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	345462	A. BUILDING _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS-BREVARD	300 MORRIS ROAD BREVARD, NC 28712

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 12/15/24 through 12/18/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 2L3J11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/15/24 through 12/18/24. Event ID #2L3J11. The following intakes were investigated: NC00209019, NC00210113, NC00214525, NC00220097, NC00224341. 6 of the 6 complaint allegations did not result in deficiencies. Past non-compliance was identified at CFR 483.45 at tag F755 at a scope and severity D. Substandard Quality of Care was identified at CFR 483.24 at tag F680 at a scope and severity F and an extended survey was conducted.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff	F 565		1/16/25

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

Electronically Signed | 01/17/2025

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F 565	Continued From page 1 person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated concerns and/or suggestions voiced by residents during Resident Council meetings for 12 of 14 months reviewed (October 2023, November 2023, January 2024, February 2024, March 2024, April 2024, May 2024, June 2024, July 2024, August 2024, October 2024, and November 2024). Findings included: Review of the Resident Council Minutes for the	F 565	Corrective action for the residents found to be affected by the deficient practice. On 1/8/2025, the Administrator reviewed Resident Council and interviewed Resident Council President regarding concerns noted between October 2023 and December 2024. Per the interview with Resident Council President, all concerns noted between those times have been resolved to the satisfaction of the resident council with the exception of outings for residents and menus being posted in advance and made available to	

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F 565	Continued From page 2 period 10/26/23 through 11/21/24 revealed the following: a. The Resident Council meeting minutes dated 10/26/23 revealed the section for old business noted resident concerns with dietary and showers. There was no indication of the facility's response to these concerns listed under old business. Under New Business there were noted concerns from residents with residents being able to go shopping and staff being loud in hallways. b. The Resident Council meeting minutes dated 11/30/23 revealed no sections for old or new business and no indication the minutes from the Resident Council meeting held on 10/26/23 were read, approved, revised and/or resolved. Further review of Resident Council minutes revealed documented resident concerns of them still being upset with dietary related to food, resident being able to go shopping for themselves, not being able to open door to dining room, and resident bed in room needing fixed. c. The minutes from the Resident Council meeting held on 12/28/23 were not available for review due to the president and other members of the resident council being sick and the meeting was cancelled. d. The Resident Council meeting minutes dated January 2024 revealed no sections for old or new business and no indication the minutes from the Resident Council meeting held on 11/30/23 were read, approved, revised and/or resolved. There was nothing documented on the minutes under old business from the previous resident council meeting. Further review of the Resident Council minutes revealed documented resident concerns	F 565	all residents. The Administrator asked the Resident Council President if she would allow him to attend the next meeting to discuss how to better ensure resident concerns were addressed and followed up with. The Resident Council President agreed. Administrator explained that outings would resume as soon as a new facility van driver was fully trained since the previous driver had suddenly expired. The Administrator educated the Dietary Manager to print menus a week in advance and that copies would be distributed to residents that were not able to view the menu boards. The Resident Council President agreed that this was a satisfactory resolution to the concerns. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. On 1/8/2025, the Administrator reviewed the policy and procedure for Resident Council Meetings with Activity Director (AD). The Administrator educated AD on how to differentiate between an individual concern and a Resident Council concern, and how to document and report each type of concern. The Administrator instructed the AD to follow the policy and procedure to facilitate Resident Council meetings to include, but not limited to, addressing old business, resolutions to old business, recordings the Council's response to resolutions, and introducing new business. Any newly hired AD□s will	

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F 565	Continued From page 3 with dietary regarding menus and food, night shift being short staffed, and timeliness of call lights being answered. e. The Resident Council meeting minutes dated February 2024 revealed no sections for old or new business and no indication the minutes from the Resident Council meeting held in January 2024 were read, approved, revised and/or resolved. There was nothing documented on the minutes under old business from the previous resident council meeting. Further review of the Resident Council minutes revealed documented resident concerns with dietary regarding menus, dessert portions, and making sure nourishment rooms were being stocked nightly specifically with sandwiches. f. The Resident Council meeting minutes dated March 2024 revealed no sections for old or new business and no indication the minutes from the Resident Council meeting held in February 2024 were read, approved, revised and/or resolved. There was nothing documented on the minutes under old business from the previous resident council meeting. Further review of the Resident Council minutes revealed documented resident concerns with dietary regarding menus and food, night shift being short staffed, and timeliness of call lights being answered. g. The Resident Council meeting minutes dated April 2024 revealed no sections for old or new business and no indication the minutes from the Resident Council meeting held in March 2024 were read, approved, revised and/or resolved. There was nothing documented on the minutes under old business from the previous resident	F 565	receive this education via the Administrator/DHS to ensure that the policies and procedures are followed to maintain compliance. Systemic changes made to ensure that the deficient practice will not recur. The Activities Director will bring all concerns from the Resident Council Meeting to the Administrator for review within hours of the meeting. The Administrator will distribute all concerns forms to the appropriate departments for follow-up and resolution. The concern forms will be returned to the Administrator who will review completion and corrective actions. The Administrator will return concern forms to the AD to be reviewed as old business during the next Resident Council will be immediately brought to the attention of the Administrator for further action, Plans to monitor its performance to make sure that the solutions are sustained. Resident Council minutes will be presented to the Quality Assurance and Process Improvement meeting monthly by the AD for review to ensure ongoing compliance. Date of compliance: January 16, 2025	

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council meeting. Further review of the Resident Council minutes revealed documented resident concerns with dietary regarding menus and food, night shift being short staffed, and timeliness of call lights being answered.

h. The Resident Council meeting minutes dated May 2024 revealed no sections for old or new business and no indication the minutes from the Resident Council meeting held in April 2024 were read, approved, revised and/or resolved. There was nothing documented on the minutes under old business from the previous resident council meeting. Further review of the Resident Council minutes revealed documented resident concerns with dietary regarding holiday meals, mold in the shower room and on the shower curtain, and the coffee machine located in the lobby being broken.

i. The Resident Council meeting minutes dated June 2024 revealed no indication that the minutes from the Resident Council meeting held in May 2024 were read, approved, revised and/or resolved. There was nothing documented on the minutes under old business from the previous resident council meeting. Further review of the Resident Council minutes revealed documented resident concerns with dietary regarding menus and food portions, and bathrooms not being large enough.

j. The Resident Council meeting minutes dated July 2024 revealed no indication that the minutes from the Resident Council meeting held in June 2024 were read, approved, revised and/or resolved. There was nothing documented on the minutes under old business from the previous resident council meeting. Further review of the Resident Council minutes revealed documented

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resident concerns with dietary regarding menus and condiments, coffee machine located in the lobby needing to be repaired, and more outings for residents.

k. The Resident Council meeting minutes dated August 2024 revealed no sections for old or new business and no indication the minutes from the Resident Council meeting held in July 2024 were read, approved, revised and/or resolved. There was nothing documented on the minutes under old business from the previous resident council meeting. Further review of the Resident Council minutes revealed documented resident concerns with windows and pictures needing to be cleaned and nursing staff not cleaning off toilets after a resident accident.

l. The minutes from the Resident Council meeting held on September 2024 were not available for review due to members of the Resident Council being sick and the meeting was cancelled.

m. The Resident Council meeting minutes dated October 2024 revealed no indication that the minutes from the Resident Council meeting held in August 2024 were read, approved, revised and/or resolved. There was nothing documented on the minutes under old business from the previous resident council meeting. Further review of the Resident Council minutes revealed documented resident concerns with doors to resident's rooms not staying open on their own, staff vacuuming halls during resident meals, and more activities scheduled for residents and their families.

n. The Resident Council meeting minutes dated November 2024 revealed no indication that the

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minutes from the Resident Council meeting held in October 2024 were read, approved, revised and/or resolved. There was nothing documented on the minutes under the section for old business from the previous Resident Council meeting. Further review of the resident council minutes revealed no new business.

A Resident Council group interview was conducted on 12/17/24 at 3:30 PM. During the interview, Residents #4, #44, #51, and #56, who attend Resident Council meetings regularly, all stated they felt facility staff did not really address their concerns or suggestions because the only response they typically received from staff, if they received one at all, was "it was being looked into" but never any satisfactory resolution and some of the issues continued to happen. Resident #4, who was the Resident Council President, added they understood some of the concerns they voiced couldn't be fixed right away but it would be nice to receive some form of communication back as to what was being done. The residents all agreed they would like to know they were being heard and receive feedback from the administration on the efforts that had been made or attempted to resolve their concerns and/or suggestions.

Review of facility grievance log from October 2023 through December 2024 revealed no grievances had been received from Resident Council.

During an interview on 12/16/24 at 10:35 AM, the Activity Director (AD) confirmed she attended and recorded the minutes for the Resident Council monthly meetings. The AD explained that she had not received any formal training on how to

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conduct or record minutes from the Resident Council meetings and was not aware that she needed to document during each meeting old business and how any concerns from the previous meetings had been addressed or resolved. She stated she had asked the previous Administrator about completing a grievance form for any Resident Council concerns and the previous Administrator had informed her that when residents voiced any concerns and/or suggestions during the Resident Council meetings, the AD was to inform the Social Worker (SW), or the Director of Nursing (DON) and they would "look into them." The AD stated sometimes the residents would let her know during the meetings if an issue or concern had been resolved or was improving, but she never received an actual response back from the SW or the DON as to how the concerns had been resolved. She revealed most of the same concerns were mentioned during the meetings each month and she continued to document those concerns in the Resident Council minutes and inform the SW or DON. The AD revealed moving forward she would prefer to write any concerns or suggestions from Resident Council meetings on a grievance form so she could have some form of a paper trail showing the concerns had been reviewed and were being addressed.

During an interview on 12/17/24 at 10:18 AM, the Social Worker (SW) revealed the AD would come to her with concerns from Resident Council and she would usually just pass those concerns to the correct department head. She stated that she would have only completed a grievance form brought to her from Resident Council if it involved a specific resident concern and if she felt like that concern rose to the level of a grievance. She

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revealed once she informed the department heads of the concerns from Resident Council, she was never made aware of the resolutions, so she was never able to inform the AD of any resolutions to the concerns. The SW stated that moving forward she could see where it would be more beneficial for grievance forms to be completed during Resident Council so a resolution could be addressed and documented.

A telephone interview with the former Administrator on 12/17/24 at 1:45 PM revealed she had informed the AD to notify the SW or the DON with any concerns or suggestions brought to her during Resident Council so they could be discussed with the appropriate department heads. She stated the only time a grievance would have been completed during Resident Council meetings was if a specific resident had a concern or grievance. She revealed she was not aware the AD had not been informed of the resolutions regarding the concerns from Resident Council. When asked if she had reviewed any of the minutes from Resident Council over the past year or had discussed with the AD on how to document minutes from resident council, the previous Administrator stated that she was sure she had reviewed some of the Resident Council minutes but could not recall any specific details of the minutes or how they were documented.

During an interview on 12/18/24 at 1:31 PM, the Director of Nursing (DON) revealed previously the AD would bring to her or the SW any concerns from the Resident Council. She stated she would address those concerns with the department heads, but there was no written grievance of the concern and no documented resolution. She revealed she could see where it would be more

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F 565	Continued From page 9 beneficial to have a grievance from completed for any concerns brought up during Resident Council so those concerns could be addressed and the resolutions documented, and they could be addressed with the council during the following meeting. During an interview on 12/18/24 at 2:31 PM, the current Administrator revealed he began his employment at the facility on October 28, 2024. He stated although he could not speak to the exact process of the former Administration, he did not believe they were completing grievance forms regarding grievances from resident council. He revealed his preference would be for the AD to complete grievance forms for any concerns/suggestions brought up during Resident Council meetings. The Administrator also revealed once the grievance forms from Resident Council meetings were completed, they would be given to the SW for them to be distributed out to the responsible departments for their review. He stated he would also be notified of the grievances as he was the facility "grievance official" and they would also be discussed during morning meeting. The Administrator revealed once the grievances were resolved, those grievances would be distributed back to the AD for review at the following Resident Council meeting. He stated that moving forward with this process would help with making sure any grievances or suggestions from Resident Council were being addressed and the departments responsible were being held accountable.	F 565		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585		1/16/25

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§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her

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grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

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F 585	Continued From page 12 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to implement their grievance policies and procedures when Resident #81 reported her dentures were missing for 1 of 3 residents reviewed for grievances. The findings included: Review of the facility grievance policy revised 1/10/2024 defines a grievance as follows: A grievance includes but is not limited to complaints with respect to care and treatment that has been furnished to a patient, as well as that which has not been furnished, the behavior of staff and of other patients, and other concerns regarding the patient ' s facility stay. The grievance policy procedure includes - If the grievance is taken and a response can be started, complete the Action Taken and Findings section of the Grievance/Complaint form: Healthcare centers and give it to the Administrator or designee. -If the grievance is associated with a missing item, refer to the Missing Item Policy and associated forms. The grievance policy also reads The	F 585	Corrective action for the residents found to be affected by the deficient practice. Resident #81 was discharged from the facility on 12/17/2024. Facility communicated with family and agreed to replace missing dentures. Family will schedule appointment and acquire dentures and facility will reimburse family for the cost. Family is pleased with the resolution. Corrective action for other residents having the potential to be affected by the same deficient practice. Administrator conducted a 30-day audit of Facility Grievance Log on 1/9/2025 to ensure written grievance documentation and investigations are completed per guidelines and policy guidelines and policy and procedures. A new grievance will be written and resolved per policy if any exceptions are found. Administrator directed Clinical Competency Coordinator	

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F 585	Continued From page 13 Administrator will be responsible for overseeing the grievance process: The administrator or designee will track the grievance on the Grievance/Complaint Log Form: Healthcare Centers. This will provide a central place for all grievances; The Administrator or designee will then refer the grievance to the appropriate department for investigation if it has not already been referred. The Administrator or designee will record the date of the referral and sig the Grievance/Complaint Log Form: Healthcare Centers. The policy also reads the Administrator, or designee will be responsible for follow-up with the patient, to determine the grievance has been resolved and to ensure the grievance process is understood, The Administrator or designee will complete the Grievance/Complaint Log form: Healthcare Centers indicating whether the problem was resolved and document reactions to the resolution. The policy also reads the Grievance/Complaint should be resolved within 3 business days. Resident #81 was admitted to the facility on 12/05/2024 and was discharged on 12/17/2024. Resident #81 was admitted to the facility with diagnoses that included after care following joint replacement surgery, fracture of right femur. An admission Minimum Data Set (MDS) dated 12/9/2024 revealed Resident #81 was cognitively intact. During an interview on 12/15/2024 at 4:28pm Resident #81 stated her dentures had been missing since the day after she was admitted and wanted to know what would be done about it. Resident #81 stated she had put her dentures in	F 585	to begin refresher training to all staff on 1/10/2025 regarding facility grievance documentation and expected timeframe for resolution. Training on the facility grievance process will be provided to all new employees as part of orientation. Systemic changes made to ensure that the deficient practice will not recur. On 1/10/25, the Administrator educated Social Worker on Grievance Policy including ensuring follow up with residents grievances is properly documented on a Grievance Form and that the resolution is recorded correctly and within the timeframe stipulated in the Grievance Policy. Grievance Forms will be recorded in the Grievance Log, and a copy of the Grievance will be submitted to the Administrator for review and assignment. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator will conduct audits weekly audits for 4 weeks and monthly 2 months to ensure written grievance documentation continues to be completed per policy and procedures. The results of these audits will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months or until Committee determines the deficient practice is fully resolved. Date of compliance:	

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a napkin on her overbed table because she did not have a denture cup. Resident #81 said she had told lots of people they were missing, and staff had looked for them, but Resident #81 wanted to know what would be done since her dentures were still missing. Resident #81 stated no one had followed up with her.

Review of Resident #81's progress notes revealed a note dated 12/6/2024 written by the Social Worker that read, "Resident informed Director of Nursing (DON) that she took out her dentures and put them in a napkin and is concerned that dentures have been thrown in the trash. Room searched by DON and Activity Director (AD) and unable to locate. Trash was searched and DON and AD went through recent trash in the dumpster and were not able to find dentures."

Review of the grievance logs revealed there was no record of a grievance filed on 12/6/2024 or in December 2024 for Resident #81.

During an interview on 12/16/2024 at 1:40pm the Social Worker (SW) stated she was aware Resident #81 had dentures missing, that Resident #81 had wrapped them in a napkin and believed they were thrown away. The SW stated the facility investigated missing items and if negligent actions were found the facility will replace the item. If it cannot be decerned what happened to an item then the facility does not have to replace the item. The SW stated the Director of Nursing (DON) and Activities Director (AD) #1 had searched dietary, and the dumpster and Resident #81's bed for the missing dentures and they were not found. The SW stated Resident #81 had been informed the facility was

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not liable to replace dentures due to not being able to verify how they were lost, but was unsure of the exact day Resident #81 was informed. The SW stated she had talked to her about her dentures.

Further review of progress notes revealed there were no other progress notes related to discussing the result of the grievance report with Resident #81.

On 12/16/2024 at 1:46pm the SW stated she was completing the grievance report right now because she had forgotten to complete it, when the grievance report for Resident #81's missing dentures was requested.

During a follow up interview on 12/17/2024 at 10:07am the SW stated when a resident has lost dentures and they could not be found, it was handled differently based on each situation. The SW stated she would have started the process today (12/17/2024) of trying to get an appointment for Resident #81 with her dentist, but the resident was discharging home today. The SW stated a grievance report is normally followed up on and completed within three days and that a grievance report should be started once they have looked and can't find the missing item. The SW verified the Administrator was the facility grievance official. The SW stated the Administrator #1 was going to contact his boss regarding the policy of replacing dentures. The SW verified there was no documentation that replacement dentures were offered, no documentation of follow up with Resident #81 was documented.

Review of a copy of the requested grievance

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report was received on 12/17/2024, and revealed the grievance report was dated as being received 12/6/2024. SW signature was dated 12/6/2024, Grievance report contained Administrator #1's signature but no date, and the SW signature that she had informed Resident #81 of completed grievance report on 12/9/2024.

During an interview on 12/18/2024 at 1:40pm the Director of Nursing (DON) stated Resident #81 said she had lost her dentures. DON looked in the trash and dumpster and could not find Resident #81's upper dentures. The DON stated Resident #81 had a denture cup in her room. The DON stated for long term care residents the facility would start working to get dentures replaced, with short term situations, the DON was unaware of how it would be handled. The DON stated she expected the facility to talk to Resident #81's daughter and find out who the Dentist was and the facility would make an appointment. The DON verified Resident #81 went home with upper dentures missing. The DON stated anyone involved could fill out a grievance report once the facility knew they could not be found.

During an interview on 12/18/2024 at 2:35pm the Administrator #1 stated he was aware Resident #81 was missing her upper dentures, and that he had interviewed Resident #81. The result of the interview was that Resident #81 had rolled her dentures up in a napkin because she reportedly did not have a denture cup, but the Administrator stated when talking with Resident #81 regarding her dentures a denture cup was found in Resident #81 ' s room in the bedside drawers. The Administrator stated he discussed with Resident #81 that since they could not verify how the dentures were lost, the facility was not liable

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F 585	Continued From page 17 to replace them. The Administrator stated he would expect a grievance report to be started immediately, and that social services normally completed the form and it was reviewed by the Administrator. The Administrator stated anyone can start the Grievance report then turn it in to the social worker to determine who needs to follow up. The Administrator verified the grievance for Resident #81 was not on the grievance log for December of 2024. The Administrator was unsure why this grievance report was not on the grievance log for December 2024, he said he had not reviewed or signed it yet. The Administrator reviewed the copy of the grievance and verified it had his signature, but the Administrator was unaware of the date he signed the grievance form for Resident #81, and thought a grievance form had been started immediately. The Administrator verified he was the facility Grievance official.	F 585		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.	F 607		1/16/25

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F 607	Continued From page 18 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to implement their abuse policy and procedure in the areas of reporting to administration, completing a thorough investigation and failing to notify adult protective services, when Resident #85 reported that three staff members had held his arms down in bed and would not let him go to the bathroom and yelled at him not to ring the call light. This deficient practice occurred for 1 of 3 residents reviewed for abuse. The findings included: The facility's "Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property Policy" revised 10/27/2020, defined abuse "as the willful infliction of injury, unreasonable confinement intimidation or punishment." The facility's "Reporting Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property Policy" revised 7/29/2019 read "1. Any	F 607	Corrective action for the residents found to be affected by the deficient practice. On 1/10/2025, Area Vice President of Operations provided 1:1 education for current Administrator on Abuse Policy specific to fully investigating and documenting all allegations or observations of abuse or neglect. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. On 1/10/2025, the Administrator initiated interviews with all alert and oriented regarding allegations of abuse. On 1/10/2025, the Administrator requested the DHS to obtain current skin assessments for all non-alert and oriented	

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F 607	Continued From page 19 allegation, suspicion, or identified occurrence is identified involving patient abuse, neglect, exploitation, mistreatment, and misappropriation of property, including injuries of unknown source, exploitation, mistreatment, and misappropriation of property, including injuries of unknown source, should be reported immediately to the Administrator of the provider entity, 2. Adult protective services should be notified in accordance with state law through established procedures of any allegations of abuse, neglect, exploitation or mistreatment including injuries of an unknown source and misappropriation of patient property." The facility's "Investigation of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property Policy" reads "The Administrator of the provider is responsible for assuring that an accurate and timely investigation is completed" the policy further reads "Documentation of the investigation should include, but not limited to, the following- Signed statements from pertinent parties" also reads "interviews should be conducted of all individuals who have relevant information, utilizing open ended questions. Written statements from any involved parties should be obtained. Statements should be gathered from the following individuals: the suspect, the person(s) making accusation(s); the patient involved; reliable patients who may have witnessed the incident and any other persons who may have information." A review of the Initial Allegation Report submitted to the state agency on 3/10/24 indicated the report was marked as an abuse investigation. The report revealed that Resident #85 had stated "sometime last night or this am those 3 girls	F 607	residents. No new concerns of abuse or neglect resulted from the interviews or skin checks. Systemic changes made to ensure that the deficient practice will not recur. All employees to be educated on abuse and neglect policy starting 1/10/2025. Any employee who has not received education by 1/16/2025 will be provided education prior to the beginning of their next scheduled shift. Any newly hired employees will receive education on Abuse and Neglect reporting during general orientation. The following audits will be conducted monthly x 3 months: 1) The Administrator or designee will interview 10 interview able residents using questionnaires regarding allegations of abuse. 2) Administrator or designee will interview 10 partners using questionnaires regarding allegations of abuse. 3) The DHS or designee will perform skin assessments for 10 non-interview able residents to document any signs of abuse or neglect. Plans to monitor its performance to make sure that the solutions are sustained. The results of the audits will be submitted for review by the Administrator during the monthly Quality Assurance Performance	

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F 607	Continued From page 20 came in here and yelled at me and held my hands down and wouldn't let me go to the bathroom. One of them told me not to ring my call light again." The initial investigation report also indicated Adult Protective Services (APS) was not notified. A review of the investigation report for Resident #85 revealed there was no interview or statement of what was reported included from Resident #85, the report indicated Resident #85 reported staff had yelled at him, held his hands down and told him not to ring his call bell again, there was no statement from NA #3, there was no statement from Nurse #1 or Nurse #2, no statement from the AD #1 or the DON. Further review of the FRI revealed the AD #1 had notified the DON on 3/9/2024 at 11am by telephone, The DON interviewed Resident #85 on 3/9/2024 at 6:30pm. The DON spoke to the Administrator #2 on the phone at 9:30pm on 3/9/2024. Multiple attempts were made to contact Resident #85 for interview but were not successful. During an interview on 12/18/2024 at 1:16pm NA #3 stated she was familiar with Resident #85. NA #3 stated on 3/9/2024 Resident #85 was upset early during the shift (7am-7pm) after breakfast and reported night shift had held him down. NA #3 stated she immediately reported this to Nurse #1, who told her to notify the Activity Director (AD)#1, who was the Manager on Duty. NA# 3 stated she reported to AD #1 what Resident #85 had reported to her and saw the AD #1 go talk to Resident #85. NA #3 stated Resident # 85 had not named a specific staff member but blamed the entire shift. NA #3 stated no one interviewed her regarding what Resident	F 607	Improvement (QAPI) Committee meetings monthly x 3 months or until the Committee determines compliance is sustained. Quality monitoring schedule may be modified based on findings. Date of compliance: January 16, 2025	

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#85 had reported to her, and NA #3 was not asked to give a written statement. NA #3 did not recall seeing any injuries or bruises to Resident #85.

During an interview on 12/18/24 at 9:44 AM, the Activity Director (AD) #1 stated she had worked on the morning of 3/9/2024 as the manager on duty. After reviewing the daily staffing sheet from 3/9/2024, the AD #1 remembered it was NA #3 that had reported to the AD #1 on 3/9/2024. The AD #1 did not recall exactly what NA #3 had reported, but it was regarding Resident #85 had said 2 staff members had yelled at him, told him he couldn't go to the bathroom and to go to sleep, he had been up enough. The AD #1 did not recall the exact time NA #3 reported the information to her. The AD #1 stated she called the Director of Nursing (DON) and reported what Resident #85 had reported. The AD #1 stated Resident #85 was not upset when she talked to him, but he wanted to talk to the DON. The AD #1 informed Resident #85 the DON would be in later that day. The AD #1 stated as manager on duty she was not involved with the investigation, but was responsible to notify the supervisor, which is why she called the DON. The AD #1 did not recall being interviewed regarding what Resident #85 had reported to her, The AD #1 stated she did not recall writing a written statement. The AD #1 verified she had not been asked to assess Resident #85 for injuries. The AD #1 stated the DON came in later that day.

During an interview with Nurse #1 on 12/18/24 at 12:06pm Nurse #1 stated she only vaguely remembered Resident #85 but had never worked with Resident #85 and had not been assigned to the hall Resident #85 had been on.

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During an interview on 12/18/24 at 2:02pm the DON stated the AD #1 called and said that Resident #85 was upset with night shift and reported "they wouldn't let him go to the bathroom, but it can wait until you come to work tonight." The DON stated she did not go in right away because what was reported to her on the phone by the AD #1 did not require the DON to come in immediately and could wait until the DON was scheduled to come in. The DON remembered that the AD #1 had said Resident #85 had agreed to talk to the DON later that day. The DON stated she thought Resident #85 had been told he couldn't go to the bathroom alone because it wasn't safe. The DON stated if she had thought Resident #85 needed her immediately or had been abused, she would have gone to the facility immediately. The DON stated that after she was at the facility and spoke to Resident #85 she notified the Administrator #2. The DON also stated that throughout the discussion Resident #85's description of what happened changed a couple times. The DON stated she knew the accused NAs were not scheduled to be in again until 3/11/2024 and Administrator #2 thought it was not a reportable incident. The DON stated as the situation evolved the more it became evident it was a reportable incident. The DON stated the accused NAs were eventually suspended, but was not certain of the exact date the suspension was initiated. The DON stated NA# 1 and NA #2 were suspended and NA #4 turned in her resignation. The DON stated NA #1 had no previous allegations of abuse and no allegations since. The DON stated NA #2 had previous allegations regarding her demeanor and approach, but no allegations of abuse. The DON stated NA# 2 had no further

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allegations regarding demeanor, approach or abuse. The DON stated if there was an allegation she would call the administrator, interview alert and oriented residents. The DON stated she did not complete skin assessments on residents who are not alert and oriented. The DON stated alert and oriented residents were not interviewed until 3/11/2024, but the DON looked at residents and talked to residents, while she worked on 3/9/2024. The DON said typically a skin assessment is completed when a resident reports an allegation of abuse. The DON stated she knew to do that. The DON stated she did not notify APS.

During an interview on 12/18/24 at 8:47am the former Administrator (Administrator #2) stated three third shift NAs were interviewed. The Administrator # 2 stated Resident #85 was very hard of hearing, and that Resident #85 stated NAs had held him down when he wanted to go to the bathroom. The Administrator #2 stated the 3 NAs accused were interviewed by the Administrator #2 and the DON, and NA #1 and NA #2 were suspended. The Administrator #2 stated NA #4 would have been suspended but walked out from the interview and quit. The Administrator #2 stated what she recalled from the interview with NA #2 was that NA #2 said she handed him the call bell, laid it on his chest and said to Resident #85, this is our call bell, and said to ring the call bell. The Administrator stated NA #2 denied holding Resident #85's arms down. The Administrator #2 stated she went to Resident #85's room and interviewed him the next day (did not recall the exact date). Resident #85 required help getting in and out of bed but was otherwise independent, and was stand by assist. The Administrator # 2 stated when Resident #85 was

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THE OAKS-BREVARD	300 MORRIS ROAD BREVARD, NC 28712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 24 interviewed on the following Monday, she thought, Resident #85 could not remember if the alleged incident had happened over the weekend and became manipulative with the Administrator #2. The Administrator #2 further stated, she did not recall the exact dates and times from this alleged incident. The Administrator #2 stated the DON did notify her, but did not remember exactly when, just that the DON went in on a weekend to handle the complaint. The Administrator #2 stated staff was trained if there is a complaint- abuse or not- staff are trained to immediately notify the supervisor, and supervisor will determine how to proceed. The Administrator stated she would not notify APS in this instance, The Administrator stated they would only interview residents able to be interviewed or residents at risk or potential to be at risk. The Administrator #2 stated skin assessments would only be completed if the allegation was substantiated. The Administrator #2 stated normally the DON, or social worker would complete interviews of other residents. The Administrator stated she would normally interview the Nurse on the hall when the incident was reported and alleged to have happened. During an interview on 12/18/24 at 2:31pm the Administrator #1 stated he would expect protocol and policy to be followed regarding an allegation of abuse. Administrator #1 would expect an appropriate investigation to be completed and would expect law enforcement to be notified. The Administrator #1 stated an allegation of abuse required an investigation to be completed by the Administrator or designee.	F 607		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		1/16/25

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F 679	Continued From page 25 §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to ensure evening and weekend group activities were planned for the facility to meet the needs of residents who expressed that it was important to them to attend group activities for 4 of 4 residents reviewed for activities (Resident #4, #44, #51, and #56). The findings included: A review of the December 2024 activity calendar revealed group activities for the facility were only scheduled in the mornings and afternoons during the week, Monday through Friday. There were no activities scheduled for evenings or weekends at the facility except for a 10:30 AM church service every other Sunday. An interview with the Activities Director (AD) on 12/16/24 at 10:35 AM revealed she had been employed as the AD at the facility since December 2023 and typically worked Monday through Friday 8 AM to 5PM. She stated she did not have an activity assistant, so she was responsible for all the activities in the facility and since she only worked dayshift Monday through	F 679	Corrective action for the residents found to be affected by the deficient practice. On 1/13/2025, the Administrator met with Residents #4, #44, #51 and #56 during ad hoc Resident Council meeting. The Administrator addressed concerns for relating to evening and weekend activities. The Administrator told the group about implementing receptionists other support staff to conduct activities during weekends and evenings. The Administrator asked for suggestions that could be implemented by implemented by the Activities Director. The names residents accepted the proposed plan and indicated that they looked forward to participating. Corrective action for other residents having the potential to be affected by the same deficient practice. The deficient practice has potential to affect all residents. On 12/30/2024, Administrator initiated job posting for Activities Assistant for evenings and	

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F 679	Continued From page 26 Friday, it was up to the nursing staff to assist residents with activities in the evenings and weekends. The AD stated she does have activity packets with coloring sheets, word search puzzles, and some other different worksheets available for nursing staff, so they can be set out in the dayroom for residents to do in the evenings and over the weekends. She revealed they also have a church service every other Sunday, for residents who like to attend but other than that they typically have no other scheduled group activities during the evenings or on the weekends. She revealed she has had some residents complain about not having activities on the weekend or being bored on the weekends and she will try and set up an individual activity for them when she can. She stated she knew how important activities were to the residents and agreed they could benefit from having scheduled group activities in the evenings and on the weekends and could understand why residents could feel lonely, sad, or depressed and get bored with just watching television or coloring. The Activities Director revealed she would discuss with the Administrator possibly switching up some of the schedules or times for her to be able to help cover some evening and weekend activities until they could find someone to fill an activities assistant position. a. Resident #4 was admitted to the facility on 3/31/17. An annual Minimum Data Set (MDS) dated 3/08/24 indicated Resident #4 felt that it was very important to have activities that included inside and outside of the facility and doing things in an independent and group setting. The assessment	F 679	weekends to hire someone to fill the role. On 1/8/2025, Activity Director changed hours to conduct activities in the evening on Wednesdays. On 1/8/2025, Administrator initiated evening and weekend activities to be delegated to receptionists and/or other assigned staff until an Activities Assistant is hired. On 1/8/2025, the Administrator instructed Activities Director to schedule evening and weekend activities and to provide any required resources to receptionists and/or other assigned staff. Upon hire of the activity assistance the Activity director will review and ensure the assistant understands the roles and responsibilities of the Activity assistant using policy and procedure and competency checklist. The Activity Director/Administrator educated the receptionist on duties for evening and weekend activities. Systemic changes made to ensure that the deficient practice will not recur Activities Director will present Activity Calendars to Administrator demonstrating evening and weekend activities prior to those calendars being posted. Beginning 1/16/2025, the Administrator and Human Resources will implement a schedule for receptionists and other staff to cover weekends and evenings for activities. Beginning 1/16/2025, an assignment sheet listing activities scheduled, residents in attendance, and signed by staff member conducting activity will be implemented to ensure activities are happening as scheduled.	

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F 679	Continued From page 27 further indicated Resident #4 was cognitively intact. An interview was conducted with Resident #4 on 12/17/24 at 3:30 PM during resident council meeting revealed there had not been scheduled evening and weekend group activities at the facility for the past year. She stated the facility does offer a church service every other Sunday morning, but nothing else and she would like to have some activities scheduled for the evenings and the weekends, so they had something to do other than watch television in their rooms or the dayroom. Resident #4 also revealed not having evening and weekend activities caused her to feel bored and lonely. She stated to her knowledge they had discussed having scheduled evening and weekend activities during resident council, but nothing had changed. b. Resident #44 was admitted to the facility on 4/04/22. A significant change Minimum Data Set (MDS) dated 4/11/24 indicated Resident #44 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #44 was cognitively intact. An interview was conducted with Resident #44 on 12/17/24 at 3:30 PM during resident council meeting revealed since she had been at the facility they have had no scheduled evening and weekend activities. She stated the facility does offer a church service every other Sunday but usually only residents that can take themselves attend the service. She revealed she felt residents would benefit from having scheduled	F 679	Plans to monitor its performance to make sure that the solutions are sustained. Administrator will audit activity assignment sheets weekly to ensure compliance with weekend and evening activities. These audits will be reviewed monthly during the Quality Assurance and Performance Improvement meeting for 3 months or until Committee determines the deficient determines the deficient practice is fully resolved. Date of compliance: January 16, 2025	

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F 679	Continued From page 28	F 679		

activities in the evenings and weekends because it would give them something to look forward to and that it can get sad and lonely in the evenings and on weekends especially if you don't have any visitors and nothing to do but watch television.

c. Resident #51 was admitted to the facility on 3/18/24.

An admission Minimum Data Set (MDS) dated 3/22/24 indicated Resident #51 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #51 was cognitively intact.

An interview was conducted with Resident #51 on 12/17/24 at 3:30 PM during resident council meeting revealed she enjoyed activities and there had been no activities scheduled for the evenings and weekends since she was admitted to the facility. She stated she often gets bored, lonely, and sometimes a little depressed especially when all she had to do in the evenings and on the weekends was watch television.

d. Resident #56 was admitted to the facility on 4/11/23.

An annual Minimum Data Set (MDS) dated 4/15/24 indicated Resident #56 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #56 was cognitively intact.

An interview conducted with Resident #56 on 12/17/24 at 3:30 PM during resident council

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meeting revealed the facility had not offered scheduled evening or weekend activities other than a church service every other Sunday mornings. She stated she enjoyed participating in activities because it gave her reasons to get up out of bed and socialize with other residents and not having them in the evenings and on weekends, the time goes by slowly and she gets lonely, bored, and sometimes depressed. Resident #56 revealed she had not addressed her concerns with the Activities Director but had discussed them with other members of resident council and they also felt residents would benefit from having scheduled activities in the evenings and on the weekends.

An interview with Nurse #2 on 12/18/24 at 10:00 AM revealed she had worked at the facility on both 1st and 2nd shift and could not recall ever seeing any scheduled group activities during the evenings or on weekends. She stated some of the residents attend a church service on Sunday mornings but other than that they can watch television in their rooms or in the dayroom, read the paper, color, or do crossword puzzles if they are able. She revealed there are not enough nursing staff on nights and weekends to assist with activities, so residents basically had to find their own activities to do. Nurse #2 stated she felt that residents get bored and depressed when they don't have activities to do and would benefit from activity staff being in the building in the evenings and on the weekends to assist with group scheduled activities.

An interview with Nursing Assistant (NA) #3 on 12/18/24 at 10:45 AM revealed she worked at the facility on both 1st and 2nd shift and was not

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F 679	Continued From page 30 aware of any scheduled activities being offered in the evenings or weekends except for a church service on Sunday mornings. She stated most activities are scheduled during the mornings and afternoons through the week and then after that residents either had to watch television in their rooms or the dayroom or read if they are able. She revealed some of the residents have family that take them out for visits but most of them are stuck in the facility 24 hours a day and would benefit from scheduled activities in the evenings and the weekends, so they have something to pass the time and feel bored and depressed. An interview with the Administrator on 12/18/24 at 2:31 PM revealed the facility has had activity assistants, off and on, who would specifically work evenings and weekends but then they would leave and the last one they had left this past December. He stated they were currently in the process of discussing possibly hiring an activity assistant to work the evening and weekends and in the meantime would be discussing with the Activities Director about possibly changing up her schedule to see if she could cover some evening and weekend shifts and incorporate some other administrative staff to assist as well. He stated he understood scheduling resident activities for evenings and on the weekends was very important and he would try his best to accommodate those needs.	F 679		
F 680 SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an	F 680		1/16/25

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F 680	Continued From page 31 activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to have a qualified professionals to direct the facility's activity program. This practice had the potential to affect all of the residents at the facility. The findings included: On 12/16/24 at 10:35 AM an interview was conducted with the Activity Director (AD). She stated that she had worked at the facility for the past several years as a nursing assistant and then became the Life Enrichment Specialist on the memory care unit around May 2023 and then moved into the AD position for the facility in December 2023 after the previous AD resigned. She stated she had never received any formal activities training from the facility, completed any state training courses, and to her knowledge was not certified. She revealed several months ago she had received an email about some state training for activities and she showed the email to	F 680	Corrective action for the residents found to be affected by the deficient practice. All residents have the potential to be affected by the deficient practice. Starting 1/13/2025, the Activities Director will be supervised by the Social Worker who holds a degree in Therapeutic Recreational Activities. The Social Worker will review and sign off on activity calendars and assessments and ensure the Activities Program meets the needs of the residents. Corrective action for other residents having the potential to be affected by the same deficient practice. The Social Worker will audit and sign off on activity and assessments weekly and ensure the Activities Program meets the	

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F 680	Continued From page 32 the previous Administrator and was told that she did not need any training and did not have to be certified. The AD stated she had researched on-line activities for residents, reviewed the previous AD calendars and notes to assist her with making activities calendars but had received no real training on what activities should be included for residents, how to adjust her schedule so she could include evening and weekend activities, training other staff to assist her with activities, or how Resident Council minutes should be documented. She revealed the Life Enrichment Specialist who was responsible for activities in the memory care unit was also not certified and had not received any formal activities training except for the training she provided to her. The AD stated she would like to have some formal activities training and to become certified in activities so that she could provide the best activities program for her residents. On 12/17/24 at 11:15 AM an interview was conducted with the Life Enrichment Specialist for the memory care unit. She stated she began her position as the Life Enrichment Specialist for the memory care unit in December 2023 after the previous AD for the facility resigned and the previous Life Enrichment Specialist who had been working the memory care unit was moved into the facility AD position. She revealed prior to taking the Life Enrichment Specialist position she had worked at the facility as a nursing assistant. The Life Enrichment Specialist revealed the only training she received prior to taking the position was from the current AD, which consisted of how to make an activities calendar and which activities the residents preferred. She stated she had researched activities for memory care residents	F 680	needs of the residents. Additionally, Social Worker will attend monthly Resident Council Meetings along with the Activities Director until the Activities Director has completed the formal training and/or tenure to meet the regulatory requirements for Qualified Activities Professional. Systemic changes made to ensure that the deficient practice will not recur. The Activities Director is registered for a State approved Activities Director program through Rowan-Cabarrus Community College. Classes begin January 27, 2025 and will be completed in April of 2025. The Activities Director and Activities Program will be monitored and supervised by the Social Worker until she has completed the program and is fully qualified to conduct Activities per CMS Regulations. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator will monitor the progress of the Activities Director□s course work to ensure she is making progress towards the goal of becoming qualified. The Administrator will present the findings of audits of the Social Workers oversight of the Activities Directors progress during the Quality Assurance and Performance Improvement meetings monthly until Committee determines the deficient practice is fully resolved. Administrator	

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F 680	Continued From page 33 on-line on her own time but had never received any formal activities training from the facility, completed any state training courses, and to her knowledge was never activities certified. The Life Enrichment Specialist revealed she would like to receive formal activities training and to become certified so that she could make sure she was providing the best activities program to her residents. A telephone interview with the former Administrator on 12/17/24 at 1:45 PM revealed she was aware the current facility AD and the Life Enrichment Specialist for the memory care unit were not formally activities trained and had not received their certifications. She stated she believed that maybe they had tried to schedule those trainings, but they got cancelled and maybe they were never re-scheduled. She revealed she just really could not recall exactly what happened or why the AD and the Life Enrichment Specialist had never been formally trained or certified in activities prior to her leaving. On 12/18/24 at 2:31 PM an interview was conducted with the Administrator. The Administrator stated he began his employment at the facility on October 28, 2024, and was just recently made aware that neither the facility AD nor the Life Enrichment Specialist were trained and certified in activities. He stated although he could not speak as to why the former Administrator had not inquired about both the AD and the Life Enrichment Specialist receiving their activities training and certification, he had spoken with their regional office about setting up formal activities training for both the AD and the Life Enrichment Specialist and had also inquired about setting them up on-line for their	F 680	will ensure compliance. Date of compliance: January 16, 2025	

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F 680	Continued From page 34 certifications.	F 680		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with	F 755	Past noncompliance: no plan of	

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staff, responsible party, the Consultant pharmacist, and the Medical Director (MD), the facility failed to have effective systems in place for the identification, storage and returning of a controlled medication (opioid) when a resident discharged home and failed to maintain the unused controlled medication for return to the pharmacy for 1 of 2 residents reviewed for pharmacy services (Resident #176).

The findings included:

Resident #176 was admitted to the facility on 06/18/2024.

Resident #176 was discharged from the facility on 07/03/2024.

A review of the physician's order dated 06/19/2024 revealed Resident #176 had an order to receive 1 tablet of Acetaminophen-Codeine (an opioid that acts on the central nervous system to relieve pain) 300-30 milligrams (mg) 4 times a day as needed for severe pain.

The 5-day admission Minimum Data Set (MDS) dated 06/21/2024 revealed Resident #176 had moderately impaired cognition.

The investigation report dated 07/30/2024 revealed the Assistant Director of Health Services (ADHS) became aware of the missing nacrotics for Resident #176's on 07/30/2024 at 5:00 PM when she was auditing narcotics for the monthly pharmacy review and return. The audit revealed a declining inventory sheet with 13 tablets of Acetaminophen-Codeine remaining. There was no medication card for the 13 tablets of Acetaminophen-Codeine and the 13 tablets of

correction required.

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Acetaminophen-Codeine were unaccounted for.

The final investigation report dated 08/02/2024 revealed an immediate narcotic count on all medication carts was completed on 07/30/2024 by the ADHS and all narcotics were accounted for. Staff interviews were conducted by the Director of Health Services (DHS) and the ADHS with 4 nurses who had worked on the 500 Hall medication cart for the previous 24 hours.

Per the facility investigation report dated 08/02/2024, staff interviews were conducted. Nurse #4 was assigned to the 500 Hall on 07/28/2024 from 7:00 AM to 7:00 PM and stated the narcotic card was in the narcotic box on the 500 Hall medication cart but could not be specific about dates or times. Nurse #5 was in orientation and assigned to work with Nurse #4 on the 500 Hall on 7/28/2024 from 7:00 AM to 7:00 PM. Nurse #5 stated the narcotic card was in the narcotic box on the 500 Hall medication cart but did not remember anything specific including dates or times. Nurse #6 was assigned to the 500 Hall on 07/29/2024 from 7:00 AM to 7:00 PM and stated the card was in the narcotic box in the 500 Hall medication cart. Nurse #7 was assigned to the 500 Hall on 07/28/2024 and 07/29/2024 from 7:00 PM to 7:00 AM and she stated she had not seen the card in the narcotic box for some time now.

A review of the declining narcotic sheet for Resident #176 was conducted on 12/17/2024 at 8:15 AM and revealed 17 tablets of Acetaminophen-Codeine had been administered and 13 tablets of Acetaminophen-Codeine remained.

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The facility was unable to provide the July 2024 controlled substance card count sheet for the 500 Hall medication cart.

An interview was conducted with Nurse #6 on 12/17/2024 at 8:45 AM. Nurse #6 stated he remembered there was a missing medication card but did not remember anything specific.

An interview was conducted with Nurse #4 on 12/17/2024 at 9:00 AM. Nurse #4 stated that she remembered an issue with a missing medication card of Acetaminophen-Codeine, but she did not remember anything else about the medication or the medication card.

An interview was conducted with Nurse #5 on 12/17/2024 at 9:30 AM. Nurse #5 stated she did not remember anything about a missing medication card of Acetaminophen-Codeine .

Multiple attempts to contact Nurse #7 were made and were unsuccessful.

During an interview with Resident #176's responsible party (RP) on 12/17/2024 at 10:10 AM, the RP stated that the facility had notified him back in the summer that Resident #176's Acetaminophen-Codeine was missing and asked him if the facility sent the medication home with Resident #176. Resident #176's RP further stated that the Acetaminophen-Codeine was not sent home with Resident #176, but he did get a prescription for the Acetaminophen-Codeine when Resident #176 was discharged from the facility in July 2024.

An interview was conducted with the ADHS on 12/17/2024 at 11:00 AM. The ADHS stated on

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07/30/2024 when she was reconciling the discontinued medications with the declining inventory sheets, she had a declining inclining inventory sheet which showed 13 tablets of Acetaminophen-Codeine remaining, but she could not locate the medication card for the Acetaminophen-Codeine. The ADHS further explained that she checked all of the medication carts and called Resident #176's family to make sure the medication was not sent home with Resident #176. The ADHS revealed that she notified the DHS and the Administrator that there was a problem with the narcotic count.

An interview was conducted with the DHS on 12/18/2024 at 8:00 AM. The DHS stated she collected all of the discontinued medications including narcotics and the declining inventory sheets from all of the medication carts on 07/28/2024 and placed them in the tall, locked cabinet in the West Medication Room. The DHS further explained that the ADHS was reconciling the medications with the declining inventory sheets and found the discrepancy with Resident #176's Acetaminophen-Codeine on 07/30/2024. The DHS also stated that the ADHS telephoned and informed her of the discrepancy and that she had checked all of the medication carts in the facility and all narcotics were accounted for. The DHS stated she arrived at the facility shortly after 5:00 PM and checked all of the medication carts and checked the medication storage rooms and was unable to locate the medication card containing 13 tablets of Acetaminophen-Codeine.The DHS explained that the facility did not send narcotics home with discharged residents and the pharmacy came to the facility once a month and collected all of the discontinued medications including narcotics.

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Prior to the monthly pharmacy visit, the ADHS and she would go through all of the medication carts and collect all of the discontinued medications and put them in the tall, locked cabinet in the West Medication Room and then the ADHS and she would reconcile the declining inventory sheets with the actual number of pills in the medication cards. The DHS further explained that this process was completed twice a month. The DHS also stated the pharmacist reviewed the reconciliation sheets with the actual medication cards during the monthly visit and the pharmacist would return the medications to the pharmacy. The DHS also stated that she and the ADHS were the only staff who had keys to access the tall, locked medication cabinet in the West Medication Storage Room. The DHS further explained that she believed when she collected all of the discontinued medications on 07/28/2024, she accidentally dropped the card containing the 13 tablets of Acetaminophen-Codeine in the trash can. The DHS explained that her arms were very full as she had collected medications from all 4 medication carts and in hindsight she should have collected all the medications and the declining inventory sheets from one medication cart and secured those in the tall, locked cabinet in the West Medication Storage room and then moved on to the next cart. She also stated that the facility had revised their medication process following this incident, and the medication(s) were now removed from the medication cart immediately and placed in the locked cabinet until the pharmacist picked them up.

An interview was conducted with the Medical Director (MD) on 12/17/2024 at 2:30 PM. The MD stated that he was aware of Resident #176's

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missing Acetaminophen-Codeine. The MD also stated that he was involved in the facility's discussion of the incident. He also reported that he had received no further reports of missing narcotics.

An interview was conducted with the Consultant Pharmacist on 12/18/2024 at 9:19 AM. The pharmacist stated that she was aware of the missing Acetaminophen-Codeine back in July and that she was involved in assisting the facility with a performance improvement plan to ensure safety of all controlled substances. She also stated that the 13 tablets of Acetaminophen-Codeine were never recovered, and it was her understanding that the DHS had lost them when she had collected the discontinued medications for pharmacy pick-up.

An interview was conducted with the previous Administrator on 12/18/2024 at 10:19 AM. The previous Administrator stated that she recalled the incident and stated that the ADHS had reported to her that during her return medication rounds the declining inventory sheet for Resident #176's Acetaminophen-Codeine was present, but the medication card was not. The previous Administrator further stated that the facility was unable to locate the missing pills after searching all the medication carts and the medication storage areas. The previous Administrator revealed that the DHS reported to her that the last time she completed the return medication rounds, she had a lot of return medications, and her hands were full, and the DHS believed she accidentally dropped the medication card in the trash when she was placing them in the locked cabinet in the medication room. The previous Administrator further explained that a process

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change was made following the incident.

An interview was conducted with the current Administrator on 12/18/2024 at 1:04 PM. The current Administrator revealed that he had only been with the facility for a few months but there had been no issues or concerns with narcotic counts or missing medications since he had started working there in October 2024. The current Administrator also stated that he had reviewed the information regarding the missing Acetaminophen-Codeine and further explained that the DHS had informed him that her hands were overflowing with medication cards and inventory sheets, and she believed the medication card was accidentally dropped in the trash.

The facility provided the following corrective action plan with a completion date of 08/07/2024.

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

Resident #176 was discharged from the facility on 07/03/2024. There was no harm or negative impact to Resident #176.

How will the facility identify other residents having the potential to be affected by the same deficient practice:

All residents prescribed controlled medications have the potential to be affected by the deficient practice.
On 07/30/2024 while auditing narcotics for monthly pharmacy review a discrepancy was noted by the Assistant Director of Health Services

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(ADHS). A descending narcotic sheet of Acetaminophen-Codeine 300-30 mg with a remaining 13 tablets was noted without the actual medication blister pack.

The ADHS and Clinical Competency Coordinator immediately performed a narcotic count of all narcotics on each cart to ensure the descending inventory narcotic sheet had been reconciled and matched on 07/30/2024. No further discrepancies were noted. Interviews were conducted with all nurses that worked the 500 Hall within the 24-hour period prior to the medication being noted as missing.

On 07/30/2024, a 24-hour report was sent to the North Carolina Department of Health and Human Services, a report was filed with local law enforcement (Report #2024-039-095).

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:

Re-education for all nurses on procedure for controlled substance reconciliation from shift to shift, storage, records, administration, acknowledgement/accounting for and what to do in the event of discrepancy was performed by the ADHS.

The Director of Health Services (DHS) and ADHS will collect discontinued narcotics and reconcile narcotics daily and place them in the locked return narcotic box.

The DHS and ADHS are the only designees to maintain access to the narcotic locked cabinet.

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Narcotics for short term rehabilitation residents will be released with the resident and or their RP with signed paperwork.

Audits will be performed to ensure that narcotic sheets and descending narcotic sheets are accounted for and match.

How will the facility monitor its corrective actions to ensure the deficient practice will not recur:

The DHS and ADHS will audit each cart to ensure narcotic inventory sheet and blister pack and signatures match X 4 weeks, then X 2 months: begin date: 07/30/2024 and end date: 10/30/2024.

Audit results will be presented at the facility's Quality Assurance Performance Improvement (QAPI) meeting by the DHS and ADHS and reviewed X 2 months.

An Ad Hoc QAPI was held 08/05/2024. Any issues and trends identified will be addressed in QAPI by attendees as they arise, and the plan will be revised to ensure compliance.

The Administrator and DHS will oversee this process until sufficient practice is maintained.

Date of Compliance: 08/07/2024

The facility's corrective action plan with a correction date of 08/07/2024 was validated onsite by observations and interviews with the Administrator, DHS, and nursing staff.

An observation was conducted during a shift transition for a medication cart between 2 nurses

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on 12/18/2024. 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 26 medications, 6 different residents and 2 different nurses was conducted on 12/16/2024 and 12/17/2024. 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 Licensed Practical Nurses (LPN), and Registered Nurses (RN) confirmed they had received education related to Misappropriation of Personal

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Property and Narcotic Process Policy. It included the process for shift-to-shift controlled medication count, narcotic storage, narcotic records, and what to do in the event of a narcotic discrepancy. The nurses 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 DHS and ADHS weekly for 4 weeks beginning on 07/30/2024. 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 DHS to the QAPI committee monthly for 2 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 DHS 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. The DHS and ADHS audited the medication carts randomly to ensure all controlled medication counts were conducted appropriately and the declining narcotic count sheets were documented properly. The Administrator and the DHS stated the interventions were successful as the facility did not have any similar issues with narcotics since then.

The compliance date of 08/07/2024 was validated.

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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		1/16/25

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F 756	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Consultant Pharmacist interviews, the facility failed to follow the pharmacy recommendations for storing narcotics in a locked and permanently affixed compartment for 1 of 2 medication rooms reviewed for medication storage (West Hall Medication Storage Room). Findings included: Review of the Consultant Pharmacy report dated 11/26/2024 revealed "Controls in refrigerator under double lock and key; in process of getting in secured lock box that is not removable from the fridge". An observation of the West Hall medication storage room was conducted on 12/17/2024 at 8:31 AM with the Assistant Director of Nursing (ADON). The narcotic lock box was inside a locked refrigerator. The narcotic lock box was not permanently affixed to the refrigerator and was removable. The narcotic lock box contained four unopened vials of Lorazepam (scheduled IV antianxiety medication). An interview was conducted with the ADON on 12/17/2024 at 8:40 AM. The ADON revealed she thought since the medication storage room was locked and the refrigerator was also locked and the medications were appropriately secured. An interview was conducted with the Consultant Pharmacist on 12/17/2024 at 9:19 AM. The Consultant Pharmacist stated the narcotic box should be permanently affixed to the refrigerator. The Consultant Pharmacist further stated that	F 756	Corrective action for the residents found to be affected by the deficient practice. Potentially all residents could be affected by the deficient practice; however, no residents were affected. Since the deficient practice was identified, there have been no orders for IM lorazepam and no vials were missing. Corrective action for other residents having the potential to be affected by the same deficient practice. The narcotic lock box was permanently secured to the door of the refrigerator by the facility Maintenance Director on December 17, 2024. On 1/13/2025, the Administrator performed an audit of Consultant Pharmacist Recommendations for the last 2 months. No additional narcotics storage recommendations were identified or reported. Systemic changes made to ensure that the deficient practice will not recur. On 1/13/2025, the Administrator educated the Director of Health Services (DHS) on timely response to the Consultant Pharmacist Recommendations relating to narcotic medication storage. Monthly Pharmacy Consultant Reports to be audited once a month x 3 months by the DHS or licensed nurse designee to ensure timely follow-up of any recommendations related to narcotic	

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F 756	Continued From page 48 removeable narcotic box had been identified as an issue and was included in the November 2024 pharmacy report. An interview was conducted with the Director of Nursing (DON) on 12/18/2024 at 8:03 AM. The DON stated that the narcotic box in the West Hall Medication Storage Room refrigerator had not been permanently affixed to the refrigerator since she was hired in April of 2021. The DON further revealed that she was aware the narcotic box should be secured and affixed to the refrigerator. An interview was conducted with the Administrator on 12/18/2024 at 8:30 AM. The Administrator stated he was aware of the narcotic box not being permanently affixed to the refrigerator. He further stated that the facility had been discussing how to affix the narcotic box to the refrigerator but had not come up with a resolution.	F 756	storage. Plans to monitor its performance to make sure that the solutions are sustained. The Assistant Director of Nursing (ADON) will review the audits monthly and will report results to the Administrator and the Quality Assurance and Performance Improvement Committee (QAPI) meetings monthly for three months or until QAPI Committee determines ongoing compliance is assured. Date of Compliance: January 16, 2025	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and Medical Director, Nurse Practitioner, Consulting Pharmacist, resident and staff interviews, the facility failed to prevent a significant medication error when they failed to enter an admission order for an as needed (PRN) migraine nasal spray, that was to be continued from the hospital discharge summary when Resident #81 admitted to the facility. As a result, Resident #81 did not have the	F 760	Resident #81 discharged on December 17, 2024. All admissions between 12/17/24 and 1/10/25 were audited for accurate reconciliation of admission orders from the discharge summary. No issues noted. Corrective action for other residents	1/16/25

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F 760	Continued From page 49 PRN migraine nasal spray during her entire stay at the facility. This affected 1 of 3 residents reviewed for medication errors. (Resident #81) The findings included: Review of Resident #81's discharge orders from the hospital dated 12/5/2024 revealed under the section: "CONTINUE these medications which have NOT CHANGED", was an order that read "butorphanol (Stadol) 10mg/ml nasal spray. Administer 1 spray into one nostril if migraine present. May repeat in one hour if pain relief is not adequate." Resident #81 was admitted to the facility on 12/05/2024 and was discharged on 12/17/2024. Resident #81 was admitted to the facility with diagnoses that included aftercare following joint replacement surgery, unspecified fracture of right femur. An admission Minimum Data Set (MDS) dated 12/9/2024 revealed Resident #81 was cognitively intact. Further record review revealed there was no physician order for Stadol in Resident #81's physicians orders. A Nurse Practitioner Progress note dated 12/5/2024 revealed in part that Resident #81 had a history of migraines and read "She (Resident #81) has a Stadol nasal spray as needed". During an interview on 12/15/2024 at 4:28pm Resident #81 stated she had not had her migraine nasal spray since she had been	F 760	having the potential to be affected by the same deficient practice. DHS and ADON received education on two-step verification for transcription of orders for new admissions from Regional Nurse Consultant on 1/14/2025. Second verification process occurs when one nurse calls and obtains verification and reconciliation of the admission orders on the discharge summary from the medical provider and inputs the order in the electronic medical records. A second nurse will review the discharge summary orders against the orders entered in the electronic medical records for accuracy. The second nurse will sign off on either the discharge summary or enter a progress note indicating a second step review and verification has occurred. Systemic changes made to ensure that the deficient practice will not recur. DHS, ADON, or licensed nurse will perform weekly audits of order entries x 4 weeks followed by monthly audits x 2 months to ensure accuracy of medication order transcriptions for new admissions. All licensed nurses have been educated on two step verification by the clinical competency coordinator. Education was completed as of 1/16/25. All new nurses will receive education on two step verification process upon hire during orientation. Plans to monitor its performance to make	

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	345462	A. BUILDING _____ B. WING _____	C 12/18/2024

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F 760	Continued From page 50 admitted. Resident #81 stated when she has a migraine she becomes sick and nauseated and she would like to have her migraine medicine. Resident #81 stated she had told multiple Nursing Assistants (NA) and Nurses that she needed her medicine for migraines but no one had gotten it for her. Resident #81 also stated she talked to the doctor about having medication for migraine while at the facility. Review of Resident #81's progress notes revealed a note written by Nurse #3 dated 12/15/2024 written at 9:58pm that read in part "Resident still upset about the Stadol not under her medication list." During an interview on 12/16/2024 at 12:43pm the Nurse Practitioner (NP) stated she was familiar with Resident #81. The NP stated when a resident was admitted she would go over the medications listed on the discharge summary, if the NP was not at the facility, a nurse would call her and read the medications from the discharge summary and the NP would tell the nurse what meds to continue and a verbal order would be written. The NP stated that she remembered the Assistant Director of Nursing (ADON) had called her for medication reconciliation for Resident #81, and the NP had not ordered to stop any of those medications. The NP was unsure why Stadol was not on Resident #81's MAR and said it was supposed to be continued when Resident #81 was admitted. The NP said maybe the med was not available at their pharmacy or had not been sent from pharmacy. The NP would expect the nurse to call the Pharmacy or the NP if medication was not received from the pharmacy or not available. The NP verified she had no communication from the Pharmacy regarding	F 760	sure that the solutions are sustained. The Assistant Director of Nursing will review the audits and will report results to the administrator and the Quality Assurance and Performance Improvement Committee (QAPI) monthly meetings Date of Compliance: January 16, 2025	

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Stadol not being available. The NP stated oral pain medication had been increased for Resident #81 when NP had seen the resident, but later clarified it was for hip pain.

During an interview on 12/16/2024 at 2:29pm the Assistant Director of Nursing (ADON) stated when a resident is admitted she will call the doctor or NP and go over the medications on the discharge summary verbally then the ADON enters the medications into the computer system and then another nurse checks them after the ADON, normally another administrative nurse. The ADON stated it had been brought to her attention that Resident #81 did not have Stadol on her MAR, and she was not sure how that happened. The ADON stated there were a lot of admissions on 12/5/2024 then the ADON stated "I think I had trouble entering that order into the computer system and I forgot to go back, probably got interrupted". The ADON verified the order for Stadol had not been entered into the computer system as it should have been. The ADON was unsure which nurse had double checked the admission orders for Resident #81.

During an interview on 12/16/2024 at 2:43pm Nurse #3 stated Resident #81 had complained about headaches. Nurse #3 stated "last week the doctor was notified and took care of it by increasing the oral pain medication."

During an interview on 12/17/2024 at 9:19am the Consulting Pharmacist verified the facility policy for new admissions is a double check system by the nurses to verify medications are entered into the computer system correctly, and that document would be scanned into the residents electronic medical record and saved as the

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verified discharge summary.

Further review of Resident #81's electronic medical record revealed it did not contain a verified discharge summary for Resident #81.

During an interview on 12/17/2024 at 2:27pm the Medical Director stated he was familiar with Resident #81 and had seen her on 12/10/2024 and there was no complaint of headaches or migraines at that time. The Medical Director was not aware Stadol was supposed to be continued for Resident #81. The Medical Director stated he had seen it on the discharge summary but thought there had been a concern about it interacting with other medications. The Medical Director was not aware the ADON had omitted entering the Stadol order into the computer system and that the NP had intended for it to be continued. The Medical Director stated that for medication reconciliation the admission orders were to be called to the NP or medical director if they were not in the building, the nurse calling would initial medications to be continued, enter them into the computer system, then the nurse who double checks would verify and initial as the second check, then that initialed discharge summary would be scanned into the resident's record as the verified discharge summary, then it could be reviewed by the NP or Medical Director. The Medical Director reviewed Resident #81's electronic medical record and verified there was not a verified discharge summary in Resident #81's electronic medical record. The Medical Director stated the medication reconciliation for Resident #81 did not appear to have been completed correctly and he would address it at the next quality meeting.

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F 760	Continued From page 53 During an interview on 12/18/2024 at 1:40pm the Director of Nursing (DON) stated she had not heard complaints of headaches from Resident #81, just general pain. The DON verified the ADON completed entering the admission orders and that they were checked by another administrative nurse, then the verified discharge summary was scanned into the electronic medical record. The DON was not aware Resident #81's electronic medical record did not contain a verified discharge summary or that Resident #81 had not had her PRN migraine medication while residing in the facility. The DON expected admission orders to be completed with a double check and the verified discharge summary to be scanned into the resident's record. During an interview on 12/18/2024 at 2:33pm the Administrator stated he was not well versed in the admission process but would expect if a resident has a discharge summary with a medication list and the provider orders to continue the medication, the Administrator expected the ordered medications to continue.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		1/16/25

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F 761	Continued From page 54 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to store narcotics in a locked permanently affixed compartment for 1 of 2 medication rooms reviewed for medication storage (West Hall Medication Storage Room). Findings included: An observation of the West Hall medication storage room was conducted on 12/17/2024 at 8:31 AM with the Assistant Director of Nursing (ADON). The narcotic lock box was inside a locked refrigerator. The narcotic lock box was not permanently affixed to the refrigerator and was removable. The narcotic lock box contained four unopened vials of Lorazepam (scheduled IV antianxiety medication). An interview was conducted with the ADON on 12/17/2024 at 8:40 AM. The ADON revealed she thought since the medication storage room was locked and the refrigerator was also locked and	F 761	Corrective action for the residents found to be affected by the deficient practice. Potentially all residents could be affected by the deficient practice; however, no residents were affected. Since the deficient practice was identified, there have been no orders for IM Lorazepam and no vials were missing. Corrective action for other residents having the potential to be affected by the same deficient practice. The narcotic lock box containing 4 vials of IM Lorazepam was secured to the door of the refrigerator by the facility Maintenance Director on December 17, 2024. Systemic changes made to ensure that the deficient practice will not recur.	

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F 761	Continued From page 55 the medications were appropriately secured. An interview was conducted with the Consultant Pharmacist on 12/17/2024 at 9:19 AM. The Consultant Pharmacist stated the narcotic box should be permanently affixed to the refrigerator. The Consultant Pharmacist further stated that removeable narcotic box had been identified as an issue and was included in the November 2024 pharmacy report. Review of the Consultant Pharmacy reported dated 11/26/2024 revealed "Controls in refrigerator under double lock and key; in process of getting in secured lock box that is not removable from the fridge". An interview was conducted with the Director of Nursing (DON) on 12/18/2024 at 8:03 AM. The DON stated that the narcotic box in the West Hall Medication Storage Room refrigerator had not been permanently affixed to the refrigerator since she was hired in April of 2021. The DON further revealed that she was aware the narcotic box should be secured and affixed to the refrigerator. An interview was conducted with the Administrator on 12/18/2024 at 8:30 AM. The Administrator stated he was aware of the narcotic box not being permanently affixed to the refrigerator. He further stated that the facility had been discussing how to affix the narcotic box to the refrigerator but had not come up with a resolution.	F 761	On 1/13/2025, The Administrator educated the Director of Health Services (DHS) on properly securing narcotics in the med room refrigerator. The narcotic lock box to be audited once a month X 3 months by the DHS or licensed nurse designee to ensure that it remains securely attached to the refrigerator interior. Plans to monitor its performance to make sure that the solutions are sustained. The Assistant Director of Nursing will review the audits monthly and will report results to the Administrator and the Quality Assurance and Performance Improvement Committee (QAPI) meetings monthly for three months or until QAPI Committee determines ongoing compliance is assured. Date of compliance: January 16, 2025	