STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING ______ B. WING ______	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 7/17/24 through 7/18/24. Event ID# 3SXN1. The following intakes were investigated NC00214204, NC00216542, and NC00218868. One of the 5 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 record review, staff and physician interviews, the facility failed to protect residents' rights to be free from misappropriation of controlled medications for 1 of 1 resident (Resident #1) reviewed for misappropriation of residents' property. Findings included: The facility's Abuse, Neglect, or Misappropriation of Resident Property policy last revised 3/10/17 read in part that the facility will do whatever is in its control to prevent mistreatment, neglect, exploitation, and abuse of our residents or misappropriation of their property.	F 602	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/01/2024

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

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F 602	Continued From page 1 Resident #1 was admitted to the facility on 1/26/24 with diagnoses which included hip fracture and non-Alzheimer's dementia. A review of the initial allegation report dated 4/30/24 revealed the facility became aware of the incident on 4/30/24 at 6:00 AM when 2 staff members reported an allegation of misappropriation of Resident #1's morphine medication by a nurse. The 5-day investigation report dated 5/06/24 revealed the allegation of misappropriation of residents' property was substantiated. Nurse #1's urine drug screen tested positive for morphine on 5/06/24 and he was terminated. Resident #1's missing morphine medication was replaced at facility expense. An interview on 7/17/24 at 8:26 PM with Nursing Assistant (NA) #1 revealed she was working night shift on 4/30/24 on the same hall as Nurse #1. NA #1 stated around 4:00 AM she was sitting at the nurses' station, and she observed Nurse #1 take a brown bottle in a plastic bag out of the medication cart and place it on top of the medication cart. Nurse #1 then got another bottle of liquid out of the medication cart. NA #1 was unable to clearly see what Nurse #1 did with either medication bottle, but when he turned around, he had a medication syringe with clear liquid in it and stated he was going to give Resident #1 the mixture of both medications. NA #1 observed Nurse #1 walked down the hall toward Resident #1's room. NA #1 observed on top of the medication cart a medication cup which had liquid in it. Nurse #1 returned to the nurses' station and picked up his soda can. Nurse #1	F 602		

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F 602	Continued From page 2	F 602		

filled the medication cup that had liquid already in it with soda and then went into the bathroom. NA #1 noted that on the medication cart, the medication cup of soda was bubbling. Nurse #1 came back to the medication cart and had his back to NA #1 and she observed Nurse #1's head tilted back like he had drunk something. When Nurse #1 moved and NA #1 could see the top of the medication cart, the medication cup of liquid and soda was gone. NA #1 was unable to observe what Nurse #1 did with the medication cup and was unable to clarify the color of the liquid in the cup. NA #1 was confused and unsure what to do and decided to contact the Director of Nursing (DON) around 6:00 AM.

An interview on 7/17/24 at 10:13 AM with NA #2 revealed she was working night shift on 4/30/24 on the same hall as Nurse #1. Around 4:00 or 4:30 AM, while sitting at the nurses' station, NA #2 observed Nurse #1 take a medication bottle out of the medication cart and poured blue liquid into a medication cup. NA #2 observed the liquid in the medication cup to be blue, like 'mouthwash'. NA #2 stated she observed Nurse #1 take a medication syringe down to Resident #1's room and left the medication cup of blue liquid on top of the medication cart. When Nurse #1 returned to the nurses' station, he picked up his soda can, drank the blue liquid from the medication cup and went into the bathroom. NA #2 was with NA #1 when she called the DON around 5:00 or 6:00 AM to report the incident.

An attempt to interview Nurse #1 on 7/17/24 at 11:24 AM was unsuccessful and he did not return the call.

An interview on 7/17/24 at 1:33 PM with the

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F 602	Continued From page 3 Director of Nursing revealed that NA #1 had contacted her and reported her observations. When she arrived at the facility, she obtained a urine sample from Nurse #1 which was sent for drug testing. Nurse #1 was suspended and terminated on 5/06/24 when his urine drug test was positive for morphine, opiates, cannabinoids, and tetrahydrocannabinol (THC)(the main psychoactive part of marijuana). An interview on 7/17/24 at 2:47 PM with the Physician revealed Resident #1 was on scheduled and as needed pain medication and she did not believe the resident had as adverse effects from missing a dose of pain medication. The facility provided the following corrective action plan with a completion date of 5/06/24. Problem statement included: The administrator filed a report with the North Carolina Board of Nursing, notified DEA (drug enforcement agency) with Loss Report Letter on 5/06/24 and notified the facility Medical Director, Graham County DSS, Graham County Sherriff's Department, and Resident Representative of findings of investigation via telephone on5/06/24. An investigation report was sent to the local area Ombudsman and Health Care Personal Agency on 5/6/24. The resident was not billed for this medication. Address how the facility will identify other residents having the potential to be affected by the deficient practice: A medication count of all controlled drugs was conducted by the Registered Nurse supervisors on 4/30/24 to ensure all controlled medication	F 602		

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F 602	Continued From page 4 counts were accurate and available as ordered by the physician. No concerns were identified during this audit. On 4/30/24 the consulting pharmacist was in the facility to perform a routine audit to include controlled substances and on 5/06/24 the pharmacist was notified of the incident and medications that were diverted were replaced by the pharmacy as appropriate. On 4/30/24, all residents who received controlled medications for pain were assessed by the Assistant Director of Nursing and the Registered Nurse supervisors for pain to include signs and symptoms of pain both verbal and non-verbal to ensure pain levels were being addressed appropriately. Any concerns were reported to the charge nurse, Director of Nursing or Assistant Director of Nursing and addressed immediately. The Medical Director was notified, and orders were given as appropriate. No concerns were identified. An in-service was initiated on 4/30/24 by the Director of Nursing and the Assistant Director of Nursing on Abuse Neglect, Misappropriation, Reporting, Reporting, Code of Ethics, and Diversion. An in-service was also initiated on 4/30/24 by the Administrator with all nurses and medication aides to include agency staff regarding Controlled Substance Diversion to include: the definition, implications, and the process for returning controlled medications. All education was completed by 5/03/24. Any nurse or medication aide to include agency staff that have not completed the education as stated above by the completion date will do so by their next scheduled shift. Any newly hired licensed nurse, medication aide or agency staff will receive the above stated in-service education during orientation prior to their first shift.	F 602		

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

On 4/30/24, the Administrator 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. The in-service also included ensuring all nurses and medication aides are administering medications per the provider's order. All in services were completed by 5/03/24. After 5/03/24, all nurses or medication aides to include agency and newly hired nurses and medication aides that have not received the in-service training will complete prior to working their next scheduled shift.
The pharmacy will conduct monthly cart and med-pass audits to ensure nurses and medication aides, including agency and newly hired nurses, are following policy and procedures related to medication administration. All residents who are receiving a controlled substance for pain management will be monitored every shift for signs and symptoms of pain both verbal and non-verbal to ensure pain levels are being addressed appropriately. Any concerns will be reported to the charge nurse, Director of Nursing or Assistant Director of Nursing and addressed immediately.

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

A 100 % audit of all ordered controlled medications will be reviewed by the Director of Nursing Assistant Director of Nursing weekly x4 weeks and compared to the Controlled

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F 602	Continued From page 6 Substance Count Sheets, medication administration record, and/or the return drug requisition slips to ensure all controlled substance medications are being administered or have been returned to pharmacy as required per policy and there are no signs of drug diversion. Medication pass audits were completed by the Director of Nursing or Assistant Director of Nursing 3x/week for 4 weeks. All areas of concern were addressed during the audits including re-educating nurses. The Director of Nursing reviewed the conducted audits weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately. Any concerns will be addressed and investigated immediately. The Medical Director and Responsible Party will be notified of any concerns and care-plans/care-guides will be updated as appropriate. The Administrator or Director of Nursing will present the findings of the audit tools to the Quality Assurance Performance Improvement Committee monthly for 2 months. The Quality Assurance Performance Improvement 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. QAPI meetings were held on 5/30/24 and 6/27/24. Date of Compliance: 5/06/24 The facility's corrective action with a correction date of 5/06/24 was validated onsite by interviews with the DON and nursing staff. Nursing staff confirmed they had received in-service training regarding pharmacy policy on safeguarding of controlled medications in	F 602		

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F 602	Continued From page 7 medication carts, signing of shift-to-shift count sheets, tracking total number of sheets of controlled medications in the locked medication cart with the count sheet and proper procedures for return of discontinued controlled medications to the pharmacy. Interview with the DON revealed after the incident she had immediately educated all nurses on pharmacy policy of controlled medications. She had audited the controlled medications and ensured a 100% pain audit of residents to include complaints of pain and signs and symptoms of pain. She stated the interventions were successful as the facility had not had any diversion incidents since then.	F 602		