 26 nurses and Medication Aide staff members.

Review of the report for theft or loss of controlled substances revealed it was submitted to DEA on 12/11/24 by the DON and identified 2 tablets of hydrocodone/acetaminophen 5-325 mg were lost or stolen.

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Notification of the Board of Nursing in the state Nurse #8 was licensed included her license number, date of termination, and dates of employment from 08/29/24 through 12/11/24 and noted the positive oral drug screen for oxycodone with confirmation the information was received on 12/11/24 and an investigation into issue would be opened and necessary action taken if needed.

Audit tools of the narcotic books on Halls 200, 300, 400, and 500 continued and were completed on 12/9/24, 12/10/24, 12/11/24, 12/16/24, 12/17/24, 12/19/24, 12/23/24, 12/27/24 with no issues identified. On 1/2/25, 1/10/25, 1/17/25, 1/24/25, 1/31/25, 2/7/25, 2/14/25, 2/21/25, 2/28/25, 3/7/25, and 3/14/25 with no issues identified.

Interviews conducted with Nurse and Medication Aide staff revealed they were able to explain misappropriation of resident property was abuse and drug diversion could result in loss of their job and licensure. They had received in-service education to report abuse and suspected drug diversion immediately to their Supervisor, DON, or Administrator. Nurse and Medication Aide staff explained when administering a controlled medication, they wrote the date, time, and number of pills given and subtracted from amount remaining and verification of the controlled declining records for accuracy was done with the oncoming staff member to ensure the count was correct. Nurse and Medication Aide staff explained the policy for wasting a controlled medication included always get a second signature to witness and verify the medication was wasted.

Interviews with family members of dependent

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F 602	Continued From page 21 residents revealed no concerns were shared related to pain. Interviews with alert and oriented residents revealed no concerns were shared related to receiving pain medication or ineffective pain medication. Observations revealed no resident concerns were identified related to uncontrolled pain. The compliance date of 12/12/24 was validated.	F 602		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of pressure ulcer care (Resident #96), fall (Resident #35), and discharge (Resident #84) for 3 of 20 residents reviewed for MDS accuracy. 1. Resident #96 was admitted to the facility 05/28/24 with a diagnosis including rhabdomyolysis (breakdown of muscle tissue). Review of Resident #96's physician orders dated 05/30/24 included to apply betadine three times a day to bilateral (both sides) knee unstageable wounds, left forearm unstageable wound, right cheek unstageable wound, right thigh unstageable wound, and unstageable wound to right heel.	F 641	F641 ACCURACY OF ASSESSMENTS Resident #96: MDS (Minimum Data Set) assessment for Resident #96 dated 6/04/2024 was corrected by the MDS Coordinator on 3/20/2025. All current residents with pressure ulcers have the potential to be affected. All MDS assessments completed for residents identified with pressure ulcers in the past 30 days were reviewed for accurate coding of M1200E (Pressure ulcer/injury care) on 4/4/2025 by the MDS Coordinator. Any corrections needed were completed on 4.4.2025 by the MDS Coordinator. MDS Coordinator was educated on	4/14/25

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F 641	Continued From page 22 Review of the admission Minimum Data Set (MDS) assessment dated 06/04/24 revealed Resident #96 had one stage 3 pressure ulcer (an ulcer that extends through the top two layers of skin) present upon admission, eight unstageable pressure ulcers due to coverage of wound bed by slough (soft dead tissue) and/or eschar (hard dead tissue), and one deep tissue injury (a pressure injury that damages tissue under the skin) present on admission. The MDS further indicated Resident #96 had a pressure reducing device for her bed and did not receive pressure ulcer/injury care. Review of Resident #96's May 2024 and June 2024 Treatment Administration Record (TAR) revealed she received pressure ulcer care as ordered. An interview with the MDS Coordinator on 03/20/25 at 2:11 PM revealed Resident #96's quarterly MDS assessment dated 06/04/24 should have reflected she received pressure ulcer care, and it was an oversight. During a joint interview on 03/20/25 at 5:10 PM, both the Administrator and Director of Nursing (DON) stated they would expect MDS assessments to be completed accurately. 2. Resident #35 was admitted to the facility 04/01/22 with a diagnosis including lack of coordination. Review of the discharge return anticipated Minimum Data Set (MDS) assessment dated 03/07/25 revealed he had one fall with injury since the prior assessment.	F 641	accurate coding of the MDS assessment for M1200E on 4/3/2025 by the Regional MDS Consultant. All MDS assessments completed for residents identified with pressure ulcers will be audited weekly x 4 weeks by the MDS Coordinator, then every other week x 2, then each monthly thereafter for 3 months until compliance achieved. The MDS Coordinator will complete any needed corrections of the MDS assessment. Results will be presented at the monthly QAPI (Quality Assurance Performance Improvement) meeting until the IDT(Interdiciplinary Team) concludes this goal has been achieved. Compliance date: 04/14/25 Resident #35: MDS assessment for Resident #35 dated 3/07/2025 was corrected by the MDS Coordinator on 3/20/2025. All residents who have sustained a fall have the potential to be affected. All MDS assessments completed for residents currently residing in the facility and those identified as discharged within the past 30 days were reviewed for accurate coding of J1900C (Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), Number of falls since Admission or Prior assessment Major Injury) on 4/4/2025 by the MDS Coordinator. Any necessary corrections were made by the MDS Coordinator. MDS Coordinator was educated on 4/3/2025 by the Regional MDS Consultant	

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F 641	Continued From page 23 Nursing documentation dated 03/07/25 at 7:25 AM noted Resident #35 had a fall this morning and was noted with a bruise on his nose, an abrasion (scraped area) on his forehead and left hip. Resident #35 was able to move all his extremities with no signs or symptoms of pain. Nursing documentation dated 03/07/25 at 5:46 PM noted Resident #35 reported pain in his left shoulder, the Nurse Practitioner (NP) was notified, and an order was received to obtain an x-ray of his left shoulder. A NP note dated 03/07/25 at 11:02 PM noted Resident #35's x-ray revealed a left shoulder dislocation and orders were given to send him to the hospital. The hospital discharge summary dated 03/09/25 noted a left shoulder CT-scan (detailed x-ray) dated 03/08/25 showed a chronic healed glenohumeral dislocation (the upper arm bone comes out of the shoulder socket), and a head CT-scan dated 03/08/25 revealed Resident #35 had an acute (sudden onset) left subdural hematoma (when a blood vessel between the skull and brain is damaged). A joint interview with the MDS Coordinator and Director of Nursing (DON) on 03/18/25 at 3:38 PM revealed when the discharge MDS was coded, they were not aware that Resident #35 had a subdural hematoma. They stated they were more focused on possible injury to his shoulder and did not completely read the hospital discharge summary when he returned to the facility.	F 641	on proper and accurate coding of J1900C. All MDS assessments completed for residents currently residing in the facility and those identified as discharged return anticipated will be audited weekly x 4 weeks by the MDS Coordinator, then every other week x 2, then monthly thereafter for 3 months until compliance achieved. The MDS Coordinator will make any needed corrections of the MDS assessment. Results will be presented at the monthly QAPI meeting until the IDT concludes this goal has been achieved. Compliance date: 04/14/25 Resident #94: MDS assessment for Resident #94 was corrected by the MDS Coordinator on 3/20/2025. All residents that have been discharged have the potential to be affected. All MDS assessments completed for residents with discharges within the past 30 days were audited for accuracy of A2105 (Discharge Status) by the MDS Coordinator on 4/4/2025. Any necessary corrections were completed by the MDS Coordinator. The MDS Coordinator was educated on 4/3/2025 by the Regional MDS Consultant on proper and accurate coding of A2105. All MDS Discharge assessments will be audited weekly x 4, then every other week x 2, then each monthly thereafter. for 3 months until compliance achieved. The MDS Coordinator will make any needed corrections of the MDS assessment. Results will be presented at the monthly QAPI meeting until the IDT concludes this	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 24 A follow-up interview with the MDS Coordinator on 03/18/25 at 3:54 PM revealed she would have coded Resident #35's discharge MDS assessment as having had a fall with major injury if she had been aware of the subdural hematoma. During a joint interview on 03/20/25 at 5:10 PM, both the Administrator and DON stated they would expect MDS assessments to be completed accurately. 3. Resident #94 was admitted to the facility on 01/09/25. A nurse progress note dated 01/29/25 at 10:30 AM revealed all medications and follow-up appointments were reviewed with Resident #94 and his family member. Resident #94 discharged home from the facility with family at 10:35 AM. The discharge-return not anticipated Minimum Data Set (MDS) assessment dated 01/29/25 indicated Resident #94 was discharged to an acute hospital. The MDS assessment further noted there was an active discharge plan in place for Resident #94 to return to the community. During an interview on 03/19/25 at 12:15 PM, the MDS Coordinator confirmed Resident #94 discharged home on 01/29/25. She explained the discharge status on the MDS assessment dated 01/29/25 indicating Resident #94 discharged to the hospital was a coding error and should have reflected Resident #94 discharged to the community. During a joint interview on 03/20/25 at 5:10 PM, both the Administrator and Director of Nursing stated they would expect for MDS assessments	F 641	goal has been achieved. Compliance date: 04/14/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345305	A. BUILDING _____ B. WING _____	C 03/20/2025

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F 641	Continued From page 25 to be completed accurately.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level II was completed after a new mental health diagnosis for 1 of 3 residents (Resident #77) reviewed for PASRR. The findings include: Review of Resident #77's medical record revealed the resident was admitted to the facility on 11/17/24 and a PASRR level I was completed. The resident was diagnosed with schizoaffective	F 644	F644 COORDINATION OF PASARR AND ASSESSMENTS PASARR (Preadmission Screening and Resident Review) redetermination for Resident #77 was completed by the MDS (Minimum Data Set) Coordinator and Social Worker on 3/20/2025. All current residents have the potential to be affected. All current residents were reviewed for new mental health diagnoses by the MDS	4/14/25

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F 644	Continued From page 26 disorder on 2/13/25 and no PASRR level II was completed. During an interview on 3/20/25 at 10:59 AM with the Social Worker (SW) she revealed PASRR level II should be completed upon admission for residents with a mental health diagnosis and when a resident has had a change of condition or a newly added mental health diagnosis. She stated she had begun working at the facility in January 2025 and was currently receiving training from the Minimum Data Set (MDS) Coordinator on how and when level II PASRR should be completed. She revealed that given Resident #77's newly added mental health diagnosis of schizoaffective disorder, PASRR level II should have been completed, and believed it had just been overlooked. During an interview on 3/20/25 at 2:02 PM with the MDS Coordinator she revealed PASRR level II should be completed upon admission for residents with a mental health diagnosis and when a resident has had a change of condition or a newly added mental health diagnosis. She stated Resident #77 received a new mental health diagnosis of schizoaffective disorder in February 2025 and a PASRR level II should have been completed and believed it was just an oversight on her part. During an interview on 3/20/25 at 5:26 PM with the Administrator she revealed PASRR level II should be completed in a timely manner upon the admission of a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #77's newly added mental health diagnosis in February	F 644	Coordinator and Social Worker on 3.31.2025. Residents who had a new mental health diagnosis had PASARR redeterminations initiated on 3/20/2025 (resident #77) by the MDS Coordinator and Social Worker. The Regional MDS Consultant educated MDS Coordinator and Social Worker on coordination of PASRR and assessments to reflect a review of resident statuses to ensure PASRR's are updated on 4/3/2025. All residents will be reviewed for new mental health diagnoses weekly x 4 weeks, then every other week x 2, then monthly thereafter for 3 months by the MDS Coordinator and Social Worker. The MDS Coordinator and Social Worker will complete PASARR redetermination requests as needed. Results will be presented at the monthly QAPI meeting until the IDT concludes this goal has been achieved. Compliance date: 04/14/25	

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F 644	Continued From page 27 2025 a PASRR level II should have been completed.	F 644		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) re-evaluation after a significant change in physical or mental status for 1 of 3 sampled residents reviewed for PASRR (Resident #7). Findings included: Resident #7 was admitted to the facility on 04/12/10 with diagnoses that included moderate intellectual disabilities and anxiety disorder. A PASRR Level II determination notification letter dated 12/31/18 revealed Resident #7 had a Level II PASRR with no expiration date. The significant change in status Minimum Data Set (MDS) assessment dated 09/06/24 revealed Resident #7 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. The North Carolina Medicaid Uniform Screening	F 646	F646 MD/ID SIGNIFICANT CHANGE NOTIFICATION PASRR (Preadmission Screening and Resident Review) notification for Resident #7 was completed by the MDS Coordinator and Social Worker on 3/20/2025. All current residents have the potential to be affected. All current residents were reviewed for a change in significant change in physical or mental status by the MDS Coordinator and Social Worker on 3/31/2025. Resident who had significant change in physical or mental status had PASARR redetermination completed or 4/1/2025 for resident #7. MDS Coordinator and Social Worker were educated on compliance with PASRR notification with significant change assessment by the Regional MDS Consultant on 4/3/2025.	4/14/25

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F 646	Continued From page 28 Tool (NC MUST) inquiry dated 03/19/25 revealed Resident #7 received a Level II PASRR effective 12/31/18 with no expiration date. There were no requests for re-evaluation after 12/31/18. During an interview on 03/19/25 at 12:15 PM, the MDS Coordinator revealed the previous Social Worker (SW) left employment in December 2024 and since that time, she had been submitting requests for PASRR re-evaluations until the current SW learned the process. The MDS Coordinator explained the previous SW would have been the one who would have submitted a request for a re-evaluation following Resident #7's significant change MDS assessment dated 09/06/24, if needed. The MDS Coordinator explained Resident #7 already had Level II PASRR at the time the significant change was identified and she (MDS Coordinator) wasn't aware that a referral needed to be made when a resident had a physical decline in condition. During an interview on 03/20/25 at 5:10 PM, the Administrator revealed the MDS Coordinator filled in to cover the PASRR process during the transition of the previous SW leaving in December 2024 and the new SW starting in January 2025. She stated once the SW was acclimated to the position, she would be responsible for requesting PASRR Level II evaluations when needed. The Administrator stated requests for a Level II PASRR re-evaluation should be made when a resident had a significant change in condition and per the regulatory guidelines.	F 646	All residents will be reviewed for significant change in physical or mental status weekly x 4 weeks, then every other week x 2, then each monthly thereafter for 3 months by the MDS Coordinator and Social Worker. The MDS Coordinator and Social Worker will complete PASARR redetermination requests as needed. Results will be presented at the monthly QAPI meeting until the IDT concludes this goal has been achieved. Compliance date: 04/14/25	