STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-Raleigh	2420 Lake Wheeler Road Raleigh, NC 27603

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with the Pharmacy Consultant and staff interviews, the facility failed to have effective systems in place for the return of controlled medications to the pharmacy which resulted in the controlled medication being diverted from the medication cart for 1 of 1 resident reviewed for pharmacy services (Resident #13). The findings included: Resident #13 was admitted to the facility on [DATE] and discharged on 1/7/25. Review of a certificate of inventory and destruction form with no date completed by Nurse #2 revealed she had started a return to pharmacy of 11 tablets of 5 mg oxycodone HCL for Resident #13 discharged on 1/7/25. Review of the facility reported incident investigation dated 1/23/25 revealed the narcotic count for the 100-hall medication cart was not correct the evening of 1/18/25 during narcotic reconciliation completed by the off going Nurse #1 and oncoming Nurse #2. The 100-hall medication cart was found to be missing one narcotic count sheet for oxycodone HCL (hydrochloride) for Resident #13. An investigation was initiated, all medication carts were audited, and the missing narcotic count sheet for Resident #13 was not found. In a telephone interview with Nurse #1 on 6/24/25 at 6:34 pm she stated she worked on the 100-hall medication cart on 1/18/25 from 7:00 am until 7:00 pm. Nurse #1 stated Nurse #2 came in for her shift at 7:00 pm and found the discrepancy of missing oxycodone HCL during the narcotic reconciliation process. Nurse #1 further stated Nurse #2 called the Director of Nursing (DON) and reported the discrepancy. Nurse #1 stated Nurse #2 would not let her talk with the DON and Nurse #1 waited for approximately 20 minutes for her ride, clocked out and left the facility. Nurse #1 explained Nurse #2 had started a return of Resident #13's narcotic medications on 1/17/25 but did not finish. Nurse #1 stated Resident #13's narcotic count sheet and the oxycodone HCL tablets were in a plastic bag in the narcotic drawer on 1/18/25 at the beginning of her shift at 7:00 am. Nurse #1 stated she thought she had put the plastic bag which contained the oxycodone HCL and narcotic count sheet for Resident #13 back in the narcotic drawer of the medication cart but was not sure. Nurse #1 stated she did not know what happened to the narcotics and was not sure if she threw them away or put them in the recycling bin. Nurse #1 stated she was terminated on 1/23/25 because of the missing medications and leaving the medication cart unlocked. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview with Nurse #2 on 6/25/25 at 11:56 am, stated the narcotic count on the 100-hall medication cart was correct at the end of her shift on 1/18/25 at 7:00 am. Nurse #2 indicated she was the off going nurse and Nurse #1 was the oncoming nurse. Nurse #2 explained she returned to the facility on 1/18/25 at 7:00 pm. Nurse #2 stated during the narcotic count reconciliation she found the discrepancy of missing oxycodone HCL during the narcotic reconciliation process. Nurse #2 further stated Nurse #1 said she did not take the narcotics, and she (Nurse #2) could check her bag. Nurse #2 called the DON and reported the discrepancy. Nurse #2 further stated the DON asked to speak with Nurse #1 and Nurse #1 refused and left the facility. Nurse #2 indicated the narcotic count was correct on 1/18/25 at 7:00 am and Resident #13's oxycodone HCL and narcotic count sheet was in the narcotic drawer on the medication cart. Nurse #2 stated Resident #13's oxycodone HCL and narcotic count sheet was not packaged in a bag and the narcotic count sheet was in the notebook. Nurse #2 stated she had started a return of narcotics but could not remember the date she started this return of narcotics or the resident's name. Nurse #2 further stated it was all the nurses' responsibility to return discharged and/or discontinued medications to the pharmacy. During an interview with Nurse #3 on 6/25/25 at 8:53 am, she stated she worked on the 100-hall medication cart on 1/17/25 from 7:00 am until 7:00 pm and the narcotic count was correct with 11 tablets remaining and the narcotic count sheet was in the narcotic binder. Nurse #3 explained that Nurse #2 called her on 1/18/25 around 7:00 pm and reported to her Nurse #1 did not want to count narcotics with her at the beginning of her shift around 7:00 pm. Nurse #3 stated Nurse #2 reported to her that Nurse #1 left the facility and did not finish the reconciliation of narcotics and Nurse #2 finished the reconciliation herself and found the discrepancy and reported this to Nurse #3 on 1/18/25. Nurse #3 stated she did not come to the facility on 1/18/25 when Nurse #2 called her concerning the discrepancy but came to the facility on 1/19/25 (Sunday) and notified the police of the missing narcotics. Review of the police report dated 1/19/25 revealed the police department was notified on 1/19/25 at 3:49 pm regarding larceny of medication from the facility. It was documented a follow-up investigation would be conducted at a later date and time regarding the security camera footage. The security footage was not available to view. No charges were filed on this date due to lack of evidence; however, if further evidence was discovered charges would be pursued. During a telephone interview with the Pharmacy Consultant on 6/25/25 at 10:37 am, stated she was made aware of the missing narcotics and narcotic count sheet on 1/18/25 by the Director of Nursing (DON). The Pharmacy Consultant explained that the nursing staff fill out a pharmacy certificate of inventory and destruction form with the resident's name/discharge date /medication strength/quantity/reason for return. The Pharmacy Consultant further explained that the resident's discharged medications were placed in a safe in the DON's office. The Pharmacy Consultant stated these medications were picked up monthly. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 6/25/25 at 8:35 am, she stated the discrepancy with the narcotic count was reported to her by Nurse #2 on 1/18/25 at approximately 7:00 pm. The DON further stated she tried to speak with Nurse #1 on 1/18/25 and Nurse #1 refused to speak with her. Nurse #2 reported to her that Nurse #1 left the faciity on 1/18/25. The DON indicated she called Nurse #1 on 1/19/25 and Nurse #1 did not answer. The DON explained that narcotic/medication cart keys were to be always kept with a nurse on their person. Two nurses are responsible for completion of the narcotic count at change of shifts: one outgoing and one oncoming nurse. She further explained any discrepancy found must be reported immediately and an investigation would be started. The DON indicated she, and the Administrator started the investigation process on 1/20/25. The DON stated the nurses from either shift can return discontinued/discharged medications and the process should be done from start to finish which involved: filling out a pharmacy certificate of inventory and destruction form with the resident name/discharge date /medication and strength/quantity/reason for return/2 sets of nurse initials. The count sheet and medication are put into a bag and medications are given to her. She is the 3rd signature verifying count. If the return was started on the night shift (7:00 pm until 7:00 am) the medications and count sheets are kept in the narcotic drawer of the medication cart until the next day. The DON states she keeps the medications in a locked safe in her office until the pharmacy comes to pick them up and Pharmacy comes monthly for controlled medications. The DON indicated she expected the nursing staff to complete the return process once it was started and the medications that are discontinued or from a resident's discharged to be completed as soon as the medication is discontinued and when the resident is discharged from the facility. An interview with the Administrator on 6/25/25 at 3:00 pm stated her expectation was for nursing staff to count narcotics on the cart each shift, and both ongoing and oncoming staff sign off the narcotic count was completed and was correct. The Administrator indicated the nursing staff should have returned Resident #13's discharged medication as soon as he was discharged from the facility. The facility provided the following corrective action plan with a compliance date of 1/23/25. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #13 was missing oxycodone, as identified on 1/18/25. Resident #13 was sent to the hospital on 1/7/25 and did not return to the facility following his hospital admission. Per record review, Resident #13 did receive his oxycodone, as ordered, prior to his discharge to the hospital. The oxycodone was to be returned to the pharmacy as the patient had already discharged on 1/7/25. The oxycodone for Resident #13 was billed to the facility, therefore no misappropriation was substantiated during this investigation. Nurse #1 was identified as the nurse responsible for the medication cart on 1/18/25 when the oxycodone was identified as missing. Nurse #1 was placed on suspension on 1/18/25 pending investigation. Nurse #1 was terminated from employment on 1/23/25 due to negligence in performing her job duties. Nurse #1 did not work between 1/18/25 and 1/23/25. The facility Nursing Home Administrator made a report to the NC Board of Nursing related to the job performance issues identified for Nurse #1, on 2/10/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #2 reported to the Director of Nursing (DON) that the card of oxycodone and the narcotic count sheet for the missing oxycodone was also missing from the narcotic count book. Nurse #2 stated that she counted with Nurse #1 at 7:00 a.m. on 1/18/25 and both the card of oxycodone and the narcotic count sheet were present at that time. Nurse #2 stated that at 7:00 p.m. on 1/18/25, both the card of oxycodone and the narcotic count sheet were missing. Nurse #3 stated she worked on the 100 hall on 1/17/25. Nurse #3 stated that at 7:00 p.m. on 1/17/25 she completed the narcotic count with Nurse #2. Nurse #3 stated that at that narcotic count, the card of oxycodone for Resident #13 was present with 11 tablets remaining and that the narcotic count sheet was present in the binder. Nurse #4 reported that he picked up a set of keys from his computer keyboard and had them in his pocket when he went on break, at approximately 3:30 p.m. on 1/18/25. Nurse #4 stated when he returned from break he identified that the keys were for Nurse #1 med cart, and he returned them to her. Nurse #4 stated at no time did he access the med cart assigned to Nurse #1 on 1/18/25. The DON confirmed with the pharmacy that they sent 30 tablets of oxycodone to the facility on [DATE]. The DON reviewed the medication administration record (MAR) for Resident #13 and there are 19 tablets signed out from that card of oxycodone. This card of oxycodone could not be located at the facility on 1/18/25 and the narcotic count sheet for the narcotic count binder is also missing for that card. Local Police Department was notified of the missing oxycodone on 1/18/25. Adult Protective Services was notified of the missing oxycodone on 1/18/25. The North Carolina Department of Health and Human Services was notified of the missing oxycodone on 1/18/25. All licensed nurses received education, on 1/24/25, provided by the Clinical Competency Coordinator, RN, regarding the following: Medication Cart and Narcotic Security Policy and Procedure for Controlled Substances Controlled inventory count sheets Policy and Procedure for return of controlled substances to the pharmacy Nurses who did not receive the mandatory training on 1/24/25 received the training prior to the start of their next shift. New nurses, hired after 1/24/25, will receive this training during general orientation. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Social Services interviewed all current residents with a BIMS score of 10, or higher, related to medication Administration and pain management, on 1/18/25. None of the residents interviewed indicated a concern with not getting their pain meds when they request them, or when they are ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) obtained a list of all as needed pain medication orders from the pharmacy for the past 30 days, on 1/18/25. The Director of Health Services completed an audit, on 1/18/25, of the PRN (as needed) sign-out sheets to identify any concerns related to use of as needed medications and also compared the narcotic sign out sheets to the Medication Administration Record (MAR) to identify any missing documentation. Per the audit, all as needed (PRN) medications were administered in compliance with the physician order, however, there was a pattern identified of Nurse #1 signing out her resident's as needed medications on the controlled drug record but failing to sign them out on the medication administration record in the resident record. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. All licensed nurses received education, on 1/24/25, provided by the Clinical Competency Coordinator, RN, (CCC) regarding the following: Medication Cart and Narcotic Security Policy and Procedure for Controlled Substances Controlled inventory count sheets Policy and Procedure for return of controlled substances to the pharmacy Nurses who did not receive the mandatory training on 1/24/25 received the training prior to the start of their next shift. New nurses will receive this education material during their General Orientation to the facility, provided by the Clinical Competency Coordinator, RN. The facility reviewed the incident and investigation at a Quality Assurance Performance Improvement committee meeting on 1/23/25. The Quality Assurance Performance Improvement committee did not offer any additional recommendations for corrective measures. The Director of Health Services, or Assistant Director of Health Services began monitoring shift change narcotic count documentation and controlled inventory count sheets at the time of identification of this incident on 1/18/25, to ensure that the policy and procedure for Medication Cart and Narcotic Security, controlled substances and inventory count sheets were followed at shift change. The consulting pharmacist was also notified of the incident at the time the facility identified it and requested to increase monitoring of Medication and Narcotic security, controlled inventory count and the policy and procedure for controlled substances. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Health Services or Assistant Director of Health Services will complete monitoring of the shift change narcotic count documentation and controlled inventory count sheets, 5 times per week, for four weeks, starting on 1/23/25. After 4 weeks, audits will be completed once per week, for 8 weeks. Additional monitoring will be determined by the facility Quality Assurance Performance Improvement committee, to ensure sustained compliance. Monitoring will also include observation of medication cart security and medication administration record as needed documentation. The Director of Health Services will be responsible for reporting audit results to the Nursing Home Administration at the facility Quality Assurance Performance Improvement committee meeting. All future areas of concern identified related to medication and narcotic security, controlled inventory count sheets, or the policy and procedures for controlled substances will be thoroughly investigated and corrective measures will be taken as appropriate. Date of compliance: 1/23/25 On 6/25/25 the facility's plan of correction (POC) was validated by the following: Social Services interviewed residents on 1/18/25 related to pain medication administration and pain management. No concerns were identified. The DON completed audits of PRN pain medication on 1/18/25 and no concerns were noted; however, a pattern was noted for Nurse #1 failing to document PRN pain medication administration on the medication administration record (MAR) in the resident record. Adult Protective Services, The North Carolina Department of Health and Human Services, and the local Police Department were notified on 1/8/25. Interviews and record review verified education was conducted for staff as indicated in the corrective action plan. The facility's compliance date was validated as 1/23/25.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, staff interviews, the facility failed to ensure the medical record was accurate regarding administration of Oxycodone Hydrochloride (HCL) (an opioid medication which is a controlled substance) for 1 of 1 resident (Resident #13) reviewed for accuracy of medical records. The findings included: A physician's order for Resident #13 dated 12/6/24, read Oxycodone HCL 5 mg to be administered 1 tablet every 6 hours as needed for moderate to severe pain. A review of the narcotic controlled substance count record for Resident #13 revealed Nurse #1 signed out one Oxycodone HCL 5 mg on the following dates: - 12/8/24 at 9:30 am - 12/11/24 at 8:45 am - 12/12/24 at 8:00 am - 12/17/24 at 1:30 pm - 12/20/24 at 3:00 pm - 12/22/24 at 9:00 am - 12/22/24 at 6:00 pm - 12/24/24 at 8:00 am A review of the Medication Administration Record (MAR) for Resident #13 revealed no documentation by Nurse #1 for the Oxycodone HCL 5 mg on the following dates: - 12/8/24 at 9:30 am - 12/11/24 at 8:45 am - 12/12/24 at 8:00 am - 12/17/24 at 1:30 pm - 12/20/24 at 3:00 pm - 12/22/24 at 9:00 am - 12/22/24 at 6:00 pm (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/24/24 at 8:00 am In a telephone interview with Nurse #1 on 6/24/25 at 6:34 pm, stated she could not remember if she signed out the medication on the MAR on those dates. In an interview with the DON on 6/25/25 at 8:35 am stated her expectation was for the nursing staff to document medication administration accurately and promptly after the medication was given. The facility provided the following corrective action plan. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 1/18/25 the Director of Health Services (DHS) identified that the Medication Administration Record (MAR) documentation for the oxycodone did not reconcile with the narcotic count sheet for Resident #13. During the facility investigation the DHS confirmed that there was a pattern of Nurse #1 signing out her resident PRN medication on the controlled drug record but failing to sign them out on the MAR in the resident record. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Health Services (DHS) obtained a list of all as needed PRN pain medication orders from the pharmacy for the past 30 days, on 1/18/25. The DHS completed an audit, on 1/18/25, of the PRN sign out sheets to identify any concerns related to documentation of PRN medications on the MAR. Per the audit, all as needed (PRN) medications were proved to be accurately documented on the MAR excluding Nurse #1s documentation. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. All licensed nurses received education, on 1/24/25, provided by the Clinical Competency Coordinator, RN, (CCC) regarding accurate documentation on the MAR. Medication aides were not utilized at the facility. Nurses who did not receive the mandatory training on 1/24/25 received the training prior to the start of their next shift. New nurses will receive this education material during their General Orientation to the facility, provided by the CCC. The facility reviewed the documentation at a QAPI meeting on 1/23/25. The QAPI did not offer any additional recommendations for corrective measures. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DHS will complete monitoring of documentation on the MAR of narcotics, 5 times per week, for four weeks, starting on 1/23/25. After 4 weeks, audits will be completed once per week, for 8 weeks. Additional monitoring will be determined by the facility QAPI committee, to ensure sustained compliance. Monitoring will also include observation of medication cart security and MAR PRN documentation. The DHS will be responsible for reporting audit results to the Nursing Home Administration at the facility QAPI meeting. Correction Date 1/23/25 On 6/25/25 the facility's plan of correction (POC) was validated by the following: The DON completed audits of PRN pain medication on 1/18/25 and no concerns were noted; however, a pattern was noted for Nurse #1 failing to document PRN pain medication administration on the medication administration record (MAR) in the resident record. Interviews and record review verified education was conducted for staff as indicated in the POC. The facility reviewed the documentation at a QAPI meeting on 1/23/25. The QAPI did not offer any additional recommendations for corrective measures. The DON continued monitoring of documentation on the MAR of narcotics, 5 times per week, for four weeks, starting on 1/23/25. After 4 weeks, audits were completed once per week, for 8 weeks. Additional monitoring was determined by the facility QAPI committee, to ensure sustained compliance. Monitoring also included observation of medication cart security and MAR PRN documentation. The DON was responsible for reporting audit results to the Nursing Home Administration at the facility QAPI meeting. The facility's compliance date was validated as 1/23/25.