Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056006	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	186 ONE CENTER STREET FRANKLIN, NC 28734

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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services (DSS) conducted an annual survey and three complaint investigations on 03/11/25 through 03/13/25. The complaint investigations were initiated by DSS on 02/12/25, 03/04/25 and 03/07/25.	D 000	Responses to the cited deficiences do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared solely as a matter of compliance with state laws.	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to serve therapeutic diets as ordered to 1 of 3 sampled residents (Resident #6) related to nectar thickened liquids. The findings are: Review of Resident #6's current FL2 dated 10/02/24 revealed: -Diagnoses included alzheimer's disease. -An order for nectar thickened liquids. Review of Resident #6's record revealed she was admitted to hospice on 06/18/25. Observation of the lunch meal service on 03/11/25 between 12:03pm and 12:45pm revealed: -Resident #6 was served nectar thickened tea and water. -The tea and water were served over ice.	D 310	10A NCAC 13F. 0904 (e)(4) Nutrition and Food Service The RN Consultant will conduct staff training on therapeutic diets to include nutritional supplements and thickened liquids The Executive and/or Care Coordinators will audit all resident diets and educate staff on where to locate diets. The Executive Director and/or Care Coordinator will monitor no less than three meals per week for 90 days to ensure residents receive physician ordered therapeutic diets.	04/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Hall | TITLE: Executive Director | (X6) DATE: 4/17/2025

LSB Reviewed and acknowledged 04/21/25

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D 310	Continued From page 1 -Resident #6 was served both yogurt with pureed fruit and sherbet for dessert. Interview with a personal care aide (PCA) on 03/11/25 at 12:03pm and 03/12/25 at 11:30am revealed: -She served Resident #6 nectar thickened tea and water over ice. -She did not know a thickened liquid beverage should not be served over ice. -She was trained how to prepare thickened liquids by other PCAs. -She did not remember being trained by any dietary staff. -She did not remember being told ice could not be served with thickened liquid beverages. Interview with a medication aide (MA) on 03/11/25 at 12:13pm and 03/12/25 at 12:45pm revealed: -She served Resident #6 nectar thickened tea over ice by accident. -She knew thickened liquids should not be served over ice. -She did not prepare the beverage; it was on the cart and she just served it. -She was trained how to prepare thickened liquids by the Resident Care Coordinator (RCC) and the Special Care Coordinator (SCC). -She did not remember being trained by any dietary staff. Interview with another PCA on 03/11/25 at 1:03pm and 03/12/25 at 8:05am revealed: -She served Resident #6 sherbet because all other residents were served sherbet. -She forgot sherbet was a thin liquid and was not to be served to someone who was ordered thickened liquids. -She was trained how to prepare and serve thickened liquids years ago but could not	D 310		

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remember who conducted the training.

Interview with the Food Service Director (FSD) on 03/11/25 at 12:56pm revealed:
-She retrained all PCAs and MAs how to prepare and serve thickened liquids after they were initially trained by their supervisor.
-Resident #6 was served yogurt with pureed fruit for dessert at lunch because sherbet was a thin liquid and not appropriate for someone ordered thickened liquids.

Interview with the Administrator on 03/11/25 at 1:30pm revealed:
All staff were trained by either the RCC or SCC how to prepare and serve thickened liquids.
-The FSD also trained staff after they had been trained by the SCC a or RCC.
-She was not aware staff were serving thickened liquids over ice.

Interview with Resident #6's primary care provider (PCP) on 03/11/25 at 1:35pm revealed:
-She did not remember why Resident #6 was ordered thickened liquids.
-Resident #6's thickened liquid orders were written by the Hospice provider.

Telephone interview with Resident #6's hospice provider on 03/12/25 at 9:45am revealed:
-Resident #6 was transitioned to hospice care on 03/30/24.
-The dietary orders for her food intake was indicated to be "as tolerated" which included her solid and liquid intake.
-Whenever a new resident was transitioned into hospice care the hospice staff discussed dietary issues with the responsible party and noted any concerns or requests about the resident's intake.
-There were no concerns or requests when

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D 310	Continued From page 3 Resident #6 was transitioned into hospice care. -Resident #6 was allowed comfort foods such as ice cream, although she was at an increased risk for aspiration. Interview with Resident #6's family member on 03/13/25 at 12:25pm revealed: -Resident #6 had been ordered nectar thick liquids for more than 5 years. -Resident #6 liked ice cream and sherbet and never had any difficulty swallowing it. -She received palliative care and the family was fine with her eating/drinking anything she wanted and could tolerate.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 8 sampled residents (Residents #7 and #8) related to medication used to treat pain. The findings are: 1. Review of Resident #7's FL2 dated 11/08/24	D 358	10A NCAC 13F .1004(a) Medication Administration RN Consultant will provide training on the importance of administering physician prescribed medications to include comfort medications. In addition, RN Consultant will provide training and education on appropriate reporting of suspicion that resident is not receiving medication as prescribed. The Care Coordintors will complete a MAR to cart for all residents. Care Coordinators will observe no less than 10 medication administrations per week for 90 days. The RN Consultant will monitor med passes during sight visits.	4/28/2025

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D 358	Continued From page 4 revealed diagnoses included essential hypertension, atrial fibrillation, diverticulosis of the intestine, gastroesophageal reflux disease without esophagitis, hypothyroidism, long-term use of anticoagulants, and type II diabetes mellitus without complications. Review of Resident #7's physician order dated 03/31/24 revealed morphine concentrate 100mg/5ml (20mg/ml) oral solution 5mg (0.25ml) every four hours as needed for pain or trouble breathing quantity of 4ml. Review of Resident #7's morphine concentrate pharmacy dispense history report revealed prescription #276746 for morphine concentrate 100mg/5ml 4 ml (16 0.25ml syringes) was sent to the facility on 04/01/24. Review of Resident #7's morphine concentrate electronic controlled substance count sheet (CSCS) entries dated 04/01/24-04/30/24 revealed there were 16 syringes of morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) received on 04/02/24. Review of Resident #7's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) every four hours as need for pain or shortness of breath. -There were no documented administrations of morphine concentrate in April 2024. Review of Resident #7's May 2024 eMAR revealed: -There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) every four hours as need for pain or shortness of breath.	D 358		

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D 358	Continued From page 5 -There were no documented administrations of morphine concentrate in May 2024. Review of Resident #7's physician order dated 06/05/24 revealed increase morphine concentrate 100mg/5ml (20mg/ml) oral solution 5mg (0.25ml) every two hours as needed for pain or trouble breathing. Review of Resident #7's June 2024 eMAR revealed: -There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) every four hours as need for pain or shortness of breath from 06/01/24-06/04/24. -There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) every two hours as need for pain or shortness of breath from 06/05/24-06/30/24. -There were no documented administrations of morphine concentrate in June 2024. Review of Resident #7's physician order dated 07/28/24 revealed concentrate 100mg/5ml (20mg/ml) oral solution 5mg (0.25ml) every four hours. Review of Resident #7's July 2024 eMAR revealed: -There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) four times a day scheduled at 7:00am, 12:00pm, 4:00pm, and 8:00pm start date of 07/29/24 at 4:00pm to 07/31/24 at 8:00pm. -There were 10 occurrences out of 10 opportunities morphine concentrate 5mg was documented as administered. -There were 5 occurrences out of 10 opportunities morphine concentrate 5mg was documented as administered by Staff A, a former	D 358		

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medication aide (MA).
-There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) every two hours as needed for pain and shortness of breath.
-The morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) every two hours as needed was documented as administered on 8 occurrences.

Review of Resident #7's morphine concentrate controlled substance (CS) report entries dated 07/28/24-07/31/24 revealed Staff A documented 5 administrations of morphine concentrate 5mg from prescription #276746 on 07/29/24 at 4:34pm, on 07/30/24 at 12:00pm, on 07/30/24 at 4:00pm, on 07/31/24 at 12:00pm, and on 07/31/24 at 4:00pm.

Telephone interview with a local law enforcement officer on 03/13/25 at 2:11pm revealed:
-Staff A who had previously worked at the facility was arrested on 01/22/25.
-The former MA was in possession of multiple syringes.
-Four of the syringes had pharmacy labels on them.
-One labeled syringe was identified as morphine concentrate belonging to Resident #7 from prescription #276746.

Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 10:40am revealed:
-Receipt of controlled substances from the pharmacy required two MAs to verify the count and start the count in the electronic CSCS for resident for who the controlled substance had been ordered.
-The controlled substances were counted at the end of each shift by two MAs to verify the

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accuracy of the inventory.
-A single syringe waste of morphine concentrate could be witnessed by two MAs and documented in the electronic CSCS system.
-The former MA must have documented administering Resident #7's morphine concentrate but "pocketed it" instead.

Telephone interview with the facility's contracted pharmacy on 03/13/25 at 11:18am revealed:
-The pharmacy dispensed 16 prefilled syringes of morphine concentrate 100mg/ml (20mg/5ml) 0.25mg (5mg) for Resident #7 on 04/01/24.
-The facility had not reported the diversion of Resident #7's morphine concentrate to the pharmacy.
-Once controlled substances arrived at the facility, the controlled substances were no longer the responsibility of the pharmacy.

Telephone interview with a hospice representative on 03/13/25 at 11:31am revealed:
-When a resident was transitioned to hospice care, comfort medications were ordered and made available to the facility for the resident whether they were needed or not.
-Comfort medications included morphine for managing pain and shortness of breath at the end-of-life.
-The hospice nurse began visiting Resident #7 daily for end-of-life visits and would speak to the medication aide (MA) to ask for updates and to verify if they had enough medications.
-The hospice nurse does not visualize the medication on hand on the medication cart but notes what the MA reported to them.
-Resident #7 was on scheduled morphine and as needed for pain management and shortness of breath.

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D 358	Continued From page 8 Based on interviews and record reviews it was determined Resident #7 was not interviewable. Refer to interview with the Administrator on 03/13/25 at 8:55am. 2. Review of Resident #8's FL2 dated 04/25/24 revealed diagnoses included chronic venous hypertension, tachycardia, peripheral vascular disease and rhabdomyolysis (skeletal muscle breakdown). Review of Resident #8's physician's orders dated 10/11/24 revealed an order for Morphine concentrate (100mg/5ml (20mg/ml) 0.25ml (5mg), by mouth, every 4 hours PRN (as needed), for pain or trouble breathing. Review of Resident #8's physician's orders dated 10/13/24 revealed: -Change Morphine concentrate (100mg/5ml (20mg/ml) 0.25ml (5mg) every 4 hours, scheduled, for pain or trouble breathing to be administered sublingually. -Start Morphine concentrate (100mg/5ml (20mg/ml) 0.25ml (5mg) every 2 hours PRN, sublingually. Review of Resident #8's morphine concentrate electronic controlled substance count sheet (CSCS) entries dated 10/13/24 through 10/16/24 revealed there were 30 syringes of morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) received on 10/13/24. Attempted telephone interview with a representative from the facility's contracted pharmacy on 03/12/25 at 2:21pm was unsuccessful.	D 358		

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D 358	Continued From page 9 Review of Resident #8's October 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Morphine concentrate (100mg/5ml), 0.25ml every 4 hours. -There was documentation the former MA administered Morphine concentrate 0.25ml once on 10/13/24 and three times on 10/14/24. -There was an entry for Morphine concentrate (100mg/5ml), 0.25ml every 2 hours, PRN and there was no documentation it was administered PRN. Telephone interview with a local law enforcement officer on 02/17/25 at 2:12pm revealed: -A MA who had previously worked at the facility was arrested on 01/22/25. -The former MA was in possession of multiple syringes. -Four of the syringes had pharmacy labels on them. -Three labeled syringes were identified as morphine concentrate belonging to Resident #8 from prescription #813647. Telephone interview with another local law enforcement officer on 03/13/25 at 2:11pm revealed: -The MA who had previously worked at the facility was arrested on 01/22/25. -The former MA was in possession of multiple syringes. -Four of the syringes had pharmacy labels on them and were traced back to the facility. Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 10:40am revealed: -Receipt of controlled substances from the pharmacy required two MAs to verify the count and start the count in the electronic CSCS for	D 358		

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resident for who the controlled substance had been ordered.
-The controlled substances were counted at the end of each shift by two MAs to verify the accuracy of the inventory.
-The former MA must have documented administering Resident #8's morphine concentrate but "pocketed it" instead.

Telephone interview with a hospice representative on 03/13/25 at 11:31am revealed:
-When a resident was transitioned to hospice care, comfort medications were ordered and made available to the facility for the resident whether they were needed or not.
-Comfort medications included morphine for managing pain and shortness of breath at the end-of-life.
-The hospice nurse would verify with the medication aide (MA) if there was enough comfort care medications available for the resident at each visit.
-The hospice nurse did not visualize the medication on hand on the medication cart but noted what the MA reported to them.
-Resident #8 was on both scheduled morphine and as needed for pain management and shortness of breath.

Based on interviews and record reviews it was determined Resident #8 was not interviewable.

Refer to interview with the Administrator on 03/13/25 at 8:55am

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Interview with the Administrator on 03/13/25 at 8:55am revealed:
-On 01/30/25, she was informed by local law enforcement there were morphine syringes belonging to two residents from the facility found

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D 358	Continued From page 11 in the possession of a former MA. -The former MA was arrested on 01/22/25. -The former MA had been terminated by the Administrator on 11/25/24. -She did not know how the MA diverted the morphine concentrate other than taking doses she documented as administered.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of a controlled substance for 2 of 3 residents (#7 and #8) sampled who received pain medication. The findings are: Review of the facility's medication handling policy revealed: -If a medication is contaminated or spilled note the amount spilled on the Medication/Controlled Substance Destruction Record Destruction Form. -If a medication is contaminated (such as dropped, etc.) use the next available dose and notify the Resident Care Coordinator for further action for replacement of the medication as needed.	D 392	10A NCAC 13F. 1008(a) Controlled Substances RN Consultant will educate Community Med Staff on the facility's medication handling policy to include narcotic destruction. Care Coordinator and/or Executive Director will reconcile the controlled narcotic counts and destruction logs no less than twice weekly for 90 days. The narcotic destruction logs will be kept in the Executive Directors office. RVPO will follow up with reviewing narcotic destruction logs during site visits.	4/28/2025

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D 392	Continued From page 12 -A dose of any medication prepared for administration and accidentally contaminated or not administered shall be destroyed at the facility according to the facility's standards and (10A NCAC 13F .1007). Review of the facility's policy on controlled substance destruction record revealed: -The medication destruction record is completed for any controlled substance requiring facility destruction. -The destruction record was to be maintained in the resident chart. Review of the facility's policy on medication handling upon the discharge or death of a resident revealed: -Prescribed medications are the property of the resident and shall not be given to, or taken by, other staff or residents. -Medications, including controlled medications, shall be destroyed at the facility as it relates to discontinuation of medication following the death of the resident. Review of the facility's policy on the disposal of medications revealed: -The reasons for the disposal of medications include resident refused after the medication was prepared, medication was dropped on the floor or contaminated, medication has expired, and medication has been discontinued per the resident's physician. -Medications to be disposed of are to be placed in the Drug Buster container located in the medication storage area or medication room. -Records of medications disposed of or returned to the pharmacy for disposal (if allowed by state law) include the resident's name, medication name and strength, amount disposed of or	D 392		

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returned, and the method of disposal if destroyed in the community.
-All medications are disposed of according to state and federal rules and regulations.
-Records will be maintained in the resident's file.

1. Review of Resident #7's FL2 dated 11/08/24 revealed diagnoses included essential hypertension, atrial fibrillation, diverticulosis of the intestine, gastroesophageal reflux disease without esophagitis, hypothyroidism, long-term use of anticoagulants, and type II diabetes mellitus without complications.

a. Review of Resident #7's physician's order electronic prescription dated 07/28/24 revealed there was an order for morphine concentrate 100mg/5ml (20mg/ml) oral solution 5mg (0.25ml) scheduled 4 times a day for pain or trouble breathing.

Review of Resident #7's physician's order electronic prescription dated 08/07/24 revealed there was an order for morphine concentrate 100mg/5ml (20mg/ml) oral solution 5mg (0.25ml) three times a day for pain.

Review of Resident #7's physician's order electronic prescription dated 08/19/24 revealed:
-There was an order for morphine concentrate 100mg/5ml (20mg/ml) oral solution 5mg (0.25ml) three times a day for pain and every 2 hours as needed for pain and trouble breathing.
-The prescription was written for a quantity of 30 milliliters with no refills.
-There was an electronic note by the pharmacy staff dated 08/19/24 that indicated 15ml was dispensed on 08/19/24.

Review of Resident #7's pharmacy packing slip

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D 392	Continued From page 14 dated 08/19/24 revealed prescription #667730 for 15ml (60 0.25mg prefilled syringes) of morphine concentrate 100mg/5ml were received by staff on 08/20/24. Review of Resident #7's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) four times a day for pain scheduled at 7:00am, 12:00pm, 4:00pm, and 8:00pm from 08/01/24-08/07/24 at 4:00pm. -The morphine was documented as administered four times a day for 27 occurrences out of 30 opportunities. -There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) three times a day for pain scheduled at 8:00am, 2:00pm, and 8:00pm from 08/08/24-08/31/24. -The morphine was documented as administered three times a day for 67 occurrences out of 72 opportunities. -There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) every 2 hours as needed for pain. -The morphine was documented as administered 2 occurrences as needed on 08/04/24 at 7:14am and on 08/26/24 at 11:51pm. Review of Resident #7's controlled substance (CS) record for morphine concentrate three times a day dated 08/20/24-08/27/24 revealed: -There were 60 0.25ml prefilled syringes of morphine concentrate three times a day received on 08/20/24. -On 08/20/24 at 1:12pm, one morphine concentrate was documented as administered with a remaining balance of 59. -On 08/20/24 at 7:31pm, one morphine	D 392		

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concentrate was documented as administered with a remaining balance of 58.
-On 08/21/24 at 7:12am, one morphine concentrate was documented as administered with a remaining balance of 57.
-On 08/21/24 at 12:03pm, 57 morphine concentrates were documented wasted from the three times a day supply.
-On 08/21/24 at 12:04pm, 30 morphine concentrate were documented as received to the three times a day supply.
-On 08/21/24 at 8:51pm, one morphine concentrate was documented as administered with a remaining balance of 29.
-On 08/22/24 at 7:05am, one morphine concentrate was documented as administered with a remaining balance of 28.
-On 08/22/24 at 3:20pm, one morphine concentrate was documented as administered with a remaining balance of 27.
-On 08/23/24 at 7:56am, one morphine concentrate was documented as administered with a remaining balance of 23 (inaccurate count).
-On 08/23/24 at 2:37pm, one morphine concentrate was documented as administered with a remaining balance of 22.
-On 08/23/24 at 8:52pm, one morphine concentrate was documented as administered with a remaining balance of 21.
-On 08/24/24 at 7:12am, one morphine concentrate was documented as administered with a remaining balance of 20.
-On 08/24/24 at 1:00pm, one morphine concentrate was documented as administered with a remaining balance of 19.
-On 08/24/24 at 8:42pm, one morphine concentrate was documented as administered with a remaining balance of 18.
-On 08/25/24 at 7:05am, one morphine

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D 392	Continued From page 16 concentrate was documented as administered with a remaining balance of 17. -On 08/25/24 at 1:06pm, one morphine concentrate was documented as administered with a remaining balance of 16. -On 08/25/24 at 8:33pm, one morphine concentrate was documented as administered with a remaining balance of 15. -On 08/26/24 at 7:08am, one morphine concentrate was documented as administered with a remaining balance of 14. -On 08/26/24 at 2:50pm, one morphine concentrate was documented as administered with a remaining balance of 13. -On 08/26/24 at 8:34pm, one morphine concentrate was documented as administered with a remaining balance of 12. -On 08/27/24 at 9:37am, one morphine concentrate was documented as administered with a remaining balance of 11. -On 08/27/24 at 11:06am, 14 morphine concentrate were documented as received to the three times a day supply with a remaining balance of 25. -On 08/27/24 at 2:46pm, one morphine concentrate was documented as administered with a remaining balance of 24. -On 08/27/24 at 7:11pm, two morphine concentrates were documented as received to the three times a day supply with a remaining balance of 26. -On 08/27/24 at 8:49pm, one morphine concentrates were documented as administered with a remaining balance of 25. Review of Resident #7's controlled substance (CS) record for morphine concentrate every two hours as needed dated 08/21/24-08/27/24 revealed: -On 08/21/24 at 12:03pm, 57 morphine	D 392		

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concentrates were documented wasted from the three times a day supply.
-On 08/21/24 at 12:05pm, 26 morphine concentrates were documented as received into the as needed every 2 hours supply (inaccurate count).
-On 08/26/24 at 11:51pm, one morphine concentrate was documented as administered with a a remaining balance of 28 (inaccurate count).
-On 08/27/24 at 11:08am, 16 morphine concentrates were documented as received to the every two hours as needed supply with a remaining balance of 44.
-On 08/27/24 at 7:10pm, two morphine concentrates were documented as wasted and "moved to scheduled order" with a remaining balance of 42.

Review of the controlled substance staff ending and staff starting report for third shift on 08/22/24 revealed:
-On 08/22/24 at 7:11pm, Hall 300 required one attempt to reconcile the medication cart CS count.
-On 08/22/24 at 7:15pm, Hall 400 required four attempts to reconcile the medication cart CS count and an override of the count was completed by a Care Manager who was also documented as the oncoming medication aide (MA) for third shift.
-On 08/22/24 at 7:24pm, Hall 200 required four attempts to reconcile the medication cart CS count and an override of the count was completed by a Care Manager who was also documented as the oncoming MA for third shift.
-On 08/22/24 t 7:30pm, Hall 100 required two attempts to reconcile the medication cart CS count and an override of the count was completed by a Care Manager who was also

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D 392	Continued From page 18 documented as the oncoming MA for third shift. Interview with a MA on 03/12/25 at 11:00am revealed: -MAs were allowed to receive and process CS deliveries from the pharmacy. -A MA could check in CS deliveries and enter the received amount into the eMAR system and did not require verification of the counts by a second MA. -The oncoming shift MA and the MA who was leaving shift were required to count CS on the medication cart and enter the results in the electronic CS record. -The MAs had three chances to enter the correct number of CS. -After the failed third attempt the administrative staff were required to look further into why the physical count did not match the electronic count. -The computer would lock and not allow the MAs to go any further until the CS count discrepancy was resolved. Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 10:40am revealed: -One MA was required to sign and date the pharmacy packing slip with CS and then fax the signed copy back to the pharmacy. -The original signed pharmacy packing slip was then filed in the RCC office. -The MA then entered the starting count in the electronic CS record for each CS received in the delivery. -The off going MA and oncoming MA were required to count all of the CS on the medication cart and verify the counts by entering the counts in the electronic CS record. -If the CS count entered did not match the electronic CS record, the computer would allow you to try two additional times to enter the correct	D 392		

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D 392	Continued From page 19 count. -After the third attempt, it required the Administrator, RCC or Special Care Coordinator (SCC) to verify the count and enter the correct count before the electronic system would allow staff to document in the electronic system. -MAs did not have access to visualize the computer CS count or modify the CS without help from the administrative staff. -The facility's contracted pharmacy would not accept the return of CS. -All CS had to be wasted in the facility by use of chemical destruction. Interview with the Special Care Coordinator (SCC) on 03/12/25 at 11:09am revealed: -An MA could verify the waste of one dose of a CS with another MA, the RCC or SCC, or the Administrator by use of chemical destruction. -Larger quantities of CS were required to be wasted by two of the administrative staff (RCC, SCC, or the Administrator) by use of chemical destruction. A subsequent interview with the RCC on 03/12/25 at 4:15pm revealed: -A wasted entry on the CS record was used to electronically move CS supply from one order to another order for the same resident. -If borrowed was noted in the comment section of the CS record it meant staff borrowed doses from one residents CS supply to administer to another resident. Interview with the Administrator on 03/13/25 at 8:55am revealed: -On 01/30/25, a local law enforcement officer came to the facility to share information with her . -The officer reported a former medication aide (MA) had been arrested.	D 392		

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-The former MA had been terminated on 11/25/24.
-The former MA was found to be in possession of morphine in syringes.
-The morphine syringes had pharmacy labels identifying some prescribed for Resident #7.
-She called the corporate supervisor and reported the incident to him on 01/30/25.
-He instructed her to complete a 24 hour report and send it to the health care personnel registry (HCPR).
-He instructed her to complete an investigation and send the five day report to the HCPR.
-He did not instruct her to notify the facility's contracted pharmacy about the drug diversion.
-She did not notify the facility's contracted pharmacy about known drug diversion.
-She did not know she was supposed to notify the pharmacy of known drug diversion.
-She notified the families of the affected residents.
-She notified the department of social services.
-She held an inservice about controlled substances with all of the MAs.
-She asked staff to report anything "out of the ordinary" to management.
-The procedure for receipt of controlled substances was adjusted to include a two person verification of amounts received.
-When the local Department of Social Services came in to do their investigation, she printed a CS report on Resident #7.
-She reviewed the CS report and noticed entries for wastes of quantities of two doses and four doses of Resident #7's morphine concentrate.
-She did not communicate this finding with corporate management.
-She did not contact the facility's contracted pharmacy to report her observation.
-She did not see any "huge amount of waste" so

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she did not report it.

Telephone interview with the facility's pharmaceutical review pharmacist on 03/13/25 at 2:03pm revealed:
-He reviewed the resident charts from a "medical perspective" online.
-Then he sent his recommendations to the resident's primary care providers.
-He visited the facility once a quarter.
-He would choose 5 or 6 random residents and check the CS physical count against the electronic record to make sure the balances matched.
-He had not noticed any discrepancies in the sampled residents CS counts.

b. Review of Resident #7's physician's order electronic prescription dated 03/31/24 revealed:
-There was an order for morphine concentrate 100mg/5ml (20mg/ml) oral solution 5mg (0.25ml) every 4 hours as needed for pain or trouble breathing.
-The prescription was written for a quantity of 4 milliliters with no refills.
-There was an electronic note by the pharmacy staff dated 04/01/24 that indicated 4ml was dispensed on 04/01/24.

Review of Resident #7's pharmacy packing slip dated 04/01/24 revealed prescription #276746 for 4ml (16 0.25mg prefilled syringes) of morphine concentrate 100mg/5ml were received by staff on 04/02/24.

Review of Resident #7's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) every four

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hours as need for pain or shortness of breath.
-There were no documented administrations of morphine concentrate in April 2024.

Review of Resident #7's May 2024 eMAR revealed:
-There was an entry for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) every four hours as need for pain or shortness of breath.
-There were no documented administrations of morphine concentrate in May 2024.

Review of Resident #7's controlled substance (CS) records dated 04/02/24-05/19/24 revealed:
-There were 16 morphine concentrate received on 04/02/24.
-There was a CS record on 05/19/24 at 9:29pm waste of 2 morphine concentrate documented as "borrowed" with no further comment.

Interview with the Resident Care Coordinator on 03/12/25 at 4:15pm revealed borrowed noted in the comment section of the CS record meant staff borrowed doses from one residents CS supply to administer to another resident.

Interview with the Administrator on 03/13/25 at 8:55am revealed:
-Borrowed noted in the comment section of the CS record meant staff borrowed dose from one residents CS supply to administer the CS to another resident.
-The only reason for staff to borrow a CS was if the pharmacy had not delivered new medications for a resident.
-The facility had access to a local pharmacy as backup to ensure medications were available in the facility for administration.
-She could not explain why staff borrowed Resident #7's morphine to give to another

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resident when the morphine could have been obtained through the local backup pharmacy.

2. Review of Resident #8's FL2 dated 04/25/24 revealed diagnoses included chronic venous hypertension, tachycardia, peripheral vascular disease and rhabdomyolysis (skeletal muscle breakdown).

Review of Resident #8's physician's orders dated 10/11/24 revealed an order for Morphine concentrate (100mg/5ml (20mg/ml) 0.25ml (5mg), by mouth, every 4 hours PRN (as needed), for pain or trouble breathing.

Review of Resident #8's physician's orders dated 10/13/24 revealed:
-Change Morphine concentrate (100mg/5ml (20mg/ml) 0.25ml (5mg) every 4 hours, scheduled, for pain or trouble breathing to be administered sublingually.
-Start Morphine concentrate (100mg/5ml (20mg/ml) 0.25ml (5mg) every 2 hours PRN, sublingually.

Review of Resident #8's morphine concentrate electronic controlled substance (CS) record entries dated 10/13/24 through 10/16/24 revealed there were 30 syringes of morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) received on 10/13/24.

Attempted telephone interview with a representative from the facility's contracted pharmacy on 03/12/25 at 2:21pm was unsuccessful.

Review of Resident #8's October 2024 electronic medication administration record (eMAR) revealed:

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D 392	Continued From page 24 -There was an entry for Morphine concentrate (100mg/5ml), 0.25ml every 4 hours at 2:00am, 6:00am, 10:00am, 2:00pm. 6:00pm and 10:00pm. -There was documentation the former MA administered Morphine concentrate 0.25ml once on 10/13/24 and three times on 10/14/24. -There was an entry for Morphine concentrate (100mg/5ml), 0.25ml every 2 hours, PRN and there was no documentation it was administered PRN. Review of Resident #8's CS record dated 10/13/24 through 10/16/24 revealed: -There was documentation 30 morphine concentrate every four hours were received on 10/13/24 at 4:16am. -On 10/13/24 at 4:09pm, one morphine concentrate was documented by the former medication aide (MA) as administered with a balance of 28. -On 10/13/24 at 8:10pm, 1 morphine concentrates was documented as wasted by the former MA, with the reason documented as "other" leaving a balance of 27. -On 10/14/24 at 12:01pm, one morphine concentrate was documented by the former MA as administered with a balance of 23. -On 10/14/24 at 3:27pm, one morphine concentrate was documented by the former MA as administered with a balance of 22. -On 10/14/24 at 5:29pm, one morphine concentrate was documented by the former MA as administered with a balance of 21. -There was no documentation on 10/17/24 the 12 morphine concentrate were destroyed in the drug buster by the RCC and Administrator. Interview with the Administrator on 03/13/25 at 8:55am revealed: -She did not know why a morphine concentrate	D 392		

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D 392	Continued From page 25 would be documented as wasted. -Staff should explain why a dose would need to be wasted by writing a note in the comments column. Interview with the Resident Care Coordinator on 03/12/25 at 4:22pm revealed: -The CS record utilized a drop down menu and only allowed three reason to be documented; received, administered and wasted. -The staff documented "wasted" if they needed to borrow it for another resident. -By documenting "wasted" the count would remain correct. -Staff should have documented in the comments section why the medication was "wasted"; examples such as it was destroyed, it was borrowed for another resident, it was dropped. etc.	D 392		
D 394	10A NCAC 13F .1008 (c & d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the	D 394	10A NCAC 13F .1008 (c&d) Controlled Substance Clinical Nurse Consultant will educate Med Staff on the appropriate medication disposal policy in relation to controlled substances. Care Coordinator and/or Executive Director will reconcile controlled substance counts and distructions logs no less than two times weekly for 90 days.	4/28/2025

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D 394	Continued From page 26 controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to record the strength, dosage form, and destruction method for controlled substances for 2 of 2 sampled residents (Residents #7 and #8). The findings are: Review of the facility's Medication Handling Upon	D 394		

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D 394	Continued From page 27 The Death of a Resident policy revealed medications, including controlled medication, shall be destroyed at the facility as it relates to discontinuation of medication following the death of the resident. Review of the facility's controlled substance destruction record policy revealed: -The medication destruction record was to be completed for any controlled substance requiring facility destruction. -The destruction record was to be maintained in the resident chart. Review of the facility's policy on the disposal of medications revealed: -The reasons for the disposal of medications include resident refused after the medication was prepared, medication was dropped on the floor or contaminated, medication has expired, and medication has been discontinued per the resident's physician. -Medications to be disposed of are to be placed in the Drug Buster container located in the medication storage area or medication room. -Records of medications disposed of or returned to the pharmacy for disposal (if allowed by state law) include the resident's name, medication name and strength, amount disposed of or returned, and the method of disposal if destroyed in the community. -All medications are disposed of according to state and federal rules and regulations. -Records will be maintained in the resident's file. 1. Review of Resident #7's FL2 dated 11/08/24 revealed: -Diagnoses included essential hypertension, atrial fibrillation, diverticulosis of the intestine, gastroesophageal reflux disease without	D 394		

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D 394	Continued From page 28	D 394		

esophagitis, hypothyroidism, long-term use of anticoagulants, and type II diabetes mellitus without complications.
-There was an order for lorazepam (used to treat anxiety) 0.5mg one tablet every two hours as needed.
-There was an order for morphine concentrate (used to treat pain) 100mg/5ml (20mg/ml) 0.25ml (5mg) three times daily.
-There was an order for morphine concentrate 100mg/5ml (20mg/ml) 0.25ml (5mg) every two hours as needed for pain or shortness of breath.

Review of Resident #7's medication disposition form dated 02/24/25 revealed:
-Required information on the form included resident name, prescription number, medication name, quantity returned, reason code, and initials for verification of deposit or destruction of medication.
-There was an entry for lorazepam, quantity 20, destroyed due to resident death.
-There was an entry for morphine 0.25ml, quantity 28, destroyed due to resident death.
-There was a second entry for morphine, quantity 19, destroyed due to resident death.
-The entries were documented as verified by the Administrator and Special Care Coordinator (SCC).
-There was no documentation of the strength and dosage forms of the controlled substances destroyed.
-There was no documentation of the destruction method used.

Refer to the interview with the Resident Care Coordinator on 03/12/25 at 10:40am.

Refer to the telephone interview with the facility's contracted pharmacy's Executive Director on

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D 394	Continued From page 29 03/13/25 at 11:18am. Refer to the interview with the Administrator on 03/13/25 at 8:55am and 12:11pm. 2. Review of Resident #8's FL2 dated 04/25/24 revealed: -Diagnoses included chronic venous hypertension, tachycardia, peripheral vascular disease and rhabdomyolysis (skeletal muscle breakdown). Review of Resident #8's physician's orders dated 10/11/24 revealed: -Lorazepam 0.5mg, 1 tablet every 4 hours, for restlessness/anxiety. -Morphine sulfate (100mg/5ml) 0.25ml, by mouth, every 4 hours scheduled for pain or trouble breathing. Review of Resident #8's physician's orders dated 10/13/24 revealed: -Change Lorazepam 0.5mg, 1 tablet every 4 hours, scheduled, to be administered sublingually. -Start Lorazepam 0.5mg, 1 tablet sublingually every 2 hours PRN (as needed). -Change Morphine sulfate (100mg/5ml), 0.25ml every 4 hours, scheduled, for pain or trouble breathing to be administered sublingually. -Start Morphine sulfate (100mg/5ml), 0.25ml every 2 hours, PRN. Review of Resident #8's medication disposition form dated 10/17/24 revealed: -Required information on the form included resident name, prescription number, medication name, quantity returned, reason code, and initials for verification of deposit or destruction of medication.	D 394		

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D 394	Continued From page 30 -There was an entry for lorazepam 0.5, quantity 24, destroyed due to resident death. -There was an entry for morphine, quantity 12, destroyed due to resident death. -The entries were documented as verified by the Administrator and Special Care Coordinator (SCC). -There was no documentation of the prescription number. -There was no documentation of the strength and dosage forms of the controlled substances destroyed. -There was no documentation of the destruction method used. Refer to the interview with the Resident Care Coordinator on 03/12/25 at 10:40am. Refer to the telephone interview with the facility's contracted pharmacy's Executive Director on 03/13/25 at 11:18am. Refer to the interview with the Administrator on 03/13/25 at 8:55am and 12:11pm. Interview with the Resident Care Coordinator (RCC) on 03/12/25 at 10:40am revealed: -The facility's contracted pharmacy would not allow the facility to return controlled substances for destruction. -Controlled substances were destroyed at the facility using a chemical destruction method supplied by their contracted pharmacy. -Two managers were required to witness destruction of controlled substances. -The Administrator, the RCC, or the Special Care Coordinator (SCC) were considered "managers" and were allowed to witness controlled substance destruction. -A medication disposition form had to be	D 394		

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D 394	Continued From page 31 completed when medications were destroyed. -The form required the prescription number, name of the drug, quantity of the drug, and the initials of the two managers who were completing the chemical destruction. Telephone interview with the facility's contracted pharmacy's Executive Director on 03/13/25 at 11:18am revealed: -The pharmacy did not accept returns of controlled substances. -The facility destroyed controlled substances at the facility using chemical destruction. -The pharmacy provided the facility with a form to document destruction of controlled substances. -Destruction of controlled substances was required to be witnessed by two facility administrative staff. Interview with the Administrator on 03/13/25 at 8:55am and 12:11pm revealed: -She was the designee for destruction of controlled substances. -Destruction of controlled substances were always witnessed by two people one of which had to be herself, the RCC or the SCC. -Destruction of controlled substances were documented on a form provided by the pharmacy. -She and the other care managers provided the requested information on the form. -The drug buster container was kept in the Administrator's office, under the desk.	D 394		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law	D 399	10A NCAC 13F. 1008(h) Controlled Substance RN Consultant will educate Resident Care Coordinator, Special Care Coordinator and the Executive Director on rule area .1008 (h) to specify notification to pharmacy during a drug diversion.	4/28/2025

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D 399	Continued From page 32 enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to report known drug diversion for 2 of 2 sampled residents (Residents #7 and #8) to the facility's contracted pharmacy and document action taken. The findings are: Interview with the Administrator on 03/13/25 at 8:55am revealed: -On 01/30/25, a local law enforcement officer came to the facility to share information with her . -The officer reported a former medication aide (MA) had been arrested. -The former MA had been terminated on 11/25/24. -The former MA was found to be in possession of morphine in syringes. -The morphine syringes had pharmacy labels identifying them as prescribed for one current resident and a former deceased resident of the facility. -She called the corporate supervisor and reported the incident to him on 01/30/25. -He instructed her to complete a 24 hour report and send it to the health care personnel registry	D 399	Executive Director and/or Care Coordinators will conduct random narcotic count audits during mid shifts. RVPO will review future suspected drug diversions and will partner with the Executive Director and/or designee to ensure compliance with rule area .1008 (h) to include notification to appropriate parties.	

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D 399	Continued From page 33 (HCPR). -He instructed her to complete an investigation and send the five day report to the HCPR. -He did not instruct her to notify the facility's contracted pharmacy about the drug diversion. -She did not notify the facility's contracted pharmacy about known drug diversion. -She did not know she was supposed to notify the pharmacy of known drug diversion. Telephone interview with the Executive Director of the facility's contracted pharmacy on 03/13/25 at 11:18am revealed: -The facility did not report the incident of drug diversion to the pharmacy. -"This" phone call had been the first he had heard about the incident. -He would communicate with his corporate facility contact to find out what action needed to be taken. Telephone interview with the facility's Regional Vice President of Operations on 03/13/25 at 4:02pm revealed: -The community was responsible for reporting the known drug diversion to the pharmacy. -He just "did not think" to instruct the Administrator to notify the pharmacy of the known drug diversion. -The accused former employee no longer worked at the facility and had not been able to divert other medication as of 11/25/24. The facility failed to report a known drug diversion to the pharmacy and failed to document the action taken after they were informed of a drug diversion on 01/30/25. This failure was detrimental to the health and welfare of the residents and constitutes a Type B violation.	D 399		

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D 399	Continued From page 34 The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/11/25 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 28, 2025.	D 399		