

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF PROVIDER OR SUPPLIER Pruitthealth-Rockingham		STREET ADDRESS, CITY, STATE, ZIP CODE 804 South Long Drive Rockingham, NC 28379	

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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197</p> <p>Based on record review, observations and staff interviews, the facility failed to honor a resident's choice to receive coffee as requested for 1 of 3 residents reviewed for choices (Resident #10). The reasonable person concept was applied for Resident #10 due to his inability to express his feelings and a reasonable person would feel angry and frustrated if their choices were not met.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety disorder and aphasia (difficulty expressing self).</p> <p>An annual Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #10 had moderately impaired cognition and required setup assistance for eating.</p> <p>On 2/18/25 at 10:59 AM, an interview occurred with the Floor Technician. He explained that on 11/12/24 he witnessed Resident #10 yelling out for coffee in the dining room and Nurse Aide (NA) #1 removed Resident #10 from the dining room instead of providing him with a cup of coffee as requested.</p> <p>A phone interview was conducted with NA #1 on 2/19/25 at 5:51 PM. She explained that on 11/12/24 Resident #10 was in the dining room, had completed his lunch meal and was requested more coffee. She was in the middle of assisting another resident at his table with their lunch and told him, give me a few minutes. She stated Resident #10 became agitated and she removed him from the dining room instead of providing him with coffee.</p> <p>On 2/17/25 at 10:33 AM, Resident #10 was observed sitting up in his bed with a cup of coffee in front of him. He was unable to recall the events of 11/12/24.</p> <p>A phone interview occurred with the Administrator and Director of Nursing (DON) on 2/20/25 at 1:01 PM. They explained that Resident #10 received meals in the dining room per his choice and loved drinking black coffee. The DON indicated that coffee was often used to help ease his anxiety and agitation when present. They both indicated that Resident #10 should have been provided with coffee as requested on 11/12/24.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>50415</p> <p>Based on record review and staff interviews, the facility failed to maintain documentation of resolved grievances and evidence of the results of all grievances for 9 of 13 months reviewed (December 2023 to August 2024).</p> <p>Findings included:</p> <p>During an interview with Administrator #1, the current administrator, on 2/17/25 at 4:20 PM she stated the grievances from December 2023 through August 2024 were not available and could not be reviewed because she did not have the grievances.</p> <p>On 2/17/25 at 4:30 PM the Social Worker was interviewed. She stated the former administrator, Administrator #2, would not allow her to assist in the grievance process. She indicated Administrator #2 told her the administrator's role was the grievance official, and that the Social Worker was not to touch the grievances. The Social Worker stated she did not know where the grievance log (which was a record of the grievances) or the copies of grievances were kept.</p> <p>Administrator #2, the former administrator, was interviewed by phone on 2/18/25 at 10:07 AM and stated when she left the facility in August 2024, she gave the grievance log binder to the Director of Nursing in a box of stuff. She further stated the Social Worker also had copies of the grievances during the time she was the Administrator from December 2023 to August 2024.</p> <p>The Director of Nursing (DON) was interviewed on 2/18/25 at 3:51 PM. She stated Administrator #2 had called her in August 2024 after Administrator #2 was no longer employed at the facility and asked the DON to meet at a grocery store parking lot in a nearby town so Administrator #2 could return some papers belonging to the facility. She stated Administrator #2 handed her a box from her car, and the DON indicated she put the box in her car's trunk. The DON stated that she did not open the box to check the contents, but that she placed the box in the Administrator #1's office when she went back to work.</p> <p>The current administrator, Administrator #1, was interviewed on 2/17/25 at 4:20 PM. She stated she began working for the facility on 8/18/24. She stated she had searched her office and throughout the facility, but she had not been able to find the grievances or grievance logs from December 2023 to August 2024. She indicated she was unsure if grievances were recorded before she became the Administrator because she was informed by the Social Worker, the former administrator would not allow the Social Worker to participate in the grievance process. However, she stated she would continue to search for the grievances and the grievance log. During a follow up interview with Administrator #1 on 2/20/25 at 2:22 PM, she stated she began working with the Social Worker to assist with the grievance process when she became the Administrator in August 2024. She indicated grievances were discussed during the morning meeting each day, and each month the Social Worker would report to her regarding any further action required for grievances which were of concern.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility provided a copy of the Quality Assurance and Performance Improvement (QAPI) meeting minutes dated 8/27/24 and a copy of its Performance Improvement Plan (PIP) dated 8/27/24 to review for a potential determination of past noncompliance. The measures and systemic changes put into place and monitoring in the corrective action plan did not address the deficient practice. As a result, the survey team was unable to make a determination of past noncompliance for grievances.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197</p> <p>Based on record review, resident and staff interviews, the facility failed to protect a resident's right to be free from staff to resident abuse when Nurse Aide #1 tilted Resident #10's wheelchair back, let it back down then pushed the wheelchair forcefully down the hall. This was for 1 of 8 residents reviewed for accidents.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety disorder, aphasia (difficulty expressing self) and lack of coordination. Resident #10 resided on the D Hall.</p> <p>A review of the facility Initial Allegation Report, investigation, and statements revealed on 11/12/24 Resident #10 was in the dining room when Nurse Aide (NA) #1 was observed tilting Resident #10's wheelchair back, letting it go back to the ground, pushing Resident #10's wheelchair forcefully down the hall and returning to the dining room without ensuring Resident #10 was safe. NA #1 was suspended pending the outcome of the investigation and then terminated. All staff received education on abuse.</p> <p>An annual Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #10 had moderately impaired cognition and verbal behavioral symptoms one to three days during the look back period. He had limited range of motion to bilateral lower extremities and utilized a wheelchair for mobility. He was coded with setup assistance for wheelchair mobility of 50 feet with two turns. Resident #10 was coded as weighing 152 pounds and was 72 inches tall.</p> <p>Resident #10's care plan, last reviewed 11/21/24 included the following problem areas:</p> <ul style="list-style-type: none"> - Resident required assist with Activities of Daily Living (ADL) related to impaired mobility and cognitive status and was at risk for further decline in ADL function. - Resident had physical behavioral symptoms towards others (hitting, kicking, scratching). The interventions included to avoid power struggles, maintain a calm environment and approach to resident and divert resident's behavior as much as possible. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/19/25 at 5:51 PM, a phone interview was conducted with NA #1. She was able to recall the events of 11/12/24 and stated she was in the dining room assisting residents with their lunch meal and Resident #10 was asking for coffee. She stated he had finished his meal, and she told him to give me a few minutes. She stated Resident #10 began yelling out, so she attempted to pull him away from the table. She stated he was holding on to the table and his feet were on the floor. NA #1 confirmed she tilted the wheelchair back a little to get Resident #10's feet off the floor so she could wheel the chair and then let it back down. NA #1 stated it was not normal to tilt the wheelchair back but wanted to get his feet off the floor so she could move the wheelchair. She stated, I pushed him through the double doors of D hall and remember the floor technician standing there. NA #1 stated that Resident #10 resided on the D hall. NA #1 confirmed she was suspended pending the investigation and never returned to the facility.</p> <p>On 2/18/25 at 10:59 AM, an interview occurred with the Floor Technician who witnessed the events of 11/12/24. He explained that he was walking up D Hall and could see clearly in the dining room. He heard Resident #10 yelling out for coffee and had his meal tray in front of him. NA #1 was observed pulling Resident #10 away from the table, tilting the wheelchair back where Resident #10's legs were in the air and letting it drop back down to the ground. During this time Resident #10 was heard yelling leave me alone. The Floor Technician stated he began to walk in the dining room to intervene and was told by NA #1 don't touch him. NA #1 was then observed pushing Resident #10 to the double doors of the dining room and D hall, pushing the wheelchair forcefully and returning to the dining room. The Floor Technician stated the wheelchair rolled approximately 20 feet before coming to a stop on its own. He stated he reported the incident immediately to NA #2/staffing scheduler.</p> <p>On 2/18/25 at 2:32 PM, an interview was completed with NA #2/staff scheduler. She explained that she was approached by the floor technician and housekeeper who reported the incident they observed between Resident #10 and NA #1. She recalled they stated Resident #10 was in the dining room at the table and saw NA #1 remove him from the table as he was yelling out leave me alone. NA #1 tilted the wheelchair back, letting it go back down the ground then forcefully pushed Resident #10's wheelchair out on the hallway. It was reported that NA #1 turned around and walked back into the dining room. NA #2 stated she observed Resident #10 sitting in the hallway in a calm demeanor, after the allegation occurred. She reported the allegation directly to the Director of Nursing (DON).</p> <p>A phone interview occurred with the Housekeeper on 2/19/25 at 5:43 PM who observed the interaction between Resident #10 and NA #1 on 11/12/24. She explained she was standing at the nurse's station on the D Hall and observed NA #1 trying to pull Resident #10 away from the dining room table. After she pulled him away from the table, she tilted the wheelchair back where Resident #10's feet were off the ground and then let it go back towards the ground. NA #1 was observed pushing Resident #10's wheelchair roughly through the double doors of the dining room and D hall, turning around and returning to the dining room. She stated the Floor Technician began to walk in the dining room and was told by NA #1 don't touch him. The housekeeper stated that she didn't feel any resident should be treated this way. She reported it immediately to NA #2/staffing scheduler.</p> <p>On 2/17/25 at 10:33 AM, Resident #10 was observed sitting up in his bed with a cup of black coffee in front of him. He was unable to recall the event of 11/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview was completed with the DON and Administrator on 2/20/25 at 1:01 PM. The DON explained on 11/12/24 she was notified by NA #2/staffing scheduler regarding the allegation of abuse witnessed by the housekeeping staff towards Resident #10. This was reported immediately to the Administrator and NA #1 was removed from the facility. The police department was notified, and the investigation began. The DON stated she assessed Resident #10, no injuries were noted and he had a calm demeanor. The Administrator and DON stated they were able to view video footage at the time that revealed Resident #10 was in the dining room at a table and NA #1 was assisting another resident at his table with the lunch meal. NA #1 was observed going to Resident #10, pulling him away from the table, tilting the wheelchair then putting it back down. She was then seen forcefully pushing the wheelchair at the double doors of the hallway and returning to the dining room. The Administrator stated that they substantiated the allegation of abuse and terminated NA #1. She said there was zero tolerance for abuse at the facility.</p> <p>A phone interview was completed with the Floor Technician on 2/24/25 at 2:56 PM. He explained that NA #1 had no change in her demeanor during the incident on 11/12/24 and was heard telling Resident #10 you need to quit your hollering while she was pushing him towards the doorway. He stated that the wheelchair came to a stop on its own after rolling approximately 20 feet. He recalled Resident #10's feet were on the floor sliding with the wheelchair. He did not witness any verbalizations from the resident during the incident but stated he had a look of surprise on his face.</p> <p>A second phone interview occurred with the DON and Administrator on 2/24/25 at 3:06 PM. They explained that Resident #10 was able to self-propel with his feet when up in the wheelchair. At the time of the incident on 11/12/24 Resident #10 had his feet on the floor sliding along with the wheelchair. They stated the wheelchair came to a stop on its own. On assessment Resident #10 had a calm demeanor. They both indicated that NA #1 was slightly hostile when she was asked to leave the facility on 11/12/24. The DON stated NA #1 stated she was assisting another resident with their meal, Resident #10 kept hollering and she felt like it was bothering the other residents to the reason why she removed him from the dining room. The Administrator stated that NA #1 was approximately 5 feet 7 inches in height.</p> <p>The facility was unable to provide evidence of a thorough, and complete, plan of correction regarding the facility's failure to protect a resident's right to be free from staff to resident abuse which would have allowed the survey team to evaluate if the facility would be eligible for past non-compliance.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50415</p> <p>Based on record reviews, and pharmacist and staff interviews, the facility failed to protect the resident's right to be free from misappropriation of narcotic medications (oxycodone and hydrocodone) prescribed to treat pain. This affected 6 of 6 residents reviewed for misappropriation (Residents #6, #54, #223, #55, #27, and #224).</p> <p>The findings included:</p> <p>A review of the facility policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property effective 12/1/01, revised 10/27/20 and reviewed 1/11/24, revealed it is the policy of PruittHealth and its affiliated entities to actively preserve each patient's right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, mistreatment and misappropriation of patient property. The Organization and its partners should assure that best efforts are made to prevent any occurrences of any form of abuse, neglect, and exploitation.</p> <p>Further review of the policy revealed misappropriation of patient property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent.</p> <p>a. Resident #6 was admitted to the facility on [DATE].</p> <p>A review of the active physician orders for Resident #6 for August 2024 included an order dated 4/9/24 for Oxycodone-acetaminophen 5-325 milligrams (mg) tablet, one tablet by mouth twice a day; hold for sedation.</p> <p>A review of the controlled drug form revealed Resident #6 was signed out as receiving oxycodone-acetaminophen by Nurse #6 on 8/10/24 at 9:00 PM. Nurse #6 documented the number of pills left was 28. The corrected count completed by the Director of Nursing on 8/11/24 indicated there were 26 pills left.</p> <p>A review of Resident #6's Medication Administration Record (MAR) for August 2024 revealed Nurse #6 administered one oxycodone-acetaminophen tablet at 9:00 PM on 8/10/24.</p> <p>b. Resident #54 was admitted to the facility on [DATE].</p> <p>A review of the active physician orders for Resident #54 for August 2024 included an order dated 5/29/24 for hydrocodone-acetaminophen tablet, 5-325 mg; one tablet by mouth three times a day as needed for pain.</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 - Some</p>	<p>A review of the controlled drug form revealed Resident #54 was signed out as receiving hydrocodone-acetaminophen by Nurse #6 on 8/10/24 at 9:00 PM and at 4:00 AM on 8/11/24. Nurse #6 documented the number of pills left after the first dose was 12 and she documented the number of pills left after the second dose was 11. The corrected count on the Controlled Drug Form completed by the Director of Nursing on 8/11/24 indicated there were 9 pills left.</p> <p>A review of Resident #54's August 2024 MAR revealed Resident #54 did not receive hydrocodone-acetaminophen on 8/10/24 or 8/11/24.</p> <p>c. Resident #223 was admitted to the facility on [DATE].</p> <p>A review of the active physician orders for Resident #223 for August 2024 included an order dated 8/6/24 for oxycodone 5 mg tablet, one tablet every 8 hours as needed for pain.</p> <p>A review of the Controlled Drug Form revealed Resident #223 was signed out for one oxycodone tablet on 8/10/24 at 9:00 PM by Nurse #6 leaving a remaining number of pills as 26. Resident #223 was also signed out one oxycodone tablet on 8/11/24 at 4:30 AM by Nurse #6 leaving the remaining number of pills at 25. The corrected count on the controlled drug form completed by the Director of Nursing on 8/11/24 indicated there were 23 pills left.</p> <p>A review of Resident #223's August 2024 MAR revealed Resident #223 did not receive oxycodone on 8/10/24 or on 8/11/24.</p> <p>d. Resident #55 was admitted to the facility on [DATE].</p> <p>A review of the active physician's order for Resident #55 for August included an order dated 6/25/24 for oxycodone 5 mg tablet, one tablet four times a day as needed for pain.</p> <p>A review of the Controlled Drug Form revealed Resident #55 had one oxycodone tablet signed out by Nurse #6 on 8/11/24 at 5:30 AM leaving a total of 25 pills. The corrected count completed by the Director of Nursing on 8/11/24 indicated there were 22 pills left.</p> <p>A review of Resident #55's August 2024 MAR revealed Resident #55 did not receive oxycodone on 8/11/24 at 5:30 AM.</p> <p>e. Resident #27 was admitted to the facility on [DATE].</p> <p>A review of the active physician's orders for Resident #27 for August 2024 included an order dated 5/11/24 for oxycodone 5 mg tablet, one tablet every six hours as needed for pain.</p> <p>A review of the Controlled Drug Form revealed that Resident #27 had one tablet signed out on 8/10/24 at 11:30 PM by Nurse #6 leaving a total of 17 pills and one signed out on 8/11/24 at 6:00 AM by Nurse #6 leaving a total of 16 pills. The corrected count completed by the Director of Nursing on 8/11/24 indicated there were 14 pills left.</p> <p>A review of Resident #27's August 2024 MAR revealed Resident #27 did not receive oxycodone on 8/10/24 or 8/11/24.</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 - Some</p>	<p>f. Resident #224 was admitted to the facility on [DATE].</p> <p>A review of the active physician's orders for Resident #224 for August 2024 included an order dated 8/8/24 for oxycodone 5 mg tablet, one tablet three times a day as needed for pain.</p> <p>A review of the Controlled Drug Form revealed that Nurse #6 signed out one oxycodone for Resident #224 on 8/10/24 at 9:00 PM leaving a total number of 18 pills left.</p> <p>A review of Resident #224's August 2024 MAR revealed Resident #224 did not receive oxycodone on 8/10/24.</p> <p>An initial report was submitted to the North Carolina Department of Health and Human Services Division of Health Service Regulation by Interim Administrator #3 on 8/11/2024 at 11:20 PM. The allegation of misappropriation of property was made on 8/11/2024 when narcotic discrepancies were found on six resident's narcotic records involving Nurse #6.</p> <p>A review of the facility investigation completed by Administrator #3 on 8/11/2024 revealed on 8/11/2024 at 11:20 PM the Director of Health Services (DHS) was notified by Nurse #3 that Nurse #6 stated she had a migraine and was going to the emergency room . When Nurse #3 went to the unit where Nurse #6 was assigned, Nurse #3 observed medication cups filled with pills with initials written on the cups on top of the medication cart. Nurse #3 called Nurse #7 to assist her with counting the narcotic medication and reviewing pill cups; Nurse #3 and Nurse #7 were unable to account for 10 narcotic pills. No medications had been signed as they were given. Residents who could be interviewed denied receiving medication that evening. Following review by Nurse #3, Nurse #7, and DHS, Nurse #3 and Nurse #7 gave medications to residents in Nurse #6's assignment. The DHS reviewed the facility cameras in Nurse #6's assignment area and medication cart. Other employees were observed walking past the medication cart; nobody had touched the medication cart until reviewed by Nurse #3 and Nurse #7. DHS contacted Nurse #6 and told her she needed to return to the facility to account for the missing narcotic pills; Nurse #6 did not return to the facility at that time. A report was made with the local police department. While the police department was in the facility, Nurse #6 returned to the facility approximately an hour after speaking with the DHS and attempted to retrieve her bag but left the facility again as the DHS was attempting to interview her regarding the occurrence. Nurse #6 stated to the DHS, I don't know what happened to it. Nurse #6 was suspended pending investigation. Nurse #6 went to the facility to retrieve her bag on 8/13/24. She provided a urine sample per request which showed a trace of opiate; urine sample sent per facility protocol for further review. Nurse #6 gave her verbal resignation to the Human Resources Coordinator on 8/13/24.</p> <p>A review of Nurse #6's timecard for 8/10/24 revealed she was scheduled to work from 7:00 PM to 7:00 AM. According to the time captured, she clocked in at 6:50 PM and clocked out at 7:16 AM. Nurse #6's timecard for 8/11/24 revealed she was scheduled to work from 7:00 PM to 7:00 AM. According to the time captured, she clocked in at 7:05 PM and clocked out at 9:03 PM.</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 - Some</p>	<p>A witness statement dated 8/11/24 by Nurse #3 read she was made aware Nurse #6 left the facility. The statement read around 10:00 PM she walked to the D hall and noted the medication cart was sitting at the top of the C hall with cups of pills sitting on top of the cart. The statement continued that Nurse #3 and Nurse #4 counted the cart and noted the narcotic count was off. Because of the pills on top of the cart in cups Nurse #3 called Nurse #7 to help go through the pills to see if they matched the narcotics in the cart drawer. It was noted there were 10 pills missing. The Director of Nursing (DON) was then called and made aware. The cart was not touched or any pills given off the cart until the DON arrived and counted the cart with Nurse #3. The DON took the keys and called the Administrator afterwards.</p> <p>An interview with Nurse #3 occurred on 2/19/25 at 5:50 AM, and she stated she worked on the A hall the night of 8/11/24 and was training Nurse #4 regarding the medication pass. She stated Nurse #6 worked the D hall. She indicated Nurse #6 was the lead nurse that night. Nurse #3 stated Nurse #6 complained to her about having a headache and that she was tempted to take a resident's narcotic. Nurse #3 indicated she informed Nurse #6 that would be the dumbest thing she ever did. She did not report the statement to the DON because she did not believe Nurse #6 was serious. Nurse #3 stated that Nurse #6 had called her at some point during the night and wanted Nurse #4 to pass the pills for her before she left the facility. Nurse #3 stated she informed Nurse #6 that Nurse #4 could not pass pills for her. Nurse #3 further stated she had received a text message from Nurse #7 notifying her that Nurse #6 left her cart and went to the hospital. Nurse #3 indicated she did not make it to the D hall until 9:00 or 10:00 PM after she finished the medication pass on the A hall. She stated Nurse #7 had pushed the cart to the top of the hall where she could watch it since the cart had cups of pills on top of it and had noted the keys to the cart were sitting on top of it. Nurse #3 stated that she and Nurse #7 counted the narcotics and noted several were not signed out and missing from multiple residents' medication cards. She indicated she called the DON to report the missing narcotics.</p> <p>A witness statement dated 8/11/24 by Nurse #7 read around 8:30 PM she was approached by Nurse #6 who told her she was going to the emergency room across the street for a migraine cocktail and she would return shortly after. Nurse #7 wrote she informed Nurse #6 that her cart needed to be counted, and Nurse #7 was unable to accept the keys to the cart until this was done. Nurse #7 wrote she continued to pass the medications to the residents on the C hall. Nurse #7 further wrote between 8:45 PM and 9:00 PM she received a call from Nurse #6 stating she had left and was at the emergency room and would not be returning to the facility because she was loopy from the medications she received for her migraine. Nurse #7's statement indicated Nurse #6 had slurred speech. According to the statement, Nursing Assistant (NA) #4 notified Nurse #7 he had seen the D hall medication cart with 25-30 medication cups on top without supervision. Nurse #7 wrote she and NA #4 pulled the medication cart to the top of C hall within her sight while she continued to pass medications to the residents on the C hall. The statement continued at around 10:00 PM Nurse #7 was summoned to go to the D hall cart because Nurse #3 wanted to speak with her and informed her some narcotics were missing from a resident's cup. She stated Nurse #3 called the DON to make her aware of the missing narcotics around 10:15 PM.</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 - Some</p>	<p>An interview was conducted with Nurse #7 on 2/20/25 at 11:48 AM, she stated Nurse #6 had reported her head was hurting on the night of 8/11/24. She indicated one of the NAs informed her the medication cart on the D hall had a bunch of medications on top of it. Nurse #7 stated she thought Nurse #6 might be outside smoking so she pulled the medication cart to the hall where she was working so she could keep an eye on it. Nurse #7 indicated she later found out that Nurse #6 had left the facility without asking anyone to count the cart with her. She stated at some point she had received a text from Nurse #6 saying she was not going to return to the facility. Nurse #7 stated until she walked to the D hall cart, she was unaware there were cups of pills or anything laying on that cart. She indicated she also found the keys to the cart lying underneath the straws. Nurse #7 stated Nurse #3 called the DON who came into the facility. She stated the DON counted the narcotics with Nurse #3 and Nurse #7 and found a bunch of medications had been pulled but not given. After counting the narcotics, the cart was left in the DON's hands.</p> <p>A witness statement dated 8/15/24 by NA #4 read on the evening of 8/11/24 he spoke with Nurse #6 who complained to him about having a headache. He wrote he was walking the halls performing his duties of Firewatch when he became concerned when he saw the D hall medication cart in the middle of the hall with at least 25-30 cups full of pills. His statement reflected he notified Nurse #7, and she walked with him to the cart and took control of the situation where she pushed the D hall cart over to the C hall where Nurse #7 was working where the cart remained as far as he knew.</p> <p>NA #4 could not be reached for an interview after multiple attempts were made.</p> <p>Nurse #6 was called for an interview on 2/20/25 at 10:42 AM. After initial phone greetings and introductions she refused to be interviewed and hung up the phone.</p> <p>The Director of Nursing was interviewed on 2/18/25 at 1:30 PM, and she stated she was notified by Nurse #3 on the night of 8/11/24 of the missing narcotics. The DON indicated when she arrived at the facility that night, she began an investigation of the event which included a review of the camera footage for Nurse #6's work area. The DON stated Nurse #6 came in to work her scheduled shift on 8/11/24 but left before it was finished. She indicated that Nurse #6 left her cart down the hall where she was working and that an NA noticed about 16 cups lined up on top of the cart with medications in them. She stated NA #4 reported to the nurse when he saw the medication cups and the nurses on duty counted the medications in the cart when they went to the hall. She further stated after counting, the nurses noted a significant number of narcotics were missing and the nurses called Nurse #6 to ask where the missing medications were. She stated Nurse #6 told the nurses she would be back to handle it. The DON stated she called the Administrator to notify her of the events. The DON reported that she collected the medication cups full of pills from the medication cart and tried to identify the pills in the cups and to whom they might have belonged. She noted all the cups had initials written on them. She stated that Nurse #6 never could tell her what happened to the missing narcotics when she spoke with her by phone. The DON stated all the nurses know to count on and off narcotics at shift change. The nurses know if there are any discrepancies, they need to notify the DON. She further stated the nurses received medication administration training after the event.</p> <p>The Pharmacist was interviewed on 2/19/25 at 4:02 PM. She stated she was notified of the missing narcotics at the facility, but she couldn't recall the date she was notified. The Pharmacist stated it was completely inappropriate. She indicated she visited the facility shortly after the event and completed a medication pass in-service with the nursing staff and taught what was appropriate and what was inappropriate when passing medications.</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 - Some</p>	<p>Administrator #3 was interviewed on 2/20/25 at 12:10 PM. She stated she had just taken the interim role of Administrator a day or two before the incident occurred. She indicated the DON had notified her regarding a nurse who left mid-shift leaving medications on the cart and of missing narcotic medications. She stated the DON contacted the Drug Enforcement Administration, the North Carolina Board of Nursing and reported the incident to the State. She stated that the DON was the one who worked on the event.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50415</p> <p>Based on record review and staff interviews, the facility failed to develop an individualized and comprehensive care plan in the area of anticoagulant medication (Resident #25). This was for 1 of 21 residents whose care plans were reviewed.</p> <p>The findings included:</p> <p>Resident #25 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure and atrial fibrillation.</p> <p>A review of the active medication orders for Resident #25 for February 2025 revealed an order for Xarelto (an anticoagulant medication) 20 milligrams, one tablet once a day for atrial fibrillation.</p> <p>The medication had a start date of 4/7/23.</p> <p>A quarterly Minimum Data Set (MDS) assessment for Resident #25 dated 1/7/25 indicated Resident #25 was cognitively intact. He was coded as receiving an anticoagulant.</p> <p>Resident's #25's active care plan updated 1/8/25 did not have a focus for anticoagulant medication.</p> <p>On 2/20/25 at 2:40 PM an interview was conducted with the MDS nurse. She verified Resident #25 did not have a focus for anticoagulant therapy on the care plan and that it should have included one. She stated that the missing medication focus was an oversight, and she would correct the care plan.</p> <p>The Director of Nursing was interviewed on 2/20/25 at 2:53 PM and stated that Resident #25 should have had an accurate care plan that included a focus that he was taking an anticoagulant medication.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50415</p> <p>Based on record reviews, Pharmacist, and staff interviews, the facility failed to follow professional standards to prepare and administer medications to residents one at a time and had pre-poured pills in medication cups left on top of a medication cart (D hall) prepared by Nurse #6 for dispensing during the 9:00 PM medication pass. This affected 13 of 27 residents residing on D hall (#40, #226, #228, #58, #54, #227, #223, #225, #7, #36, #224, #55, and #20).</p> <p>The findings included:</p> <p>A review of the facility policy titled Medication Administration: General Guidelines effective 4/1/98, revised 4/10/24 and reviewed 7/22/24 read in part under the headline titled Procedure:</p> <p>Medications are administered at the time they are prepared. Medications are not pre-poured/pre-set/pre-crushed. Only one patient/resident's medications are prepared and administered at a time.</p> <p>Only the licensed or legally authorized personnel that prepare a medication may administer it. This individual records the administration on the patient/resident's MAR (medication administration record) at the time the medication is given. At the end of each medication pass the person administering the medications reviews the paper MAR or the electronic version of e-MAR (electronic medical administration record) to ascertain that all necessary doses were administered, and all administered doses were documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.</p> <p>The following residents were identified during the facility's investigation completed by the Director of Nursing (DON) as having cups of their evening medications pre-poured and left on top of the D hall medication cart.</p> <p>a. Resident #40 was admitted to the facility on [DATE].</p> <p>A review of Resident #40's August 2024 active physician orders revealed the following medications:</p> <p>-An order dated 7/25/24 for Doxepin capsule 25 milligrams (mg) 50 mg, 2 capsules by mouth at bedtime.</p> <p>-An order dated 8/3/24 for doxycycline hyclate capsule 100 mg, 1 capsule by mouth twice a day for 10 days to be given at 9:00 AM and 9:00 PM.</p> <p>b. Resident #226 was admitted to the facility on [DATE].</p> <p>A review of Resident #226's August 2024 active physician orders revealed the following medications:</p> <p>-An order dated 6/14/24 for atorvastatin tablet 10 mg, 1 tablet by mouth once a day at bedtime.</p> <p>-An order dated 6/17/24 for buspirone tablet 7.5 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-An order dated 6/14/24 for gabapentin capsule 100 mg, 1 capsule by mouth three times a day at 09:00 AM, 02:00 PM and, 09:00 PM.</p> <p>-An order dated 6/14/24 for hydralazine tablet 50 mg, 1 tablet by mouth twice a day at 09:00 AM and 9:00 PM.</p> <p>-An order dated 6/14/24 for magnesium oral tablet 400 mg, 1 tablet by mouth once a day at bedtime.</p> <p>-An order for methocarbamol tablet 500 mg, 1 tablet by mouth three times a day at 9:00 AM, 1:00 PM, and 9:00 PM.</p> <p>-An order dated 6/14/24 for metoprolol tartrate tablet 50 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 6/14/24 for omeprazole capsule, delayed release 20 mg, 1 capsule by mouth twice a day at 6:00 AM and 9:00 PM.</p> <p>-An order dated 6/14/24 for potassium chloride tablet extended release 10 milliequivalents (mEq), 1 capsule by mouth twice a day at 09:00 AM and 09:00 PM.</p> <p>-An order dated 6/14/24 for tramadol 50 mg, 1 tablet by mouth once a day at bedtime.</p> <p>-An order dated 6/14/24 for Zyrtec (cetirizine) tablet 10 mg, 1 tablet once a day at 9:00 PM.</p> <p>c. Resident #228 was admitted to the facility on [DATE].</p> <p>A review of Resident #228's August 2024 active physician orders revealed the following medications:</p> <p>-An order dated 1/22/24 for atorvastatin tablet 80 mg, 1 tablet by mouth once a day at bedtime.</p> <p>-An order dated 1/22/24 for duloxetine capsule, delayed release 60 mg, 1 capsule by mouth once a day at bedtime.</p> <p>-An order dated 1/22/24 for ferrous sulfate tablet 325 mg (65 mg iron), 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 3/27/24 for Remeron oral 22.5mg tablet, 1 tablet by mouth once a day at bedtime.</p> <p>d. Resident #58 was admitted to the facility on [DATE].</p> <p>A review of Resident #58's August 2024 active physician orders revealed the following medications:</p> <p>-An order dated 3/28/24 for Atorvastatin tablet 40 mg, 1 tablet by mouth once a day at bedtime.</p> <p>-An order dated 4/28/24 for colchicine tablet 0.6 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 5/29/24 for melatonin tablet 3 mg, 3 tablets (9 mg) by mouth once a day at bedtime.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-An order dated 3/28/24 for metoprolol tartrate tablet 25 mg, 1 tablet by mouth every 12 hours at 09:00 AM and 09:00 PM.</p> <p>-An order dated 5/11/24 for omeprazole capsule, delayed release 20 mg, 1 tablet by mouth twice a day at 6:00 AM and 9:00 PM</p> <p>e. Resident #54 was admitted to the facility on [DATE].</p> <p>A review of Resident #54's August 2024 active physician orders revealed the following medications:</p> <p>-An order dated 3/15/24 for atorvastatin tablet 80 mg, 1 tablet by mouth once a day at bedtime.</p> <p>-An order dated 6/13/24 for Colace (docusate sodium) capsule 100 mg, 1 capsule by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 3/15/24 for Depakote (divalproex) tablet, delayed release 250 mg, 1 tablet by mouth once a day at 9:00 PM.</p> <p>-An order dated 6/2/25 for Senna-S (sennosides-docusate sodium) 8.6-50 mg tablet, 2 tablets by mouth once a day at bedtime.</p> <p>f. Resident #227 was admitted to the facility on [DATE].</p> <p>A review of Resident #227's August 2024 active physician orders revealed the following medications</p> <p>-An order dated 7/27/24 for benzotropine tablet 1 mg, give 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM</p> <p>-An order dated 7/27/24 for gabapentin capsule 100 mg, 1 capsule by mouth twice a day at 9:00 AM and 9:00 PM</p> <p>-An order dated 7/27/24 for potassium chloride capsule, extended release 10 mEq, give 2 capsules by mouth every 12 hours at 9:00 AM and 9:00 PM</p> <p>-An order dated 7/27/24 for senna tablet 8.6 mg, give 1 tablet by mouth once a day at bedtime.</p> <p>-An order for Tylenol Extra Strength (acetaminophen) tablet 500 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM</p> <p>g. Resident #223 was admitted to the facility on [DATE]</p> <p>A review of Resident #223's August 2024 active physician orders revealed the following medications:</p> <p>-An order dated 8/6/24 for acetaminophen extra strength 500 mg tablet, 2 tablets by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 8/6/24 for atorvastatin tablet 40 mg, 1 tablet by mouth once a day at bedtime.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-An order dated 8/6/24 for buspirone 7.5 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 8/6/24 for doxazosin 2 mg, 1 tablet by mouth once a day at bedtime.</p> <p>-An order dated 8/6/24 for duloxetine capsule, delayed release, 1 capsule by mouth once a day at bedtime.</p> <p>-An order dated 8/6/24 for gabapentin caplet 300 mg, 1 caplet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 8/6/24 for Seroquel (quetiapine) tablet 25 mg, 1 tablet by mouth three times a day at 9:00 AM, 2:00 PM, and 9:00 PM.</p> <p>h. Resident #225 was admitted to the facility on [DATE].</p> <p>A review of Resident #225's August 2024 active physician orders revealed the following medications:</p> <p>-An order dated 2/11/23 for baclofen tablet 20 mg, 1 tablet twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 1/19/24 for divalproex tablet, delayed release 125 mg, 1 tablet by mouth once a day at bedtime.</p> <p>-An order dated 6/28/24 for ferrous sulfate tablet 325 mg (65 mg iron), 1 tablet by mouth three times a day at 9:00 AM, 2:00PM, and 9:00 PM.</p> <p>-An order dated 2/9/23 for gabapentin capsule 300 mg, 1 capsule three times a day at 9:00 AM, 1:00 PM, and 9:00 PM.</p> <p>-An order dated 2/11/23 for metformin tablet 1,000 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 2/11/23 for metoprolol succinate tablet extended release 24-hour 50 mg, 1.5 tablets twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 3/22/23 for Vitamin C (ascorbic acid(vitamin C) tablet 500 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>i. Resident #7 was admitted to the facility on [DATE].</p> <p>A review of Resident #7's August 2024 active physician orders revealed the following medications:</p> <p>-An order dated 11/8/23 for atorvastatin 10 mg, 1 tablet by mouth once a day at bedtime.</p> <p>-An order dated 11/8/23 for Protonix (pantoprazole) tablet, delayed release 40 mg, 1 tablet by mouth twice a day at 6:30 AM and 9:00 PM.</p> <p>j. Resident #36 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #36's August 2024 active physician orders revealed the following medication:</p> <p>-An order written 7/25/24 for Risperdal (risperidone) tablet 0.5 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>k. Resident #224 was admitted to the facility on [DATE].</p> <p>A review of Resident #36's August 2024 active physician orders revealed the following medications:</p> <p>-An order dated 7/29/24 for Eliquis (apixaban) tablet 2.5 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order dated 7/29/24 for sennosides-docusate sodium tablet 8.6-50 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>l. Resident #55 was admitted to the facility on [DATE].</p> <p>A review of Resident #55's August 2024 active physician orders revealed the following medications:</p> <p>-An order written on 4/18/24 for tamsulosin 0.4 mg, 1 tablet by mouth once a day at 9:00 PM.</p> <p>-An order written on 4/25/24 for trazodone 100 mg, 1 tablet by mouth once a day at bedtime.</p> <p>m. Resident #20 was admitted to the facility on [DATE].</p> <p>A review of Resident #20's August active physician orders revealed the following medications:</p> <p>-An order written on 5/28/24 for calcitriol capsule 0.25 mg, take 1 capsule by mouth every 12 hours at 9:00 AM and 9:00 PM.</p> <p>-An order written on 5/28/24 for docusate sodium capsule 100 mg, take 1 capsule by mouth every 12 hours on 9:00 AM and 9:00 PM.</p> <p>-An order written on 5/28/24 for donepezil 5 mg, take 1 tablet by mouth once a day at bedtime.</p> <p>-An order written on 6/18/24 for ferrous sulfate tablet 325 mg (65 mg iron), 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order written on 5/28/24 for memantine tablet 5 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order written on 5/28/24 for metoprolol tartrate 12.5 mg take 12.5 mg by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>-An order written on 5/28/24 for pantoprazole tablet delayed release 40 mg, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-An order written on 7/8/24 for potassium chloride tablet extended release 20 mEq, 1 tablet by mouth twice a day at 9:00 AM and 9:00 PM.</p> <p>A review of Nurse #6's timecard for 8/11/24 revealed she was scheduled to work from 7:00 PM to 7:00 AM. According to the time captured, she clocked in at 7:05 PM and clocked out at 9:03 PM.</p> <p>A witness statement dated 8/11/24 by Nurse #3 read she was made aware Nurse #6 left the facility. The statement read around 10:00 PM she walked to the D hall and noted the medication cart was sitting at the top of the C hall with cups of pills sitting on top of the cart. Because of the pills in cups on top of the cart Nurse #3 called Nurse #7 to help go through the pills to see if they matched the narcotics in the cart drawer.</p> <p>An interview with Nurse #3 occurred on 2/19/25 at 5:50 AM, and she stated she worked on the A hall the night of 8/11/24 and was training Nurse #4 regarding the medication pass. She indicated Nurse #6 worked the D hall and was the lead nurse that night. Nurse #3 stated that Nurse #6 had called her at some point during the night and wanted Nurse #4 to pass the pills for her before she left the facility. Nurse #3 stated she informed her that Nurse #4 could not pass pills for her. Nurse #3 further stated she had received a text message from Nurse #7 later that evening notifying her that Nurse #6 left her cart and went to the hospital. Nurse #3 indicated she did not make it to the D hall until 9:00 or 10:00 PM after she finished the medication pass on the A hall. She stated Nurse #7 had pushed the cart to the top of the hall where she could watch it since the cart had cups of pills on top of it and had noted the keys to the cart were sitting on top of it. Nurse #3 stated she reported the incident to the DON who then came to the facility. She stated the DON removed the cups of pills from the cart and had Nurse #3 and Nurse #7 interview the alert and oriented residents to determine if they had received their evening medications. The DON also reviewed the camera footage of the D hall to determine if the medication pass had been done. After verifying the medication pass had not been done, Nurse #3 and Nurse #7 administered the evening medications to the residents on the D hall from their medications in the cart.</p> <p>A witness statement dated 8/11/24 by Nurse #7 read around 8:30 she was approached by Nurse #6 who told her she was going to the emergency room across the street for a migraine cocktail and she would return shortly after. Nurse #7 wrote she informed Nurse #6 that her cart needed to be counted, and Nurse #7 was unable to accept the keys to the cart until this was done. Nurse #7 wrote she continued to pass the medications on the C hall. Nurse #7 further wrote between 8:45 PM and 9:00 PM she received a call from Nurse #6 stating she had left and was at the emergency room and would not be returning to the facility because she was loopy from the medications she received for her migraine. Nurse #7's statement indicated Nurse #6 had slurred speech. According to the statement, Nursing Assistant (NA) #4 notified Nurse #7 he had seen the D hall medication cart with 25-30 medication cups on top without supervision. Nurse #7 wrote she and NA #4 pulled the medication cart to the top of C hall within her sight while she continued to pass medications to the residents on the C hall.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Pruitthealth-Rockingham		STREET ADDRESS, CITY, STATE, ZIP CODE 804 South Long Drive Rockingham, NC 28379	
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with Nurse #7 on 2/20/25 at 11:48 AM, she stated Nurse #6 had reported her head was hurting on the night of 8/11/24. She indicated one of the NAs informed her the medication cart on the D hall had a bunch of medications on top of it. Nurse #7 stated she thought Nurse #6 might be outside smoking so she pulled the medication cart to the hall where she was working so she could keep an eye on it. Nurse #7 indicated she later found out that Nurse #6 had left the facility without asking anyone to count the cart with her. She stated at some point she had received a text from Nurse #6 saying she was not going to return to the facility. Nurse #7 stated until she walked to the D hall cart, she was unaware there were cups of pills or anything laying on that cart. She indicated she also found the keys to the cart lying underneath the straws. Nurse #7 stated Nurse #3 called the DON who came into the facility. Nurse #7 stated she, the DON, and Nurse #3 found a bunch of medications had been pulled but not given. After counting the narcotics, the cart was left in the DON's hands.</p> <p>A witness statement dated 8/15/24 by NA #4 read on the evening of 8/11/24 he spoke with Nurse #6 who complained to him about having a headache. He wrote he was walking the halls performing his duties of Firewatch when he became concerned after he saw the D hall medication cart in the middle of the hall with at least 25-30 cups full of pills. His statement reflected he notified Nurse #7, and she walked with him to the cart and took control of the situation where she pushed the D hall cart over to the C hall where Nurse #7 was working where the cart remained as far as he knew.</p> <p>NA #4 could not be reached for an interview after multiple attempts were made.</p> <p>Nurse #6 was called for an interview on 2/20/25 at 10:42 AM. After initial phone greetings and introductions she refused to be interviewed and hung up the phone.</p> <p>The Director of Nursing was interviewed on 2/18/25 at 1:30 PM, and she stated Nurse #6 came in to work her scheduled shift on 8/11/24 but left before it was finished. She indicated that Nurse #6 left her medication cart down the hall where she was working and that an NA noticed about 16 cups lined up on top of the cart with medications in them. She stated the NA #4 reported to the nurse when he saw the medication cups and the nurses on duty counted the medications in the cart when they went to the hall. The DON reported that she collected the medication cups full of pills from the medication cart and took them to her office where she tried to identify the pills in the cups and to whom they might belong and noted all the cups had initials written on them. The DON stated she instructed Nurse #3 and Nurse #7 to administer the medications to the residents on the D hall from the medication cart once they determined the medication pass had not been completed by Nurse #6. She stated medications should not have been sitting on top of the cart without supervision. She further stated the nurses received medication administration training after the event.</p> <p>The Pharmacist was interviewed on 2/19/25 at 4:02 PM. She stated she was notified about the cups of pills sitting on the medication cart at the facility, but she couldn't recall the date she was notified. The Pharmacist stated it was completely inappropriate. She indicated she visited the facility shortly after the event and completed a medication pass in-service with the nursing staff and taught what was appropriate and what was inappropriate when passing medications.</p> <p>Administrator #3 was interviewed on 2/20/25 at 12:10 PM. She stated she had just taken the interim role of Administrator a day or two before the incident occurred. She indicated the DON had notified her regarding a nurse who left mid-shift leaving medications on the cart.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's investigation documentation provided during the survey was reviewed. The documentation did not reveal a process for ongoing monitoring to ensure professional standards were observed and met by the nursing staff who were responsible for administering medications to residents which would have allowed the survey team to evaluate if the facility would be eligible for past non-compliance.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197</p> <p>Based on record review, and Wound Care Practitioner and staff interviews, the facility failed to obtain treatment orders when pressure areas were identified on readmission from the hospital and nursing staff provided treatments without a physician's order. This deficient practice affected 1 of 7 residents reviewed for pressure ulcers (Resident #221).</p> <p>The findings included:</p> <p>Resident #221 was originally admitted to the facility on [DATE]. She required hospitalization from [DATE] to 5/1/24 for acute stroke. Resident #221 had other diagnoses that included peripheral vascular disease, Alzheimer's disease and congestive heart failure.</p> <p>A nursing progress note dated 5/3/24 indicated that Resident #221 had two small skin openings noted on the buttocks. Barrier cream applied during incontinence care.</p> <p>A significant change in status Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #221 was moderately impaired with decision making skills. She required maximum assistance with bed mobility and was dependent on staff for toileting hygiene and transfers. She was coded with pressure ulcer over a bony prominence and two stage two pressure ulcers.</p> <p>Resident #221's care plan included a problem area dated 5/6/24 for having wounds and was at risk for deterioration in wound status or wound infection. The interventions included provide wound care as ordered and wound consult as ordered and as needed.</p> <p>Resident #221 was hospitalized from 5/7/24 to 5/9/24.</p> <p>A nursing progress note dated 5/9/24 indicated that Resident #221 had a wound to the sacral area and red area to the left outer heel.</p> <p>A review of the hospital discharge and after visit summaries dated 5/9/24, included no treatment orders for a wound to the sacral area or red area to the left outer heel.</p> <p>A review of the physician orders for Resident #221 from 5/9/24 to 5/13/24 did not include any treatment orders for a sacral wound or red area to the left outer heel.</p> <p>Resident #221 was transferred to the hospital on 5/27/24 for mental status changes and did not return to the facility.</p> <p>A phone interview occurred with Nurse #10 on 2/20/25 at 3:45 PM. She completed the readmission assessment on 5/9/24 and was assigned to care for Resident #221 on 5/10/24. Nurse #10 stated she couldn't recall Resident #221 or what might have happened when she was readmitted to the facility. Nurse #10 further explained that she no longer was employed at the facility but when a resident returned from the hospital with a wound, she would dress the area with a dry dressing to make sure it was clean. She was unable to explain why a physician order was not obtained for treatment to care for the sacral wound or left heel redness on readmission to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/21/25 at 11:48 AM, an interview occurred with Nurse #11 who was assigned to care for Resident #221 on 5/11/24 and 5/12/24. She was unable to recall if Resident #221 had any wounds when she returned from the hospital on 5/9/24. She explained that typically she would make sure a dry dressing was in place until a resident was seen by the wound care provider if someone returned from the hospital with any wounds. She could not recall if she had provided any wound care to Resident #221 on the days she was assigned to care for her.</p> <p>Attempts were made to contact Nurse #12 without success. She had been assigned to care for Resident #221 on 5/13/24.</p> <p>A Wound Care progress note dated 5/14/24 indicated that Resident #221 was seen for evaluation and management of a wound to the sacrum and left heel. Both wounds were classified as pressure in origin. The sacral wound was classified as a Stage 3 wound and measured 4.2 centimeters (cm) in length, 3.8 cm in width and 0.3 cm in depth. There were no signs of acute soft tissue infection. Wound care orders were provided to apply silver alginate daily. The left heel wound was classified as a deep tissue pressure injury and measured 4.2 cm in length and 4 cm in width. Wound care orders were provided to apply Betadine daily.</p> <p>A review of Resident #221's physician orders included the following orders:</p> <ul style="list-style-type: none"> - An order dated 5/14/24 for Betadine to the left heel every day. - An order dated 5/15/24 to cleanse the sacrum with wound cleanser, apply silver alginate and a foam dressing every day. <p>On 2/20/25 at 11:11 AM, a phone interview occurred with Wound Care Provider #1 who completed the initial evaluation for Resident #221s wounds on 5/14/24. He stated he believed there was a dressing present on the sacrum but didn't document that and was unsure what the facility was using as a treatment prior to his evaluation. He explained that Resident #221 had a stage 3 sacral wound and a deep tissue pressure injury on the left heel. At the time of the evaluation there was no concern for infection. The Wound Care Provider #1 stated he would have expected the facility to obtain wound care orders for the sacral wound and left heel wound prior to her being evaluated on 5/14/24.</p> <p>The Director of Nursing (DON) was interviewed on 2/20/25 at 1:01pm via phone. She verified there was a nursing progress note dated 5/9/24 indicating that Resident #221 readmitted from the hospital with a wound to her sacrum and redness to her left heel. She stated she was unable to find a physician order for the treatment of the sacral wound and left heel redness from 5/9/24 to 5/14/24. The DON stated she had a lot of new nurses during May 2024 and was unable to explain why there was no treatment order obtained for Resident #221 when she was readmitted from the hospital with skin breakdown to her sacrum and redness to her left heel. The DON stated that in May 2024 she did not have a wound care nurse. She recalled being present with the Wound Care Provider on 5/14/24 and felt like there was a dressing on the sacral wound but was unable to state who or when it was placed on the sacral wound.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>46095</p> <p>Based on record review and staff interviews, the facility failed to ensure accurate daily Posted Nurse Staffing sheets for 3 of 30 days reviewed (01/24/25, 01/27/25, and 02/07/25).</p> <p>The findings included:</p> <p>A review of the daily Posted Nurse Staffing sheets compared to the Staff Schedule/Assignment sheets from 01/18/25 through 02/18/25 revealed discrepancies in the area of actual unlicensed Nursing Assistants (NAs) that worked.</p> <p>On 01/24/25 during 1st shift (7:00 AM-7:00 PM), the daily Posted Nurse Staffing sheet revealed 7 unlicensed staff worked and the Staff Schedule/Assignment sheet revealed 5 unlicensed staff worked.</p> <p>On 01/27/25 during 1st shift (7:00 AM-7:00 PM), the daily Posted Nurse Staffing sheet revealed 8 unlicensed staff worked and the Staff Schedule/Assignment sheet revealed 5 unlicensed staff worked.</p> <p>On 02/07/25 during 1st shift (7:00 AM-7:00 PM), the daily Posted Nurse Staffing sheet revealed 7 unlicensed staff worked and the Staff Schedule/Assignment sheet revealed 5 unlicensed staff worked.</p> <p>A phone interview was conducted on 02/21/25 at 11:48 AM with the NA #2/Staffing Scheduler. She verified that the daily Posted Nurse Staffing sheets compared to the Staff Schedule/Assignment sheets for 01/24/25, 01/27/25, and 02/07/25 reflected the incorrect number of unlicensed staff. She stated she was unaware she was to count 2 staff as 1 if they were splitting a shift.</p> <p>A phone interview was conducted on 02/21/25 at 11:55 AM with the Administrator. She stated she was unaware the daily Posted Nurse Staffing sheets were incorrect. She indicated the daily Posted Nurse Staffing sheets should accurately reflect the correct number of staff working.</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>50415</p> <p>Based on observations, record review, and Pharmacist and staff interviews, the facility failed to label an open and in use insulin pen with the resident's name or prescribing information that was stored in 1 of 2 medication carts (D hall cart) and the facility failed to keep unopened insulin pens refrigerated per manufacturer instructions and discard expired medications in 1 of 2 medication carts (A hall cart).</p> <p>The findings included:</p> <p>a. An observation was conducted on 2/18/25 at 11:20 AM of the D hall medication cart with Nurse #2. The observation revealed one (1) Lantus Solostar insulin pen with an open date of 2/10/25, but it did not have a label indicating the resident's name or prescribed dose for whom it was being used. An interview with Nurse #2 conducted at the same time revealed insulin pens should be labeled with the resident's name and the date it was opened. She stated insulin pens should be discarded 28 days after opening. The insulin pen was given to Nurse #2 to discard.</p> <p>b. An observation was conducted on 2/21/25 of the A hall medication cart at 8:15 AM with Nurse #5. The observation of the cart revealed one (1) Tresiba Flex insulin pen that was sealed and one (1) Lantus Solostar insulin pen that was also sealed. A blue sticker on the packages for both insulin pens stated, refrigerate until opened. The observation also revealed an opened and available for use Lantus Solostar insulin pen that was dated 12/12/24. Nurse #5 was interviewed at the time of the observation and stated that unopened insulin pens should be stored in the refrigerator per the manufacturer's instructions until they were opened and in use. She also stated that insulin pens should be discarded 28 days after opening. The medications were given to Nurse #5 to discard.</p> <p>An interview was conducted with the Director of Nursing on 2/21/25 at 8:20 AM. She stated that unopened insulin should be stored in the refrigerator until it was opened and insulin pens should be labeled with the resident's name, prescribing information, and the date they were opened. She stated insulin should be discarded 28 days after opening. The Director of Nursing stated she had the third shift nursing staff check the medication carts, and she had been training the Assistant Director of Nursing to check the carts every week. She further stated that the pharmacist checked the carts when she visited every month.</p> <p>An interview was conducted with the Pharmacist on 2/21/25 at 10:14 AM. She stated that she visited the facility each month to review medications. She stated insulin pens should be stored in the refrigerator until they were opened per the manufacturer's instructions and opened insulin pens should be disposed of after 28 days. She stated during her visit to the facility in January this year that she had removed an insulin pen from one of the carts with a date of 12/12/24, and that staff must have added it back to the cart instead of disposing of it. She stated that insulin pens should be labeled with a resident identifier, and the resident's name is best.</p>		