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	345569	A. BUILDING _____ B. WING _____	C 04/24/2025

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SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 4/21/25 through 4/24/25 The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # L93711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/21/2025 through 4/24/2025. Event ID #L93711. The following intakes were investigated: NC00228020, NC00228041, NC00225237, NC00224585, NC00223088, and NC00218253. 1 of the 12 complaint allegations resulted in deficiency.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and Pharmacist interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medication for 2 of 2 residents reviewed for misappropriation of property (Residents #299 and #300). The findings included:	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 05/08/2025

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a. Resident #299 was admitted to the facility on 11/6/23.

A review of Resident #299's May 2024 Physician's orders revealed an order for Tramadol 50 milligrams (mg) 1 tablet by mouth every 4 hours as needed for moderate and severe pain.

A review of a Pharmacy Narcotic Delivery Slip dated 5/31/24 revealed 2 medication cards each containing 30 pills of Tramadol 50 mg were delivered by the pharmacy and signed in as being received by 2 facility nurses.

Resident #299 was discharged from the facility on 4/4/25.

b. Resident #300 was admitted to the facility on 9/27/22.

A review of Resident #300's May 2024 Physician's orders revealed an order for Oxycodone 5 mg 1 tablet by mouth every 6 hours as needed for moderate pain.

A review of a Pharmacy Narcotic Delivery Slip dated 5/31/24 revealed 2 medication cards each containing 30 pills of Oxycodone 5 mg were delivered by the pharmacy and signed in as being received by 2 facility nurses.

Resident #300 was discharged from the facility on 3/10/25.

A telephone interview was completed on 4/23/25 at 2:14 pm with Director of Nursing (DON) #2. DON #2 stated on 6/14/24 Nurse #1 observed

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during her morning medication pass Residents #299 and #300 were each missing 1 narcotic medication card containing 30 pills and the corresponding medication count sheet. DON #2 stated Nurse #1 revealed Resident #299 had 2 cards of Tramadol 50 mg and their corresponding count sheets and Resident #300 had 3 cards of Oxycodone 5 mg and their corresponding count sheets on 6/12/24 (the last day she worked) and now Resident #299 had 1 card of Tramadol 50 mg and the count sheet and Resident #300 had 2 cards of Oxycodone 5mg and their count sheets remaining. DON #2 stated Nurse #1 informed her during the narcotic medication count on 6/14/24 with the off going nightshift Nurse (Nurse #2), there was no discrepancy in the number of narcotic medication count sheets versus narcotic medication cards. DON #2 revealed an investigation was immediately initiated on 6/14/24, and the missing narcotic medications and the count sheets were unable to be located. DON #2 stated during the investigation it was discovered Nurse #2 had written on the Shift Change Controlled Substance Count Check form 2 narcotic medication prescription numbers of medications she had removed and allegedly sent back to the pharmacy on 6/13/24. DON #2 stated Nurse #2 had not written the residents' names by the prescription numbers or the reason for returning the medications, which is required. DON #2 stated the pharmacy was called and the prescription numbers were discovered to be fictious, and the pharmacy had not received any narcotic medications for Residents #299 or #300. DON #2 stated an audit of all narcotic medications, and their count sheets were completed, and no concerns were noted. The DON stated the State Agency, Department of Social Services, Police Department, Drug

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Enforcement Agency, and reported Nurse #2 to the Board of Nursing for alleged drug diversion were notified of the suspected misappropriation of narcotic medications. DON #2 stated she attempted to contact Nurse #2 to have her come in for an interview but was unsuccessful. The DON stated she notified the staffing agency that employed Nurse #2 of the suspicion and to also have Nurse #2 placed on the do not return list. DON #2 stated the facility replaced Residents #299 and #300's medication and at no time were they without pain medication. DON #2 stated the facility put a Performance Improvement Plan in place following the event.

An interview was completed on 4/23/25 at 2:36 pm with Medication Aide #1. Medication Aide #1 stated she worked on the dayshift on 6/13/24 and did not recall any discrepancies in the narcotic medication count cards or count sheets. Medication Aide #1 stated she did not normally work that medication cart, so she would not have immediately recognized if any narcotic medication cards were missing.

An interview was completed on 4/23/25 at 2:49 pm with Unit Nurse Manager #1. Unit Nurse Manager #1 stated Nurse #1 notified her of her suspicion of Residents #299 and #300 each missing 1 full narcotic medication card on 6/14/24. Unit Nurse Manager #1 stated she notified DON #2, and an investigation was initiated. Unit Nurse Manager # 1 stated a 100% audit was completed of all the medication carts and medication storage rooms, and the missing medications were unable to be located. Unit Nurse Manager #1 stated she continued to randomly audit narcotic medication count sheets, shift to shift narcotic counts, and Shift Change

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Controlled Substance Count Check sheets for discrepancies and has had no further concerns.

A telephone interview was completed on 4/24/25 at 8:38 am with Nurse #1. Nurse #1 stated she was frequently assigned to care for Residents #299 and #300 during the dayshift. Nurse # 1 stated she was scheduled to work dayshift on 6/10/24, 6/11/24, 6/12/24, and 6/14/24. Nurse #1 stated she recalled on 6/12/24 Resident #299 had 2 full cards of narcotic medication and Resident #300 had 1 partial narcotic medication card and 2 full cards of narcotic medication. Nurse #1 stated when she completed her shift-to-shift narcotic medication count with Nurse #2 at the beginning of her dayshift on 6/14/24 the narcotic medication count was correct, and the number of narcotic medication count sheets matched the total number of narcotic medication cards. Nurse #1 stated it was during her morning medication when she noticed Residents #299 and #300 were each missing a card of narcotic medication and the corresponding medication count sheet. Nurse #1 stated both residents rarely requested the as needed narcotic pain medication, therefore a whole card should not have been used in the time she was away from the facility. Nurse #1 stated she searched the medication cart and medication storage room and was unable to locate the missing medication. Nurse #1 stated she alerted Unit Nurse Manager #1 and DON #2 of the missing medications.

A telephone interview was completed on 4/24/25 at 8:44 am with Administrator #2. Administrator #2 stated DON #2 notified her of the missing narcotic medications on 6/14/24 and an investigation was started. Administrator #2 stated the missing narcotic medications, and their count sheets were unable to be located. Administrator

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#2 stated multiple attempts were made to contact Nurse #2, but they were unsuccessful. Administrator #2 stated the staffing agency that employed Nurse #2 was notified of the allegations and to not send Nurse #2 back into the facility. Administrator #2 stated a narcotic medication diversion report for Nurse #2 was filed with the Board of Nursing.

A telephone interview was completed on 4/24/25 at 11:00 am with the facility's Pharmacist. The Pharmacist verified the pharmacy did not receive any cards of Tramadol 50 mg for Resident #299 or Oxycodone 5 mg for Resident #300 on or around 6/13/24.
A telephone interview was completed on 4/24/25 at 11:13 am with Nurse #3. Nurse #3 was unable to recall if she signed in narcotic medications for Residents #299 and #300 on 5/31/24. Nurse #3 stated it was the facility's policy to have 2 nurses count and sign verifying the medication on the Pharmacy Narcotic Delivery Slip matched the medication delivered.

An attempt to contact the investigating officer on 4/24/25 at 11:25 am was made, however it was unsuccessful.

An interview was completed at 1:37 pm with Administrator #1. Administrator #1 stated she was not employed at the facility during the time of the misappropriation of the residents' narcotic medication. Administrator #1 stated she has had no concern of misappropriation of narcotic medication since becoming Administrator of the facility.

Multiple attempts made to contact Nurse #2 were unsuccessful.

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F 602	Continued From page 6 The facility provided the following corrective action plan with a date of 6/14/24 to begin monitoring and a completion date of 6/18/24. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 06/14/2024 Resident #2 was assessed for pain by the Unit Manager and found to have no changes in pain level. The physician was notified with no new orders. At no time was resident without access to prescribed pain medication. On 06/14/2024 the following agencies were notified regarding the incident of unaccounted for narcotics: Local Police (1:30pm), Adult Protective Services (1:32pm) and the State Agency (2:07pm.) The Pharmacy was notified on 06/18/2024 for replacement of medications. On 06/18/2024 the Drug Enforcement Agency notification was made by the Administrator via an online reporting system. The Staffing Agency was notified by the Director of Nursing regarding suspected misappropriation of narcotic medication and the removal of their employee from our schedule as well as her being added to a do not return list for the facility. The agency indicated that they would initiate an investigation and report to the Board of Nursing. On 7/12/24 Nurse #3 the facility initiated a report of alleged narcotic drug diversion to the NC State Board of Nursing. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/14/24 the Unit Nurse Managers completed an audit of the last 30 days of ordered narcotic	F 602		

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medications to ensure the medications were in the medication carts, administered, or returned to the pharmacy per protocol. The Director of Nursing (DON) will initiate an investigation for any identified areas of concern.
On 6/14/24 the DON/Unit Nurse Managers completed an audit of 100% of all residents' Controlled Substance Count sheets in comparison to the narcotic medication blister packs in the medication cart to ensure there were no discrepancies in the count of the medications.
On 6/14/24 the DON/Designee will inspect the narcotic blister pill packages for any tampering of medications.
On 6/14/24 the Unit Nurse Managers initiated assessments of all residents for pain. The Charge Nurse will address and initiate non-pharmacological interventions, pain medication, and/or Physician notification for any identified areas of concern during the audit. The audit will be completed by 6/14/24.
On 6/14/24 the Unit Nurse Managers completed 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 areas of concern.
On 6/18/24 the Human Resources Coordinator will complete an audit of all nurses and medication aides license verifications and HCPI checks. All areas of concern will be addressed during the audit.
On 6/14/24 the Nursing Supervisor reviewed packing slips for the past 30 days to ensure all narcotic medications were checked in appropriately and accounted for.

3. Address what measures will be put into place or systemic changes made to ensure that the

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deficient practice will not recur.
On 6/14/24 the Nursing Supervisor initiated an in-service with all nurses and medication aides regarding Controlled Substance Diversion to include the definition, implications, and the process for returning narcotic medications.
All in-services will be completed on 6/18/24. After 6/18/24, all nurses or medication aides that have not worked and received the in-service will complete upon their next scheduled shift.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.
Include dates when corrective action will be completed.
The decision to monitor the system for monitoring of narcotics was made on 06/14/2024 by the Administrator and Director of Nursing and presented to the Quality Assurance Committee on 06/14/2024.
100% of all ordered narcotic medications will be reviewed by the DON/Unit Nurse Manager weekly x 4 weeks and 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 the Controlled Substance Audit tool. All areas of concern will be addressed during the audit including reeducating nurses. The DON will review and initial the audits weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed appropriately.
The Administrator or DON will present the findings of the Audit Tools to the QAPI Committee monthly for 2 months. The QAPI Committee will

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F 602	Continued From page 9 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. Alleged date of compliance: 6/18/24	F 602		