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D 000	Initial Comments The Adult Care Licensure Section and the Hoke County Department of Social Services conducted a follow-up survey and complaint investigation on 05/07/24 - 05/08/24. The complaint investigation was initiated by the Hoke County Department of Social Services on 05/02/24.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Non-compliance continues with increased severity resulting in death, serious physical harm, abuse, neglect, or exploitation. THIS IS A TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 7 residents (#6, #7, #9) observed during the medication pass including errors with a rapid-acting insulin used to lower blood sugar (#6), a medication for acid reflux (#7), and an antipsychotic (#9); and for 2 of 5 sampled residents (#3, #5) including errors with a controlled substance used to treat moderate to severe pain (#3), an inhaler for shortness of	D 358		

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breath (#5), and a medication for cough and congestion (#5).

The findings are:

1. The medication error rate was 10% as evidenced by 3 errors out of 28 opportunities during the 8:00am medication pass on 05/08/24.

a. Review of Resident #6's current FL-2 dated 04/25/24 revealed diagnoses included transient ischemic attack and prostate cancer.

Review of Resident #6's physician's order dated 03/15/24 revealed an order for Novolog insulin inject 3 times a day as per sliding scale: 80 - 150 = give 10 units; 151 - 200 = give 12 units; 201 - 250 = give 14 units; 251 - 300 = give 16 units; 301 - 350 = give 18 units; 351 - 400 = give 20 units; 401 - 999 - give 22 units; hold all insulin if blood sugar is less than (<) 120. (Novolog is rapid-acting insulin used to lower blood sugar. According to the manufacturer, the Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles. Once the needle is inserted into the skin, the dose knob should be pushed all the way in and held for at least 6 seconds to ensure the full amount is injected.)

Review of Resident #6's physician's orders revealed no documentation the orders to administer Novolog sliding scale insulin and to hold all insulin had been clarified.

Review of Resident #6's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog insulin inject 3

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times a day as per sliding scale: 80 - 150 = give 10 units; 151 - 200 = give 12 units; 201 - 250 = give 14 units; 251 - 300 = give 16 units; 301 - 350 = give 18 units; 351 - 400 = give 20 units; 401 - 999 - give 22 units; hold all insulin if blood sugar is less than (<) 120.
-Novolog sliding scale insulin was scheduled at 8:00am, 12:00pm, and 5:00pm.
-The resident's blood sugar ranged from 96 - 257 from 05/01/24 - 05/08/24.

Observation of the 8:00am medication pass on 05/08/24 revealed:
-Resident #6's blood sugar was 96 at 8:05am.
-The medication aide (MA) dialed 10 units on the Novolog Flexpen and administered insulin into Resident #6's right abdomen at 8:08am.
-The MA did not perform a 2-unit air shot prior to dialing the insulin pen to 10 units to ensure no air bubbles were present and to ensure insulin was flowing from the pen.
-The MA held the insulin pen in the skin for 7 seconds but did not hold the dose knob down after the last click was heard.
-The MA did not hold the insulin pen in the skin with the dose knob pressed in for at least 6 seconds after injecting the needle and pressing the button to allow time for the full amount of insulin to be injected.

Interview with the MA on 05/08/24 at 2:32pm revealed:
-She recalled an order a couple of months ago to hold Resident #6's insulin if his blood sugar was < 120.
-She had not noticed the hold order conflicted with the parameters in the Novolog sliding scale order.
-She administered 10 units of Novolog sliding scale insulin that morning, 05/08/24, because it

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came up on the eMAR to administer 10 units.
-She was not sure about needing to do a 2-unit air shot with the Novolog insulin pen.
-She was not aware the dose button needed to be held in after the last click was heard.

Interview with Resident #6 on 5/08/24 at 5:39pm revealed:
-The MAs administered insulin to him every day.
-The MAs did not hold his insulin to his knowledge.
-He denied any symptoms of high or low blood sugar.

Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 1:58pm revealed:
-The MAs had been trained and checked off on the proper use of insulin pens.
-The MAs were trained to prime the insulin pen with a 2-unit air shot and they should hold the injection for 10 to 15 seconds.
-She thought Resident #6's insulin should be held if his blood sugar was <120 regardless of the sliding scale insulin order.

Interview with the Administrator on 05/08/24 at 2:13pm revealed:
-Resident #6's insulin orders should have been clarified by the MAs, the RCC, or the Assistant RCC.
-The MAs had been trained on the proper technique for use of insulin pens.

Telephone interview with Resident #6's primary care provider (PCP) on 05/08/24 at 4:07pm revealed:
-The MAs should use the proper technique for Resident #6's Novolog Flexpen to ensure the correct dosage was administered.
-Not using proper technique could cause the

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resident's blood sugar to be a little more elevated.
-The order to hold insulin if blood sugar < 120 was for the resident's Lantus insulin (long-acting insulin).
-No one from the facility had contacted her prior to today, 05/08/24, to clarify the hold order.

b. Review of Resident #7's current FL-2 dated 02/29/24 revealed:
-Diagnoses included chronic ischemic heart disease, polyneuropathy, and spinal stenosis.
-There was an order for Pantoprazole 40mg 1 tablet 2 times a day for acid reflux. (Pantoprazole is used to treat acid reflux.)

Review of Resident #7's primary care provider's (PCP) order dated 04/01/24 revealed:
-There was an order to stop Pantoprazole 40mg 1 tablet twice a day.
-There was an order to start Pantoprazole 20mg 1 tablet twice a day.

Review of Resident #7's hospital discharge summary dated 05/06/24 revealed:
-The resident was admitted to the hospital on 05/03/24 and discharged on 05/06/24.
-The resident was diagnosed with a urinary tract infection (UTI).
-There was an order for Pantoprazole 40mg 1 tablet twice a day.

Observation of the 8:00am medication pass on 05/08/24 revealed:
-The medication aide (MA) prepared and administered one-half of a Pantoprazole 40mg tablet to Resident #7 at 8:27am.
-The resident was administered Pantoprazole 20mg instead of Pantoprazole 40mg as ordered.

Review of Resident #7's May 2024 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Pantoprazole 20mg 1 tablet 2 times a day for heartburn scheduled at 8:00am and 4:00pm.
-Pantoprazole 20mg was documented as administered from 05/01/24 - 05/02/24 (8:00am) and again on 05/06/24 at 4:00pm.
-Pantoprazole 20mg twice a day was not documented as administered from 4:00pm on 05/02/24 through 8:00am on 05/06/24.
-Pantoprazole 20mg was documented as discontinued on 05/06/24.
-There was a second entry for Pantoprazole 40mg 1 tablet 2 times a day for gastroesophageal reflux disease (GERD) scheduled at 8:00am and 8:00pm.
-Pantoprazole 40mg was documented as administered from 8:00pm on 05/06/24 through 8:00am on 05/08/24.

Observation of Resident #7's medications on hand on 05/08/24 at 1:46pm revealed:
-There was a supply of Pantoprazole 40mg tablets in a manufacturer bottle dispensed by a Veteran's Administration (VA) pharmacy on 02/28/24.
-The computer printed instructions on the prescription label were to take 1 tablet twice daily.
-There were handwritten instructions in black ink on the prescription label to "give 2 tablets" above the printed instructions.
-There was "20mg" handwritten in black ink above the printed medication name, Pantoprazole.
-There was a sticker just below the printed instructions with "directions changed, refer to chart".
-The Pantoprazole 40mg tablets in the bottle had been split and were half tablets (20mg).

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D 358	Continued From page 6 Interview with the MA on 05/08/24 at 1:44pm revealed: -She did not know who had handwritten instructions on Resident #7's Pantoprazole prescription label. -She administered one-half tablet of Pantoprazole that morning, 05/08/24 because she misread the label and thought one-half tablet was 40mg. Interview with Resident #7 on 05/08/24 at 5:40pm revealed: -He received Pantoprazole everyday but he was not sure how much he received. -He had acid reflux "from time to time". Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 2:06pm revealed: -The MAs should read the eMAR and administer medications as ordered. -Resident #7 complained of having a hard time swallowing at times due to indigestion and acid reflux. Interview with the Administrator on 05/08/24 at 2:23pm revealed: -The MAs were supposed to read the eMAR instructions and the medication label and if they did not match, the MAs were supposed to check the order in the resident's record. -The MA could have administered 2 of the half tablets of Pantoprazole to equal 40mg. Telephone interview with Resident #7's PCP on 05/08/24 at 4:07pm revealed: -She was not aware Resident #7's order and dosage for Pantoprazole changed when he was discharged from the hospital on 05/06/24. -She did not have concerns about Resident #7 receiving 20mg of Pantoprazole instead of 40mg	D 358		

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as he had not complained of acid reflux symptoms to her.

c. Review of Resident #9's current FL-2 dated 05/03/24 revealed:
-Diagnoses included Lewy body dementia, rapid atrial fibrillation, seizure disorder, anemia of acute blood loss, essential hypertension, and closed fracture of the right distal femur.
-There was an order for Haldol 5mg in the morning and 5mg before bedtime. (Haldol is an antipsychotic and may be used to treat mood disorders.)

Observation of the 8:00am medication pass on 05/08/24 revealed:
-The medication aide (MA) prepared and administered one-half of a Haldol 5mg tablet to Resident #9 at 8:47am.
-The resident was administered Haldol 2.5mg instead of Haldol 5mg as ordered.

Review of Resident #9's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Haldol 5mg give 1 tablet 2 times a day for agitation, hold for sedation.
-Haldol 5mg was scheduled for 8:00am and 8:00pm.
-Haldol 5mg was documented as administered at 8:00pm on 05/02/24 and from 8:00pm on 05/03/24 through 8:00am on 05/08/24.
-The resident was documented as hospitalized from 8:00am on 05/01/24 through 8:00am on 05/02/24 and at 8:00am on 05/03/24.

Observation of Resident #9's medications on hand on 05/08/24 at 1:16pm revealed:
-There was a supply of Haldol 5mg tablets dispensed on 04/13/24 with instructions to take

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0.5 tablet (2.5mg) every 6 hours as needed for agitation.
-Each bubble contained one-half Haldol 5mg tablet (2.5mg) and there were 24 half tablets remaining.
-There was no supply of whole Haldol 5mg tablets available for administration.

Interview with the MA on 05/08/24 at 1:15pm revealed:
-There was no other supply of Haldol available for administration for Resident #9.
-She had not noticed the Haldol supply on hand was half tablets instead of whole Haldol 5mg tablets.
-There should have been a direction change sticker on the medication label.
-Resident #9 would get agitated and curse, resist care, and refuse medications at times.

Interview with the Memory Care Director (MCD) on 05/08/24 at 1:23pm revealed:
-The MAs were supposed to notify her if the medication label did not match the eMAR.
-No one had reported any discrepancies with Resident #9's Haldol.
-She was not working on the day Resident #9 returned from the hospital on 05/03/24 so she did not know why the order was not entered into the eMAR system.
-The MA on duty at the time the order was received would have been responsible for processing the order.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 05/08/24 at 1:28pm revealed:
-The only order they had on file for Resident #9 was from April 2023 and it was for Haldol 5mg take ½ tablet every 6 hours as needed for

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agitation.
-The pharmacy did not receive the hospital discharge summary or FL-2 dated 05/03/24 with an order for Haldol 5mg twice a day.

Interview with the Administrator on 05/08/24 at 2:23pm revealed:
-The MAs were supposed to read the eMAR instructions and the medication label and if they did not match, the MAs were supposed to check the order in the resident's record.
-The MA could have administered 2 of the half tablets of Haldol to equal 5mg.

Telephone interview with Resident #9's PCP on 05/08/24 at 4:07pm revealed:
-Resident #9 should have received Haldol 5mg instead of 2.5mg.
-Resident #9 had a history of dementia, depression, and behaviors.
-Not receiving the full dose of Haldol was concerning because the resident could start having behaviors, like agitation.

Based on observations, interviews, and record reviews, it was determined that Resident #9 was not interviewable.

2. Review of Resident #3's current FL-2 dated 03/06/24 revealed:
-Diagnoses included chronic pain, fracture of the shoulder, fracture of the femur, immobility syndrome, and morbid obesity.
-There was an order for Oxycodone/Acetaminophen 5mg/325mg take 1 tablet every 6 hours.
(Oxycodone/Acetaminophen is a controlled substance used to treat moderate to severe pain.)

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Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 03/06/24.

Review of Resident #3's incident report dated 04/02/24 at 10:06am revealed:
-The resident was sent to the emergency room (ER) on 03/12/24 and initially, she was not supposed to return to the facility.
-The resident returned from the hospital on Tuesday night, 03/26/24, at almost 10:00pm.
-The resident did not have any of her Oxycodone/Acetaminophen 5/325mg tablets available for administration.
-The resident's Oxycodone/Acetaminophen 5/325mg tablets should have been in the controlled substance lock box in the medication cart because all of her other medications were still at the facility.
-The facility reached out to the primary care provider (PCP) through telemed and requested a refill for the medication on Wednesday, 03/27/24, once it was discovered there was none in the facility.
-They sent over an order for a 3-day supply to the pharmacy to hold her over until the PCP came to the facility on Friday, 03/29/24.
-The medication aide (MA) reported on Thursday, 03/28/24, that the medication was still not in the facility.
-The MA was told to get the PCP to write a full prescription on Friday, 03/29/24, once the PCP was in the facility.
-The PCP wrote a new prescription on Friday, 03/29/24, and on Saturday, 03/30/24, the medication was still not in the facility.
-The pharmacy was contacted and the pharmacy reported the resident could not get the medication filled until 03/31/24.
-The medication was delivered on 04/01/24.

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-The pharmacist reported no medications had been sent back to the pharmacy.
-There were 120 Oxycodone/Acetaminophen 5/325mg tablets delivered to the facility on 03/08/24.
-On 03/11/24, the resident had 110 pills remaining when a cart audit was completed.
-All MAs were asked about the missing pills and no one could explain what happened to the medication.
-The Administrator and the corporate office were contacted.
-A health care personnel registry (HCPR) report was done and the provider and police were contacted.
-No injuries were observed at the time of the incident.
-No witnesses were found.
-The person who prepared the incident report was documented as the Administrator.

Review of a HCPR 24-hour and 5-day report dated 04/01/24 revealed:
-The allegation was diversion of facility drugs.
-There were approximately 108 Oxycodone/Acetaminophen 5/325mg tablets missing for Resident #3.

Review of Resident #3's hospital discharge summary dated 03/26/24 revealed:
-The resident was admitted to the hospital on 03/12/24 and was discharged on 03/26/24.
-The resident required a surgical procedure to remove her gall bladder.
-There was an order to continue taking Oxycodone/Acetaminophen 5/325mg.
-There was an order for Oxycodone 5mg 1 tablet every 8 hours as needed for up to 5 days.
(Oxycodone is an immediate-released controlled substance used to treat moderate to severe pain.

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D 358	Continued From page 12 Review of Resident #3's March 2024 electronic medication administration record (eMAR) revealed: -There was no entry for Oxycodone 5mg 1 every 8 hours as needed and none was documented as administered. -There was an entry for Oxycodone/Acetaminophen 5/325mg give 1 tablet every 6 hours for pain scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm. -Oxycodone/Acetaminophen was documented as not being administered from 8:00am on 03/12/24 through 8:00pm on 03/26/24 due to the resident being hospitalized. -Oxycodone/Acetaminophen was documented as not being administered from 2:00am on 03/27/24 through 8:00pm on 03/31/24 due to medication not in stock, except from 8:00pm on 03/29/24 through 2:00pm on 03/30/24 when the resident was documented as hospitalized. -There was a total of 17 doses of Oxycodone/Acetaminophen documented as not being administered from 03/27/24 - 03/31/24 due to the medication being unavailable. Review of Resident #3's electronic progress notes for March 2024 revealed: -Resident #3 returned to the facility from the hospital on 03/26/24 at 9:55pm. -On 03/29/24 at 8:24pm, the resident was complaining of abdominal and leg pain; the resident was given a prn (as needed) Gabapentin (used to treat nerve pain) but it was ineffective. -About 1 hour later, the resident asked to be sent to the hospital so emergency medical services (EMS) was called. -On 03/30/24 at 8:46pm, the resident stated she could not sleep due to not having her Oxycodone/Acetaminophen.	D 358		

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D 358	Continued From page 13 -On 03/31/24 at 1:13pm, staff documented the Oxycodone/Acetaminophen was not at the facility. -On 03/31/24 at 7:26pm, staff documented they were waiting for a new order for Oxycodone/Acetaminophen. -On 04/01/24 at 1:16pm, staff documented the medication should be in tonight. -On 04/01/24 at 5:27pm, the resident stated she was having pain in her left leg; a "prn" medication was given (name of medication not specified); resident also stated none of her pain medications were working. -On 04/03/24 at 2:41am, (after the resident started back receiving Oxycodone/Acetaminophen on 04/02/24), staff documented the resident was not having pain and resting. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for Oxycodone/Acetaminophen 5/325mg give 1 tablet every 6 hours for pain scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm. -Oxycodone/Acetaminophen was documented as not being administered from 2:00am on 04/01/24 through 8:00pm on 04/01/24 due to the medication being unavailable. -Oxycodone/Acetaminophen was documented as not being administered at 2:00am on 04/03/24 due to the resident not having pain and resting. -Oxycodone/Acetaminophen was documented as not being administered from 8:00am on 04/05/24 through 8:00pm on 04/06/24 due to medication being ordered from the pharmacy and not arrived yet and resident ran out of medication, medication had been ordered. -Oxycodone/Acetaminophen was documented as not being administered at 2:00am on 04/10/24 due to the resident resting and not complaining of	D 358		

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pain.
-There were 2 doses of Oxycodone/Acetaminophen documented as not administered due to the resident resting and not having pain.
-There was a total of 11 doses of Oxycodone/Acetaminophen documented as not being administered from 04/01/24 - 04/06/24 due to the medication being unavailable.

Review of Resident #3's controlled substance record (CSR) for Oxycodone/Acetaminophen 5/325mg revealed:
-There was a CSR for 120 Oxycodone/Acetaminophen 5/325mg tablets dispensed and received on 03/08/24.
-The first dose was documented as administered on 03/09/24 at 2:00am and the last dose documented was on 03/12/24 at 2:00am, leaving a balance of 108 tablets.
-There were no doses of Oxycodone/Acetaminophen documented as administered from 8:00am on 03/12/24 through 8:00pm on 04/01/24 (resident was hospitalized from 03/12/24 - 03/26/24).
-There was a second CSR for 12 Oxycodone/Acetaminophen 5/325mg dispensed on 03/31/24 and received on 04/02/24.
-The first documented dose used from this supply was 04/02/24 at 2:00am and the last dose was documented as administered on 04/05/24 at 2:00am, leaving a balance of 0.
-There was a third CSR for 120 Oxycodone/Acetaminophen 5/325mg tablets dispensed on 04/06/24 and received date not documented.
-The first documented dose from this supply was 04/07/24 at 8:00am and the last dose documented was 05/07/24 at 1:51pm, leaving a balance of 3 tablets.

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D 358	Continued From page 15 -There were no doses of Oxycodone/Acetaminophen documented as administered from 8:00am on 04/05/24 through 8:00pm on 04/06/24. Review of Resident #3's pharmacy dispensing record dated 03/01/24 - 05/07/24 revealed: -There were 120 Oxycodone/Acetaminophen 5/325mg tablets dispensed on 03/08/24. -There were 12 Oxycodone/Acetaminophen 5/325mg tablets dispensed on 03/27/24. -There were 120 Oxycodone/Acetaminophen 5/325mg tablets dispensed on 04/06/24. Review of Resident #3's primary care provider (PCP) triage note dated 03/27/24 revealed: -The resident just came back last night from the hospital after gall bladder surgery. -The resident did not have any pain medication because the hospital did not send any hard prescriptions. -The on-call triage provider ordered a 3-day emergency supply of Oxycodone/Acetaminophen. -The facility was to follow-up with the PCP for a full prescription before the 3-day supply ran out. Review of Resident #3's ER visit note dated 03/29/24 revealed: -The resident arrived to the ER on 03/29/24 at 6:23pm with complaint of knee and leg pain. -The resident had difficulty ambulating and intermittent worsening of knee pain. -The resident started having sharp knee pain last night. -The resident was diagnosed with chronic knee pain and sent back to the facility. Review of Resident #3's PCP visit note dated 03/29/24 revealed: -The resident was being seen to establish primary	D 358		

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care for chronic and acute care conditions.
-The resident had a recent ER visit and a recent surgical procedure.
-The resident reported she was feeling okay except for chronic pain.
-The PCP noted she would be refilling the resident's pain medication today.

Telephone interview with a pharmacy technician on 05/08/24 at 3:15pm revealed:
-An electronic prescription for Oxycodone/Acetaminophen 5/325mg was sent to the pharmacy on 03/29/24 at 12:11pm by Resident #3's PCP.
-The 03/29/24 prescription for the Oxycodone/Acetaminophen 5/325mg was profiled only until it could be filled.
-The original fill date for the Oxycodone/Acetaminophen 5/325mg was 03/08/24 and 120 tablets were delivered to the facility on 03/08/24 at 11:36pm.
-The 120 tablets that had been delivered to the facility on 03/08/24 should have been enough to get Resident #3 through 04/06/24 and she was not sure why the resident needed the 3-day supply that was requested on 03/29/24.
-The first day Resident #3's insurance would pay again for the Oxycodone/Acetaminophen was 03/31/24.
-On 04/02/24, 12 tablets of Oxycodone/Acetaminophen 5/325mg were delivered to the facility.
-The pharmacy was not made aware by the facility that it was an emergency situation and if they had been notified the Oxycodone/Acetaminophen 5/325mg could have been delivered on a Sunday, 03/31/24.
-The prescription for Oxycodone 5mg 1 every 8 hours as needed for up to 5 days was never dispensed because the order did not have the

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drug enforcement agency (DEA) number for the provider.
-The pharmacy attempted to get the DEA number and would have alerted the facility it was needed.

Interviews with Resident #3 on 05/02/24 at 10:00am and on 05/07/24 at 9:20am revealed:
-When Resident #3 returned to the facility on 3/26/24 she had a lot of pain in her right leg.
-She described her pain as a 7 on a scale from 1-10 (with 10 being the most severe pain) when she returned to the facility from the hospital.
-When she asked for anything for pain she was told by the MAs that her Oxycodone/Acetaminophen 5/325mg tablets were missing and she had no orders for pain medications therefore she could not get anything for the pain.
-A few days after returning to the facility, she had a telehealth visit with the PCP and was given an order for Oxycodone/Acetaminophen 5/325mg.
-On 03/29/24, she asked to be sent to the local ER due to being in a lot of pain in her right leg.
-She thought the pain in her right left might have been a blood clot.
-It was a while before she was given anything for pain from the facility staff.

Interview with a MA on 05/08/24 at 9:30am revealed:
-On 03/12/24, Resident #3 was given one Oxycodone/Acetaminophen 5/325mg at 2:00am, the CSR was completed and the remaining medication was put back in the lock box on the medication cart.
-She was told by the Resident Care Coordinator (RCC) that Resident #3 would not be returning to the facility sometime after the resident was admitted to the hospital on 03/12/24.
-She was not sure who pulled Resident #3's

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medications from the medication cart.
-She knew they had been pulled because she saw them in the medication room on the counter.
-She had not noticed if the Oxycodone/Acetaminophen 5/325mg medication was on the counter as well.
-When Resident #3 returned she was informed by the on-call supervisor that it was okay for the resident to be given her prescribed medications, all the medications were in the facility except for the Oxycodone/Acetaminophen 5/325mg.
-She was never asked directly about the missing Oxycodone/Acetaminophen 5/325mg.
-She heard about it in passing about two weeks later.
-The night Resident #3 came back into the facility, the resident was in pain, asked for pain medication, but there was nothing to give her.

Interview with the Assistant Resident Care Coordinator (ARCC) on 05/08/24 at 8:35am revealed:
-A couple of days after Resident #3 was sent to the ER on 03/12/24 and admitted, she was informed that after discharge from the hospital the resident would be discharged to a skilled nursing facility.
-She was not sure why Resident #3 had to be discharged to a skilled nursing facility.
-The RCC asked a former MA to take all of Resident #3's medications from the medication cart.
-She was not sure if that had been done.
-There was nothing to show if the medications had been taken off the cart or if they had been sent back to the pharmacy.
-Resident #3's maintenance medications were still on the counter in the medication room, however the Oxycodone/Acetaminophen 5/325mg was not there.

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D 358	Continued From page 19 -She had no knowledge of who handled the Oxycodone/Acetaminophen 5/325mg last. -No one in the facility had knowledge of anything "being off "with the Oxycodone/Acetaminophen 5/325mg until Resident #3 came back to the facility on 03/26/24. -A supervisor should have checked behind the MA to make sure Resident #3's medications had been pulled and properly disposed of. Interview with the RCC on 05/08/2024 at 11:10am revealed: -When Resident #3 was in the hospital in March 2024, she had taken Resident #3's regular medications out of the medication cart but left the Oxycodone/Acetaminophen 5/325mg in the locked box in the medication cart. -The medications were put in the medication storage room. -She planned on sending the medications back, to the pharmacy however, she never got around to it. -She did not know the timeframe in which the medications should have been sent back to the pharmacy. -MAs could send medications back to the pharmacy but none of the MAs were instructed to send Resident #3's medications back. -She felt the Oxycodone/Acetaminophen 5/325mg would be safe in the medication cart as they were in the controlled substance locked box. -The CSR for Resident #3's Oxycodone/Acetaminophen was still in the CS book on the medication cart. -The MAs should have continued to count the Oxycodone/Acetaminophen 5/325mg at change of each shift. -If the MAs had counted the Oxycodone/Acetaminophen 5/325mg at each shift change the missing medication could have	D 358		

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been caught sooner.
-She had no idea the Oxycodone/Acetaminophen 5/325mg was missing until Resident #3 returned to the facility on 03/26/24.
-She thought Resident #3 was just out of the Oxycodone/Acetaminophen 5/325mg or that they had been sent back to the pharmacy.
-She was not sure if Resident #3 received any medication for pain while she was waiting for the Oxycodone/Acetaminophen 5/325mg to be delivered.
-On Wednesday, 03/27/24, she requested a refill of the Oxycodone/Acetaminophen 5/325mg through the PCP's telemed system.
-She was notified on Thursday, 03/28/24, by a MA that Resident #3's Oxycodone/Acetaminophen 5/325mg had not been delivered to the facility.
-Resident #3's PCP wrote a prescription for Oxycodone/Acetaminophen 5/325mg on Friday, 03/29/24.
-Resident #3's Oxycodone/Acetaminophen 5/325mg was still not delivered on Saturday, 03/30/24.
-She called the pharmacy to find out why the Oxycodone/Acetaminophen 5/325mg had not been delivered.
-She was informed by the pharmacy it was too early for the Oxycodone/Acetaminophen 5/325mg to be filled, the earliest it could be filled would be 03/31/24.
-She was informed by the pharmacy that none of Resident #3's medications including the Oxycodone/Acetaminophen 5/325mg had been sent back to the pharmacy.
-Resident #3's Oxycodone 5mg 1 every 8 hours for up to 5 days was never received by the facility because the pharmacy said there was a conflict with numbers.

Interview with Administrator on 05/08/24 at

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D 358	Continued From page 21 4:03pm revealed: -She was made aware on 04/01/24 by the RCC that Resident #3's Oxycodone/Acetaminophen 5/325mg could not be found. -She was not aware Resident #3 had missed taking any of her pain medications until the RCC made her aware on 04/01/24. -The RCC had taken Resident #3's regular medications off the medication cart, however, the Oxycodone/Acetaminophen 5/325mg tablets were left in the locked box on the medication cart where the RCC felt they would be safe. -The RCC ordered Resident #3 some more Oxycodone/Acetaminophen 5/325mg the next day after she returned to the facility from the hospital but they never came. -She could not answer why the MAs were not still counting the Oxycodone/Acetaminophen 5/325mg every shift since the CSR and Oxycodone/Acetaminophen 5/325mg where still on the medication cart. -The MAs should have still been counting the Oxycodone/Acetaminophen 5/325mg since the CSR was still on the cart. Telephone interview with Resident #3's PCP on 05/08/24 at 4:05pm revealed: -She conducted a telehealth visit with Resident #3 on 03/29/24. -Resident #3 complained of pain in her back, shoulder, knees and legs. -On 03/29/24, she wrote a prescription for a 3-day supply (12 tablets) of Resident #3's Oxycodone/Acetaminophen 5/325mg. -Before the telehealth visit on 03/29/24, she was not notified the resident was not receiving Oxycodone/Acetaminophen for pain. -She was not made aware of the missing Oxycodone/Acetaminophen 5/325mg tablets. -The missed doses of	D 358		

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Oxycodone/Acetaminophen 5/325mg would cause Resident #3 more discomfort and pain.

3. Review of Resident #5's current FL-2 dated 04/02/24 revealed diagnoses included type 2 diabetes mellitus, gastroenteritis, and hypertension.

Interview with Resident #5 on 05/07/24 at 10:00am revealed:
-The resident was seen by her primary care provider (PCP) approximately two weeks ago.
-The PCP prescribed an inhaler and cough syrup to the resident due to congestion and cough.
-The resident had been waiting over a week for her inhaler and cough syrup.
-The resident continued to have cough and congestion.
-The facility had not administered any cough syrup or an inhaler to her.

Telephone interview with Resident #5's contracted pharmacy provider on 05/08/24 at 4:45pm revealed:
-The pharmacy received an order for Ventolin HFA inhaler (used for shortness of breath) and Chest Congestion Relief DM (a cough suppressant and expectorant for congestion) from the PCP on 05/03/24.
-The pharmacy sent the Ventolin HFA inhaler and Chest Congestion Relief DM to the facility on 05/03/24.

Review of Resident #5's May 2024 electronic medication administration record (eMAR) revealed there was no entry for Ventolin HFA inhaler or Chest Congestion Relief DM for the month of May.

Observation of Resident #5's medications on

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D 358	Continued From page 23 hand on 05/08/24 at 10:00am revealed there was no Ventolin HFA inhaler or Chest Congestion Relief DM for the resident on the medication cart. Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 4:50pm revealed: -The facility received Resident #5's Ventolin HFA inhaler and Chest Congestion Relief DM on 05/03/24. -Resident #5's new medications should have been on the eMAR and available to administer to the resident on 05/03/24. -The MAs were responsible for ensuring new medications sent from the pharmacy were entered onto the eMARs. Interview with the Administrator on 05/08/24 at 5:35pm revealed: -Resident #5's medications should have been entered on the eMARs as soon as they were received by the pharmacy. -The facility did not have a policy for entering in new prescriptions onto the eMAR when they came from the pharmacy. -She expected the MAs to ensure new medications sent from the pharmacy were entered onto the eMARs. Telephone interview with Resident #5's PCP on 05/08/24 at 4:30pm revealed: -The resident was seen by her on 05/03/24. -She prescribed Resident #5 Ventolin HFA inhaler and Chest Congestion Relief DM. -She sent the orders to the pharmacy on 05/03/24. -If Resident #5 did not receive her prescriptions, the resident's cough and congestion could worsen and she may need to be sent to the hospital. _____	D 358		

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D 358	Continued From page 24 The facility failed to administer medications as ordered to 3 of 7 residents observed during the medication pass on 05/08/24, including errors with rapid-acting insulin, an antipsychotic, and a medication for acid reflux. Resident #3 missed 28 doses of Oxycodone/Acetaminophen, a narcotic pain medication used to relieve moderate to severe pain, after returning from a hospitalization requiring surgical removal of her gall bladder. The resident also took the medication for chronic knee and leg pain. The resident described her pain as a 7 on a scale from 1-10 (with 10 being the most severe pain) when she missed the doses of pain medication and she required a hospital emergency room (ER) visit on 03/29/24 due to the pain in her legs and knees. The resident also never received prn (as needed) Oxycodone for up to 5 days after returning from the hospital related to surgery. The failure of the facility to administer medications as ordered resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/08/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 7, 2024.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the	D 366		

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staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure medication staff who administered medications actually observed 1 of 5 residents (#8) taking their medications during the morning medication pass observed in the special care unit (SCU) on 05/08/24.

The findings are:

Review of the facility's Medication Administration Policies and Procedures with effective date of 10/01/20 revealed the recording of the administration on the medication administration record (MAR) shall be by the staff person who administered the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication prior to the administration of another resident's medication.

Review of Resident #8's current FL-2 dated 04/05/24 revealed:
-Diagnosis included unspecified dementia.
-The resident was documented as intermittently disoriented.
-The resident was documented as having wandering behaviors.

Review of Resident #8's physician's order dated 04/29/24 revealed an order for Miralax 17g (grams) mixed with 6 ounces of fluid once daily,

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hold for loose stool. (Miralax is laxative used to treat and prevent constipation.)

Review of Resident #8's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax Oral Packet give 17g one time a day, mix with 6 ounces of fluid scheduled at 8:00am.
-Miralax was documented as administered from 05/02/24 - 05/08/24.

Observation of the 8:00am medication pass in the special care unit (SCU) on 05/08/24 revealed:
-Resident #8 was sitting at a table with 3 other residents in the SCU dining room eating breakfast.
-There were 2 personal care aides (PCAs) sitting at the table providing feeding assistance to other residents at the table.
-The medication aide (MA) prepared morning medications for Resident #8, including 17g of Miralax mixed in water in a 7-ounce cup.
-The MA gave the resident the cup with Miralax mixed in water to the resident to take his oral pills at 8:38am.
-The resident drank about half of the water with Miralax and put the cup on the table.
-The MA did not attempt to have the resident drink the rest of the water with Miralax while she was observing.
-The MA walked away from the resident and stated she would come back to check on the resident later.
-The MA did not stay in the dining room to observe the resident and did not notify the PCAs there was medication in the resident's water cup.
-The MA left the dining room, went back to the nurses' station and to the medication cart.
-The MA prepared medications for another

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resident in the SCU and walked down the hall away from the dining room.
-The MA went in the last room on the right of the hallway to administer medications to the other resident.
-The MA could not see the dining room or Resident #8.
-The MA finished administering medications to the other resident, walked back up the hallway and returned to the medication cart to document administration of the medications.
-At 8:49am, the MA went back into the dining room to Resident #8's table and retrieved the cup that was used for Resident #8's Miralax.
-The cup with Miralax was empty.

Interview with the MA on 05/08/24 at 1:15pm revealed:
-She was aware she was supposed to observe residents take their medications.
-She should have stayed and observed Resident #8 drink all of the Miralax.

Interview with the Memory Care Director (MCD) on 05/08/24 at 1:35pm revealed:
-The MAs had been trained and knew they were supposed to observe all residents take all their medications.
-The MA should have encouraged Resident #8 to drink all the Miralax while she was observing the resident.
-The PCAs were not qualified MAs and not qualified to observe residents take their medications.

Interview with the Administrator on 05/08/24 at 2:19pm revealed:
-The MAs had been trained to stay and observe each resident take their medications.
-Resident #8 was in the SCU and the MA should

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D 366	Continued From page 28 have observed the resident drink all the Miralax. Based on observations, interviews, and record review, it was determined that Resident #8 was not interviewable.	D 366		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure accurate reconciliation of the administration of a controlled substances for 1 of 4 sampled residents (#3) who missed multiple doses of a controlled substance used to treat moderate to severe pain due to the medication being missing, unaccounted for, and unavailable for administration resulting in severe pain for the resident. The findings are: Review of the facility's controlled substances policies and procedures dated 10/01/20 revealed: -It was the policy of the facility to ensure the special handling, storage, disposal, and record keeping of controlled substances according to applicable regulatory standards. -Prior to the end of each shift, the authorized	D 392		

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associate that was reporting off duty would count the controlled substances with the authorized associate who was reporting on duty.
-In the event the count did not match the controlled substances on hand, the Health and Wellness Director (HWD) would be notified immediately.
-The HWD was responsible for investigating discrepancies to determine the cause of such occurrences.

Review of Resident #3's current FL-2 dated 03/06/24 revealed:
-Diagnoses included chronic pain, fracture of the shoulder, fracture of the femur, immobility syndrome, and morbid obesity.
-There was an order for Oxycodone/Acetaminophen 5mg/325mg take 1 tablet every 6 hours.
(Oxycodone/Acetaminophen is a controlled substance used to treat moderate to severe pain.)

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 03/06/24.

Review of Resident #3's incident report dated 04/02/24 at 10:06am revealed:
-The resident was sent to the emergency room (ER) on 03/12/24 and initially, she was not supposed to return to the facility.
-The resident returned from the hospital on Tuesday night, 03/26/24, at almost 10:00pm.
-The resident did not have any of her Oxycodone/Acetaminophen 5/325mg tablets available for administration.
-The resident's Oxycodone/Acetaminophen 5/325mg tablets should have been in the controlled substance locked box in the

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medication cart because all of her other medications were still at the facility.
-The facility reached out to the primary care provider (PCP) through telemed and requested a refill for the medication on Wednesday, 03/27/24, once it was discovered there was none in the facility.
-They sent over an order for a 3-day supply to the pharmacy to hold her over until the PCP came to the facility on Friday, 03/29/24.
-The MA reported on Thursday, 03/28/24, that the medication was still not in the facility.
-The MA was told to get the PCP to write a full prescription on Friday, 03/29/24, once the PCP was in the facility.
-The PCP wrote a new prescription on Friday, 03/29/24, and on Saturday, 03/30/24, the medication was still not in the facility.
-The pharmacy was contacted and the pharmacy reported the resident could not get the medication filled until 03/31/24.
-The medication was delivered on 04/01/24.
-The pharmacist reported no medications had been sent back to the pharmacy.
-There were 120 Oxycodone/Acetaminophen 5/325mg tablets delivered to the facility on 03/08/24.
-On 03/11/24, the resident had 110 pills remaining when a cart audit was completed.
-All MAs were asked about the missing pills and no one could explain what happened to the medication.
-The Administrator and the corporate office were contacted.
-A health care personnel registry (HCPR) report was done and the provider and police were contacted.
-No injuries were observed at the time of the incident.
-No witnesses were found.

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D 392	Continued From page 31 -The person who prepared the incident report was documented as the Administrator. Review of a HCPR 24-hour and 5-day report dated 04/01/24 revealed: -The allegation was diversion of facility drugs. -There were approximately 108 Oxycodone/Acetaminophen 5/325mg tablets missing for Resident #3. Review of Resident #3's hospital discharge summary dated 03/26/24 revealed: -The resident was admitted to the hospital on 03/12/24 and was discharged on 03/26/24. -The resident required a surgical procedure to remove her gall bladder. -There was an order to continue taking Oxycodone/Acetaminophen 5/325mg. Review of Resident #3's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone/Acetaminophen 5/325mg give 1 tablet every 6 hours for pain scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm. -There were 12 doses of Oxycodone/Acetaminophen 5/325mg documented as administered from 03/09/24 - 03/12/24 (2:00am) prior to the resident being admitted to the hospital on 03/12/24. -Oxycodone/Acetaminophen was documented as not being administered from 8:00am on 03/12/24 through 8:00pm on 03/26/24 due to the resident being hospitalized. -Oxycodone/Acetaminophen was documented as not being administered from 2:00am on 03/27/24 through 8:00pm on 03/31/24 due to medication not in stock, except from 8:00pm on 03/29/24 through 2:00pm on 03/30/24 when the resident	D 392		

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was documented as hospitalized.
-There was a total of 17 doses of Oxycodone/Acetaminophen documented as not being administered from 03/27/24 - 03/31/24 due to the medication being unavailable.

Review of Resident #3's electronic progress notes for March 2024 revealed:
-Resident #3 returned to the facility from the hospital on 03/26/24 at 9:55pm.
-On 03/29/24 at 8:24pm, the resident was complaining of abdominal and leg pain; the resident was given a prn (as needed) Gabapentin (used to treat nerve pain) but it was ineffective.
-About 1 hour later, the resident asked to be sent to the hospital so emergency medical services (EMS) was called.
-On 03/30/24 at 8:46pm, the resident stated she could not sleep due to not having her Oxycodone/Acetaminophen.
-On 03/31/24 at 1:13pm, staff documented the Oxycodone/Acetaminophen was not at the facility.
-On 03/31/24 at 7:26pm, staff documented they were waiting for a new order.
-On 04/01/24 at 1:16pm, staff documented the Oxycodone/Acetaminophen should be in that night.
-On 04/01/24 at 5:27pm, the resident stated she was having pain in her left leg; a prn medication was given (name of medication not specified); resident also stated none of her pain medications were working.
-On 04/03/24 at 2:41am, (after the resident started back receiving Oxycodone/Acetaminophen on 04/02/24), staff documented the resident was not having pain and resting.

Review of Resident #3's April 2024 eMAR revealed:

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D 392	Continued From page 33 -There was an entry for Oxycodone/Acetaminophen 5/325mg give 1 tablet every 6 hours for pain scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm. -Oxycodone/Acetaminophen was documented as not being administered from 2:00am on 04/01/24 through 8:00pm on 04/01/24 due to the medication being unavailable. -Oxycodone/Acetaminophen was documented as not being administered at 2:00am on 04/03/24 due to the resident not having pain and resting. -Oxycodone/Acetaminophen was documented as not being administered from 8:00am on 04/05/24 through 8:00pm on 04/06/24 due to medication being ordered from the pharmacy and not arrived yet and resident ran out of medication, medication had been ordered. -Oxycodone/Acetaminophen was documented as not being administered at 2:00am on 04/10/24 due to the resident resting and not complaining of pain. -There was a total of 2 doses of Oxycodone/Acetaminophen documented as not being administered due to the resident resting and not having pain. -There was a total of 11 doses of Oxycodone/Acetaminophen documented as not being administered from 04/01/24 - 04/06/24 due to the medication being unavailable. Review of Resident #3's controlled substance record (CSR) for Oxycodone/Acetaminophen 5/325mg dispensed on 03/08/24 revealed: -There were 120 Oxycodone/Acetaminophen 5/325mg tablets dispensed and received on 03/08/24. -The first dose was documented as administered on 03/09/24 at 2:00am and the last dose documented was on 03/12/24 at 2:00am, leaving a balance of 108 tablets.	D 392		

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D 392	Continued From page 34 -There were no doses of Oxycodone/Acetaminophen documented as administered from 8:00am on 03/12/24 through 8:00pm on 04/01/24 (resident was hospitalized from 03/12/24 - 03/26/24). -There was no documentation on the CSR to reconcile and account for the remaining 108 tablets of Oxycodone/Acetaminophen 5/325mg tablets that were dispensed on 03/08/24. Review of Resident #3's CSR for Oxycodone/Acetaminophen 5/325mg dispensed on 03/31/24 revealed: -There were 12 Oxycodone/Acetaminophen 5/325mg dispensed on 03/31/24 and received on 04/02/24. -The first documented dose used from this supply was 04/02/24 at 2:00am and the last dose was documented as administered on 04/05/24 at 2:00am, leaving a balance of 0. Review of Resident #3's CSR for Oxycodone/Acetaminophen 5/325mg dispensed on 04/06/24 revealed: -There was a third CSR for 120 Oxycodone/Acetaminophen 5/325mg tablets dispensed on 04/06/24 and received date not documented. -The first documented dose from this supply was 04/07/24 at 8:00am and the last dose documented was 05/07/24 at 8:00am, leaving a balance of 4 tablets. -There were no doses of Oxycodone/Acetaminophen documented as administered from 8:00am on 04/05/24 through 8:00pm on 04/06/24. Review of the controlled substance shift count sheets for the assisted living (AL) side of the facility revealed:	D 392		

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D 392	Continued From page 35 -There was a sheet with dates ranging from 03/24/24 - 04/01/24 with no discrepancies for the shift counts documented. -There were 14 occasions that only one staff (off-going or oncoming) signed the shift count sheets. -There were 10 shifts where staff failed to document whether the count was correct. -No shift count was documented as being done on 03/31/24 at 3:00pm. Observation of Resident #3's medications on hand on 05/07/24 at 10:45am revealed: -There was a supply of Oxycodone/Acetaminophen 5/325mg tablets dispensed on 04/06/24. -There were 4 of 120 tablets remaining. Review of Resident #3's pharmacy dispensing record dated 03/01/24 - 05/07/24 revealed: -There were 120 Oxycodone/Acetaminophen 5/325mg tablets dispensed on 03/08/24. -There were 12 Oxycodone/Acetaminophen 5/325mg tablets dispensed on 03/27/24. -There were 120 Oxycodone/Acetaminophen 5/325mg tablets dispensed on 04/06/24. Review of Resident #3's PCP triage note dated 03/27/24 revealed: -The resident just came back last night from the hospital after gall bladder surgery. -The resident did not have any pain medication because the hospital did not send any hard prescriptions. -The on-call triage provider ordered a 3-day emergency supply of Oxycodone/Acetaminophen. -The facility was to follow-up with the PCP for a full prescription before the 3-day supply ran out. Review of Resident #3's ER visit note dated	D 392		

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D 392	Continued From page 36 03/29/24 revealed: -The resident arrived to the ER on 03/29/24 at 6:23pm with complaint of knee and leg pain. -The resident had difficulty ambulating and intermittent worsening of knee pain. -The resident started having sharp knee pain last night. -The resident was diagnosed with chronic knee pain and sent back to the facility. Telephone interview with a pharmacy technician on 05/08/24 at 3:15pm revealed: -An electronic prescription for Oxycodone/Acetaminophen 5/325mg was sent to the pharmacy on 03/29/24 at 12:11pm by Resident #3's PCP. -The 03/29/24 prescription for the Oxycodone/Acetaminophen 5/325mg was profiled only until it could be filled. -The original fill date for the Oxycodone/Acetaminophen 5/325mg was 03/08/24 and 120 tablets were delivered to the facility on 03/08/24 at 11:36pm. -The 120 tablets that had been delivered to the facility on 03/08/24 should have been enough to get Resident #3 through 04/06/24 and she was not sure why the resident needed the 3-day supply that was requested on 03/29/24. -The first day that Resident #3's insurance would pay for Oxycodone/Acetaminophen 5/325mg again was 03/31/24. -On 04/02/24, 12 tablets of Oxycodone/Acetaminophen 5/325mg were delivered to the facility. -The pharmacy was not made aware by the facility that it was an emergency situation and if they had been notified the Oxycodone/Acetaminophen 5/325mg could have been delivered on a Sunday.	D 392		

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D 392	Continued From page 37 Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 05/08/24 at 4:51pm revealed: -They had not received any return of Resident #3's 108 unaccounted for Oxycodone/Acetaminophen 5/325mg tablets. -There was no documentation that any supply of Resident #3's Oxycodone/Acetaminophen 5/325mg tablets had been returned to the facility. Interviews with Resident #3 on 05/02/24 at 10:00am and on 05/07/24 at 9:20am revealed: -When Resident #3 returned to the facility on 3/26/24, she had a lot of pain in her right leg. -She described her pain as a 7 on a scale from 1-10 (with 10 being the most severe pain) when she returned to the facility from the hospital. -When she asked for anything for pain she was told by the medication aides (MAs) that her Oxycodone/Acetaminophen 5/325mg tablets were missing and she had no orders for pain medications, therefore, she could not get anything for the pain. -A few days after returning to the facility, she had a telehealth visit with the PCP and was given an order for Oxycodone/Acetaminophen 5/325mg. -On 03/29/24, she asked to be sent to the local ER due to being in a lot of pain in her right leg. -She thought the pain in her right left might have been a blood clot. -It was a while before she was given anything for pain from the facility staff. Interview with a MA on 05/08/24 at 9:30am revealed: -On 03/12/24, Resident #3 was given one Oxycodone/Acetaminophen 5/325mg tablet at 2:00am, the CSR was completed, and the remaining medication was put back in the locked box in the medication cart.	D 392		

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D 392	Continued From page 38 -She was told by the Resident Care Coordinator (RCC) that Resident #3 would not be returning to the facility some time after the resident was admitted to the hospital on 03/12/24. -She was not sure who pulled Resident #3's medications from the medication cart. -She knew they had been pulled because she saw them in the medication room on the counter. -She had not noticed if the Oxycodone/Acetaminophen 5/325mg medication was on the counter as well. -When Resident #3 returned she was informed by the on-call supervisor that it was okay for the resident to be given her prescribed medications; all the medications were in the facility except for the Oxycodone/Acetaminophen 5/325mg. -She was never asked directly about the missing Oxycodone/Acetaminophen 5/325mg. -She heard about it in passing about two weeks later. -The night Resident #3 came back into the facility, the resident was in pain, asked for pain medication, but there was nothing to give her. Interview with a second MA on 05/07/24 at 9:30am revealed: -The MAs did controlled substance counts and the end of each shift. -This was supposed to include all controlled substances in the medication cart. -There were some missing pills a few months ago for Resident #3. -She was not at the facility when the pills were missing so she had not administered any of the Oxycodone/Acetaminophen to the resident. -She was not aware of any other missing controlled substances or discrepancies. Interview with a third MA on 05/07/24 at 10:15am revealed:	D 392		

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D 392	Continued From page 39 -The MAs did controlled substance counts each shift. -Resident #3's Oxycodone/Acetaminophen was on hand and available when she last administered it but she could not recall the date. -She could not recall if Resident #3's Oxycodone/Acetaminophen was in the medication cart and being counted during shift counts while the resident was in the hospital. Interview with the Assistant Resident Care Coordinator (ARCC) on 05/08/24 at 8:35am revealed: -A couple of days after Resident #3 was sent to the ER on 03/12/24 and admitted to the hospital, she was informed that after discharge from the hospital the resident would be discharged to a skilled nursing facility. -She was not sure why Resident #3 had to be discharged to a skilled nursing facility. -The RCC asked a former MA to take all of Resident #3's medications from the medication cart. -She was not sure if that had been done. -There was nothing to show if the medications had been taken off the cart or if they had been sent back to the pharmacy. -Resident #3's maintenance medications were still on the counter in the medication room, however, the Oxycodone/Acetaminophen 5/325mg was not there. -She had no knowledge of who handled the Oxycodone/Acetaminophen 5/325mg last. -No one in the facility had knowledge of anything "being off "with the Oxycodone/Acetaminophen 5/325mg until Resident #3 came back to the facility on 03/26/24. -A supervisor should have checked behind the MAs to make sure Resident #3's medications had been pulled and properly disposed of.	D 392		

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D 392	Continued From page 40 Interview with the RCC on 05/08/24 at 11:10am revealed: -When Resident #3 was in the hospital in March 2024, she had taken Resident #3's regular medications out of the medication cart but left the Oxycodone/Acetaminophen 5/325mg in the locked box in the medication cart. -The regular medications were put in the medication storage room. -She planned on sending the medications back to the pharmacy but she never got around to it. -She did not know the timeframe in which the medications should have been sent back to the pharmacy. -MAs could send medications back to the pharmacy but none of the MAs were instructed to send Resident #3's medications back. -She felt the Oxycodone/Acetaminophen 5/325mg would be safe in the medication cart as they were in the controlled substance locked box. -The CSR for Resident #3's Oxycodone/Acetaminophen was still in the CS book on the medication cart. -The MAs were responsible for doing controlled substance counts prior to changing shifts and exchanging the medication cart keys. -The MAs should have reported any discrepancies to her, but none were reported. -The MAs should have continued to count the Oxycodone/Acetaminophen 5/325mg at the change of each shift even though the resident was out of the facility. -If the MAs were counting the Oxycodone/Acetaminophen 5/325mg at each shift change, the missing medication should have been identified sooner. -She had no idea the Oxycodone/Acetaminophen 5/325mg was missing until Resident #3 returned to the facility on 03/26/24.	D 392		

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D 392	Continued From page 41 -She thought Resident #3 was just out of the Oxycodone/Acetaminophen 5/325mg or that they had been sent back to the pharmacy. -She was not sure if Resident #3 received any medication for pain while she was waiting for the Oxycodone/Acetaminophen 5/325mg to be delivered. -On Wednesday, 03/27/24, she requested a refill of the Oxycodone/Acetaminophen 5/325mg through the PCP's telemed system. -She was notified on Thursday, 03/28/24, by a MA that Resident #3's Oxycodone/Acetaminophen 5/325mg had not been delivered to the facility. -Resident #3's PCP wrote a prescription for Oxycodone/Acetaminophen 5/325mg on Friday, 03/29/24. -Resident #3's Oxycodone/Acetaminophen 5/325mg was still not delivered on Saturday, 03/30/24. -She called the pharmacy to find out why the Oxycodone/Acetaminophen 5/325mg had not been delivered. -She was informed by the pharmacy it was too early for the Oxycodone/Acetaminophen 5/325mg to be filled, the earliest it could be filled would be 03/31/24. -She was informed by the pharmacy that none of Resident #3's medications including the Oxycodone/Acetaminophen 5/325mg had been sent back to the pharmacy. Interview with Administrator on 05/08/24 at 4:03pm revealed: -She was made aware on 04/01/24 by the RCC that Resident #3's Oxycodone/Acetaminophen 5/325mg could not be found. -She was not aware Resident #3 had missed taking any of her pain medications until the RCC made her aware on 04/01/24. -The RCC had taken Resident #3's regular	D 392		

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D 392	Continued From page 42 medications off the medication cart, however, the Oxycodone/Acetaminophen 5/325mg tablets were left in the locked box in the medication cart where the RCC felt they would be safe. -The RCC ordered Resident #3 more Oxycodone/Acetaminophen 5/325mg the next day after she returned to the facility from the hospital but they never came. -She could not answer why the MAs were not still counting the Oxycodone/Acetaminophen 5/325mg every shift since the CSR and Oxycodone/Acetaminophen 5/325mg were still on the medication cart. -The MAs should have still been counting the Oxycodone/Acetaminophen 5/325mg since the CSR was still on the cart. Telephone interview with Resident #3's PCP on 05/08/24 at 4:05pm revealed: -She conducted a telehealth visit with Resident #3 on 03/29/24. -Resident #3 complained of pain in her back, shoulder, knees and legs. -On 03/29/24, she wrote a prescription for a 3-day supply (12 tablets) of Resident #3's Oxycodone/Acetaminophen 5/325mg. -Before the telehealth visit on 03/29/24, she was not notified the resident was not receiving Oxycodone/Acetaminophen for pain. -She was not made aware of the missing Oxycodone/Acetaminophen 5/325mg tablets. -The missed Oxycodone/Acetaminophen 5/325mg would cause Resident #3 more discomfort and pain. _____ The facility failed to ensure accurate reconciliation and accountability for Resident #3's Oxycodone/Acetaminophen, a controlled substance used to treat moderate to severe pain. Resident #3 had chronic leg and knee pain and	D 392		

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D 392	Continued From page 43 had an order to take Oxycodone/Acetaminophen scheduled every 6 hours. When the resident returned from a hospitalization requiring surgery to remove her gall bladder on 03/26/24, there were 108 Oxycodone/Acetaminophen tablets missing and unavailable for administration, resulting in multiple missed doses and the resident having severe pain and requiring an emergency room visit on 03/29/24 for leg and knee pain. The failure of the facility to accurately account for and reconcile the controlled substance resulted in serious physical harm and neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/08/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 7, 2024.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.	D 399		

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D 399	Continued From page 44 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a suspected drug diversion of 108 tablets of a controlled substance used to treat moderate to severe pain for 1 of 1 resident (#3) was reported to the facility's contracted pharmacy. The findings are: Review of the facility's controlled substances policies and procedures dated 10/01/20 revealed: -The facility would ensure that all known drug diversions were reported to the pharmacy, local law enforcement agency, and Health Care Personnel Registry (HCPR) as required by state law, and that all suspected drug diversions were reported to the pharmacy. -There would be documentation of the contact and action taken. Review of Resident #3's current FL-2 dated 03/06/24 revealed: -Diagnoses included chronic pain, fracture of the shoulder, fracture of the femur, immobility syndrome, and morbid obesity. -There was an order for Oxycodone/Acetaminophen 5mg/325mg take 1 tablet every 6 hours. (Oxycodone/Acetaminophen is a controlled substance used to treat moderate to severe pain.) Review of Resident #3's incident report dated 04/02/24 at 10:06am revealed: -The resident was sent to the emergency room (ER) on 03/12/24 and initially, she was not supposed to return to the facility. -The resident returned from the hospital on Tuesday night, 03/26/24, at almost 10:00pm.	D 399		

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D 399	Continued From page 45 -The resident did not have any of her Oxycodone/Acetaminophen 5/325mg tablets available for administration. -The resident's Oxycodone/Acetaminophen 5/325mg tablets should have been in the controlled substance locked box in the medication cart because all of her other medications were still at the facility. -The facility reached out to the primary care provider (PCP) through telemed and requested a refill for the medication on Wednesday, 03/27/24, once it was discovered there was none in the facility. -They sent over an order for a 3-day supply to the pharmacy to hold her over until the PCP came to the facility on Friday, 03/29/24. -The medication aide (MA) reported on Thursday, 03/28/24, that the medication was still not in the facility. -The MA was told to get the PCP to write a full prescription on Friday, 03/29/24, once the PCP was in the facility. -The PCP wrote a new prescription on Friday, 03/29/24, and on Saturday, 03/30/24, the medication was still not in the facility. -The pharmacy was contacted and pharmacy reported the resident could not get the medication filled until 03/31/24. -The medication was delivered on 04/01/24. -The pharmacist reported no medications had been sent back to the pharmacy. -There were 120 Oxycodone/Acetaminophen 5/325mg tablets delivered to the facility on 03/08/24. -On 03/11/24, the resident had 110 pills remaining when a cart audit was completed. -All MAs were asked about the missing pills and no one could explain what happened to the medication. -The Administrator and the corporate office were	D 399		

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contacted.
-A HCPR report was done and the provider and police were contacted.
-No injuries were observed at the time of the incident.
-No witnesses were found.
-There was no documentation that the facility's contracted pharmacy was notified of the suspected drug diversion.
-The person who prepared the incident report was documented as the Administrator.

Review of a 24-hour HCPR Initial Allegation Report dated 04/01/24 revealed:
-The allegation was diversion of resident drugs.
-The date of the incident was documented as 04/01/24 at 5:00pm.
-The accused individual information was blank with no one documented as accused.
-The allegation description included there were approximately 108 Oxycodone/Acetaminophen 5/325mg tablets missing for Resident #3.
-It was documented there was reasonable suspicion of a crime, and the incident was reported to the local police department on 04/01/24 at 6:30pm.
-There was no documentation that the suspected drug diversion was reported to the facility's contracted pharmacy.
-The report was signed by the Administrator and dated 04/01/24.

Review of a 5-day HCPR Investigation Report dated 04/05/24 revealed:
-The accused individual was documented as "unknown".
-The allegation was diversion of resident drugs.
-The date of the incident was documented as 04/01/24 at 5:00pm.
-The allegation description included there were

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approximately 108 Oxycodone/Acetaminophen 5/325mg tablets missing for Resident #3.
-There were no witnesses documented.
-The allegation was documented as substantiated by the Administrator, but the facility was unsure who took the medication.
-The incident was reported to the local county Department of Social Services (DSS) on 04/03/24 and local law enforcement on 04/01/24.
-There was no documentation the suspected drug diversion was reported to the facility's contracted pharmacy.
-The report was signed by the Administrator and dated 04/05/24.

Interview with the Resident Care Coordinator (RCC) on 05/08/24 at 11:10am revealed:
-When Resident #3 was in the hospital in March 2024, she had taken Resident #3's regular medications out of the medication cart but left the Oxycodone/Acetaminophen 5/325mg in the locked box in the medication cart.
-She planned on sending the medications back, to the pharmacy however, she never got around to it.
-She had no idea the Oxycodone/Acetaminophen 5/325mg tablets were missing until Resident #3 returned to the facility on 03/26/24.
-At first, she thought Resident #3 was just out of the Oxycodone/Acetaminophen 5/325mg or that they had been sent back to the pharmacy by a MA.
-On Wednesday, 03/27/24, she requested a refill of the Oxycodone/Acetaminophen 5/325mg through the PCP's telemed system.
-She was notified on Thursday, 03/28/24, by a MA that Resident #3's Oxycodone/Acetaminophen 5/325mg had not been delivered to the facility.
-Resident #3's PCP wrote a prescription for Oxycodone/Acetaminophen 5/325mg on Friday,

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D 399	Continued From page 48 03/29/24. -Resident #3's Oxycodone/Acetaminophen 5/325mg was still not delivered on Saturday, 03/30/24. -She called the pharmacy to find out why the Oxycodone/Acetaminophen 5/325mg had not been delivered. -She was informed by the facility's contracted pharmacy that it was too early for Resident #3's Oxycodone/Acetaminophen 5/325mg to be filled; the earliest it could be filled was 03/31/24. -She was informed by the facility's contracted pharmacy that none of Resident #3's medications including the Oxycodone/Acetaminophen 5/325mg had been sent back to the pharmacy. -She did not notified the pharmacy of the missing and suspected drug diversion of Resident #3's Oxycodone/Acetaminophen 5/325mg tablets because she did not know it needed to be reported to the pharmacy. Interview with Administrator on 05/08/24 at 4:03pm revealed: -She was made aware on 04/01/24 by the RCC that Resident #3's Oxycodone/Acetaminophen 5/325mg could not be found. -She was not aware Resident #3 had missed taking any of her pain medications until the RCC made her aware on 04/01/24. -She had no idea what happened Resident #3's Oxycodone/Acetaminophen 5/325mg tablets. -The RCC notified Resident #3's PCP of the drug diversion. -She called local law enforcement and the facility's corporate office and made them aware of the drug diversion. -She thought she had called the facility's contracted pharmacy and notified the of the drug diversion but she had not documentation of the notice to the pharmacy.	D 399		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 399	Continued From page 49 Telephone interview with a pharmacy technician on 05/08/24 at 3:15pm revealed: -An electronic prescription for Oxycodone/Acetaminophen 5/325mg was sent to the pharmacy on 03/29/24 at 12:11pm by Resident #3's PCP. -The 03/29/24 prescription for the Oxycodone/Acetaminophen 5/325mg was profiled only until it could be filled. -The original fill date for the Oxycodone/Acetaminophen 5/325mg was 03/08/24 and 120 tablets were delivered to the facility on 03/08/24 at 11:36pm. -The 120 tablets that had been delivered to the facility on 03/08/24 should have been enough to get Resident #3 through 04/06/24 and she was not sure why the resident needed the 3-day supply that was requested on 03/29/24. -The first day Resident #3's insurance would pay for any Oxycodone/Acetaminophen 5/325mg again was 03/31/24. -On 04/02/24, 12 tablets of Oxycodone/Acetaminophen 5/325mg were delivered to the facility. -The pharmacy was not made aware by the facility that it was an emergency situation and the medication was missing; if they had been notified the Oxycodone/Acetaminophen 5/325mg could have been delivered on a Sunday, 03/31/24. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 05/08/24 at 4:51pm revealed: -None of Resident #3's Oxycodone/Acetaminophen 5/325mg tablets had been returned to the pharmacy. -The pharmacy had not received notification of the missing and suspected drug diversion of Resident #3's Oxycodone/Acetaminophen	D 399		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	R-C 05/08/2024

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D 399	Continued From page 50 5/325mg tablets. -The only call the pharmacy received about the suspected drug diversion was that morning, 05/08/24. -Someone from the facility called that morning, 05/08/24, and wanted documentation that the facility had called the pharmacy about the suspected drug diversion of Resident #3's Oxycodone/Acetaminophen 5/325mg tablets. -There was no documentation of the facility notifying the pharmacy of the suspected drug diversion.	D 399		