STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345263	A. BUILDING _____ B. WING _____	C 06/05/2025

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/2/25 through 6/5/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 5Q3111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/2/25 through 6/5/25. Event ID# 5Q3111. The following intakes were investigated NC00228919, NC00224641, NC00220473 and NC00220470. 1 of the 6 complaint allegations resulted in a 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 observations, record review, and staff and Pharmacy Consultant interviews, the facility failed to protect the resident's right to be free from misappropriation of controlled medications for 1 of 3 residents reviewed (Resident #473). The findings included: Resident #473 was admitted to the facility on	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 06/23/2025

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07/18/2024. The resident was discharged from the facility on 08/15/2024.

A physician order dated 07/18/2024 read Oxycodone HCL (controlled pain medication) oral tablet 5 milligrams (mg). Give 2 tablets by mouth every 6 hours as needed for pain.

A packing slip from the pharmacy dated 08/03/24 revealed that 120 Oxycodone 5 mg tablets were delivered to the facility on 08/03/24 no time noted. Nurse #2 and Nurse #3 initialed the packing slip along with the courier from the pharmacy.

The facility reported incident dated 08/07/2024 read in part, the Director of Nursing (DON) and Administrator were notified that a count of a resident's narcotic medication revealed a discrepancy. Facility verified that the resident still had an adequate supply of medication. All residents were safe and protected in the facility. This report was signed by the facility Administrator.

The shift change controlled substance count check for the gray cart (cart where Resident #473's-controlled substances were stored) was counted by the following two nurses at the following dates and times:

- Nurse #3 and Nurse #10 at 11:00 PM on 08/03/2024 and was correct.
- Nurse #9 and Nurse #3 at 7:30 AM on 08/04/2024 and was correct.
- Nurse #10 and Nurse #9 at 3:20 PM on 08/04/2024 and was correct.
- Nurse #3 and Nurse #10 at 11:00 PM on 08/04/2024 and was correct.
- Nurse #6 and Nurse #3 at 7:00 AM on

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08/05/2024 and was correct.
- Nurse #7 and Nurse #6 at 11:00 PM on 08/05/2024 and was correct. Nurse #6 was on duty when the discrepancy was noted.

A written statement by the former Assistant Director of Nursing (ADON) was typed on 08/08/2024 and reported that on 08/05/2024 at approximately 3:30 PM, she completed a narcotic audit on all three facility medication carts. The ADON reported a medication error to the DON, because the electronic Medication Administration Record (eMAR) showed that a full dose of two (2) tablets was given to the resident, but only one (1) tablet was documented on the declination narcotic sheet. The ADON reported that the DON notified the ADON at 4:40 PM that the discrepancy was not a medication error and told the ADON to conduct a further investigation. It was the ADON's discovery at approximately 6:00 PM on 08/05/2024 that 1 of 4 declining count sheets and 1 card of medications (oxycodone 5 mg) were unable to be located after a thorough review of all medication carts and narcotic books. The ADON's statement did not reveal when the DON was notified about the missing medication. The ADON further wrote that a thorough search of all medication carts and narcotic books was conducted. The shift-to-shift count sheet was correct, showing 33 cards on the cart that matched the amount of declination sheets in the narcotic book.

At 5:46 PM on 06/04/2025 an attempt was made to speak to the former ADON and was unsuccessful.

The former DON's witness statement was dated 08/06/2024 and read, in part, that on 08/06/2024

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she noticed that Resident #473's oxycodone was signed off card 2 of 4 on a new prescription set. She stated that she was informed that card 1 of 4 for the resident's oxycodone was not on the cart, and she instituted a full audit and investigation of all narcotics, the eMARs, medication carts, shift to shift count sheets, packing slips, and returned drugs. The DON stated that the investigation revealed that card 1 card of Oxycodone 5 mg 30 tablets that had been delivered to the facility on 08/03/24 and placed on the medication cart was missing. Her statement read that no other resident's medications were missing, and all counts were correct on all other carts in the facility. She wrote that she notified the Administrator and removed Nurse #6 from staffing. The statement read that on 08/07/2024 the Staff Development Coordinator (SDC) and ADON escorted Nurse #6 to the DON's office to inform her of the discrepancies. The DON stated that she informed Nurse #6 that all parties suspected would be suspended and be required to complete drug tests. The statement revealed that Nurse #6 refused and was escorted out of the building.

An attempt to speak to the former DON was made on 06/04/25 at 4:08 PM and was unsuccessful.

A written statement by Nurse #9 dated 08/06/2024 was reviewed and revealed that she was assigned to the gray hall cart on 08/03/2024 and 08/04/2024 beginning at 7:00 AM on both days. She wrote that on both days the narcotic cards and number of declining count sheets were correct.

Nurse #9 was interviewed at 9:34 AM on

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06/05/2025, and she stated that if the controlled substance count sheet was full, then it would be placed in the DON's box with the empty pill card matching it stapled together. When asked about the process, Nurse #9 stated that it was usual to place the pill blister pack cards in order (e.g. 1 of 2 and 2 of 2).

A written statement given by Nurse #3 on 08/06/2024 read that she worked a shift on 08/02/2024 and was aware that Resident #473 only had about five to six (5-6) oxycodone pills remaining. The nurse reported being concerned that the pills would run out, so she arranged for the daytime nurse [Nurse #9] to call the pharmacy and verify that the refill was ordered. The oxycodone arrived at the facility by courier on 08/03/2024 and she counted the narcotics with a second nurse [Nurse #2], and she was at the nurses' station with the other nurse when they were adding the medications to their carts. She reported not physically going to the other nurses' [Nurse #2] cart to see her add them on her cart at that time.

An interview with Nurse #3 was conducted at 9:10 AM on 06/05/2025 and revealed that she did not remember Resident #473. Nurse #3 stated that the process to receive medications from the pharmacy courier is that the carrier of the main keys will count and sign receipt of the medications. If narcotics were delivered from the pharmacy, then the pharmacy courier and two nurses will count the narcotics and sign the pharmacy packing slip. Nurse #3 stated that if she counted medications and sheets on a cart and signed it, then that meant it was correct.

A witness statement written on 08/06/2024 by

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Nurse #2 revealed that medication came from the pharmacy on 08/03/2024 and that she counted the medications with another nurse (Nurse #3) and the pharmacy courier. She stated that she worked the orange hall, and the other nurse (Nurse #3 worked gray hall) and Nurse #2 did not physically watch Nurse #3 put the narcotics on her medication carts.

On 06/04/2025 at 5:45 PM, Nurse #2 was interviewed by phone. She worked nightshift on the orange hall cart 08/03/2024 and 08/04/2024. Nurse #2 stated that she and Nurse #3 signed in the medications with the pharmacy courier on 08/03/2024. Nurse #2 did not watch Nurse #3 on Gray Hall put the narcotics in the cart.

A witness statement given by Nurse #10 on 08/05/2024 revealed that when she administered a dose of oxycodone 10 mg to the resident on 08/04/2024, she had taken the last pill off of one card and then took one off the next card. She did not remember what the card number was or what order the cards were in. She stated she believed at the time there was at least 3 cards of Resident #473's oxycodone left on the medication cart.

Nurse #10 was interviewed by phone at 12:06 PM on 06/05/2025, and she stated that the pill packs of oxycodone were signed out and given out of order. For instance, instead of using card 1 of 4, card 2 was started. She explained that when she counted the narcotic cards at the beginning of the shift, she would count like 13 of 13 in chronological order. Then she would count the pills card for card. Nurse #10 stated that if the count was off on either the sheets or the cards, then she would report it to the DON. She said that if a prescription number was added or subtracted,

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then she would look in the cart to see what was newly added and look for the prescription card and sheet of what was taken out. Nurse #10 stated that she would always check the prescription number on the card with the prescription number written on the count sheet and performed the count of cards and pills with another nurse. She stated that she never noticed a pill card or count sheet out of order for Resident #473.

The witness statement given by the former Staff Development Coordinator (SDC) was dated 08/07/2025 and revealed that she walked Nurse #6 from the front door of building on 08/05/2024 to the DON office. The statement revealed that Nurse #6 was asked to write a statement and refused to write anything. Nurse #6 also refused to do a drug screen and stated that she no longer worked at the facility. The statement read that Nurse #6 was escorted out of the building.

At 8:55 AM on 06/05/2025 an attempt to speak to the former SDC was unsuccessful.

An attempt to speak to Nurse #6 was made at 10:46 AM on 06/04/2025 and was unsuccessful.

A Pharmacy Consultant was interviewed via phone at 3:05 PM on 06/04/2025 and revealed that 120 Oxycodone 5 mg tablets (4 cards of 30) were delivered by the courier in the early hours of 08/03/2024. The packing slip was initialed by the pharmacy courier and was signed by two nurses at the facility. The receipt of medications is not time stamped by the nurses at the facility. The pharmacist stated that check marks beside each listed medication were verified before it left the facility and that 30 pills of oxycodone 5 mg per

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card were delivered for a total of 120 pills of oxycodone 5 mg.

A phone interview was completed on 06/05/2025 at 2:18 PM with the former Administrator on duty on the date of the incident. He stated that he vaguely remembered the name of Resident #473. The former Administrator did not recall details of the misappropriation or the specific date.

The facility provided the following corrective action plan:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice?

- The DON and the ADON completed a 100% controlled substance audit of all carts and medication rooms on 08/06/2024. No additional discrepancies observed.

- On 08/06/2024, the DON/ADON/Unit Manager inspected the narcotic blister pill packages for any tampering of medications.

On 08/07/2024, the DON reported Nurse #6 to the Board of Nursing (BON).

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

- On 08/06/2024 the DON/ADON initiated assessment of all residents for pain. The DON/ADON will ensure that staff will initiate non-pharmacological interventions, pain medications and/or physician notification for any

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identified areas of concern during the audit. The audit will be completed by 08/08/2024.

- On 08/06/2024, the ADON/DON/SDC initiated interviews with all alert and oriented residents regarding (1) Do you have any concerns with medication administration to include pain medication? A concern form will be completed for any identified area of concern. Completed on 08/07/2024.

- On 08/08/2024, the DON/ADON completed an audit of the last 30 days of ordered narcotic medications to ensure the medications were in the medication cart, administered, or returned to pharmacy per protocol. They also will ensure that the numbers for any returns match the count sheet vs. the return sheet. The DON will initiate an investigation into any identified areas of concern.

- On 08/08/2024, the DON/ADON completed a 100% audit of all residents' Controlled Substance Count sheets in comparison to the narcotic medication blister packs in the medication art to ensure there were no discrepancies in the count of the medications.

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

On 08/06/2025 the Administrator, DON, ADON, and SDC held a ad hoc Quality Assurance (QA) meeting and discussed the issue and implemented a plan to correct.

- On 08/06/2024, the DON/ADON/SDC initiated an in-service with all nurse and medication aides

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regarding Controlled Substance Diversion to include: the definition, implications, and the process for returning narcotic medications, new shift-to-shift report, appropriately counting medications during shift change, signage of new shift change sheets to include number of sheets, two nurse signature when adding medications to the cart, procedure for what to do if discrepancy is discovered and to contact administration staff for guidance. All nursing staff will be assigned to education for medication administration process.

- All in-services will be completed on 08/11/2024. After 08/11/2024, all nurses or medication aides that have not worked and received the in-service will complete upon their next scheduled shift.

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

- 100% of all ordered narcotic medications will be reviewed by the DON/ADON/Unit Manager 5 times a week, for 8 weeks. They will compare the medication name, dose, number, card number and number of tablets during this audit. This will be compared to the Controlled Substance Count Sheets, medication administration record, and/or return of drug slips to ensure the narcotic medications are being administered or have been returned to the pharmacy as required per policy and there are no signs of drug diversion utilizing a Controlled Substance Audit tool. All areas of concern will be addressed during the audit including re-educating nurses. The DON will review all audits.

- The Administrator or DON will present the findings of the Audit Tool to the Quality Assurance

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F 602	Continued From page 10 Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will meet monthly for 2 months and review the Audit Tools to determine trends and/or issues that may need further interventions and the need for additional monitoring. Date of compliance: 08/12/2024 During the onsite validation on 06/05/2025 it was observed that staff were entering new narcotic entries correctly and documenting appropriately on the declining count sheets. Upon narcotic book reviews, it was noted that shift-to-shift counts were performed and documented with two signatures. A count of the number of narcotic sheets was documented at each count. A review of the narcotic count sheet audit by the DON was reviewed and found to be performed. An observation of the narcotic count sheets and actual narcotic cards in the art were found matching and in order. Staff interviews revealed that they had received education in the process of having two nurses sign in controlled substances on the packing slip with the courier and two nurses signing in on the medication count sheets. Upon observation, the DON was maintaining file folders with narcotic tracking information. The Administrator was interviewed and stated that the results of the narcotic count audits were discussed in each QAPI meeting. Meeting minutes supported that this was being done. The correction action's completion date of 8/12/2024 was validated.	F 602		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		6/28/25

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§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be

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F 655	Continued From page 12 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan that addressed the resident's anticoagulant (blood thinner) therapy and pain medication for 1 of 5 residents reviewed for baseline care plan (Resident #523). The findings included: Resident #523 was admitted to the facility on 5/30/2025 with diagnoses that included a history of deep vein thrombosis (a blood clot in a deep vein), and pulmonary embolism (a serious medical condition involving a blockage in a lung artery), avascular necrosis of bilateral lower extremities (a condition where bone tissue dies due to insufficient blood supply) on chronic opiate therapy, lower quadrant pain. Resident #523's baseline care plan dated 5/31/2025 did not include goals and interventions for the use of anticoagulant therapy or the use of narcotic/pain medication. Record review revealed Resident #523 had admission orders for: Xarelto 20 milligram (mg) give one tablet by mouth one time a day for blood thinner. Oxycodone HCL 5mg tablet give one by mouth four times daily for pain. Oxycodone HCL 5mg tablet give one by mouth every six hour as needed (PRN) for pain	F 655	Macon Valley-F655 Baseline Care Plans " Macon Valley Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. " Macon Valley Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Macon Valley Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Problem Statement: " On 6/5/2025, it was alleged that the facility failed to develop a baseline care plan that addressed the resident's anticoagulant (blood thinner) therapy and pain medication for 1 of 5 residents reviewed for baseline care plan (Resident #523). Address how the corrective action will be	

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F 655	Continued From page 13 Tramadol HCL 50mg tablet give one by mouth every six hours as needed for pain A review of Resident #523's Medication Administration Record (MAR) for May and June of 2025 revealed: Resident #523 received Xarelto 20mg daily from 6/1/2025 through 6/4/2025. Resident #523 received doses of Oxycodone HCL on 5/30/2025 through 6/3/2025. Resident #523 received doses of Tramadol HCL on 6/1/2025 through 6/3/2025 During an interview on 06/04/25 5:16 PM Nurse #2 stated she was working when Resident #523 was admitted and Nurse #2 and Nurse #3 worked together on completing Resident #523's admission. Nurse #2 stated Nurse #3 worked on completing the assessments for Resident #523. During an interview on 6/5/2025 9:04 AM Nurse #3 stated she did complete some of the admission paperwork for Resident #523 to help Nurse #2. Nurse #3 stated she did not complete the baseline care plan, that it was normally completed by one of the Administration Nurses. During an interview on 6/5/2025 at 9:14 AM the Unit Manager #1 stated she normally completed the baseline care plan for new admissions. The Unit Manager #1 stated if a resident was admitted on Friday evening, the Baseline Care Plan would be completed on Monday unless she happened to be in the facility on the weekend. The Unit Manager #1 stated there was not anyone who completed baseline care plans on the weekend. The Unit Manager #1 verified Resident #523 was admitted on an anticoagulant therapy and scheduled and as needed pain medication on	F 655	accomplished for those residents found to have been affected by the deficient practice: " The facility licensed administrator is responsible for implementing the plan of correction. " On 6/5/25 a baseline care plan was implemented for resident #523 for anticoagulant (blood thinner) therapy and pain management. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 6/16/25, the Director of Nursing, Assistant Director of Nursing and Unit Manager completed a 100% audit of all residents baseline care plans admitted within the past 30 days to ensure a baseline care plan was in place to include pain and anti-coagulation (blood thinners) as well as other areas triggered by the resident assessments, diagnosis list, and medications ordered. Any areas of concern identified will be addressed immediately. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " Beginning 6/16/25, all new admissions will be reviewed by the nursing supervisor, the Director of Nursing, Assistant Director of Nursing, or Unit Manager within 48 hours of admission to ensure care plan has been completed. " On 6/20/25, the Staff Development Coordinator and the Director of Nursing	

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F 655	Continued From page 14 5/30/2025 and the baseline care plan did not include goals or interventions for anticoagulant therapy, or pain/narcotic medication. The Unit Manager #1 stated she normally would have completed the baseline care plan on Monday morning, but their Annual Survey had started and it had not been completed. During a joint interview with the Director of Nursing (DON), Regional Assistant Vice President, and Administrator on 6/5/2025 at 2:01 PM the DON stated the Unit Manager #1 completed the baseline care plan for new admissions and if the resident was admitted on Friday evening the Unit Manager #1 would complete the baseline care plan Monday morning. The DON stated she expected if a resident had anticoagulant therapy and pain medication ordered, that it would be included on the baseline care plan. The Regional Assistant Vice President stated the baseline care plan should be completed within 48 hours of admission. The Regional Assistant Vice President also stated the facility had a new weekend supervisor that was not aware that baseline care plans needed to be completed on the weekend due to being new and still learning the position. The Administrator stated she expected the baseline care plan to be completed within 48 hours of admission and for anticoagulant therapy and pain medication to be included in the baseline care plan for residents that received anticoagulant therapy and pain medication.	F 655	initiated in-service education with all licensed nurses to include agency and contract nurses to ensure all residents who were admitted would have a baseline care place to include pain and anti-coagulation (blood thinners) as well as other areas triggered by the resident assessments, diagnosis list, and medications ordered. Any areas of concern identified will be addressed immediately. The in-service education was concluded on 6/20/2025. Any licensed nurse to include agency or contract nurses who have not received the education by 6/20/2025 will receive before their next scheduled shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " Beginning 6/23/25, The Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit 5 residents per week for 4 weeks to include all new admissions to ensure the resident has a baseline care plan in place to include pain and anti-coagulation (blood thinners) as well as other areas triggered by the resident assessments, diagnosis list, and medications ordered. Any areas of concern identified will be addressed immediately. " The Administrator and Director of Nursing will take all audits to the facility QAPI (Quality Assurance Performance Improvement) meeting monthly for 1 month to review with the QAPI (Quality Assurance Performance Improvement) committee. The QAPI (Quality Assurance Performance Improvement) committee	

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F 655	Continued From page 15	F 655	will determine the need for any further monitoring. Date of Compliance: 06/28/2025	
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner (NP), and Medical Director interviews the facility failed to ensure a resident ' s scheduled pain medication was administered as ordered for 1 of 1 resident reviewed for pain. Resident #523 stated the missed pain medication caused her pain level to be greater than a 10 on 5/31/2025 and caused her to cry and almost scream. The findings included: Resident #523 was admitted to the facility on 5/30/2025 with diagnoses that included enterocolitis (inflammation in the small intestine and colon's inner lining) due to clostridium difficile (inflammation of the colon caused by bacteria), essential hypertension, osteoporosis, history of deep vein thrombosis (a blood clot in a deep vein), and pulmonary embolism (a serious medical condition involving a blockage in a lung artery), congestive heart failure, avascular necrosis of bilateral lower extremities (a condition where bone tissue dies due to insufficient blood supply) on chronic opiate therapy, lower quadrant	F 697	Macon Valley F697 Pain Management Problem Statement: " On 6/5/25, it was alleged that the facility failed to failed to ensure a resident ' s scheduled pain medication was administered as ordered for 1 of 1 resident reviewed for pain. Resident #523. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " The facility licensed administrator is responsible for implementing the plan of correction. " On 5/31/25, oxycodone 5mg arrived from the pharmacy and placed on the cart for Resident # 523. " On 5/31/25, resident #523 was administered scheduled oxycodone 5mg at 9pm with no other doses missed. Pain scale performed prior to medication given was stated at a 5 on 0-10 scale and after medication was given pain was stated at a 0 on 0-10 scale.	6/28/25

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F 697	Continued From page 16 pain. Resident #523 was admitted with physician's orders that included: A physician order dated 05/30/25 read, Oxycodone HCL (pain medication) 5 milligrams (mg) by mouth four times a day and every 6 hours as needed for pain. A physician order dated 05/30/25 read, Tramadol HCL (pain medication) 50mg give one tablet by mouth every 6 hours as needed for pain. A review of #523's Medication Administration Record (MAR) dated May 2025 revealed the following: Scheduled oxycodone HCL 5mg on 5/30/2025 at 9:00 PM was documented as administered by Nurse #2 with a pain level of 0. Pain scale every shift monitoring documented by Nurse #2 at a level of 0. During a telephone interview on 06/04/25 5:16 PM Nurse #2 stated she was assigned to Resident #523 when she was admitted to the facility and Resident #523 arrived at the facility at approximately 9:30 to 10:00 PM on 5/30/2025. Nurse #2 stated Resident #523 was alert and oriented. Nurse #2 stated the oxycodone HCL 5mg, for Resident #523 was obtained from the emergency medication kit. Nurse #2 stated when Resident #523 was admitted on 5/30/2025 she did not appear to be in a lot of pain and reported a pain level of 0 when scheduled pain medication was administered.	F 697	" On 6/2/25, resident #523 was seen by the MD for initial visit with no new orders given. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: " On 6/16/25, the Director of Nursing, Assistant Director of Nursing and Unit Manager completed a 100% audit of all residents who had admitted to the facility in the past 30 days who are taking a controlled substance for pain had their medication on the medication cart and the medication for pain was being given as ordered. Any areas of concern identified will be addressed immediately. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: " Beginning 6/16/25, all new orders to include new admission orders for controlled substances for pain will be reviewed by the nursing supervisor, the Director of Nursing, Assistant Director of Nursing, or Unit Manager within 24 hours of admission to ensure that these medications have been sent from the pharmacy and placed on the medication cart. Any concerns identified will be addressed immediately. " On 6/20/25, the Staff Development Coordinator and the Director of Nursing initiated in-service education with all licensed nurses to include agency and contract nurses to ensure all residents who received an order for a controlled substance to be given for pain would be	

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F 697	Continued From page 17 Review of Resident #523's MAR dated May 2025 revealed the following: Scheduled oxycodone HCL 5mg on 5/31/2025 at 9:00 am, 1:00 PM and 5:00 PM was documented by Nurse #1 as other see nurses notes. Review of Resident #523's medical record revealed: An electronic Medication Administration Record (eMAR) note dated 5/31/2025 at 11:34 AM written by Nurse #1 that read: "oxycodone HCL oral tablet 5mg give 1 tablet by mouth four times a day for pain- waiting on pharmacy". An eMAR note dated 5/31/2025 at 3:02 PM written by Nurse #1 that read: "oxycodone HCL oral tablet 5mg give 1 tablet by mouth four times a day for pain- waiting on pharmacy". An eMAR note dated 5/31/2025 at 5:41 PM written by Nurse #1 that read: "oxycodone HCL oral tablet 5mg give 1 tablet by mouth four times a day for pain- pharmacy". Pain scale every shift monitoring documented by Nurse #1 at a level of 4. No as needed doses of Oxycodone were initialed as being administered. No as needed doses of Tramadol were initialed as being administered. During an interview on 6/4/2025 at 11:02 AM Nurse #1 was accompanied by the Assistant Director of Nursing (ADON). Nurse #1 stated she was an agency nurse and started at the facility	F 697	taken from the e-kit if not on the medication cart and the provider notified for further guidance if not available in the e-kit. Any areas of concern identified will be addressed immediately. The in-service education was concluded on 6/20/2025. Any licensed nurse to include agency or contract nurses who have not received the education by 6/20/2025 will receive before their next scheduled shift. Any newly hired licensed nurses to included agency or contract nurses that are hired after 6/20/25 will receive education during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: " Beginning 6/23/25, The Director of Nursing, Assistant Director of Nursing, or Unit Manager will audit 5 residents per week for 4 weeks to ensure residents with orders for pain who have a controlled substance has it available on the medication cart available for the nurse to give. Any areas of concern identified will be addressed immediately. " The Administrator and Director of Nursing will take all audits to the facility QAPI (Quality Assurance Performance Improvement) meeting monthly for 1 month to review with the QAPI (Quality Assurance Performance Improvement) committee. The QAPI (Quality Assurance Performance Improvement) committee will determine the need for any further monitoring. Date of Compliance: 06/28/2025	

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the week prior. Nurse #1 verified she was assigned to Resident #523 on 5/31/2025 and 6/1/2025. Nurse #1 stated Resident #523 was alert and oriented. Nurse #1 stated Resident #523's medication had not been delivered from the pharmacy on 5/31/2025. Nurse #1 stated she had pulled some medications from the emergency medication kit for Resident #523 and that she initially did not know where the emergency controlled medications were located, because she had received her tour from maintenance and was only shown in passing where the emergency medication kit was located. Nurse #1 stated she later asked another nurse working about a backup for controlled medications and was told which nurse had the keys to the emergency-controlled medication kit. Nurse #1 stated she went with the nurse who had the key to pull the tramadol HCL for Resident #523, which is when Nurse #1 realized the emergency controlled medication kit was located next to the emergency medication kit. Nurse #1 stated she was not aware oxycodone HCL 5mg was in the emergency-controlled medication kit. Nurse #1 verified she had told Resident #523 the oxycodone HCL 5mg was not available from the pharmacy on 5/31/2025. Nurse #1 stated she did not call the pharmacy or the on-call provider regarding not having Resident #523's scheduled oxycodone. Nurse #1 stated she observed Resident #523 crying with no tears and holding her hands bending them towards her face shaking her hands, then talking with no problem when other staff entered the room, then crying again when staff left. During a follow up interview on 6/5/2025 at 1:00 PM Nurse #1 stated on 5/31/2025 she administered as needed Tramadol HCL to Resident #523 after obtaining it from the emergency medication kit, but forgot to document

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it on the MAR. Nurse #1 stated Resident #523 had a pain level of 8 when the as needed tramadol was administered on 5/31/2025 and "quieted down after the medication was given so I figured her pain was at a zero." Nurse #1 stated she was very busy on 5/312025 and that is probably why she forgot to document that she administered tramadol HCL 50mg to Resident #523. Nurse #1 stated she did not call the provider because she was told they were to call the on-call provider. Nurse #1 stated she called and left a message for the on-call provider and did not hear back. Nurse #1 verified there was no documentation she had called the on-call provider. Nurse #1 stated she did not attempt to call the pharmacy, and did not ask any other nurses, and did not call the facilities on-call nurse regarding not having Resident #523's scheduled oxycodone HCL 5mg.

During an interview on 6/5/2025 at 12:49 PM Nursing Assistant (NA) #1 stated she worked with Resident #523 on 5/30/2025 and 5/31/2025. NA #1 recalled Resident #523 stated she was hurting on 5/31/2025 but her pain medication had not come in. NA #1 stated Resident #523 said her legs were hurting her. NA #1 stated on 5/30/2025 she did not observe Resident #523 cry but did observe Resident #523 cry on 5/31/2025 and attempted to comfort Resident #523 and reported Resident #523's reports of pain to the nurse passing medications. NA #1 did not recall the name of the nurse passing meds, but stated she was new.

Review of Resident #523's (MAR) dated May 2025 revealed the following:

Scheduled oxycodone 5mg 5/31/2025 at 9:00 PM

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documented by Nurse #2 as administered with a pain level 5.

Pain scale every shift monitoring documented by Nurse #2 at a level 0.

During a telephone interview on 06/04/25 5:16 PM Nurse #2 stated on 5/31/2025 she noticed a big difference in Resident #523, Nurse #2 stated Resident #523 was crying and acting differently, and Resident #523 stated her pain level was a 5 when scheduled pain medication was administered on 5/31/2025. Nurse #2 stated on 6/1/2025 Resident #523 started to ask for tramadol HCL, instead of the scheduled oxycodone. Nurse #2 stated Resident #523 reported her primary care provider had tried to change the oxycodone prior to admission to the hospital. Nurse #2 stated she discussed with Resident #523 what medications were ordered for her at the facility. Nurse #2 told Resident #523 she would administer the tramadol, and if Resident #523 did not have relief, there was scheduled and as needed oxycodone ordered that could be administered.

Review of Resident #523's MAR dated June 2025 revealed the following:
Pain scale every shift monitoring documented by Nurse #2 at a level 0.

PRN tramadol 50mg 6/1/2025 at 3:15 AM documented by Nurse #2 with a pain level of 4.

Review of Resident #523's MAR dated June 2025 revealed the following:

Scheduled oxycodone 5mg 6/1/2025 at 9:00 AM documented by Nurse #1 as other/see nurses

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notes.

Scheduled oxycodone 5mg 6/1/2025 at 1:00 PM documented by Nurse #1 as other/see nurses notes.

PRN tramadol 50mg 6/1/2025 at 12:25 PM documented by Nurse #1 with a pain level of 8.

Scheduled oxycodone 5mg 6/1/2025 at 5:00 PM documented by Nurse #1 as refused.

Review of Resident #523's medical record revealed:

An eMAR note dated 6/1/2025 at 12:21 PM written by Nurse #1 that read: "oxycodone HCL oral tablet 5mg give 1 tablet by mouth four times a day for pain- pharmacy".

An eMAR note dated 6/1/2025 at 12:25 PM written by Nurse #1 that read: tramadol HCL 50mg give 1 tablet by mouth every 6 hours as needed for pain- Resident in pain and crying 8 out of 10".

An eMAR note dated 6/1/2025 at 12:26 PM written by Nurse #1 that read: "oxycodone HCL oral tablet 5mg give 1 tablet by mouth four times a day for pain- pharmacy".

An eMAR note dated 6/1/2025 at 2:47 PM written by Nurse #1 that read in part "PRN administration was: Effective- Follow up Pain Scale was : 1".

An eMAR note dated 6/1/2025 at 3:55 PM written by Nurse #1 that read "oxycodone HCL oral tablet 5mg give 1 tablet by mouth four times a day for pain- (Resident) States I want to talk to my doctor

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about staying on it, the hospital said it would hurt my liver but it helps with the pain".

Pain scale every shift monitoring documented by Nurse #1 at a level of 2.

A nursing progress note dated 6/1/2025 at 5:31 PM written by Nurse #1 that read:
"This resident has been crying due to pain. She has been given PRN medications throughout this day. At this time, she is resting in her bed with eyes closed, respirations even and non-labored. Staff will continue to monitor this resident throughout this shift and follow the current plan of care."

During an interview on 6/4/2025 at 11:02 AM Nurse #1 was accompanied by the Assistant Director of Nursing (ADON). Nurse #1 stated on 6/1/2025 Resident #523 had stated the oxycodone worked better, but did not want to take the oxycodone until she talked to the doctor, because Resident #523 said her primary care provider had previously said she shouldn ' t take it. Nurse #1 stated that was why the 6/1/2025 5:00 PM oxycodone was documented as refused. Nurse #1 stated Resident #523 was quieter on 6/1/2025 and did not act out as much.

Review of Resident #523's MAR dated June 2025 revealed the following

PRN tramadol 50mg 6/1/2025 at 8:48 PM documented by Nurse #2 with a pain scale of 5.

Scheduled oxycodone 5mg 6/1/2025 at 9:00 PM documented by Nurse #2 as refused with a pain level of 5.

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	345263	A. BUILDING _____ B. WING _____	C 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACON VALLEY NURSING AND REHABILITATION CENTER	3195 OLD MURPHY ROAD FRANKLIN, NC 28734

(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
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During an interview on 6/3/2025 at 8:30am Resident #523 stated she had not received some of her scheduled pain medication on 5/31/2025 or 6/1/2025, and the nurses told her it was because the medication had not been received from the pharmacy. Resident #523 stated the missed pain medication caused her pain level to be greater than a 10 on 5/31/2025 and caused her to cry and almost scream. Resident #523 stated she always experienced pain. Resident #523 stated she had sharp pain in both ankles and it increased when she moved. Resident #523 described her abdominal pain as strong and stated the pain would come and go. Resident #523 stated prior to her admission her primary care provider had tried to change her medications, but it didn't work, and the hospital had put her back on the medicine that helped. Resident #523 stated after she was admitted to the facility her pain was much worse during the weekend, and it was getting better since her medication had arrived on Sunday (6/1/2025) night.

During a telephone interview on 06/04/25 at 4:30 PM Nurse #5 stated on 6/2/2025 Resident #523 appeared to have a pain level of 1 or 2. Nurse #5 stated Resident #523 had asked for pain medication but had to wait for the next time it was due. Nurse #5 stated Resident #523 did not mention missed pain meds over the weekend. Nurse #5 stated she pulled Resident #523's oxycodone from the emergency medication kit on 6/2/2025 and reported to the NP that a script was needed. Nurse #5 was not aware Resident #523 did not receive oxycodone as ordered on 5/31/2025 and 6/1/2025. Nurse #5 thought all scheduled doses had been pulled from the emergency controlled medication kit. Nurse #5 stated any nurse was able to call the on-call

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pharmacy, provider or the DON if there were any issues with a resident not having an ordered medication.

A Nurse Practitioner (NP) note dated 6/2/2025 that read in part: "needs hard script for her pain medication per Nurse" and "Pain is currently controlled ". NP note lists a past medical history that included in part: chronic opiate therapy, multiple non-obstructing renal calculi, Left Lower Quadrant abdominal pain, acute on chronic pain. Patient is oriented to person place time and situation.

During a telephone interview on 6/04/25 at 3:37 PM the Nurse Practitioner (NP) stated when she saw Resident #523 on 6/2/2025, Resident #523 was concerned about how she would get her meds at home, related to her primary care provider and being able to have blood work completed when she was at home. The NP stated Resident #523 did not mention she had not received pain medication over the weekend. The NP stated Nurse #5 reported Resident #523 had been given oxycodone from the backup emergency kit over the weekend and needed a script sent to the pharmacy. The NP was not aware Resident #523 had not received her oxycodone as scheduled on 5/31/2025 and 6/1/2025. The NP stated during her visit with Resident #523 she had not observed Resident #523 crying and Resident #523 appeared comfortable. The NP stated Resident #523's cognition was intact. The NP stated after 5:00 PM during the week and on the weekend, there are on-call providers that are part of their group. If a resident was admitted and the hospital did not send a script, the on-call provider could have been called to send in an electronic script if the

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resident needed the medication and it was not in the back up box. The NP stated she would expect residents to receive their ordered medication from the emergency controlled medication kit if it was available.

A progress note from the Medical Director dated 6/3/2025 that read in part: "pain in ankles" under general review. Under physical exam the note read in part: "No acute distress or pain", "Patient is oriented to person place time and situation."

During an interview on 6/3/2025 at 11:20 AM the Medical Director stated he had seen Resident #523 that morning, and she did not report missing pain medication over the weekend. The Medical Director stated Resident #523 was alert and oriented and did not appear to be in significant pain. The Medical Director stated he would expect medications to be administered as ordered and pulled from the emergency controlled medication kit when available. The Medical Director stated they have on-call providers available after 5:00 PM during the week and on weekends.

An observation on 6/4/2025 at 3:30 PM of the facility's emergency-controlled medication kit revealed a list of medication that was contained in the kit, and the list included oxycodone 5mg and tramadol 50mg.

During a joint interview with the Director of Nursing (DON), and Administrator on 6/5/2025 at 2:01 PM the DON stated she was in the facility on 5/31/2025 and no one had reported Resident #523 did not have her scheduled pain medication that was ordered. The DON stated she had reordered medications for the controlled

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emergency medication kit from the pharmacy on 5/30/2025 that would have the emergency-controlled medication kit completely full after the medication were delivered by the pharmacy the night of 5/30/2025. The DON verified the emergency medication kit would hold 14 doses of oxycodone 5mg when it was fully stocked. The DON stated she expected nurses to ask other nurses, call the on-call nurse, the on-call provider or the pharmacy if a resident was missing ordered medications. The DON stated she expected nurses to obtain and administer ordered medications from the emergency controlled medication kit if the medication was available. The Administrator stated she expected ordered medications to be administered as ordered, and for the emergency medication kit to be utilized when it contained the ordered medication.