STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345322	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Hendersonville	**290 Clear Creek Road , Hendersonville, North Carolina, 28792**

(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
F0000	INITIAL COMMENTS The survey team entered the facility on 09/09/25 to conduct a complaint survey and exited on 09/09/25. Additional information was obtained offsite on 09/10/25 and 09/11/25. Therefore, the exit date was changed to 09/11/25. The following intakes were investigated: 2605099, 802365, and 802366. 8 of 8 complaint allegations did not result in deficiency.	F0000		
F0755 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	F0755	"Past Noncompliance - no plan of correction required"	

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

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

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F0755 SS = D	Continued from page 1 and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, interviews with the Pharmacist Consultant and staff, the facility failed to have effective systems in place for returning controlled narcotic medications (oxycodone-acetaminophen) to the pharmacy after a resident was discharged. The oxycodone-acetaminophen continued to be stored in the medication cart after the resident's discharge and during the monthly reconciliation of controlled substances misappropriation was identified. This occurred for 1 of 3 residents reviewed for pharmacy services (Resident #1). The findings included: Resident #1 was admitted to the facility on 7/17/25 with diagnosis including dementia and calculus of the kidney (kidney stone). The 5-day admission Minimum Data Set (MDS) dated 7/21/25 revealed Resident #1’s cognition was moderately impaired, opioid medication was taken, and scheduled pain medication was received during the lookback period. Resident #1’s physician orders included oxycodone-acetaminophen 5-325 milligram (mg) tablet give one tablet every six hours as needed for severe pain started on 8/12/25. The medication was discontinued on 8/26/25. Resident #1 was discharged from the facility to the community on 8/25/25. A review of the pharmacy proof of delivery records revealed on 8/13/25 Resident #1 received one blister card with 12 tablets of oxycodone-acetaminophen 5-325 mg and on 8/15/25 one blister card with 30 tablets. A review of the Resident #1’s oxycodone-acetaminophen 5-325 mg declining count sheet for 12 tablets received on 8/13/25 indicated it was copy made on 8/29/25. The declining count sheet revealed nurses signed out one	F0755		

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F0755 SS = D	Continued from page 2 tablet on 8/14/25 at 11:19 AM, one tablet on 8/16/25 at 5:02 PM, one tablet on 8/21/25 at 10:00 PM and two tablets on 8/24/25 at 12:49 AM and 11:36 PM. The declining count sheet indicated seven tablets remained in the blister card. A review of a second copy of Resident #1's oxycodone-acetaminophen 5-325 mg declining count sheet for 12 tablets indicated the copy was made on 8/30/25. The second copy included an additional entry made by Nurse #2. Nurse #2's signature was added to indicate she removed one tablet on 8/25/25 at 6:02 AM and six tablets remained in the blister card. A review of the Resident #1's oxycodone-acetaminophen 5-325 mg declining count sheet for the 30 tablets received on 8/15/25 had none signed out to indicate 30 tablets remained in the blister card. A review of Resident #1's Medication Administration Record (MAR) revealed one tablet of oxycodone-acetaminophen 5-325 mg was administered as follows: 8/13/25 at 11:30 AM, 8/14/25 at 11:19 AM, 8/15/25 at 10:39 AM and at 9:28 PM, 8/16/25 at 5:02 PM, 8/21/25 at 10:08 PM, 8/22/25 at 10:42 PM, 8/24/25 at 12:49 AM and at 11:36 PM. The MAR indicated nine tablets of oxycodone-acetaminophen 5-325 mg tablets were administered. The initial 24-hour allegation report completed by the Administrator revealed the facility became aware on 8/30/25 at 5:15 PM of a drug diversion incident and notified law enforcement at 6:17 PM and the state survey agency at 6:47 PM. Details of the allegation revealed one blister card of oxycodone-acetaminophen and its declining count sheet were missing from the 400 Hall medication cart. The allegation revealed Nurse #1 and Nurse #2 were assigned to the 400 Hall medication cart when the oxycodone-acetaminophen was identified as	F0755		

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F0755 SS = D	Continued from page 3 missing and suspended pending a drug test and investigation. The 5-day investigation report dated 9/5/25 revealed the facility confirmed the blister card with 30 doses of oxycodone-acetaminophen 5-325 mg was missing and Nurse #1 was terminated. The facility's corrective action revealed nurses and Medication Aides were educated on the controlled substance policy and handling process for narcotic medications and they would complete a focused audit on reconciling newly added and removed narcotic medications from the medication cart. During an interview on 9/9/25 at 1:22 PM and 3:23 PM the Director of Nursing (DON) stated on 8/29/25 as part of her monthly routine review she checked the facility's medication carts and all the controlled substances and declining count sheets were accounted for, and the counts were correct including Resident #1's oxycodone-acetaminophen 5-325 mg. The DON stated she made copies of the declining count sheets on 08/29/25 to check physician orders and ensure each controlled medication stored on the carts had an active physician's order and if not she planned to remove it and return to the pharmacy. The DON stated after reviewing the physician orders, she discovered Resident #1 was discharged on 8/25/25 and did not have an active order for oxycodone-acetaminophen and on 8/30/25 she gave copies of the declining count sheets and asked the Unit Manager to remove both blister cards from the 400 Hall medication cart. The DON stated after the 400 Hall medication cart was checked by the Unit Manager, she was informed Resident #1's oxycodone-acetaminophen 5-325 mg blister card containing 30 tablets and the declining count sheet were missing. The DON stated it was approximately 4:00 PM on 8/30/25 when the Unit Manager informed her of the missing oxycodone-acetaminophen 5-325 mg. The DON stated Nurse #1 was assigned to the 400 Hall medication cart on 8/30/25 at the time Resident #1's oxycodone-acetaminophen was discovered as missing and removed from the cart and was asked to be drug tested. The DON further revealed she made two copies of Resident #1's oxycodone-acetaminophen 5-325 mg declining count sheet for the 12 tablets because Nurse #2 added her signature and signed out an additional dose was given on 8/25/25 at 6:02 AM that was not on the first copy she had made on 8/29/25. She revealed the copy she made on 8/29/25 Nurse #2 had signed out Resident #1's oxycodone-acetaminophen 5-325 mg last dose was given on 8/24/25 at 11:39 PM and seven tablets	F0755		

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F0755 SS = D	Continued from page 4 were remaining but after she reviewed the original declining count sheet that was removed from the cart on 8/30/25 Nurse #2 had signed out an additional dose to indicate the last dose of oxycodone-acetaminophen 5-325 mg was given on 8/25/25 at 6:02 AM and six tablets remained and why she made a second copy. The DON stated she asked Nurse #2 about adding her signature on declining count sheet and signed out a dose was given on 8/25/25 at 6:02 AM and Nurse #2 told her she had borrowed it and given it to a different resident but could not recall who. The DON stated she reviewed the physician orders and determined one other resident had an order for oxycodone-acetaminophen 5-325 mg and their medication was available, and Nurse #2 did not need to borrow from Resident #1. The DON revealed she checked Resident #1's MAR and no oxycodone-acetaminophen 5-325 mg was administered on 8/25/25 at the time Nurse #2 signed it out. The DON revealed Nurse #2 was asked to obtain a drug screen test and on 8/31/25 her results were negative. During an interview on 9/10/25 at 2:46 PM, the Unit Manager stated when doing the monthly audit for controlled narcotics that needed to be sent back to pharmacy she was given a copy of the declining count sheet for oxycodone-acetaminophen and asked to remove it from the 400 Hall medication cart. The Unit Manager stated she did not recall the name of the resident but when she checked the 400 Hall medication cart, the blister card containing 30 tablets of oxycodone-acetaminophen and the declining count sheet were missing. The Unit Manager stated she and Nurse #1 completed two medication counts and she checked the entire 400 Hall medication cart and did not find the blister card containing 30 tablets of oxycodone-acetaminophen. The Unit Manager stated she informed the DON and was asked to check the remaining medication carts, and those counts were correct. During an interview on 9/11/25 at 7:04 AM, Nurse #1 confirmed she worked on 8/30/25 and was assigned to the 400 Hall medication cart. Nurse #1 confirmed on 8/30/25 she did the count of controlled medications with Nurse #2 at the beginning of her shift at approximately 7:00 AM. Nurse #1 stated she felt the narcotic count was correct and she accepted the keys to the 400 Hall medication cart from Nurse #2. Nurse #1 stated she liked to perform a second count herself and changed her statement to indicate she did not feel the count was correct on 8/30/25 but she accepted the keys to the 400 Hall medication cart because that was what she was supposed to do and because she had residents to take	F0755		

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F0755 SS = D	Continued from page 5 care of and had to do her job. Nurse #1 stated the Unit Manager had copies of the controlled narcotic declining count sheets for the medications she wanted to remove from the locked box on the medication cart and that she did not take the missing pills and had nothing to hide. Attempts to interview Nurse #2 on 9/10/25 at 9:30 AM and 3:23 PM and 9/11/25 at 8:29 AM were unsuccessful. An interview was conducted on 9/11/25 at 11:03 AM with the Pharmacist Consultant. The Pharmacist Consultant revealed he had been coming to the facility each month since August 2024 and checked one medication cart during his visit. He rotated the medication carts to ensure all were checked including the controlled narcotic medications stored on the cart. The Pharmacist Consultant stated he reviewed controlled narcotic medications including the resident name, the amount of medication left, and ensured those matched with declining count sheet. He revealed if there was a discrepancy he would inform the nurse assigned to the medication cart and the DON either in his written report or verbally during his exit. The Pharmacist Consultant stated he had not identified any incorrect counts since August 2024 and had not found discontinued narcotic medications left on the carts during his monthly check. The Pharmacist Consultant revealed his last visit was on 9/3/25 and he was informed of the missing narcotic medication by the Administrator. A review of the quality assurance review of Resident #1's missing oxycodone-acetaminophen dated 9/5/25 included nurse interviews assigned to the 400 Hall medication cart, a list of the documentation reviewed, and referenced their monitoring tools as a plan to avoid the situation in the future. The quality assurance review was completed by the Administrator. Interviews with the Administrator were conducted on 9/9/25 at 1:22 PM and 9/10/25 at 4:45 PM. The Administrator stated it was the facility's policy and procedure for the nurses to inform the DON when a controlled narcotic medication was no longer needed on the medication cart and that failed to happen. The Administrator revealed the DON had made copies of the controlled narcotic count sheets on the medication carts on 8/29/25 and planned to remove medications that were no longer needed. The Administrator stated the facility had identified Resident #1 oxycodone-acetaminophen 5-325 mg blister card of 30	F0755		

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F0755 SS = D	Continued from page 6 tablets was missing but not who took the medication and had started the process of educating nurses and Medication Aides and monitoring of controlled substances. The Administrator revealed Nurse #1's drug test results were negative for oxycodone and opiates but positive for a substance that was against the facility's policy, and she was terminated. The Administrator revealed Nurse #2's drug test results were negative for oxycodone and opiates. He revealed Nurse #2 had not returned to work since 8/30/25 and he received her resignation on 9/5/25. The Administrator stated he confirmed with the pharmacy Resident #1 was not charged for the missing oxycodone-acetaminophen and he had reported Nurse #1 and Nurse #2 to the Board of Nursing and reported the missing oxycodone-acetaminophen to the Drug Enforcement Agency. The facility provided the following correction action plan: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. · Resident #1 is no longer a resident at the facility. Resident #1 discharged home on 8.25.25. · On 8.29.25 between 12:00 PM and 1:00 PM, the Director of Nursing (DON) made copies of all narcotic count sheets in the facility while completing an audit. At the time of the audit, former Resident #1 was noted to have 2 cards of oxycodone-acetaminophen 5/325mg along with 2 declining inventory sheets, one for each card of medication. One card (Card #1) had a remainder of 7 tablets and the other (Card #2) was a full card of 30 tablets. The last sign out on the used card (Card #1) was 8.24.25 which left 7 tablets remaining. The second full card (Card #2) of 30 tablets had no entries signed out. · On 8.30.25 at approximately 4:00 PM the DON was taking inventory of narcotics that had been discontinued and removing them from the medication carts to prepare for return to the pharmacy. The DON noted that Card #2 of oxycodone-acetaminophen for former Resident #1 and the declining inventory sheet was missing from the cart. Card #1 of oxycodone-acetaminophen for Resident #1 and the declining inventory sheet were present; however, a new entry had been signed out since the DON reviewed the card the previous day. This entry was signed out for 8.25.25 at 6:02 AM by Nurse #2 with a remainder of 6 tablets.	F0755		

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F0755 SS = D	Continued from page 7 · The DON removed the narcotic book from the medication cart at 4:05 PM on 08/30/25 and inspected for count discrepancies. Count noted to be correct, and signatures present for all dates 8.25.25 until 8.30.25 at 7:00 AM. The oncoming nurse signature (Nurse #1) for 8.30.25 at 7:00 AM was missing. · The DON interviewed Nurse #1 at 4:15 PM regarding morning count number and lack of signature at the beginning of her shift. Nurse #1 could not recall morning count number and could not explain lack of signature. Nurse #1 relieved Nurse #2 at 7:00 AM that morning. · On 08/30/2025— Approximately 4:20 PM DON confirmed that the card of 30 oxycodone-acetaminophen was not returned to the pharmacy. DON confirmed that Resident #1 did not take medication home with her. · On 8.30.25 at 4:23PM the DON notified the Administrator of the missing card of oxycodone-acetaminophen and associated declining inventory sheet, as well as the late entry dose documented on Card #1 and Nurse #1's missing signature from the narcotic inventory count that morning. · On 8.30.25 at approximately 5:00 PM Nurse #1 was removed from duty and notified that she would be suspended pending investigation, a narcotic count completed with Nurse #5 and DON as witness. Nurse #1 became upset and refused to come to office to discuss missing card and initially refused to go for drug screening. Multiple attempts made to convince nurse to come to DON office with Unit Manager as witness. Nurse #1 eventually agreed to go for drug screening. · On 8.30.25 at approximately 5:15 PM Nurse #2 contacted via phone by DON with Unit Manager 1 and Unit Manager 2 as witness to discuss missing card, need for drug screening, and suspension process. Nurse #2 was cooperative with answering questions. Nurse #2 agreed to go for drug screening. · On 8.30.25 at approximately 6:17 PM the Administrator called police. Dispatch stated an officer would either call or come to the facility. · On 8.30.25 at approximately 6:46 PM the police came to visit facility. Report filed. · On 8.30.25 at approximately 6:46 PM the initial allegation report was sent to Healthcare Personnel Investigations (HCPI).	F0755		

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F0755 SS = D	Continued from page 8 · On 8.30.25 at the time of discovery a 100% audit of all narcotic count sheets and cards was completed by the Assistant Director of Nursing (ADON) and Unit Managers x 2. No other discrepancies were identified. · On 8.30.25 at 8:01 PM the DON received a phone call from a nurse at hospital reporting that Nurse #1 came in for drug screening and had negative results. Nurse #1 was contacted by DON to request a hard copy of results for investigation purposes. · On 8.31.25 at 10:46 AM the DON received pictures of negative drug screen results from Nurse #2 who went to hospital for drug screening (she did not go the previous day as requested by DON but went on the morning of 8.31.25). · On 8.31.25 at 10:59 AM Nurse #1 was contacted by the DON to request hard copy of drug screening results. Nurse #1 responded at 12:38 PM stating she would check on the results when she returned home. At 2:28 PM Nurse #1 was contacted again by the DON requesting results. A text response was received stating she could not find them on the patient portal and likely would not be able to obtain a hard copy from the hospital until Tuesday 9.2.25 due to holiday on 9.1.25. · On 9.2.25 at 1:55 PM the DON and Administrator received a hard copy of Nurse #1's drug screening test. The test showed no positive results for opioids but was positive for Cannabis. · On 9.2.25 at 3:47 PM the Administrator and DON called Nurse #1 for further follow-up questions. Nurse #1reported that when she came into the facility on 8.30.25 at 7:00AM, she received report/count off from Nurse #2. She stated Nurse #2 gave her report and the count was correct. Whenever she was asked why her signature was missing as the oncoming nurse, she stated it was because she made sure to verify everything herself personally prior to signing anything. She reported that she was unaware of anything missing prior to DON questioning her on 8.30.25. · On 9.2.25 at 4:16 PM the Administrator phoned Nurse #2 for follow up questions. No response. Voicemail left. · On 9.3.25 at 7:52 AM the Administrator texted Nurse #2 about follow up questions. Nurse #2 responded at 8:53 AM stating she would be free in the "next 15 minutes." Administrator confirmed that was fine at 8:54 AM and attempted to Nurse #2 but she did not respond.	F0755		

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F0755 SS = D	Continued from page 9 · 09.03.25 DON texted Nurse #1 to ask her retake drug screening to ensure chain of custody was followed. Stated she was out of town but will do it as soon as she could get there…. Nurse #1 dropped off Custody Control Form on 09/04/2025 to the DON in the AM. · 09/03/2025- ~ 11:40 AM: Administrator reported issue to DEA. · On 9.3.25 at 12:40 AM the Administrator texted Nurse #2 again. No response. · On 9.3.25 at 4:09 PM the Administrator texted Nurse #2 again about the importance of responding back to us during this time. · On 9.3.25 at 5:11 PM the Administrator received a call back from Nurse #2 (with DON as witness). Nurse #2 stated that there were no narcotic discrepancies noted when she received report from Nurse #3 on 8.29.25 at 7:00PM. She stated that the next morning (8.30.25), she "counted off" and gave report to Nurse #1 at 7:00AM. When asked if she remembered how many narcotic cards were on the cart, she said "I believe 13." She acknowledged that she signed the Count Log. We asked if Nurse #1 signed the count log, and Nurse #2 stated she wasn't sure but that she borrowed Nurse #1's pen to sign it (and was able to recall that it was a pen with black ink). Nurse #2 stated that she did not recall Resident #1's narcotics that were in the cart specifically. Nurse #2 stated that she remembered her having "1 or 2" different controlled substances on the medication cart. Nurse #2 stated that she had not "worked the 400 hall cart in a while" due to "wanting a break" from it. Nurse #2 stated that she recalled Resident #1 having Tramadol and oxycodone-acetaminophen. When asked about how many bubble pack cards of oxycodone-acetaminophen she had on the cart, she stated that she remembered "the smaller one" and stated it had "around 10" oxycodone-acetaminophen on the cart. She does not recall the last time she saw the full card of oxycodone-acetaminophen. Nurse #2 stated during getting and receiving report and the "count offs" of the narcotics that typically she didn't pay attention to the actual drugs but the number of them. Administrator inquired about the last dose of oxycodone-acetaminophen that she signed as giving to Resident #1 on 8.25.25 at 6:02 PM (that was not signed out when DON did audit on 8.29.25). Nurse #2 stated she didn't recall specifically giving that but acknowledged that she could have. Nurse #2 was questioned if she knew that the DON had copied all of the narcotic logs on 8.29.25	F0755		

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F0755 SS = D	Continued from page 10 and knew that last dose of oxycodone-acetaminophen for former Resident #1 had not been signed out as of that time. Nurse #2 stated that she thought that's what happened. She was questioned as to why that last dose was signed out late and she stated that it was because "sometimes they borrow one from someone for another resident, like new admissions, if they need one." Nurse #2 acknowledged that she should not have done that. Nurse #2 stated she has no further information at this time to add related to the matter. During call, administrator and DON asked Nurse #2 to redo drug screening to ensure Chain of Custody was followed. She stated that she would as soon as possible. · 09/03/2025—DON audited current and discontinued orders of oxycodone-acetaminophen; DON audited medications of new admissions on 08/29/2025; no residents who admitted on 08/29/2025 had orders for oxycodone-acetaminophen. DON audited OmniCell (backup medication storage), and oxycodone-acetaminophen was available in OmniCell during the day of question (8/29/25). · 09/04/2025--- AM--- Nurse #1 turned in Chain of Custody Form. All nurses who worked the medication cart from 08/28/2025 until 08/30/2025 were asked to drug test. All nurses have turned in Chain of Custody forms to Administrator and DON as of 09/05/2025, except for Nurse #2. The nurses who were drug tested are: Nurse #1, Nurse #2, Nurse #3, Nurse #4, and Nurse #5. · 09/04/2025 at 4:30 PM—Administrator called dispatch at Sherrif's office to provide updated information. Dispatch transferred to the division that handles drug related matters. Left voicemail requesting a call back to provide updated information on matter. · 09/05/2025 at 8:28 AM Nurse #2 resigned via text to Administrator and DON, Nurse #2 has not gotten repeat drug screening with chain of custody as requested on 09/10/25. · 09/05/2025 at 5:07 PM Administrator sent in final report to state division responsible for investigations of healthcare personnel. · 09/05/2025 at 5:29 PM Nurse #1 attempted to be terminated via phone by Administrator and DON on not following facility policy. Nurse #1 did not answer; voicemail (VM) left to call back. Plan is to terminate due to not following facility policy. · 09/05/2025 at 3:41 PM North Carolina Board of Nursing (NCBON) notified of complaint by administrator on Nurse	F0755		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0755 SS = D	Continued from page 11 #1 and Nurse #2. · 09/05/2025 at 4:37 PM Nurse #1 was terminated via phone with Unit Manager #2 in witness. Termination cause was due to testing positive for Cannabis. · The Director of Nursing (DON) confirmed with the pharmacy on 8.30.25 that neither the resident, nor her insurance company, were billed for the missing medication. There were no negative outcomes relating to these findings. · The schedule was reviewed by the DON and Administrator on 08.30.2025. Nurse 1 had not been assigned to any other cart (other than the 400-hall cart) since 03.29.2025; Nurse 2 had not been assigned to any other cart (other than 400-hall cart) since 08.17.2025. Nurse #1's last worked shift was when she was suspended, pending-investigation, on 8.30.2025, at approximately 5:15 PM. Nurse #2's last shift worked was when Nurse #2's shift was completed from 8.29.25 to 8.30.25 (7 PM to 7 AM). · The facility management team completed an ad hoc Quality Assurance Process Improvement (QAPI) meeting on 9/2/2025 to discuss area of concern and implement this past-non-compliance (PNC) plan to correct deficient practice and plan to monitor the plan. Contributing factor to the diversion was determined to be related to pharmacy services and not removing medications from the medication carts promptly when a resident discharges home or an order is discontinued. The QAPI meeting consisted of the Unit Managers , Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Regional Nursing Consultant. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. · All current residents that have narcotic medications ordered have the potential to be affected. · The DON and nursing management team conducted 100% audit on 8.30.25 of all narcotic blister pack cards and corresponding narcotic count sheets on all 6 med carts to ensure there were no discrepancies. None were identified. Specifically, the residents that resided on the 400 Hall unit had the most potential to be affected by the deficient practice due to finding no other discrepancies on the other carts. On 08.30.2025, all residents who receive narcotics on the 400 Hall had	F0755		

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F0755 SS = D	Continued from page 12 pain levels questioned and evaluated by licensed nurses. There were no similar issues noted. · The clinical team also reviewed medical records (progress notes, evaluations, medication administration records, 24-hour report) on 8.30.25 for all residents on the affected medication cart (400 hall) from 8.29.25 - 8.30.25 to see if any of the potentially affected residents had signs and symptoms of pain not controlled by current regimen. No negative outcomes were identified. The audit included checking pain levels documented in the medication administration records for residents (both alert and oriented and those who are not alert and oriented) These reviews and audits were completed by the nursing management team as of 8.30.25. All residents who have orders for narcotics had documented pain levels on 08.30.2025 completed by clinical staff. There were no related concerns noted. · Between 09.01.2025 and 09.02.2025, the provider assessed all residents on the 400 hall unit who receive narcotic medications and discussed pain. No concerns noted in relation to investigation. · Administrator reviews grievance log and open grievances weekly on a regular basis; the administrator reviewed the last 3 months of grievances (including Resident Council concerns) on 9.3.2025; there were no related grievances noted about missing pain medications. · The Pharmacist was notified and visited facility on 09.03.2025. Pharmacist did not handle investigation; however, pharmacist did not note areas of concern during his site visit on 09.03.2025. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. · All licensed nurses and medication aides working in the facility on 8.30.25 at the time of discovery received immediate education by the DON on the facility Controlled substance policy and Narcotic handling process. 100% of licensed nurses and medication aides received the same education by the DON as of 9.2.25. Any licensed nurse or medication aide that did not receive education as of 9.2.25 will not be allowed to work until the same education is received by the Staff Development Coordinator during orientation. The education emphasized that:	F0755		

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F0755 SS = D	Continued from page 13 *If a resident discharges or expires the narcotic cards must be removed from the cart immediately and given to a nursing supervisor to secure in preparation for return to pharmacy. If no nursing supervisor is in the facility the nurse must notify the DON immediately. The nurse will notify the DON of the resident discharging as well as the following information: number of narcotic cards/sheets on the medication cart; and the count of the remaining medication (such as number of pills or amount of liquid) left on the cart. The nurses will continue to count off on the sheets and number of medications each shift until they are removed by nursing management. The DON or designated nurse manager will remove the narcotics (as well as the declining count sheet) from the cart to place in the locked cabinet in the locked medication room. In the pharmacy's online system, the DON or designee will then notify the pharmacy of the narcotics needing to be picked up from the facility, which occurs Monday through Saturday. · After 9/2/2025, all new hires (that are Medication Aides or licensed nurses) will be educated on the above policies during orientation by the Staff Development Coordinator (SDC). The systemic change includes; - The education beginning on 8.30.2025 with all nurses and medication aides (conducted by the DON or designee) on the facility's policy for handling narcotics was reviewed and implemented as part of the systemic change. The policy was not amended. - As a process change, beginning on 9.3.2025, the DON or designee will review pharmacy narcotic delivery manifests to ensure every narcotic delivery is present. - At time of a narcotic order being discontinued or a resident discharges, the DON or designee will promptly remove the discontinued medication from the medication carts in preparation to return medications back to the pharmacy. In the event that there is no nurse manager in the facility, the nurse will notify the DON of the resident discharging as well as the following information: number of narcotic cards/sheets on the medication cart; and the count of the remaining medication (such as number of pills or amount of liquid) left on the cart. The nurses will continue to count off on the sheets and number of medications until they are removed by nursing management. This was implemented as a process change. - The DON or designee will verify with the pharmacy	F0755		

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F0755 SS = D	Continued from page 14 that all narcotics were promptly returned to the pharmacy. The DON will ensure that the narcotic pick-up tickets are received by the pharmacy courier to ensure successful delivery of the narcotics back to the pharmacy. The DON will verify the information via calling to receive verbal confirmation that the discontinued narcotics were received by the pharmacy. Once the pharmacy destroys the narcotics, the pharmacy will send the DON a Destruction Log, where the DON where reconcile the Destruction Log with the log of narcotics that have been returned. This was implemented as a process change. - DON or designee will routinely as part of the clinical operations meeting Monday through Friday run an order listing report to capture discontinued narcotics to ensure return to pharmacy process is followed. This was implemented as a process change. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. · Beginning on 9.3.25 the DON or designee will audit Controlled Substance Shift Inventory sheets and declining count sheets; narcotic delivery manifests (to ensure it is logged on the Narcotic Sheet Inventory Record); and conduct a visual inspection of narcotics stored on the medication carts to ensure the counts are correct. This audit will focus on reconciliation of newly added or removed narcotic cards from the medication carts. This audit will occur for all 6 med carts twice daily 7x/week x 2 weeks, then twice daily 5x/week x 2 weeks, then twice daily 3x/week x 4 weeks, then twice daily each week x 4 weeks. Any variances will be corrected at the time of audit and additional education/corrective action taken as indicated. · Beginning on 9.3.25, The DON will ensure that residents who discharge home will have medications removed from the medication cart promptly. This audit will occur for all 6 med carts twice daily 7x/week x 2 weeks, then twice daily 5x/week x 2 weeks, then twice daily 3x/week x 4 weeks, then twice daily each week x 4 weeks. Any variances will be corrected at the time of audit and additional education/corrective action taken as indicated. · Beginning on 9.3.2025, the facility will also conduct audits of pain at the following frequency: 30 Pain Evaluations monthly (15 for alert and oriented residents as well as 15 for non-alert and oriented	F0755		

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F0755 SS = D	Continued from page 15 residents). The Pain Evaluation will be conducted by the DON or designee. Monitoring will be completed by 11-25-2025, unless the Quality Assurance Process Improvement (QAPI) Committee decides to extend the audits and monitoring. Name of person responsible for ensuring compliance with the plan of correction: Preston Harness, Administrator. Date of compliance: 09/06/2025 The corrective action plan validated on 9/11/25 and included review the facility's weekly audits of controlled medications stored on the medication carts had an active physician's order. Review of the in-service education started on 8/30/25 titled, "Narcotic Count/Handling Procedure," included nurses and Medication Aide signatures. Review of pain assessments completed on the Medication Administration Record. Review of drug test results. Review of the report to the Drug Enforcement Agency, and North Carolina Board of Nursing. Observation of the controlled narcotic count performed by two nurses to review the Controlled Substance Shift Inventory was filled out correctly and matched the number of controlled medications stored on the cart, the controlled narcotic medications and declining count sheet matched the resident's name and amount of medication remaining. Interviews conducted with nurses related to the facility policy and procedures for handling discontinued controlled narcotic medications and to immediately inform the DON or designee to ensure those were removed from the cart. Interviews with sampled residents receiving controlled narcotic medications with no concerns identified. The facility's corrective action plan compliance date of 09/06/2025 was validated.	F0755		