

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/09/2025
NAME OF PROVIDER OR SUPPLIER  Warsaw Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 214 Lanefield Road Warsaw, NC 28398	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48007</b></p> <p>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.</p> <p>The findings included:</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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 replacement of medication.</p> <p>A telephone interview was attempted with the former Director of Nursing, but she was unavailable.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 the back of the two cards, when she went back to the medication cart Nurse #3 was gone.</p> <p>A telephone interview was attempted to Nurse #3, but she was unavailable.</p> <p>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.</p> <p>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.</p> <p>1b. On 7/31/24 a narcotic sheet for Resident #6 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.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>A review of the narcotic sheet with Nurse #3's signature revealed she gave Resident #6 one 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.</p> <p>A telephone interview with the former DON was attempted on 1/7/25 and 1/8/25 but she was not available.</p> <p>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.</p> <p>A telephone interview with Nurse #3 was attempted but she was not available.</p> <p>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 medication cart and narcotic drawer, staff statements and drug tested the staff identified.</p> <p>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 too early and she (the Unit Supervisor) notified the Administrator.</p> <p>A telephone interview was attempted on 1/8/25 with Nurse #4, but she was unavailable.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>A review of the delivery slip dated 11/13/24 indicated 120 tablets of Oxycodone 10 mg for Resident #1 was delivered.</p> <p>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.</p> <p>An interview with the Administrator on 1/8/25 at 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.</p> <p>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.</p> <p>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 [DATE].</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48007</b></p> <p>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.</p> <p>The findings included:</p> <p>Resident #1 was admitted into the facility on [DATE] with most recent readmission on 4/2/24 with diagnoses of non-Alzheimer's dementia, constipation, nasal congestion and hypertension.</p> <p>Resident #1's annual Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Resident #1 declined to be interviewed.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48007</b></p> <p>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).</p> <p>The findings included:</p> <p>Resident #1 was readmitted to the facility on [DATE] with diagnoses of non-Alzheimer's dementia, hypertension, constipation and nasal congestion.</p> <p>A review of Resident #1's most recent annual Minimum Data Set, dated dated dated [DATE] revealed he was cognitively intact.</p> <p>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 bed.</p> <p>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</p> <p>Resident #1 declined to be interviewed.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p>