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	345252	A. BUILDING _____ B. WING _____	C 01/09/2025

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 01/07/2024 through 01/09/2024. Event ID# SN1V11. The following intakes were investigated NC00217656, NC00224958, NC0000220449, NC00224593, NC00222775 and NC00223470. 3 of the 23 complaint allegations resulted in deficiency.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, staff, pharmacist, and police interviews the facility failed to protect residents right to be free from the diversion of a controlled narcotic pain reliever on three occasions for 2 out of 3 residents (Resident #1 and #6) reviewed for narcotic diversion. The findings included: 1a. The facility Administrator, during an interview on 1/8/25 at 9:45 AM, stated he was informed by the Assistant Director of Nursing on 7/24/24 that Resident #6's Oxycodone 5 milligrams (mg)medication cards had holes where it appeared medication was removed with tape covering the holes on the back of the card and it	F 602	1. No immediate action as time frame had already passed for resident #1 and #6. Record review reveals no missed medication and no associated pain. 2. Residents receiving narcotic medication are at risk of this practice. A complete Narcotic count on all four medication carts completed on 7/25/2024 and 8/1/2024 by former director of nursing and found to be accurate with no missing medications. 3. To prevent recurrence, facility nursing staff educated 0n 7/25/24 and 8/1/24 by the Assistant Director of Nursing for	1/17/25

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

Electronically Signed | 01/17/2025

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F 602	Continued From page 1 also appeared to her that a different medication had been placed in the card. One full card was sent back to the pharmacy for identification and the remaining pills on the other card were destroyed at the facility. He further stated that on 7/25/24 the Administrator was emailed by the facilities pharmacist that the card returned on 5/31/24 for Resident #6's Oxycodone 7.5 mg tablets had the Oxycodone 7.5 mg replaced with another medication. A review of the narcotic sheet dated 5/31/24 for Resident #6 for Oxycodone 7.5 mg noted Nurse #1 and Nurse #2 had both counted and sent back this medication to the pharmacy for destruction due to the order being changed on 5/17/24. A review of the written statement dated 7/24/25 by the Assistant Director of Nursing indicated she had called the facility pharmacy and informed them during shift count Resident #6's Oxycodone 5 mg medication cards it was noticed the cards had tape on the back and had possibly been tampered with. She was instructed to send one back for the pharmacy for identification and to destroy the medication remaining in the other card. The Administrator stated during an interview on 1/8/25 at 9:45 AM that on 7/25/24 the former Director of Nursing conducted an audit of all four of the medication carts to ensure no other controlled medications had signs of tampering, interviews were conducted with the staff, and with residents receiving controlled medications. The result of the audit indicated no issues with the blister packs in the medication carts, no residents were missing any medication, and no residents had complaints of pain or pain not being controlled. A review of interviews with the staff indicated they had no knowledge of tampering or	F 602	misappropriation of residents belongings/personal property to include medication. Nursing staff educated narcotic diversion. Moving forward, two staff members are to sign/verify the accuracy of narcotic deliveries. A narcotic card count/log in-out sheet initiated which is visually easier to track and more quickly identify discrepancies. 4. The DON or designee will monitor narcotic count logs as well as count sheets for completeness and accuracy 5 times weekly for 4 weeks, twice weekly for 4 weeks, and weekly for 4 weeks. If no further issues are identified, then monitoring may be completed on a random basis. 5. This Plan of Correction will be monitored at the monthly Quality Assurance/Improvement Committee meeting until such time consistent substantial compliance has been met.	

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replacement of medication.

A telephone interview was attempted with the former Director of Nursing, but she was unavailable.

An interview with the Assistant Director of Nursing on 1/7/25 at 8:30 AM indicated that on 7/24/24 Nurse #2 approached her with an issue with the narcotic cards. She stated that Nurse #2 showed her two cards of Oxycodone 5 mg belonging to Resident #6 with tape on the back. She stated upon further inspection it was noted that there were holes in the back of the card covered with tape and it appeared to her that the medication was not Oxycodone 5 mg. She stated she informed the Director of Nursing of the issue and called the pharmacy who instructed her to destroy the remaining pills on one card and to send the full card back to the pharmacy. She further stated that she made the pharmacy aware that the cards were a controlled medication. She also indicated that she could not legally determine what the medication in the card was and was waiting to hear from the pharmacy if the medication was Oxycodone 5 mg or something else before a diversion could be established, she was not aware of the results as of 1/7/25.

A telephone interview with Nurse #2 on 1/7/25 at 10:15 AM revealed that during the narcotic count on 7/24/24 she noted tape on the back of Resident #6's Oxycodone 5 mg cards, she asked Nurse #3, who worked the prior shift, about the tape, and she responded that the cards were crowded together and something else that she could not remember. After the count was completed Nurse #2 went to find the Assistant Director of Nursing and informed her of tape on

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the back of the two cards, when she went back to the medication cart Nurse #3 was gone.

A telephone interview was attempted to Nurse #3, but she was unavailable.

An interview with the facility Administrator on 1/8/24 at 9:45 AM indicated he was informed on 7/24/24 during narcotic count between Nurse #2 and Nurse #3 that two medication cards of Oxycodone 5 mg for Resident #6 had tape on the back of the card. Upon examination of the cards, it was noted that the blisters had been punctured, and it appeared the medication had been replaced with a different medication. He further indicated that one of the cards had been returned to the pharmacy so the medication could be identified. He also revealed he had received an email from the facility pharmacy on 7/25/24 which revealed the Oxycodone 7.5 mg for Resident #6 sent back to the pharmacy on 5/31/24 for destruction had been identified as having the Oxycodone 7.5 milligrams (mg) replaced with another medication, later determined by the pharmacy to be an over-the-counter medication. The Administrator notified the Division of Health Service Regulation and the police department on 7/25/24 of the diversion and an immediate investigation was started.

A telephone interview conducted on 1/8/24 at 4:04 PM with the General Manager of the Pharmacy revealed that when she emailed the facility on 7/25/24 Resident #6 medication card returned on 5/31/24 had 8 tablets of Oxycodone 7.5 mg replaced with an over-the-counter medication.

1b. On 7/31/24 a narcotic sheet for Resident #6

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was filled out by Nurse #3 for the removal of one Oxycodone 5 mg pill at 8:25 AM. It was determined Nurse #3 worked night shift and was not in the facility at 8:25 AM on 7/31/24. It was further determined that Resident #6 did not have a medication card for Oxycodone 5 milligrams, or a pharmacy labeled narcotic count sheet at the time of the audit.

A review of the former Director of Nursing's (DON) written statement dated 8/1/24 revealed she had been approached by Nurse #2 and informed that Nurse #3 had documented she had given Resident #6 a dose of Oxycodone 5 milligrams (mg) at 8:25 AM on 7/31/24. It was determined that Nurse #3 worked the night shift and was not at the facility at 8:25 AM on 7/31/24. The former DON conducted a random narcotic count and noted that Resident #6 did not have a medication card for Oxycodone 5 mg, or a narcotic count sheet labeled by the pharmacy. When she asked Nurse #5 why Resident #6 did not have a card of Oxycodone Nurse #5 stated it would be later that day it was delayed due to an authorization issue. The former DON requested Nurse #3 to wait in her office and when the former DON went back to her office Nurse #3 had left the facility. She attempted to contact Nurse #3 via phone calls and text messages, on the 2nd text message Nurse #3 responded that she was at an appointment and would call when it was over. The former DON did not hear from Nurse #3 again and Nurse #3 did not respond to calls from Human Resources. Nurse #3 was terminated and the facility pressed charges against Nurse #3.

A review of the narcotic sheet with Nurse #3's signature revealed she gave Resident #6 one

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tablet of Oxycodone 5mg at 8:25 AM with 30 pills remaining. A review of the delivery slip revealed Resident #6's Oxycodone 5 mg was sent out on 7/31/24 and was received by the facility at 1:45 PM.

A telephone interview with the former DON was attempted on 1/7/25 and 1/8/25 but she was not available.

An interview with the Administrator on 1/8/24 at 9:45 AM indicated he was aware of Nurse #3 had signed off Resident #6's Oxycodone 5 mg for a time she was not in the building. He stated that both the former DON had attempted to contact her, but she never called the former DON back and did not answer other calls made by the facility. He stated he had notified the Department of Health Service Regulation, local authorities, and Department of Social Services on 8/1/24. He further stated that when Nurse #3 did not answer calls or messages after the initial contact with the former DON, Nurse #3 was terminated on 8/1/24.

A telephone interview with Nurse #3 was attempted but she was not available.

2. During the interview on 1/8/25 at 9:45 the Administrator revealed he was notified on 12/6/24 of a potential missing blister pack of Oxycodone 10 milligrams (mg) that belonged to Resident #1. The initial sweep of the facility found no issues with medication cart locks and the blister pack of Oxycodone was not found. The facility immediately began an investigation and notified the Division of Health Service Regulation, County Department of Social Services, and local law enforcement. The investigation included identifying staff who had previous access to the

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medication cart and narcotic drawer, staff statements and drug tested the staff identified.

A review of Nurse #4 written statement on 12/6/24 included she had notified the Unit Supervisor of Resident #1 required a refill of his Oxycodone 10 mg. The Unit Supervisor told her that the medication could not be refilled as it was to early and she (the Unit Supervisor) notified the Administrator.

A telephone interview was attempted on 1/8/25 with Nurse #4, but she was unavailable.

A review of the Unit Supervisors written statement dated 12/6/24 revealed Nurse #4 had requested a refill of Oxycodone 10 mg be made for Resident #1 because he had 4 tablets remaining. She contacted the pharmacy to request the refill and per the pharmacy staff Resident #1 had 120 tablets delivered on 11/13/24. The Unit Supervisor then checked the medication cart to ensure it had not been overlooked but was unable to find the medication or a narcotic sheet for the missing card. She then checked all the other medication carts, and no medication cards were found for Resident #1. She then informed the regional nurse consultant and the Administrator of the missing medication.

A review of the delivery slip dated 11/13/24 indicated 120 tablets of Oxycodone 10 mg for Resident #1 was delivered.

An interview with the Unit Supervisor on 1/8/25 at 1:30 PM indicated that she had no further information to add to her written statement.

An interview with the Administrator on 1/8/25 at

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F 602	Continued From page 7 9:45 AM revealed he was informed on 12/6/24 of a missing Oxycodone 10 mg medication card and after a sweep of the facility it was still missing. He revealed that after the card was not found he contacted the local law authorities, the Division of Health Service Regulation, and the County Department of Social Services and an immediate investigation began. The investigation included identifying who had access to the medication cart, obtained their statements, and performed a drug test on those identified individuals, all the drug tests were negative. He further indicated a new process where two nurses signed in all controlled medications when they are delivered was initiated. The Administrator stated as of 1/8/25 the medication card had not been found. A review of the identified staff statements dated 12/6/24-12/9/24 revealed that no one knew what had happened to the card of Oxycodone 10 mg for Resident #1. A telephone interview with the General Manager of the pharmacy on 1/8/25 at 4:04 PM revealed each medication card had a unique bar code and all controlled medication was verified by either her or the other pharmacist prior to being sent to facilities. She further revealed that each medication was scanned prior to being placed in the controlled medication bag to ensure the correct amount was sent to the facilities. She stated that the scan showed 4 cards of Oxycodone 10mg for Resident #1 were sent to the facility on 11/13/24.	F 602		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		1/17/25

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F 657	Continued From page 8 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to update the care plan to address a resident who was known to keep medication in his room and did not have an order or assessment for self-administration of medication for 1 of 7 (Resident #1) residents reviewed for care plans. The findings included: Resident #1 was admitted into the facility on	F 657	1. Immediately removed observed medications from resident #1 bedside on 1/8/25 by Unit Manager. Self-medication-administration assessment found resident to be safe to self-administer medications at bedside. Order were obtained from the physician and care plan updated to reflect self-medication-administration status 0n 1/8/25 by Unit Manager.	

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F 657	Continued From page 9 9/21/21 with most recent readmission on 4/2/24 with diagnoses of non-Alzheimer's dementia, constipation, nasal congestion and hypertension. Resident #1's annual Minimum Data Set (MDS) assessment dated 10/5/24 revealed he was cognitively intact. Resident #1's comprehensive care plan revised on 11/27/24 noted there was not a care plan for self-administration of medication or the potential for the family to continue to bring medications to Resident #1. On 1/8/25 at 8:00 AM an observation of Resident #1's room noted there were two medications on his bedside table and an undetermined number of medications in a clear box on his bedside table. Resident #1 was in bed with his bedside table located beside his bed. The Assistant Director of Nursing went to Resident #1's room on 1/8/25 at 8:10 AM, after being notified of the medications being observed, and found 1 box of nasal decongestant, 1 bottle of eye drops, 1 bottle of throat spray, and 1 bottle of stool softener and removed these medications from the room. An interview with the Assistant Director of Nursing on 1/8/25 at 8:30 AM indicated that she was not aware Resident #1 had medication in his room. She further indicated that she was aware Resident #1 had a history of keeping medications in his room in the past and the Unit Manager had spoken to the family regarding bringing medication into the building. Resident #1 declined to be interviewed.	F 657	2. Other residents with medications at bedside are at risk of this occurrence. Review of current residents on 1/8/25 by Assistant Director of Nursing found no other residents with OTC medications at bedside in need of care planning. 3. Facility nurses responsible for MDS and care planning educated on 1/8/25 by Assistant Director of Nursing ensuring medications at bedside are reflected in the care-plan. Residents newly receiving orders to self-administer medications will be reviewed in the clinical meeting to ensure MDS nurses are aware of the need to care-plan. Additionally, residents found with medications at bedside who are not safe to self-administer will have a care plan to alert staff to the possibility of recurrence. 4. DON or Designee to review residents who self-administer medications weekly for the presence of a complete and accurate care plan. This should occur weekly for 4 weeks, biweekly for weeks, and monthly for 4 weeks. Should no further issues be identified, DON or designee may then monitor randomly. 5. This Plan of Correction will be monitored at the monthly Quality Assurance/Improvement Committee meeting until such time consistent substantial compliance has been met.	

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F 657	Continued From page 10 An interview with the Unit Manager on 1/8/25 at 8:50 AM revealed she had been aware that Resident #1 had medication in his room in the past but not on this date. She stated the nursing assistants had usually reported when Resident #1 had medication in his room. An interview with the MDS Coordinator on 1/8/25 at 9:30 AM revealed that she was not aware that Resident #1 had medications in his room in the past or that he had medication in his room on this date. The MDS Coordinator further revealed that it had not been care planned because she was not made aware of the issue and the potential for it to happen again. The MDS Coordinator stated that the issue should have been care planned. An interview with the Administrator on 1/8/25 at 9:15 AM indicated he was not aware Resident #1 had medications on his bedside table on this date. The Administrator stated he was not aware that Resident #1 did not have a care plan regarding the issue, and it should have been addressed in the care plan.	F 657		
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		1/17/25

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F 761	Continued From page 11 §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 secure medications observed at bedside for 1 of 1 resident reviewed for medication storage (Resident #1). The findings included: Resident #1 was re-admitted to the facility on 4/2/24 with diagnoses of non-Alzheimer's dementia, hypertension, constipation and nasal congestion. A review of Resident #1's most recent annual Minimum Data Set dated 10/5/24 revealed he was cognitively intact. On 1/8/25 at 8:00 AM an observation was made of medication in Resident #1's room noted there were two medications on his bedside table and an undetermined number of medications in a clear box on his bedside table. Resident #1 was in bed with his bedside table located beside his	F 761	1. Immediately removed Over the Counter (OTC) medications from Resident #1 bedside by Unit Manager on 1/8/25. Noted Nasal Decongestant, Eye Drops, throat spray and stool softener to be removed from resident□s room.Unit Manager Completed Self-Medication-Administration Assessment with resident regarding these medications on 1/8/25. Resident found safe and competent to self-administer. Orders obtained from the physician for resident to self-administer, lock box provided for resident to store medications properly and resident locked/unlocked box by return demonstration on 1/8/25 by unit manager. 2. To identify residents at risk of this practice, current resident rooms were observed for the presence of OTC medications at bedside on 1/8/25 by	

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	345252	A. BUILDING _____ B. WING _____	C 01/09/2025

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F 761	Continued From page 12 bed. The Assistant Director of Nursing went to Resident #1's at 8:10 AM, room after being notified of the medications being observed, and found 1 box of nasal decongestant, 1 bottle of eye drops, 1 bottle of throat spray, and 1 bottle of a stool softener and removed these medications from the room Resident #1 declined to be interviewed. A review of Resident #1's January 2025 physician orders revealed on 12/7/24 an order for stool softener 2 tablets two times a day and nasal decongestant one tab twice a day. The review also revealed there were no orders found for the throat spray or eye drops. An interview with the Assistant Director of Nursing on 1/8/25 at 8:30 AM indicated that she was not aware Resident #1 had medication in his room. She further indicated that she was aware of Resident #1 had a history of keeping medications in his room in the past and the Unit Manager had spoken to the family regarding bringing medication into the building. An interview with the Unit Manager on 1/8/25 at 8:50 AM revealed she had been aware of Resident #1 having medication in his room in the past but not on this date. She stated the nursing assistants will usually report when the Resident has medication in his room. The Unit Manager stated that she had spoken to the family member who was bringing in the medication regarding any medication had to have a physician's order and to not bring in any medication for Resident #1. The Unit Supervisor stated the family member stated	F 761	Assistant Director of Nursing. None were identified. 3. Staff educated 0n 1/8/25 by Assistant Directo of Nursing to alert nurses/nurse leadership should OTC medications be observed at residents bedside for removal and/or assessment. Families/Resident Representatives of current residents also notified that any OTC medication must be brought to the nurse and not given directly to the resident. Facility Leadership completing routine assigned rounding will also now be responsible for observing for OTC medications at the time of their rounds 5 times weekly. Any identified OCT will immediately be brought to the attention of the assigned nurse or nursing leadership. 4. DON or designee to complete facility rounds to assess for the presence of OTC medications at bedside. This should be completed weekly for 4 weeks, biweekly for 4 weeks, and then monthly for 4 weeks. Should no other issues be identified, monitoring may then be completed on a random basis. 5. This Plan of Correction will be monitored at the monthly Quality Assurance/Improvement Committee meeting until such time consistent substantial compliance has been made.	

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F 761	Continued From page 13 she understood. The Unit Manager further stated that Resident #1 was probably "okay" mentally to have the medications but was unsure if he could manipulate the containers due to his arthritis. An interview with the Administrator on 1/8/25 at 9:15 AM indicated he was not aware Resident #1 had medications on his bedside table on this date. He stated he knew the Unit Manager had talked to a family member in the past regarding she could not bring medications in for Resident #1 and no resident should have medications at the bedside unless ordered by the physician.	F 761		