STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345273	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital East Greensboro	2401 South Side Boulevard Greensboro, NC 27406

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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record reviews, Pharmacy Nurse Consultant and staff interviews, the facility failed to protect the residents' right to be free from misappropriation of narcotic medications (Hydrocodone and Oxycodone) prescribed to treat pain and an antianxiety medication (Lorazepam) prescribed to treat anxiety. This affected 6 of 6 residents reviewed for misappropriation of resident property (Residents #5, #17, #223, #224, #225 and #226). The findings included: A. Resident #5 was admitted to the facility on [DATE] with diagnoses of spinal stenosis and chronic pain. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #5 was cognitively intact. A review of Resident #5's physician orders included the following: - An order dated [DATE] through [DATE] for Oxycodone 10 milligrams (mg) one tablet by mouth every six hours as needed for pain. - An order dated [DATE] for Oxycodone 10 mg one tablet by G-tube every six hours as needed for pain. A review of the Controlled Medication Utilization Record revealed Resident #5 was signed out as receiving Oxycodone 10 mg on [DATE], [DATE], [DATE], [DATE] and [DATE] by Nurse #1. A review of the Medication Administration Record (MAR) for [DATE], [DATE] and [DATE] did not reveal Resident #5 was signed out as receiving Oxycodone by Nurse #1 on [DATE], [DATE], [DATE], [DATE] or [DATE]. A review of Resident #5's medical record did not reveal any evidence of uncontrolled pain. B. Resident #17 was admitted to the facility on [DATE] with diagnoses that included spastic hemiplegia affecting the right dominant side and acute and chronic respiratory failure. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #17's physician orders included an order dated [DATE] for Oxycodone 5 mg one tablet by G-tube every eight hours as needed for pain. A quarterly MDS assessment dated [DATE] indicated Resident #17 had severely impaired cognition. A review of the Controlled Medication Utilization Record revealed Resident #17 was signed out as receiving Oxycodone 5 mg on [DATE] at 5:00 AM and [DATE] at 12:00 PM by Nurse #1. A review of the [DATE] MAR did not reveal Resident #17 was signed out as receiving Oxycodone on [DATE] at 5:00 AM or 12:00 PM by Nurse #1. A review of a time punch record for Nurse #1 on [DATE] showed she did not clock into work until 7:06 AM. A review of Resident #17's medical record did not reveal any evidence of uncontrolled pain. C. Resident #223 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure and muscle spasm. A review of Resident #223's physician orders included an order dated [DATE] for Oxycodone 5 mg one tablet via G-tube every six hours as needed for moderate pain manifested by grimacing/restlessness. A quarterly MDS assessment dated [DATE] indicated Resident #223 had severe cognitive impairment. A review of the Controlled Medication Utilization Record revealed Resident #223 was signed out as receiving Oxycodone 5 mg on [DATE] at 8:40 AM and [DATE] at 12:00 PM by Nurse #1. A review of the [DATE] MAR revealed Resident #223 was signed out as receiving Oxycodone 5 mg on [DATE] at 8:40 AM but not [DATE] at 12:00 PM by Nurse #1. A review of Resident #223's medical record did not reveal any evidence of uncontrolled pain. D. Resident #224 was admitted to the facility on [DATE] with diagnoses that included chronic pain and a stage 4 pressure ulcer of the sacral region. He was discharged to the hospital on [DATE]. A review of Resident #224's physician orders included an order dated [DATE] for Hydrocodone-Acetaminophen 5 mg-325 mg one tablet by G-tube every six hours as needed for pain. A review of the Controlled Medication Utilization Record revealed the following regarding Resident #224's Hydrocodone: - The medication was marked as popped out by accident by Nurse #1 and wasted on [DATE], [DATE] and [DATE]. The witness signature was marked as Nurse #2. - The medication was signed out as given to Resident #224 on [DATE], [DATE] at 9:00 AM, [DATE] at 2:00 PM, ,d+[DATE]//24 at 2:00 PM, [DATE] at 3:00 PM and [DATE] at 2:00 PM by Nurse #1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the [DATE] MAR revealed Resident #224 was not signed out as receiving Hydrocodone by Nurse #1 on [DATE], [DATE] at 9:00 AM, [DATE] at 2:00 PM, ,d+[DATE]//24 at 2:00 PM, [DATE] at 3:00 PM and [DATE] at 2:00 PM. A review of the Master Signature Log for staff revealed the initials for Nurse #2 did not match the Controlled Medication Utilization Record for the witnessed wastes on [DATE], [DATE] and [DATE]. A quarterly MDS assessment dated [DATE] indicated Resident #224 had severely impaired cognition. A review of Resident #224's medical record did not reveal any evidence of uncontrolled pain. E. Resident #225 was admitted to the facility [DATE] with diagnoses that included chronic respiratory failure, ankylosing spondylitis and chronic pain. He expired on [DATE]. A quarterly MDS assessment dated [DATE] indicated Resident #225 had severe cognitive impairment. A review of Resident #225's physician orders included the following: - An order dated [DATE] through [DATE] for Lorazepam 2 mg per milliliter (ml). Inject 0.25 ml intravenous every three hours as needed for anxiety/agitation/shortness of breath. - An order dated [DATE] for Lorazepam 2 mg per ml. Give 0.25 ml intravenously every two hours as needed for anxiety/agitation/shortness of breath. A review of the Controlled Medication Utilization Record revealed the automatic waste of 0.75 ml of Lorazepam was signed out by Nurse #1 on [DATE] at 11:00 AM, [DATE] at 6:20 PM, [DATE] at 10:25 AM and the waste of the 0.75 ml was witnessed by Nurse #2. In addition, Nurse #1 signed out Lorazepam on [DATE] at 8:00 AM, [DATE] at 2:00 PM, [DATE] at 5:30 PM and [DATE] at 6:34 PM and the waste of the 0.75 ml was witnessed by Nurse #3. A review of the Master Signature Log for staff revealed the initials for Nurses #2 and #3, did not match the Controlled Medication Utilization Record for the witnessed wastes of Lorazepam 0.75 ml. Review of an employee timecard for Nurse #3 indicated she clocked in to work on [DATE] at 7:00 PM. F. Resident #226 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure and chronic pain. He expired [DATE]. A review of Resident #226's physician orders included an order dated [DATE] for Hydrocodone-Acetaminophen 5 mg- 325 mg one tablet via G-tube every six hours as needed for pain. A quarterly MDS assessment dated [DATE] indicated Resident #226 had severe cognitive impairment. A review of the Controlled Medication Utilization Record revealed Nurse #1 had the following Hydrocodone-Acetaminophen 5 mg-325 mg marked as wasted by Nurse #1: - An entry on [DATE] as an error and waste witnessed by Nurse #2. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An entry on [DATE] as an error and waste witnessed by Nurse #4. - An entry on [DATE] at 5:37 PM with no reason for waste and witness signature unreadable. - An entry on [DATE] at 10:00 AM with no reason for waste and witness signature unreadable. - An entry on [DATE] with no time and waste witness signature Nurse #2. - An entry on [DATE] at 7:00 PM with no reason for waste and waste witness signature Nurse #5. - An entry on [DATE] at 9:00 PM with reason as dropped and no waste witness signature. - An entry on [DATE] at 7:16 AM with no reason for waste and waste witness signature Nurse #2. - An entry on [DATE] at 12:00 PM with reason as dropped and waste witness signature Nurse #4 - An entry on [DATE] at 1:00 PM with no reason for the waste and waste witness signature Nurse #2. - An entry on [DATE] at 12:00 PM with reason as dropped for the waste and waste witness signature #2. A review of the Master Signature Log for staff revealed the initials for Nurses #2, #4 and #5 did not match the Controlled Medication Utilization Record. An initial report was submitted to the North Carolina Department of Health Human Services Division of Health Service Regulation on [DATE] by the Administrator. The allegation of misappropriation of property was made on [DATE] when narcotic discrepancies were found on five residents narcotic records involving Nurse #1. A witness statement dated [DATE] from Nurse #2 read that the signatures for wastes with Nurse #1 were not hers. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation completed by the Director of Nursing on [DATE] revealed on [DATE] she was informed by the Unit Manager that there was a discrepancy on two Controlled Medication Utilization Records dated [DATE] by Nurse #1. Nurse #1 had signed out Oxycodone 5 mg for Resident #17 at 5:00 AM and 12:00 PM. Both administrations were not captured on the MAR and Nurse #1 did not clock into the facility to begin work on [DATE] until 7:06 AM. Therefore, she was not present in the facility at 5:00 AM. Nurse #1 also signed out Oxycodone 5 mg for Resident #223 at 12:00 PM on [DATE]. There was no documentation of this on the MAR. The previous administration was documented as 8:40 AM and the medication was ordered every six hours as needed for pain, thus it would have been too soon for the resident to have received the medication. A more thorough investigation began with all narcotic records being reviewed. It was found during the investigation that Nurse #1 signed out on the narcotic record providing Resident #5 with Oxycodone 10 mg five times with no record of the medication given on the MAR. Resident #226 had Hydrocodone-Acetaminophen ,d+[DATE] mg wasted seven times by Nurse #1 from [DATE] to [DATE] with signatures for witnessed wastes that did not match the Master Signature Log. Resident #225 was ordered Lorazepam 0.25 ml as needed with an automatic waste of 0.75 ml. There were eight witnessed wastes for this medication with questionable witness signatures. One that stood out the most was on [DATE] for a signature from Nurse #3 witnessed at 8:00 AM, 2:00 PM, 5:30 PM and 6:34 PM. Nurse #3 did not clock in for work on [DATE] until 7:00 PM. A witness statement dated [DATE] from Nurse #4 read that she had not witnessed the wasting of narcotics with Nurse #1 on [DATE] or [DATE]. The statement further read the initials that were present were not hers. On [DATE] at 8:07 AM, an interview occurred with the Unit Manager who stated that on the morning of [DATE] she was approached by Nurse #6 to look at the Controlled Medication Utilization Record for Resident #223, because the administration times for his Hydrocodone didn't look right. The medication was to be given every six hours as needed but the times of administration were to close together and weren't marked out as given on the MAR. It was also noted that Resident #17's Oxycodone 5 mg was signed out on the Controlled Medication Utilization Record as given by Nurse #1 at 5:00 AM and 12:00 PM. This was odd since Nurse #1 worked 7:00 AM to 7:00 PM that day. This was reported to the DON, who began an investigation of all the narcotic records. An interview occurred with Nurse #4 on [DATE] at 2:11 PM. She reviewed the narcotic record for Resident #226's Hydrocodone and stated that the witnessed waste signature for [DATE] and [DATE] were not hers. I didn't witness any wastes of medications with Nurse #1. Nurse #6 was interviewed on [DATE] at 2:13 PM and stated she notified the Unit Manager on [DATE] that something didn't look right on Resident #223's Controlled Medication Utilization Record. She explained she noticed his medications were signed out by Nurse #1 as being given to close together and weren't captured on the MAR and for Resident #17 the Oxycodone was signed out by Nurse #1 at a time she wasn't at the facility. A phone interview occurred with Nurse #3 on [DATE] at 9:40AM. She had a witness signature for a waste of Lorazepam 0.75 ml for Resident #225 on [DATE] at 8:00 AM, 2:00 PM, 5:30 PM and 6:34 PM on the Controlled Medication Utilization Record. Nurse #3 stated she worked 7:00 PM to 7:00 AM shift and wasn't present at the facility during those times on [DATE]. An interview occurred with Nurse #2 on [DATE] at 11:02 AM. After reviewing the narcotic records, she stated the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- For Resident #224's Hydrocodone, that was not her signature for the witnessed wastes on [DATE], [DATE] and [DATE]. - For Resident #225's Lorazepam it was not her signature for the witnessed wastes on [DATE] and [DATE]. - For Resident #226's Hydrocodone it was not her signature for the witnessed wastes on [DATE], [DATE], [DATE], [DATE] or [DATE]. Nurse #2 further stated that she did not work on [DATE]. A phone interview occurred with the Pharmacy Nurse Consultant on [DATE] at 11:17 AM. She stated the facility had identified the misappropriation of narcotics by Nurse #1 and asked for her to come and audit narcotic records to ensure they had not missed anything. She stated the facility had captured all the concerns during her review and she provided education to all the nursing staff regarding procedure for wasting medications, and misappropriation of narcotics on [DATE]. The Director of Nursing (DON) was interviewed on [DATE] at 11:27 AM and explained that during a morning meeting on [DATE] she was notified by the Unit Manager there was a discrepancy found for two residents controlled medications by Nurse #1 on [DATE]. It was noted that Nurse #1 had signed the Controlled Medication Utilization Record as giving Resident #17 his Oxycodone on [DATE] at 5:00 AM and 12:00 PM. These were not captured on the MAR and Nurse #1 didn't arrive to work until 7:06 AM on [DATE], therefore she couldn't have administered the 5:00 AM dose. Resident #223's Oxycodone was signed out on the Controlled Medication Utilization Record by Nurse #1 on [DATE] at 12:00 PM but was not captured on the MAR. This prompted the DON to do a more thorough investigation that revealed a lot of wastes with questionable signatures for the nurses that were to witness the wasting of the narcotic or no witness signatures, as well as entries on the Controlled Medication Utilization Record that were not captured on the MAR. The specific narcotic records were reviewed with the DON and revealed the following: - Resident #5 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 that was not captured on the MAR. - Resident #17 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on [DATE] at 5:00 AM when she didn't clock in for work on that day until 7:06 AM. - Resident #223 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on [DATE] at 12:00 PM and was not captured on the MAR. - Resident #224 had a waste of Hydrocodone on [DATE] where the witness signature did not match the master signature log and nurse denied the handwriting was hers. The July Controlled Medication Utilization Record had multiple times Hydrocodone was signed out by Nurse #1 and not captured on the MAR. - Resident #225 had multiple wastes of Lorazepam from Nurse #1. The witness signatures did not match the master signature log and nurses denied the handwriting was theirs. Nurse #3 wasn't at work during the times that indicated she witnessed a waste. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident #226 had wastes of Hydrocodone by Nurse #1 where there were no witness or incorrect witness signatures as well as the medication was signed out on the Controlled Medication Utilization Record and not captured on the MAR. The Administrator was interviewed on [DATE] at 2:01 PM and stated once the suspicion of misappropriation of narcotics was found the nurse was suspended pending the investigation. The police department, corporate, pharmacy, Drug Enforcement Agency and North Carolina Board of Nursing were notified. The investigation began with all the narcotic records being audited. The investigation showed that Nurse #1 was the nurse that marked waste for narcotics the most and most entries weren't reflected on the resident MAR's as being given to them. We never suspected her of taking medication prior to [DATE] as she was never visibly impaired. Once the investigation was completed Nurse #1 was terminated. Multiple unsuccessful attempts were made to contact Nurse #1. The facility provided the following corrective action plan: Corrective action for the involved residents: Resident records were reviewed as well as medications/narcotics for the residents affected. Interviews were conducted with the residents. Resident Council was completed. Pain assessments were completed. Pharmacy performed an audit of the narcotics on [DATE]. The nurse was suspended pending the investigation. On [DATE] the police department was notified. On [DATE] the Drug Enforcement Agency was notified. On [DATE] a 24 hour report was submitted, and the North Carolina Board of Nursing was notified. Corrective action for other potentially affected residents: All narcotic records as well as Medication Administration records were reviewed. A pharmacy audit was performed on [DATE] with no other concerns identified. Pain assessments were completed by the DON. Measures that were put in place or systemic changes: The Staff Development Coordinator (SDC) initiated education on [DATE] to all nurses on Controlled Substance Diversion Training and Drug Diversion Policy. How the facility plans to monitor: The DON and Unit Manager will continue their audits of the MAR, Narcotic Sheets and Medications weekly for six months then monthly for one year. The SDC will educate all new and active staff on a continued basis on Abuse, Neglect and Misappropriation. All nurses will continue, on a regular basis, to be educated by the SDC/DON on medication administration and drug diversion. The plan alleged compliance on [DATE]. As part of the validation process, the plan of correction was reviewed and verified through review of audit sheets, education records and staff interviews. Review of the facility plan of correction revealed evidence of 100% auditing of medication concerns or misappropriation, including pain assessments. The facility provided evidence of 100% staff education on Controlled Substance Diversion Training and Drug Diversion Policy completed on [DATE]. The facility reported Nurse #1 to the North Carolina Board of Nursing on [DATE]. Reports were presented to the Quality Assurance committee by the DON to ensure corrective action was appropriate. Ongoing audits were reviewed. The validation process verified the facility's date of compliance of [DATE].

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40197 Based on record reviews and staff interview, the facility failed to submit an initial report to the state regulatory agency within 24 hours of a discovery of misappropriation of resident property. This was for 6 of 6 residents (Residents #5, #17. #223, #224, #225 and #226) reviewed. The findings included: A review of the facility's Reporting Reasonable Suspicion of Crime policy, last revised 10/2022, revealed the facility would report a 24-hour investigation for a reasonable suspicion of crime no later than 24 hours if the alleged violation does not result in serious bodily injury. An interview with the Director of Nursing (DON) was conducted on 9/17/24 at 11:27 AM and indicated she was notified on 8/9/24 by the Unit Manager that there was a discrepancy on the Controlled Medication Utilization Record for Residents #17 and #223 involving Nurse #1. The DON stated she notified the Administrator and began an audit of all resident Controlled Medication Utilization Records on 8/9/24 , finding the following: - Resident #5 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 that was not captured on the MAR. - Resident #17 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on 8/7/24 at 5:00 AM when she didn't clock in for work on that day until 7:06 AM. - Resident #223 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on 8/7/24 at 12:00 PM and was not captured on the MAR. - Resident #224 had a waste of Hydrocodone on 6/6/24 where the witness signature did not match the master signature log and nurse denied the handwriting was hers. The July Controlled Medication Utilization Record had multiple times Hydrocodone was signed out by Nurse #1 and not captured on the MAR. - Resident #225 had multiple wastes of Lorazepam from Nurse #1. The witness signatures did not match the master signature log and nurses denied the handwriting was theirs. Nurse #3 wasn't at work during the times that indicated she witnessed a waste. - Resident #226 had wastes of Hydrocodone by Nurse #1 where there were no witness or incorrect witness signatures as well as the medication was signed out on the Controlled Medication Utilization Record and not captured on the MAR. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 2:01 PM, an interview occurred with the Administrator. She explained that she didn't send an initial report to the state regulatory agency within 24 hours because they were not sure if this was a misappropriation of resident medications issue or not on 8/9/24. The Administrator stated once they suspected the misappropriation of narcotic medications, the corporate agency, pharmacy, law enforcement, Drug Enforcement Agency and North Carolina Board of Nursing were notified. She acknowledged the 24 hour report was not sent to the State Agency until 8/19/24, stating we were doing the investigation and wanted to make sure the problem was corrected.