STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345478	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harnett Woods Nursing and Rehabilitation Center	604 Lucas Road Dunn, NC 28334

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff interviews, the facility failed to ensure residents were free from chemical restraints when Medication Aide (Med Aide) #1 brought melatonin to the facility and administered melatonin to Resident #16 without a physician's order, administered an additional dose of melatonin to Resident #31 with an order for 3 milligrams (mg) of melatonin and administered an additional dose of melatonin to Resident #74 with an order for 10 mg of melatonin because she wanted a quiet night. The deficient practice occurred for 3 of the 9 sampled residents for medication administration (Resident #16, Resident #31 and Resident #74). The findings included:A review of an initial allegation report dated [DATE] revealed Med Aide #1 administered melatonin to Resident #16, Resident #31 and Resident #74 without a physician's order. No physical or mental harm. A review of an investigation report dated [DATE] revealed a summary that included over the counter melatonin bottles were identified in the facility sparking investigation to which the facility determined Med Aide #1 administered over the counter melatonin to three residents without a corresponding physicians order. Residents and staff were interviewed. Medication carts were audited. Residents' charts were reviewed. Residents involved in investigation have been evaluated with no negative outcome identified. Melatonin is a supplement most commonly used for insomnia and regulating sleep cycle.A review of a witness statement dated [DATE] from Med Aide #2 revealed it was probably around 7:00 PM when she noticed the bottles. They were white with purple lids. 2 were 10 milligrams (mg) and one was 12 mg. When she opened the stock drawer they were sitting on the right side of the stock drawer. I can't remember if I pulled them and then told Nurse #1 or told Nurse #1 and then pulled them, but I put them in the cabinet in the nourishment room. A review of a witness statement dated [DATE] from Nurse #1 revealed it was during that first med pass that Med Aide #2 and I noticed the melatonin. The Med Aide stated she saw it right when she opened her drawer with stock meds and notified her. I instructed her to pull it from the cart and place it in the cabinet in the nourishment room in the SPARK (Alzheimer's) unit. That was probably between 7:30-8:00 PM on [DATE]. A review of a witness statement from Med Aide #1 revealed she brought in 3 bottles of melatonin, 5mg, 10 mg and 12 mg on [DATE]. When asked if she brought them in before she stated, No. She stated she did not give out the 12 mg, they were her personal pills. She gave 5 mg of melatonin to Resident #16, Resident #31 and Resident #74. The Med Aide was told they did not find 5 mg bottles and she stated, she only gave 5 mgs. She stated Resident #31 was wandering, Resident #16 was up until 1:00 AM, sleepy and tired and Resident #74 was also tired. She did not alert the nurses of any changes in the residents' condition. a. Resident #16 was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease with heart failure. The diagnoses list included insomnia [DATE], and Alzheimer's disease [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] had Resident #16 coded as moderately cognitively impaired, and no behaviors were coded. The [DATE] Medication Administration Record (MAR) did not reveal an order for Melatonin. b. Resident #31 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated [DATE] had Resident #31 coded as severely cognitively impaired. Resident #31 had inattention and disorganized thinking. There was no acute change in mental status from the residents' baseline. Required partial/moderate assistance with toileting and hygiene and was occasionally incontinent of bladder and always continent of bowel. The diagnoses list included insomnia [DATE] and dementia [DATE]. [DATE] Medication Administration Record (MAR) revealed an order for Melatonin Tablet 3 MG. Give 3 mg by mouth at bedtime for insomnia. Start date [DATE]. Med Aide #1 signed the MAR on [DATE] at 10:00 PM. An encounter note dated [DATE] revealed the resident is an [AGE] year-old female with a history of dementia, anxiety, wandering behaviors, and insomnia, seen for a follow-up visit. She was resting calmly in bed, reporting no pain or discomfort, and appeared happy and in no overt distress. Staff reported that she is at her baseline in terms of mood and behavior, with no new concerns raised. She is cooperative with care and experiences occasional anxiety and wandering behaviors, which are manageable with redirection. Staff also noted that the Resident had been sleeping well and maintaining a good appetite. There have been no reports of hallucinations or delusions. Her current medication regimen will be continued, and her mood and behavior will be closely monitored. c. Resident #74 was admitted to the facility on [DATE] with diagnoses including atherosclerotic heart disease of native coronary artery without angina pectoris. The quarterly Minimum Data Set (MDS) dated [DATE] had Resident #74 coded as severely cognitively impaired and had memory problems. The diagnoses list included insomnia

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to notify the Resident Representative in writing of the reason for the unplanned transfer/discharge to the hospital for 1 of 1 resident (Resident #21) reviewed for hospitalizations.The findings included:Resident #21 was admitted into the facility on [DATE]. A review of Resident #21's nursing progress notes indicated that she was transferred to the hospital on 9/2/24 and returned to the facility on 9/5/24. Resident #21 was also transferred to the hospital on 3/23/25 and returned to the facility on 3/28/25.A review of Resident #21's quarterly Minimum Data Set assessment dated [DATE] indicated she was severely cognitively impaired.A review of Resident #21's medical record indicated no documentation of the reason for the transfers was sent to the Resident Representative.A telephone interview was attempted with Resident #21's representative but they were unavailable.An interview with the Administrator on 7/9/25 at 10:00 AM indicated that she was aware of the need for documentation to be sent to the Resident Representative and she was the one who had done that during the time the Social Worker was on leave. However, the Administrator reported she stopped sending out the notice when the Social Worker returned from leave and had not informed the Social Worker that she would be responsible for the notices. The Administrator further indicated she had spoken to the Social Worker and confirmed that Resident #21's representative had not been notified of the reason for transfer by mail for either discharge.