STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375504	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North County Center for Nursing and Rehabilitation	2300 West Broadway Collinsville, OK 74021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 35474 Based on record review and interview, the facility failed to ensure controlled medications were not misappropriated for three (#4, 7, and #8) of three sampled residents who were reviewed for misappropriation. The DON identified 42 residents who resided in the facility. Findings: The Controlled Substances policy, dated April 2019, read in part, .Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift . The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, dated April 2021, read in part, .Residents have the right to be free from .misappropriation of resident property . 1. Resident #4 had diagnoses which included abnormal posture and weakness. Form 283, incident date 06/10/24, read in parts, .DON was notified that LTC resident has a missing narcotic of Hydrocodone 5-325 mg tab qty of 60 are unaccounted for. Medication was delivered on 6/5/24 by pharmacy; the total quantity delivered was 112 tabs. #1 card of 52 tabs is in facility in the med cart. On 6/9/24 the nurse on duty contacted the MD for an order for the medication to be administered. An investigation has been initiated at facility level. APS and Local PD have been contacted .Part C .Investigation is on going at this time .Administration have implemented the charge nurse to oversee med cart counts and sign-off sheets during change of shifts. Administration pull pharmacy delivery manifestations to ensure narcotic medications delivered are accounted for on the cart. DON & CMA pulled extra controlled cards off the cart and logged in for double lock up. DON notified Attorney General on 06/12/24 .Facility investigation completed. Night shift CMAs, [CMA #1 and CMA #2] temporarily put on suspension pending further investigation but her unsubstantiated on both employees. No further evidence had been found. No further medication diversions have occurred [sic] since implementing charge nurse to oversee cart card counts. Clinical Admin staff are auditing the pharmacy delivery manifestations to ensure delivery and accounted mediations are in facility. Extra controlled cards are pulled and placed into double lock up until needed. DCS contacted AG agent on 6/21/24 for any new updates. Attorney General is pending a case # to begin investigation . 2. Resident #8 had diagnoses which included chronic pain. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Form 283, incident date 06/12/24, read in parts, .DON was notified that resident medication of Hydrocodone 5-325 mg qty of 30 tabs is unaccounted for. Medication was delivered on 5/30/24 in the amount of 90. Card of 60 tabs are located on the med cart and currently being administered. DON has initiated investigation. Police Depart notified .APS notified .Part C .Investigation is ongoing at this time please see attachments. Administration have implemented the charge nurse to oversee med cart counts and sign-off sheets during change of shifts. Administration pull pharmacy delivery manifestations to ensure narcotic medications delivered are accounted for on the cart. DON & CMA pulled extra controlled cards off the cart and logged in for double lock up. DON notified Attorney General on 06/12/24 on incident .Facility investigation completed. Night shift CMAs, [CMA #1 and CMA #2] temporarily put on suspension pending further investigation but were unsubstantiated on both employees. No further evidence has been found. No further medication diversions have occurred [sic] since implementing charge nurse to oversee cart card counts. Clinical Admin staff are auditing the pharmacy delivery manifestations to ensure delivery and accounted medications are in facility. Extra controlled cards are pulled and placed in double lock up until needed .DCS contacted AG agent on 6/21/24 for any new updates. Attorney General is pending a case # to begin investigation . 3. Resident #7 had diagnoses which included cervical disc degeneration. Form 283, incident date 06/14/24, read in parts, .DON was notified that this resident did not have PRN Hydrocodone card on the cart. Staff notified pharmacy when they discovered a card of #60 tabs had been delivered in March 2024. Resident does not ask for PRN pain medication often. The last documented administration was 4/18/24. Resident has had four administrations per MAR so approximately #56 tabs are un-accounted for. Physician and pain management were notified for new prescription order .Part C .Facility investigation completed. Night shift CMAs, [CMA #1 and CMA #2] temporarily put on suspension pending further investigation but were unsubstantiated on both employees. No further evidence has been found. No further medication diversions have occurred [sic] since implementing charge nurse to oversee cart card counts. Clinical Admin staff are auditing the pharmacy delivery manifestations to ensure delivery and accounted medications are in facility. Extra controlled cards are pulled . Review of the Controlled Substance Card Count Sheet, dated 07/09/24 through 07/14/24, for D hall, revealed the following: a. the controlled medications had not been counted on 07/10/24 for the 3:00 p.m. to 11:00 p.m. or the 11:00 p.m. to 7:00 a.m. shift; b. the on-coming staff signature was blank three times out of 12 opportunities; c. the off-going staff signature was blank five times out of 12 opportunities; and d. the same employee signed as both the on-coming and off-going staff member, on 07/09/24 for the 11:00 p.m. to 7:00 a.m. shift, 07/10/24 for the 6:00 a.m. to 2:00 p.m. shift, 07/11/24 for the 6:00 a.m. to 2:00 p.m. shift, 07/12/24 for the 6:00 a.m. to 2:00 p.m. shift, 07/13/24 for the 7:00 a.m. to 2:30 p.m. shift, and 07/14/24 for the 7:00 a.m. to 11:00 p.m. shift. Review of the Controlled Substance Card Count Sheet, dated 07/15/24 through 07/18/24, for D hall, revealed the following: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. the controlled medications had not been counted on 07/15/24 for the 11:00 p.m. to 7:00 a.m. shift or on 07/18/24 for the 3:00 p.m. to 11:00 p.m. shift; b. the on-coming staff signature was blank one time out of eleven opportunities; c. the off-going staff signature was blank three times out of eleven opportunities; and d. the same employee signed as both the on-coming and off-going staff member, on 07/15/24 for the 7:00 a. m. to 3:00 p.m. shift and the 3:00 p.m. to 11:00 p.m. shift, 07/18/24 for the 6:00 a.m. to 2:00 p.m. shift and the 11:00 p.m. to 7:00 a.m. shift. Review of the Controlled Substance Card Count Sheet, dated 07/19/24 through 07/23/24, for D hall, revealed the following: a. the on-coming staff signature was blank two times out of thirteen opportunities; b. the off-going staff signature was blank two times out of thirteen opportunities; and c. the same employee signed as both the on-coming and off-going staff member, on 07/19/24 for the 7:00 a. m. to 3:00 p.m. shift and the 11:00 p.m. to 7:00 a.m. shift. Review of the Controlled Substance Card Count Sheet, dated 07/23/24 through 07/26/24, for D hall, revealed the following: a. the off-going staff signature was blank two times out of twelve opportunities; and b. the same employee signed as both the on-coming and off-going staff member, on 07/24/24 for the 7:00 a. m. to 3:00 p.m. shift and on 07/25/24 for the 11:00 p.m. to 7:00 a.m. shift. Review of the Controlled Substance Card Count Sheet, dated 07/10/24 through 07/15/24, for F hall, revealed the following: a. the controlled medications had not been counted on 07/10/24 for the 11:00 p.m. to 7:00 a.m. shift, on 07/11/24 on the 7:00 a.m. to 3:00 p.m. shift, or on 07/15/24 for the 7:00 a.m. to 3:00 p.m.; b. the on-coming staff signature was blank three times out of ten opportunities; and c. the off-going staff signature was blank five times out of ten opportunities. Review of the Controlled Substance Card Count Sheet, dated 07/16/24 through 07/19/24, for F hall, revealed the following: a. the controlled medications had not been counted on 07/18/24 for the 3:00 p.m. to 11:00 p.m. or the 11:00 p.m. to 7:00 a.m. shift; b. the on-coming staff signature was blank four times out of 11 opportunities; c. the off-going staff signature was blank four times out of 11 opportunities; and (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. the same employee signed as both the on-coming and off-going staff member on 07/16/24 for the 7:00 a. m. to 3:00 p.m. shift and on 07/19/24 for the 5:00 p.m. to 11:00 p.m. Review of the Controlled Substance Card Count Sheet, dated 07/19/24 through 07/24/24, for F hall, revealed the following: a. the controlled medications had not been counted on 07/20/24 for the 3:00 p.m. to 11:00 p.m. shift; b. the on-coming staff signature was blank one time out of 13 opportunities; c. the off-going staff signature was blank two times out of 13 opportunities; and d. the same employee signed as both the on-coming and off-going staff member on 07/19/24 for the 11:00 p. m. to 7:00 a.m. shift and on 07/22/24 for the 3:00 p.m. to 11:00 p.m. shift. On 07/26/24 at 12:53 p.m., the DON stated they had first been made aware of misappropriation of medications when staff reported on 06/09/24 that Resident #10 had a missing card of medications. They stated they counted the medication carts and found no further discrepancies on 06/09/24. The DON stated the consultant pharmacist had reconciled all controlled medications in the facility on 06/10/24 and had not identified any discrepancies. They stated after the pharmacist had reconciled they had been informed by staff Resident #4 was missing controlled medication. The DON stated they reviewed pharmacy delivery manifestations, narcotic records, and medication administration records. They stated during the investigation they had discovered on 06/12/24 Resident #8 was missing controlled medication and on 06/14/24 Resident #7 was missing controlled medication. Upon discovery of the medication misappropriation, the DON stated they inserviced staff about pharmacy and controlled drug procedures, all drug delivery receipts were given to the MDS coordinator to verify the medication on the medication carts, two CMAs were suspended pending investigation, they changed from a three ringed binder for the narcotic record to a bound hard back narcotic book, the charge nurses verified the end of shift controlled medication counting with the CMAs, the facility replaced the missing medications, and any extra cards of controlled medications were locked in the DONs office under double locks. The DON stated when staff needed the card of medication that was locked in their office the CMA and DON signed it out and reconciled the medication together. They stated they reported the misappropriation of medication to the police department, the state agency, and the Attorney General. On 07/26/24 at 2:20 p.m., the DON stated they had the misappropriation on the agenda for the next QA meeting in the coming week. They stated no further medication misappropriation had been identified since 06/14/24. On 07/26/24 at 4:03 p.m., the Controlled Substance Card Count Sheets were reviewed with the DON. They stated they had not been monitoring to ensure staff were reconciling controlled medications at the end of each shift. The DON stated they had the nurses verifying the counts during the investigations and needed to implement that intervention again to ensure compliance. On 07/26/24 at 4:33 p.m., the Controlled Substance Card Count Sheets were reviewed with the administrator. They stated the DON was responsible to monitor to ensure residents were free from medication misappropriation by reviewing the count sheets. The administrator stated the charge nurses needed to verify the reconciliation of controlled medications at the end of each shift again.