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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/28/24 through 11/1/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #6BOE11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/28/24 through 11/1/24. Event ID#6BOE11. The following intakes were investigated NC00221711, NC00221631, NC00216334, NC00215564, NC00212794, NC00212209, NC0021883, NC00210219, NC00209999, NC00209670, NC00209048, NC00208957, and NC00208859. 33 of the 33 complaint allegations did not result in deficiency.	F 000		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/19/2024

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 1 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: 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 10/5/23 with diagnoses that included aftercare for joint replacement surgery. Documentation on the October 2023 Medication Administration Record (MAR) revealed Resident	F 755	Past noncompliance: no plan of correction required.	

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 2	F 755		

#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 10/16/23 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 10/5/23.

Documentation provided by the facility on 11/1/24 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 11/7/22 with diagnoses including dementia, osteoarthritis and osteoporosis.

Documentation on the September 2023 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 10/5/23. Resident #9 was administered 28 doses of Oxycodone 5 mg capsules.

Documentation on the Packing Slip Proof of Delivery from the Pharmacy revealed 90 capsules of Oxycodone 5 mg were delivered on 9/6/23.

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 3	F 755		

Documentation provided by the facility on 11/1/24 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 9/8/23 with a diagnosis of aftercare following right knee replacement surgery.

Documentation on the September 2023 MAR revealed Resident #210 had an active physician's order for Hydrocodone-Acetaminophen 5/325 mg to be administered as 1 tablet by mouth every 6 hours as needed for pain. The MAR further revealed Hydrocodone-Acetaminophen 5/325 mg were discontinued on 10/27/23. Resident #210 had been administered 17 doses.

Documentation on the Packing Slip Proof of Delivery from the Pharmacy revealed 60 tablets of Hydrocodone-Acetaminophen 5/325 mg were delivered on 9/11/23 for Resident #210.

Documentation provided by the facility on 11/1/24 revealed there was no narcotic count sheet, or card of Hydrocodone-Acetaminophen 5/325 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 10/4/23 with diagnoses that included malignant neoplasm of ovary (ovarian cancer).

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 4	F 755		

Documentation on the October 2023 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 10/10/23. 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 10/4/23 for Resident #211.

Documentation provided by the facility on 11/1/24 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 4/25/23 with a diagnosis of aftercare following right knee replacement surgery.

Documentation on the September 2023 MAR revealed Resident #212 did not have an active physician's order for Hydrocodone-Acetaminophen 5/325 mg.

Documentation on the Packing Slip Proof of Delivery from the Pharmacy revealed 120 tablets of Hydrocodone-Acetaminophen 5/325 mg were delivered on 7/29/23 for Resident #212.

Documentation provided by the facility on 11/1/24 revealed there was no narcotic count sheet, or card of Hydrocodone-Acetaminophen 5/325 mg

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 5	F 755		

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 8/28/23 with a diagnosis of aftercare for joint replacement surgery.

Documentation on the September 2023 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 1-5 (mild to moderate pain). The MAR further revealed Oxycodone 5 mg were discontinued on 9/14/23. 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 9/5/23 for Resident #213.

Documentation provided by the facility on 11/1/24 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 9/1/23 with a diagnosis of dementia.

Documentation on the September 2023 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

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 6	F 755		

further revealed Ativan 0.5 mg was discontinued on 10/9/23 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 11/1/24 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.

Nurse #3, a witness named during the facility investigation, was interviewed on 10/29/24 at 3:03 PM. She stated DON #2 came into the facility at approximately 6:00 PM on 10/17/24. 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

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 7	F 755		

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 10/29/24 at 4:15 PM revealed DON #2 had a Doctors appointment on 10/17/23 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 10/17/24 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 10/18/24 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 November 2021 and she resigned on 10/17/23 after she refused to be

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 8	F 755		

involved in the investigation into the missing controlled medications. DON #2 was reported to the North Carolina Board of Nursing on 10/20/23. 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 10/30/24 at 8:54 AM she stated she was working late on 10/17/24 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.

In an interview with Nurse #2 on 10/30/24 at 3:41 PM she stated she and DON #1 conducted a reconciliation of controlled medications located in the pharmacy return box on 10/20/24 at the request of the Administrator. They completed a 100% audit of all discontinued controlled medication from 9/20/23 to 10/16/23 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

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 9	F 755		

#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 10/30/2024 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 10/31/2024 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

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 10	F 755		

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 10/19/23 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 10/23/23 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 10/19/23 with review of the pain assessments recorded on the MAR. This was completed on 10/23/23 with no concerns related to changes in pain.

- On 10/19/23 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 10/19/23 DON #1, Nurse #2 and Director of clinical services initiated random audits on any discontinued controlled substance between 3/27/23 and 9/20/23. If the discontinued medication was not listed on the destruction sheet on 9/20/23 return to pharmacy report, the facility attempted to locate the packing slip and

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 11	F 755		

the controlled count sheet for the medication to account for the medication.

- On 10/20/23 the Director of Clinical Services, DON #1 and Nurse #2 started a 100% audit of all discontinued controlled medications from 9/20/23 to 10/16/23 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 11/3/23. 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 10/19/23 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

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 12	F 755		

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.

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 13	F 755		

- 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 11/3/23 will not be allowed to work until the training is completed.

Quality Assurance started 10/26/23.
- 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 10/26/23 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

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 14 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 11/1/24. Confirmed date of compliance was 10/27/23. Staff interviews confirmed the facility provided education on the updated narcotic handling procedures. Record reviews indicated education was initiated on 10/19/23 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 10/27/23 was validated.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		11/22/24

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 15 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: 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 10/23/24 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	F 757	F757 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. " Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The physician was contacted on 10/29/24 by Unit manager regarding the diagnosis indication for Seroquel for resident #157. The physician identified that Resident #157 had just started Seroquel during the hospitalization and only received a few doses and the antipsychotic medication and diagnosis of schizophrenia was discontinued. Resident #157 has no noted	

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 16 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 10/29/24 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	F 757	side effects related to the medication per assessment by the Director of nursing on 10/29/24. " Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current residents with antipsychotics orders were reviewed to ensure accurate indication and diagnosis for the use of an anti-psychotic medication. This was completed by the Director of nursing on 10/29/24. The Director of Nursing reviewed the audits with the physician on 10/29/24. No other additional issues were identified. " Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing and/or designee initiated in-servicing for current registered nurses and licensed nurses to include agency staff on 10/29/24 and completed on 11-14-24 on appropriate use for medications for antipsychotic medications. This education will be provided as part of facility orientation, to include agency, for registered nurses and licensed nurses by the Director of Nursing and/or designee. This education included residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition. The condition should	

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 17 medication would be used for a short period only. 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.	F 757	be determined by the physician and documented in the medical record. " Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or Support Nurse will conduct audits on all residents with new orders for antipsychotics to ensure Residents have an appropriate indication and a diagnosis for the use of an anti-psychotic medication. These audits will be conducted weekly for two weeks and monthly for 3 months. Compliance will be monitored and the ongoing auditing program reviewed during the Quality assurance (QA) meeting. The QA meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager and the Medical Director. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction. Date of Compliance: __11_/__22__/___2024__	

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 18	F 757		

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

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 19 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.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		11/22/24

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 20 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure resident medications stored in an unattended medication cart (200 hall medication cart) for 1 of 3 medication carts. Findings included: A continuous observation was conducted of the 200 hall medication cart on 10/31/24 from 5:40 AM to 5:49 AM. The cart was parked between rooms 207 and 209, facing out into the hallway. The cart was not visible from the nurses' station. There was one Nurse Aide (NA) working on the hall and one resident sitting next to the medication cart in her wheelchair. The medication cart was observed to have the red dot on the push lock visible, which meant the push lock was not engaged. There was no staff member with the medication cart. Medication Aide #1 came out of room 208 at 5:44 AM and prepared the next resident's medications. Medication Aide #1 then left the hall, leaving the cart unlocked and the resident sitting next to it. She returned to the cart at 5:49 AM. During an interview with Medication Aide #1 at 5:50 AM she stated she left the medication cart unlocked both times she had walked away. She further stated the cart should be locked any time she was not using it. An interview with the Administrator on 10/31/24 at 6:45 AM revealed medication carts should not be	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 Label/Store Drugs and Biologicals F761 CFR(s): 483.45(g)(h)(1)(2) 483.45(g) This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure resident medications stored in an unattended medication cart (200 hall medication cart) for 1 of 3 medication carts. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 10/31/24, the DON re-educated Medication Aid # 1 on medication storage policy and locking medication/treatment cart when carts are unattended. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 10/31/24, the DON audited all med	

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 21 unlocked unless the Medication Aide was using it. The Administrator stated the Medication Aide assigned to the medication cart was responsible for them for their entire shift. In an interview with the Director of Nursing (DON) on 10/31/24 at 8:11 AM she stated the medication cart should be locked when the Medication Aide was not using it.	F 761	carts and treatment carts to ensure they were locked. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 10/31/24, the DON began re-education with all FT, PT, PRN nurses and medication aids, including agency on medication storage policy and locking medication and treatment carts when unattended. This Education was completed on 11-14-24 by the DON. This education will be provided by the Director of Nursing or designee as a part of the facility orientation, to include agency, licensed nurses, and medication aides. DON/designee will audit 4 medication carts/treatment carts per week weekly for 4 weeks, then monthly for 3 months or until resolved. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements The Director of Nurses or designee will monitor medication carts and treatment carts to assure that they are locked per policy when unattended. Monitoring will be completed weekly x 4 and then monthly x 3 or until resolved. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality	

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 _____	C 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 22	F 761	Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 11/22/24	