STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Three Rivers Health and Rehab	1403 Conner Drive Windsor, NC 27983

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48230 Based on record review, staff interview, Medical Director/Physician interview, and Pharmacist interview the facility failed to have effective safeguards and systems in place to account for, and periodically reconcile controlled medications to protect the residents right to be free from potential drug diversion. This was for 7 of 14 residents reviewed for pharmacy services for controlled medication (Resident #9, Resident #205, Resident #210, Resident #211, Resident #212, Resident #213 and Resident #221). Findings included: a. Resident #205 was admitted to the facility on [DATE] with diagnoses that included aftercare for joint replacement surgery. Documentation on the [DATE] Medication Administration Record (MAR) revealed Resident #205 had an active physician's order for Oxycodone 5 milligrams (mg) tablets to be administered as 1 tablet by mouth every 4 hours as needed for pain. The MAR further revealed Oxycodone 5 mg tablets were discontinued on [DATE] when the resident discharged home. Resident #205 was administered 4 doses of Oxycodone 5 mg tablets during her stay. Documentation on the Packing Slip Proof of Delivery from the Pharmacy revealed 28 tablets of Oxycodone 5 mg were delivered on [DATE]. Documentation provided by the facility on [DATE] revealed there was no narcotic count sheet, or card of Oxycodone 5 mg capsules found when DON #1 and Nurse #2 attempted to reconcile the discontinued controlled medications for Resident #205 to return to the pharmacy for disposal. This left 24 doses of Oxycodone 5mg tablets unaccounted for. b. Resident #9 was admitted to the facility on [DATE] with diagnoses including dementia, osteoarthritis and osteoporosis. Documentation on the [DATE] MAR revealed Resident #9 had an active physician's order for Oxycodone 5 mg capsules to be administered as 1 tablet by mouth every 4 hours as needed for moderate to severe pain. The MAR further revealed Oxycodone 5 mg capsules were discontinued on [DATE]. Resident #9 was administered 28 doses of Oxycodone 5 mg capsules. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation on the Packing Slip Proof of Delivery from the Pharmacy revealed 90 capsules of Oxycodone 5 mg were delivered on [DATE]. Documentation provided by the facility on [DATE] revealed there was no narcotic count sheet, or card of Oxycodone 5 mg capsules found when DON #1 and Nurse #2 attempted to reconcile the discontinued controlled medications for Resident #9 to return to the pharmacy for disposal. This left 62 capsules of Oxycodone 5 mg capsules unaccounted for. c. Resident #210 was admitted to the facility on [DATE] with a diagnosis of aftercare following right knee replacement surgery. Documentation on the [DATE] MAR revealed Resident #210 had an active physician's order for Hydrocodone-Acetaminophen ,d+[DATE] mg to be administered as 1 tablet by mouth every 6 hours as needed for pain. The MAR further revealed Hydrocodone-Acetaminophen ,d+[DATE] mg were discontinued on [DATE]. Resident #210 had been administered 17 doses. Documentation on the Packing Slip Proof of Delivery from the Pharmacy revealed 60 tablets of Hydrocodone-Acetaminophen ,d+[DATE] mg were delivered on [DATE] for Resident #210. Documentation provided by the facility on [DATE] revealed there was no narcotic count sheet, or card of Hydrocodone-Acetaminophen ,d+[DATE] mg found when DON #1 and Nurse #2 attempted to reconcile the discontinued controlled medications for Resident #210 to return to the pharmacy for disposal, leaving 43 tablets unaccounted for. d. Resident #211 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of ovary (ovarian cancer). Documentation on the [DATE] MAR revealed Resident #211 had an active physician's order for Oxycodone 5 mg to be administered as 1 tablet by mouth every 4 hours as needed for severe pain. The MAR further revealed Oxycodone 5 mg were discontinued on [DATE]. Resident #211 had been administered 1 dose. Documentation on the Packing Slip Proof of Delivery from the Pharmacy revealed 10 tablets of Oxycodone 5 mg were delivered on [DATE] for Resident #211. Documentation provided by the facility on [DATE] revealed there was no narcotic count sheet, or card of Oxycodone 5 mg found when DON #1 and Nurse #2 attempted to reconcile the discontinued controlled medications for Resident #211 to return to the pharmacy for disposal, leaving 9 tablets unaccounted for. e. Resident #212 was admitted to the facility on [DATE] with a diagnosis of aftercare following right knee replacement surgery. Documentation on the [DATE] MAR revealed Resident #212 did not have an active physician's order for Hydrocodone-Acetaminophen ,d+[DATE] mg. Documentation on the Packing Slip Proof of Delivery from the Pharmacy revealed 120 tablets of Hydrocodone-Acetaminophen ,d+[DATE] mg were delivered on [DATE] for Resident #212. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation provided by the facility on [DATE] revealed there was no narcotic count sheet, or card of Hydrocodone-Acetaminophen ,d+[DATE] mg found when DON #1 and Nurse #2 attempted to reconcile the discontinued controlled medications for Resident #212 to return to the pharmacy for disposal, leaving 117 tablets unaccounted for. f. Resident #213 was admitted to the facility on [DATE] with a diagnosis of aftercare for joint replacement surgery. Documentation on the [DATE] MAR revealed Resident #213 had an active physician's order for Oxycodone 5 mg to be administered as 1 tablet by mouth every 6 hours as needed for pain level between ,d+[DATE] (mild to moderate pain). The MAR further revealed Oxycodone 5 mg were discontinued on [DATE]. Resident #213 had been administered 5 doses. Documentation on the Packing Slip Proof of Delivery from the Pharmacy revealed 120 tablets of Oxycodone 5 mg were delivered on [DATE] for Resident #213. Documentation provided by the facility on [DATE] revealed there was no narcotic count sheet, or card of Oxycodone 5 mg found when DON #1 and Nurse #2 attempted to reconcile the discontinued controlled medications for Resident #213 to return to the pharmacy for disposal, leaving 115 tablets unaccounted for. g. Resident #221 was admitted to the facility on [DATE] with a diagnosis of dementia. Documentation on the [DATE] MAR revealed Resident #221 had an active physician's order for Ativan 0.5 mg (Lorazepam) to be administered as 1 tablet by mouth every 8 hours as needed for anxiety for 7 days. The MAR further revealed Ativan 0.5 mg was discontinued on [DATE] when the Resident died . Resident #221 had been administered 14 doses. Documentation on the Packing Slip Proof of Delivery from the Pharmacy revealed 90 tablets of Ativan 0.5 mg were delivered for Resident #221 with no delivery date noted. Documentation provided by the facility on [DATE] revealed there was no narcotic count sheet, or card of Ativan 0.5 mg found when DON #1 and Nurse #2 attempted to reconcile the discontinued controlled medications for Resident #221 to return to the pharmacy for disposal, leaving 76 tablets unaccounted for. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #3, a witness named during the facility investigation, was interviewed on [DATE] at 3:03 PM. She stated DON #2 came into the facility at approximately 6:00 PM on [DATE]. Nurse #3 stated she thought it was unusual as it was after her working hours and she thought DON #2 was on Family Medical Leave (FMLA) and did not expect her to be in the building. Nurse #3 further stated DON #2 approached her at the medication cart and asked if she had any controlled medication that needed to be returned to pharmacy and she gave DON #2 two cards of Oxycodone 5 mg prescribed to Resident #205 that had been discontinued. Nurse #3 revealed she held both cards up separately so the cameras could see what she was giving DON #2. Nurse #3 indicated DON #2 went to the medication storage room where the controlled medication return box was kept, she then came out with something under her arm, went to her office and then left. Nurse #3 stated a short time later the Administrator called her to ask what DON #2 was doing in the building so she explained that DON #2 had taken two cards of discontinued Oxycodone #5 out of her cart to put in the controlled medication return box and that DON #2 was the only person who had the keys to do this. An interview with the Administrator and Director of Clinical Services on [DATE] at 4:15 PM revealed DON #2 had a Doctors appointment on [DATE] for documentation to take FMLA. The Administrator asked her to bring her keys into her after her appointment. DON #2 had the only keys to the controlled medication return box. DON #2 couldn't come into the facility until after 5:00 PM and asked if she could put the keys in the Administrators office, to which she agreed. At about 6:15 PM on [DATE] the Administrator received a call from SW #1 notifying her DON #2 was in the building with her child and had gone onto 400 hall. The Administrator and Director of Clinical Services further stated that up until [DATE] the process for discarding discontinued controlled medications was solely done by DON #2. She would collect the discontinued controlled medications and their count sheets from the medication carts and put them in the double locked controlled medication return box to be reconciled and returned to pharmacy approximately every 6 months, when DON #2 called them to come. Furthermore, there was no tracking of the medication between when it was taken off the medication cart to when it was put in the controlled medication return box. They felt that this system led to the medications being easily misappropriated from the facility. The Administrator revealed DON #2 had been employed at the facility since [DATE] and she resigned on [DATE] after she refused to be involved in the investigation into the missing controlled medications. DON #2 was reported to the North Carolina Board of Nursing on [DATE]. The Administrator and Director of Clinical Services indicated changes had been made to the controlled medication removal system: 1. There are now two keyholders, DON #1 and Nurse #2. 2. Two licensed nurses must sign for the removal of the controlled medication from the medication cart. Documentation of the removal would consist of reconciliation of the number of pills left on the card against the controlled medications card count sheet and a return to pharmacy carbon copy form completed at the time of removal. DON #2 was not able to be reached for interview. In an interview with the Social Worker (SW #1) on [DATE] at 8:54 AM she stated she was working late on [DATE] and saw DON #2 come into the building with one of her children and she called the Administrator to let her know DON #2 was in the building after normal working hours. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Nurse #2 on [DATE] at 3:41 PM she stated she and DON #1 conducted a reconciliation of controlled medications located in the pharmacy return box on [DATE] at the request of the Administrator. They completed a 100% audit of all discontinued controlled medication from [DATE] to [DATE] to determine if the medications were in the controlled medication return box or if they had been sent home with residents upon discharge. They discovered controlled medications and their count sheets missing from the return box for Resident #9, Resident #205, Resident #210, Resident #211, Resident #212, Resident #213 and Resident #221. All medications had been discontinued when a resident went to the hospital, discharged home, discontinued during the residents stay or died in the facility. An interview was conducted with the facility pharmacist on [DATE] at 9:08 AM. He stated controlled medications needed to be returned to the pharmacy for destruction and could not be destroyed in the facility. He further stated the pharmacy did not know when a medication was discontinued and moved to the controlled medication return box, they only knew what was returned to them. The process was for DON #2 to call the pharmacy for a pickup, the driver would reconcile the controlled medications being returned against the list DON #2 gave him. The Pharmacist indicated that the process the facility had at that time left too many opportunities for diversion. He further indicated that the facility had changed the process after this incident so that when controlled medications were taken off the cart it was now signed off by two licensed nurses. In addition, DON #1 and Nurse #2 have received two separate keys to unlock the controlled medication return box so that they must be together to open it. The Medical Director, who was also the physician for Resident #9, Resident #205, Resident #210, Resident #211, Resident #212, Resident #213 and Resident #221 , was interviewed on [DATE] at 10:30 AM. He stated he was aware that controlled medications were discovered to be missing in October of 2023 and he felt the process of DON #2 having sole control of discontinued medications was part of the problem. The Physician further stated the facility had changed the process so that DON #1 and Nurse #2 had the keys to open the controlled medication return box, one has the key for the inside lock and one for the outside lock so that it is never opened by just one person. Additionally, signatures by two licensed Nurses are needed to remove the controlled medication from the medication cart. The facility provided the following corrective action plan: - On [DATE] the DON and support nurse (Nurse #2) began interviewing all alert and oriented residents asking questions related to medication administration concerns, pain related concerns, or misappropriation of property. This was completed on [DATE] with no concerns voiced. - Non-interviewable residents were assessed by DON #1 and Unit Manager for any acute changes in condition related to pain beginning [DATE] with review of the pain assessments recorded on the MAR. This was completed on [DATE] with no concerns related to changes in pain. - On [DATE] each medication carts narcotics were audited by the interim DON and Nurse #2. No discrepancies were found. A new narcotic count sheet was established for each medication cart. - On [DATE] DON #1, Nurse #2 and Director of clinical services initiated random audits on any discontinued controlled substance between [DATE] and [DATE]. If the discontinued medication was not listed on the destruction sheet on [DATE] return to pharmacy report, the facility attempted to locate the packing slip and the controlled count sheet for the medication to account for the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On [DATE] the Director of Clinical Services, DON #1 and Nurse #2 started a 100% audit of all discontinued controlled medications from [DATE] to [DATE] to determine if the medications were in the controlled medications return cabinet or if the medication was sent with the resident upon discharge. These audits were completed on [DATE]. Facility identified additional missing controlled medication count sheets and unclear disposition of the controlled medication. The audits did not identify missing controlled doses scheduled that impacted the resident. The residents went to the hospital, discharged from the facility or the controlled medication was discontinued during the residents stay. The facility has been unable to locate these missing medications. - On [DATE] Nurse #2 and DON #1 began inservicing all licensed nurses and medication aides/techs, including agency, on the narcotic policy and process. - The facility process to reconcile discontinued controlled substances removed from the medication cart until pharmacy pickup or when given to the resident upon discharge includes: controlled substances requires two licensed nurses to remove and secure the medications being stored until pharmacy pickup for destruction. The disposition of the medications will be indicated on the count sheet and the return to pharmacy carbon copy form. A copy of this form will be placed in the secured box with the count sheet and medication until pharmacy pick up for destruction. The card count sheet will show the change that the card was removed. Controlled substances given to residents upon discharge will be witnessed by two licensed nurses indicating disposition on the controlled substance count sheet and the count sheet will be updated. The carbon copy form indication medication was sent home with the resident will be completed and a copy will be given to the resident and the other copy will be uploaded into the medical record after review by DON #1, Nurse #2 or Administrator. - The two keys required to get into the controlled substances pending pharmacy pickup for destruction will not be kept by the same person. One key is in the possession of DON #1 and one by Nurse #2. - Controlled substances will have to be removed by two nurses from the medication cart, two nurses will have to be present to put the medications in the return to pharmacy locked cabinet along with the narcotic count sheet and the carbon copy of the form titled drugs returned to pharmacy or released to the patient. - Two nurses will have to validate when controlled medications are sent home with the resident by indicating such on the count sheet and carbon copy of the form titled drugs return to pharmacy or released to resident. The card count sheet will reflect the removal of the cards. - The carbon copy form of stored medications will then be given to the Administrator so she can reconcile the controlled drugs are accounted for in the locked return to pharmacy box or were sent home. This will be in partnership with DON #1 or Nurse #2. - The controlled medication card count sheets will be maintained on each medication cart. - DON #1 will ensure that any of the above identified staff who did not complete the inservice training by [DATE] will not be allowed to work until the training is completed. Quality Assurance started [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- DON #1 and Administrator will monitor the narcotic process weekly for 4 weeks and monthly for 2 months or until compliance is achieved. - The audit tool will include: Audits to ensure the narcotic count sheets and the narcotic card count sheets are being signed off each shift. Audits to show that discontinued controlled substance count sheets, card count sheets and return to pharmacy sheets are completed each time a narcotic is removed from the medication cart. Audits to reconcile controlled substance items that have been discontinued are stored in the controlled substance return to pharmacy box or were returned home with the resident. Audits to interview at least three residents weekly regarding any concerns regarding their medication administration and availability or misappropriation. Quality Assurance Performance and Improvement (QAPI) meeting was held on [DATE] with the Medical Director and QAPI team. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or DON #1 to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA meeting. The weekly QA meeting is attended by the Administrator, DON #1, Nurse #2, MDS coordinator, Therapy department and Dietary department manager. Onsite validation of the facility Plan of Correction was completed on [DATE]. Confirmed date of compliance was [DATE]. Staff interviews confirmed the facility provided education on the updated narcotic handling procedures. Record reviews indicated education was initiated on [DATE] regarding implementation of the controlled substance count sheet, regarding the policy on controlled substances and on facility misappropriation/abuse policy. Records further indicated the facility completed the stated QA monitoring. The compliance date of [DATE] was validated.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on record review and staff, Responsible Party (RP), and Physician interviews the facility failed to ensure a resident had an indication and a diagnosis for the use of an anti-psychotic medication. This was for 1 of 5 residents (Resident #157) reviewed for unnecessary medications. Findings included: A review of Resident #157's hospital discharge summary dated 10/23/24 did not reveal a history or a diagnosis of schizophrenia. The list of her discharge medications included Seroquel (an antipsychotic medication) 25 milligrams (mg) give 0.5 tablet by mouth every evening. Resident #157 was admitted to the facility on [DATE] with a diagnosis of schizophrenia (a serious mental health condition that affects how people think, feel, and behave). A review of Resident #157's physician's orders revealed an order initiated on 10/23/24 for Seroquel 25 milligrams (mg) give 0.5 tablet by mouth every evening for schizophrenia. A review of Physician #1's Admission Note for Resident #157 dated 10/25/24 revealed she had been sent to the facility from the hospital on her current medications which included low dose Seroquel for a brief psychotic episode during the hospitalization which was as expected with advanced dementia. Physician #1 indicated he would titrate her off this medication. A review of Resident #157's care plan revealed a focus area dated initiated on 10/28/24 for anti-psychotic medication related to a diagnosis of schizophrenia with risk of adverse side effects. The goal was for Resident #157's risk for adverse reactions related to the use of anti-psychotic medication would be minimized through the next review. An intervention was to discuss possible side effects of the medication with the resident and her RP. Her admission Minimum Data Set (MDS) assessment dated [DATE] was in progress. On 10/29/24 at 2:55 PM in a telephone interview Resident #157's RP stated Resident #157 did not have a history of schizophrenia and he was not aware that she had been given a diagnosis of schizophrenia when she was admitted to the nursing facility. He reported this would not be accurate. He went on to say while she was in the hospital prior to being admitted to the facility Resident #157 did have some delirium. He reported this was not unusual for Resident #157 after she received anesthesia. Resident #157's RP stated he had stayed with Resident #157 in the hospital, and when the delirium had not resolved after a couple of hours, he spoke with her hospital physician. Resident #157's RP reported the hospital physician told him they could start Resident #157 on Seroquel, and he agreed. He stated his understanding was this medication would be used for a short period only. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 3:45 PM an interview with Nurse #1 indicated she entered the facility admission medication orders for Resident #157 on 10/23/24. She stated she was being trained to do this, and this was the first admission she had completed. She reported the Director of Nursing (DON) had been helping her with Resident #157's admission process. Nurse #1 stated she used Resident #157's hospital discharge summary dated 10/23/24 to enter Resident #157's admission orders which included Seroquel 25 mg give 0.5 tablet by mouth every evening. She reported the hospital discharge summary didn't have a diagnosis associated with the medication, and the facility medication order entry system asked her for a diagnosis when she entered the order. She went on to say when she asked the DON what Seroquel was used for, the DON told her schizophrenia, so that is the diagnosis she entered into the order system. On 10/31/24 at 10:43 AM an interview with the DON indicated Nurse #1 had been in her office when Nurse #1 was entering Resident #157's admission orders into the system. She stated when Nurse #1 asked her what the medication Seroquel was for, she answered schizophrenia, but she had just taken this as a general question and had not realized Nurse #1 was asking specifically about what diagnosis was associated with Resident #157's use of the medication. The DON went on to say she herself had not looked at Resident #157's hospital discharge summary or anything else because Nurse #1 was sitting right beside her when Nurse #1 was entering Resident #157's admission orders into the order entry system. On 10/29/24 at 4:29 PM an interview with the Corporate Quality Nurse Consultant indicated Physician #1 had been contacted, and Resident #157's diagnosis of schizophrenia had been removed. On 10/31/24 at 10:15 AM an interview with Physician #1 indicated Resident #157 had some delirium (a confused or disoriented mental state) in the hospital and had been started on Seroquel. He stated Resident #157 did not have a diagnosis of schizophrenia. He reported if there had been a question about what the Seroquel for Resident #157 was being used for, someone should have called him. Physician #1 stated when the facility made him aware on 10/29/24 that a diagnosis of schizophrenia had been added as the reason Resident #157 was receiving Seroquel, he corrected this immediately and had discontinued the medication. On 10/31/24 at 10:33 AM an interview with MDS Nurse #1 indicated she had not yet completed Resident #157's Admission MDS assessment. She stated when she did these Admission MDS assessments the facility had a process in place whereby if there was a mental health diagnosis such as schizophrenia for a resident, she would research it thoroughly. She reported she routinely reached out to the mental health provider to obtain supporting historical documentation to ensure that the mental health diagnosis was correct. She went on to say if there had not been any supporting information for Resident #157's schizophrenia diagnosis, she would have contacted Physician #1 immediately. On 11/1/24 at 9:37 AM an interview with the Administrator indicated during the training process the DON had Nurse #1 sitting right next to her in her office when Nurse #1 entered Resident #157's admission orders into the order entry system. She stated Nurse #1 asked the DON what Seroquel was for, and the DON replied to her schizophrenia, but had not realized Nurse #1 was entering this as a diagnosis into Resident #157's medical record. The Administrator reported what should have happened was that the DON and Nurse #1 should have gone back to Resident #157's hospital discharge summary to find out why the hospital had actually been using the medication.