| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| OAK GROVE HEALTH CARE CENTER | 518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 09/03/24 through 09/06/24. The facility ws found in compliance with the requireent CFR 483.73, Emergency Preparedness. Event ID# 2FP711. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 09/03/24 through 09/06/24. Event ID#2FP711. The following intakes were investigated: NC00218793, NC00214406, NC00207973, and NC00205805.<br><br>2 of the 5 allegations resulted in a deficiency. | F 000 | | |
| F 602 SS=D | Free from Misappropriation/Exploitation<br>CFR(s): 483.12<br><br>§483.12<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and interviews with staff, residents, responsible parties, and the Medical Director (MD), the facility failed to protect resident's rights to be free of misappropriation of controlled substances for 2 of 2 residents reviewed for misappropriation of resident property (Resident #212 and Resident #49).<br><br>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 | 09/29/2024

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The facility's Abuse, Neglect, Exploitation, and Misappropriation policy, last revised on 11/16/2022, revealed in part the facility would ensure all residents were free from misappropriation of property.

a. Resident #212 was admitted to the facility on 04/23/2023 with diagnoses including diabetes mellitus, osteomyelitis of right ankle and foot, and protein-calorie malnutrition. Resident #212 was discharged from the facility on 06/05/2024.

A review of the physician's order dated 05/04/2023 revealed Resident #212 had an order to receive 1 tablet of Oxycodone (an opioid that acts on the central nervous system to relieve pain) 5 milligrams (mg) every 6 hours as needed for pain.

The quarterly Minimum Data Set (MDS) dated 07/30/2023 revealed Resident #212 had moderately impaired cognition.

The initial allegation report dated 10/02/2023 revealed the Administrator became aware of the misappropriation of residents' property on 10/02/2023 at 9:00 AM when the nurse medication count revealed a card of 30 tablets of Oxycodone 5 mg and the controlled medication count sheet were missing. On 10/02/2023, an internal investigation was initiated regarding the allegation of misappropriation of property for Resident #212.

The investigation report (5-day) dated 10/05/2023 revealed the Director of Nursing (DON) received a phone call from Nurse #1 on 10/01/2023 at 7:10 PM. Nurse #2 verified the narcotic count was incorrect on 10/01/2023 at 7:10 PM for Resident

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#212. Nurse #1 and Nurse #2 stated the count on the evening of 09/30/2023 was 27 cards and 30 sheets which were the correct counts. Nurse #1 and Nurse #2 verified the count was also 27 cards and 30 sheets on 10/01/2023 during the 7:00 AM count. On 10/01/2023 new count sheets for the month of October 2023 were distributed by Unit Manager #1. The new count sheet indicated that there were 26 cards and 29 sheets that were signed in by Med Aide #1. Nurse #1 revealed at 3:00 PM on 10/01/2023 she took over the medication cart from Med Aide #1 who was being pulled to the floor to work as a Nursing Assistant (NA). Nurse #1 stated she did not count the cart with Med Aide #1.

Per the facility investigation report dated 10/05/2023, a review of the narcotic receipt sheet was completed by the DON on 10/02/2023 which verified that Resident #212 was issued 30 tablets of Oxycodone 5 mg tablets on 09/14/2023 and the medication card was added to the medication cart. On 10/02/2023 the DON pulled a list from pharmacy to ensure narcotics were sent to the facility and matched the medications in medication cart revealing one card of 30 tablets of Oxycodone 5 mg issued to Resident #212 was missing from the medication cart per the pharmacy proof of delivery statement dated 09/14/2023.

Multiple attempts to contact Unit Manager #1 were made and were unsuccessful.

Several attempts to contact Nurse #1 and Nurse #2 were made from 09/03/2024 to 09/06/2024. The attempts were unsuccessful and there were no return calls from Nurse #1 or Nurse #2.

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An attempt to conduct a phone interview with Medication Aide #1 on 09/06/2024 at 8:30 AM was unsuccessful. The phone number was no longer in service.

During an interview with Resident #212's responsible party (RP) on 09/06/2024 at 9:10 AM, the RP stated that facility had notified him in October of 2023 that Resident #212's Oxycodone may have been diverted by an employee working in the facility at that time. The RP also stated that the facility informed him that the facility would assume responsibility for the cost of the missing medication.

An interview was conducted with the DON on 09/06/2024 at 10:20 AM. The DON stated Nurse #1 submitted to a drug test on 10/01/2023 which revealed a negative drug panel. The DON also stated Nurse #1 received written disciplinary counseling for failing to count the cart prior to accepting the cart. The DON also stated that multiple attempts were made by the facility to contact Medication Aide #1 with no success. The DON further explained that Medication Aide #1 was never heard from or seen again by the facility. The facility terminated Medication Aide #1 on 10/05/2023 and the facility notified law enforcement that they had been unable to contact or locate Medication Aide #1. Law enforcement informed the facility that a detective would be assigned to the case on 10/05/2023. Resident #212 had oxycodone available during this time frame.

An interview was conducted with the MD on 09/06/2024 at 12:00 PM. The MD stated he was aware of the incident occurring on 10/02/2023. He further stated that Resident #212 was

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assessed and had no negative outcomes. He further explained that the facility absorbed the cost of the missing medications, and the medications were not charged to Resident #212.

b. Resident #49 was admitted to the facility on 06/02/2024 with diagnoses including dementia and fracture of left femur with surgical repair.

The physician's order dated 06/02/2024 revealed Resident #49 had an order for Oxycodone 5 milligrams (mg) (an opioid that acts on the central nervous system to relieve pain); give ½ tablet (2.5mg) every 4 hours as needed for pain. The medication order was noted to be discontinued on 06/10/2024.

The 5-day Minimum Data Set (MDS) dated 06/08/204 revealed Resident #49 had moderately impaired cognition.

A review of the initial allegation report dated 06/26/2024 revealed the facility became aware of the incident on 06/25/2024 at 11:45 AM when the Administrator was notified that Nurse #1 had signed out a narcotic several times after the medication had been discontinued by the Nurse Practitioner (NP).

The 5-day investigation report dated 07/01/2024 revealed the facility completed a review of Resident #49's medication orders which revealed the Oxycodone was discontinued on 06/10/2024. Review of the narcotic sign out sheet revealed the medication had been signed out 4 times by Nurse #1 after the medication had been discontinuation. The investigation report revealed Nurse #1 had indicated that she had accidentally pulled it each time and immediately wasted it.

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The facility contacted Nurse #2 who countersigned the medication waste, Nurse #2 indicated that she only witnessed one pill being wasted and did not observe any other narcotic wastes for Resident #49. The allegation of diversion of residents' drugs was substantiated and Nurse #1 was terminated on 06/28/2024. The facility filed reports to the local law enforcement and the Drug Enforcement Agency (DEA) on 06/26/2024, and the North Carolina Board of Nursing (NC BON) on 06/28/2024. The MD and the Resident #49's responsible party were notified on 06/26/2024.

A review of the declining narcotic sheet for Resident #49 was conducted on 09/05/2024 and revealed Nurse #1 had signed out Oxycodone 5mg and Nurse #2's signature was entered under the witnessed column.

06/13/2024 at 10:30 PM with a documented wasted amount of ½ tablet.
06/16/2024 at 10:08 PM with a documented wasted amount of ½ tablet.
06/16/2024 at 10:03 AM with a documented wasted amount of ½ tablet.
06/18/2024 at 8:00 PM with a documented wasted amount of ½ tablet.

An attempt to conduct a phone interview with Nurse #1 on 09/06/2024 at 8:40 AM was unsuccessful. The phone number was no longer in service.

An attempt to conduct a phone interview with Nurse #2 on 09/06/2024 at 8:55 was unsuccessful.

During an interview with Resident #49 on

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09/06/2024 at 10:31AM, she did not recall any concerns with her medications including her pain medication.

An interview was conducted with Resident #49's Responsible Party (RP) on 09/06/2024 at 10:40 AM. The RP stated the facility had notified her in June that Resident #49's Oxycodone could have been diverted by a nurse working in the facility at that time.

An interview was conducted with the Director of Nursing (DON) on 09/06/2024 at 11:30 AM. The DON stated that Nurse #1 had signed out a narcotic that had been discontinued by the (NP) four times after it had been discontinued by the NP on 06/10/2024. When Nurse #1 was interviewed she indicated she had accidentally pulled the medication each time and immediately wasted it. Nurse #2 indicated that she only witnessed one pill being wasted and did not observe any other narcotic wastes for Resident #49. The DON stated she reported the incident to the Administrator 06/25/2024 and an investigation was initiated. The DON also stated she contacted Nurse #1 on 06/26/2024 to inform her of the facility's concerns, to obtain a statement from Nurse#1, and to notify Nurse #1 that she had been placed on suspension until the investigation could be completed. The DON further explained that Nurse #1 reported to the facility on 06/27/2024 to offer a statement and to submit to a drug test. The DON stated Nurse #1 had tested positive for the medication in question and her employment was terminated 06/28/2024. The DON stated it was determined the process to reconcile controlled medication by removing discontinued controlled medications from the medication cart was not followed by the nursing

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staff when Resident #49's Oxycodone was discontinued. The facility substantiated the allegation and closed the investigation on 07/01/2024.

An interview was conducted with the Medical Director (MD) on 09/06/2024 at 12:00 PM. The MD stated he was aware of the incident occurring 06/25/2024. He further stated that Resident #49 was assessed and had no adverse consequences noted. He further explained that the medication in question had been discontinued and Resident #49 had not missed any doses. The MD also stated that the medications were reimbursed by the facility and not charged to Resident #49.

The facility provided the following corrective action plan with a completion date of 07/01/2024.

Address how corrective actions will be accomplished for those residents to have been affected by the deficient practices:

On 10/01/23, the Director of Nursing was made aware that Resident #212 had a prescription-controlled medication card containing 30 Oxycodone 5mg pills missing from the medication cart on October 1, 2023, between 7:00am - 7:10pm.

On 06/26/24, the Director of Nursing was made aware that a resident had a total of 4 Oxycodone 5 mg pills signed out on the declining inventory count sheet and punched from the controlled drug card between 06/11/24 - 06/26/24 by the Charge Nurse (Nurse #1) after the Nurse Practitioner discontinued the Oxycodone 5mg on 06/10/24. The resident had no negative impact or

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harm as the medication was discontinued. The facility recognizes that residents prescribed controlled medication have the potential to be affected from the noncompliance of missing controlled medication.

The Director of Nursing audited the named resident's-controlled medication with declining count sheet on 06/26/24. No discrepancies noted.

The Director of Nursing and Administrator conducted an audit of all other medication carts to verify controlled medication count on 06/26/24. No discrepancies noted in the controlled medication count.

On 06/26/24 a Root Cause Analysis was completed by the Vice President of Clinical Services in regard to the missing controlled medication for the resident. It was determined through root cause analysis the system / process to reconcile controlled medication by removing discontinued controlled medication (Oxycodone 5mg) from the medication cart on 06/10/24 was not followed.

How will the facility identify other residents having the potential to be affected by the same deficient practice:
The Administrator, Director of Nursing and Social Service Director completed a quality of review of current residents prescribed controlled medication. Identified residents prescribed controlled medications was reconciled to the declining inventory county sheet to ensure the count on the sheet and card match and that medications that were ordered were available and on med carts on 07/01/24. No discrepancies noted.

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Social Service Director interviewed alert and oriented residents on 06/27/24 to ensure residents are receiving medication when they are scheduled or when they ask for it and if they are experiencing an increase in pain. No issues were noted. The Director of Nursing assessed non-interviewable residents for signs and symptoms of pain to ensure pain is being managed appropriately as well. No concerns identified.
The Executive Director and Director of Nursing interviewed staff members related to missing controlled medication as well.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:
The Vice-President of Clinical Services re-educated the Director of Clinical Services on handling-controlled medications that have been discontinued, narcotic reconciliation and the Diversion of Drugs- Zero Tolerance on.
The Director of Nursing re-educated licensed nurses and medication aides on Controlled Drugs, Drug Diversion and Pharmacy Program Management on 7/01/24.

The Executive Director and Director of Nursing re-educated staff with validation of understanding on Abuse policy with emphasis on Misappropriation of Residents Property and Drug Diversion on 6/27/24.

The Director of Nursing and Nurse Manager to complete quality monitoring on medication carts weekly for four weeks then monthly for two months to ensure all medications accounted for with count correct with nurses counting and

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documenting total cards and total count sheets beginning on 7/01/24.

How will the facility monitor its corrective actions to ensure the deficient practice will not recur:
On 6/26/24, when the missing controlled medications was identified the center Executive Director conveyed an ADHOC Quality Assurance Performance Improvement meeting to determine the root cause analysis of the deficient practice, put a plan of action in place to include quality improvement monitoring and the frequency of monitoring beginning on 7/1/24 to ensure all medications accounted for with count correct with nurses counting and documenting total cards and total count sheets including the Executive Director, Medical Director, Director of Nursing, the Manager of Social Services, the Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records Clerk, Central Supply Clerk, Admissions Director, Nurse Managers, Dietary Manager, and the Environmental Services Director.
The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement (QAPI) meeting monthly to ensure ongoing compliance times 3 months. Quality Improvement monitoring schedule will be modified based on findings of monitoring.

Date of Compliance: 07/01/2024

The facility's corrective action plan with a correction date of 07/01/2024 was validated onsite by observations and interviews with the Administrator, DON, and nursing staff.

An observation was conducted during a shift

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transition for a medication cart between 2 nurses on 09/06/2024. Nurses started with counting the total number of blister cards that contained controlled medications stored in the double-locked compartment in the medication cart and verified the balance in the narcotic count log. The nurses then counted the total number of declining narcotic sheets and verified the balance in the narcotic count log. The nurses then proceeded to count each blister card of controlled medication to ensure the quantity listing in the declining narcotic count sheets were consistent with the actual pill count. After all counts were completed and without any discrepancies, the on-coming shift nurse and the off-going shift nurse signed the narcotic count logs, and the off-going shift nurse passed the medication cart key to the on-coming shift nurse.

A Medication Administration observation which consisted of 29 medications, 4 different residents, 2 different nurses and 1 medication aide was conducted on 09/04/2024 and 09/05/2024. All the medications were administered as ordered without any issues. Controlled medication was retrieved from the double-locked compartment in the medication cart during the observation. The nurse documented the removal of the controlled medication on the declining narcotic count sheet. Random samples of 3 controlled medications were pulled from each medication cart for verification of accuracy. The controlled substance counts were consistent with the records documented in the declining narcotic count sheets.

Interviews with the nursing staff including medication aides (MA), Licensed Practical Nurses (LPN), and Registered Nurses (RN)

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confirmed they had received education related to Misappropriation of Personal Property and Narcotic Process Policy. It included the process for shift-to-shift controlled medication count, verification of on-hand controlled medications, and returning of discontinued medications to the pharmacy. The nurses and medication aides were able to describe the policy and procedures and verbalized understanding of the education. Review of audit records revealed all residents receiving controlled medications were audited by the DON weekly for 4 weeks beginning on 06/26/2024. Then monthly for 8 weeks to ensure the narcotic count was correct on each cart, shift-to-shift count was completed appropriately, and discontinued controlled medications were removed from the medication carts and returned to the pharmacy. The finding were reported by the DON to the QAPI committee monthly for 3 months for suggestions and/or recommendations; the quality improvement monitoring schedule will be modified based on finding of the monitoring.

Interview with the Administrator and the DON revealed the facility launched an in-service related to controlled medication process and accountability immediately after the incident to re-educate all the licensed nurses and medication aides. The DON audited the medication carts in-person randomly to ensure all controlled medication counts were conducted appropriately and the declining narcotic count sheets were documented properly. The Administrator and the DON stated the interventions were successful as the facility did not have any similar diversion issues since then.

The compliance date of 07/01/2024 was validated.

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|---|---|---|---|
| | 345464 | A. BUILDING _____ B. WING _____ | C 09/06/2024 |

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| OAK GROVE HEALTH CARE CENTER | 518 OLD US HIGHWAY 221 RUTHERFORDTON, NC 28139 |

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| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of Level II Pre-Admission Screening and Resident Review (PASRR) (Resident #17 and Resident #27), and anticoagulants (Resident #23). This deficient practice was identified for 3 of 3 residents reviewed for MDS accuracy.<br><br>The findings included:<br><br>1. Resident #17 was admitted to the facility on 07/18/2017 with diagnoses which included schizoaffective disorder and bipolar disorder.<br><br>Resident #17's most recent comprehensive Minimum Data Set (MDS) was an annual assessment dated 03/16/2024. The Identification Information section of the MDS assessment did not report Resident #17 had PASRR Level II determination.<br><br>Further review of Resident #17's electronic medical record (EMR) revealed Resident #17's care plan included the following area of focus, in part: The resident has a Level II PASRR related to serious mental illness (Initiated 07/18/2017; Revised 03/25/2022).<br><br>An interview was conducted on 09/05/2024 at 11:49 AM with the facility's Director of Social Services (DSS). Upon request, the DSS | F 641 | 1. On 09/05/2024 Resident #17 and Resident #27 MDS assessment was modified to accurately reflect both residents Level II PASSR status by the Minimum Data Set Nurse. On 9/25/2024 Resident #23 MDS was modified to accurately reflect that resident was on an Antiplatelet.<br><br>2. On 09/05/2024 through 09/06/2024 the Social Service Director performed quality improvement monitoring of the last 30 days of MDS assessments for accurately coding of the MDS related to the Level I and Level II PASSRs as well as 100% of all current residents to be certain they were correctly coded for appropriate PASSR levels. On 09/26/2024 the MDS Nurse performed quality improvement monitoring of the last 30 days of MDS assessments for accurate coding of anticoagulants as well as antiplatelets. Any issues identified were addressed.<br><br>3. The Minimum Data Set Nurse was re-educated by the Division Vice President of Clinical Services on accurate coding of the MDS on 09/05/2024 and newly hired MDS nurse was educated again on 9/26/2024 by the Regional MDS Consultant. Starting on 09/30/2024 The Social Service Director and/or MDS Nurse | 10/3/24 |

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| F 641 | Continued From page 14<br>reviewed Resident #17's medical record and provided a copy of Resident 17's PASRR Level II Determination Notification letter dated 12/29/2020. The letter confirmed Resident #17 was determined to have PASRR Level II status.<br><br>An interview was conducted on 09/05/2024 at 12:29 PM with the facility's MDS nurse. During the interview, the MDS nurse stated Resident #17's MDS was coded incorrectly and should have reflected a Level II PASRR.<br><br>An interview was conducted with the Administrator on 09/05/2024 at 12:45 PM. The Administrator stated that she expected the PASRR information for all residents be coded accurately on the MDS.<br><br>2. Resident #27 was admitted to the facility on 01/24/2023 with diagnoses which included bipolar disorder among others.<br><br>Review of Resident #27's PASRR Level II Determination Notification letter dated 04/24/2023 confirmed Resident #27 was determined to have PASRR Level II status.<br><br>Resident #27's most recent comprehensive Minimum Data Set (MDS) was an annual assessment dated 01/13/2024. The Identification Information section of the MDS assessment did not report Resident #27 had PASRR Level II determination.<br><br>Further review of Resident #27's electronic medical record (EMR) revealed Resident #27's | F 641 | to perform Quality Improvement Monitoring of the MDS□s for accurately coding of Level I and Level II PASSR as well as accurate antiplatelet/anticoagulant coding three times per week for 12 weeks.<br><br>4. The Executive Director introduced the plan of correction to the ADHOC Quality Assurance-Performance Improvement Committee on 09/26/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months.<br><br>5. 10/03/2024 | |

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| F 641 | Continued From page 15 | F 641 | | |

care plan included the following area of focus in part: The resident has a Level II PASRR related to bipolar disorder (Initiated 04/24/2023 and last updated 08/27/24).

An interview was conducted on 09/05/2024 at 12:29 PM with the facility's MDS nurse. During the interview, the MDS nurse stated Resident #27's MDS was coded incorrectly and should have reflected a Level II PASRR.

An interview was conducted on 09/05/2024 at 12:45 PM with the Administrator. The Administrator stated that she expected the PASRR information for all residents be coded accurately on the MDS.

3. Resident #23 was admitted to the facility on 08/03/2020 and readmitted on 05/25/2024 with diagnoses which included coronary artery disease, heart failure, hypertension and diabetes mellitus type II.

Resident #23's most recent comprehensive Minimum Data Set (MDS) was an annual assessment dated 06/20/2024. The Medications section of the MDS assessment reported Resident #23 was on an Anticoagulant with Indication noted.

Review of physician orders dated June 2024 through September 2024 revealed the resident was not prescribed an anticoagulant.

An interview was conducted on 09/05/2024 with the facility's MDS nurse. During the interview, the MDS nurse stated Resident #23's MDS was coded incorrectly and should not have reflected the resident being on an anticoagulant. She

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| F 641 | Continued From page 16<br>further stated the resident was on Aspirin 81 milligrams (mg) 1 tablet by mouth daily and although it was coded correctly as an antiplatelet it must have also been coded incorrectly as an anticoagulant. The MDS nurse indicated she would need to do additional education to clarify the difference between antiplatelet and anticoagulant.<br><br>An interview was conducted on 09/05/2024 at 12:45 PM with the Administrator. The Administrator stated that she expected the medications for all residents be coded accurately on the MDS. | F 641 | | |