STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345180	A. BUILDING _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY PINES RETIREMENT COMM	1000 WESLEY PINES ROAD LUMBERTON, NC 28358

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/12/24 through 11/14/24. The facility was found in compliance with the Requirement CFR 483.73, Emergency Preparedness. Event ID #7UXT11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 11/12/2024 through 11/14/2024. Event ID# 7UXT11. The following intakes were investigated NC00217115, NC00209482, NC00221398 and NC00210487. 2 of the 4 allegations resulted in deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility neglected to provide a breakfast tray for a dependent Resident (Resident #212) for 1 of 3	F 600	Wesley Pines acknowledges receipt of the statement of deficiencies and the purpose of this Plan of Correction to the	12/5/24

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

Electronically Signed | 12/05/2024

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F 600	Continued From page 1 residents reviewed for neglect. Findings included: Resident #212 was admitted to the facility on 7/29/20. Her diagnoses included hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke) and aphasia (loss of ability to understand or express speech). Resident #212's quarterly Minimum Data Set Assessment (MDS) dated 3/7/24 coded the Resident as cognitively impaired. She was coded as dependent with personal hygiene, toileting, oral hygiene and eating. Review of Resident #212's care plan revealed a care focus area initiated 3/11/24 that indicated that Resident #212 was at nutritional risk and interventions included staff to assist with feeding Resident at mealtimes. Facility investigation report dated 5/20/24 indicated Resident #212 was not provided with a breakfast tray on 5/15/24. The report indicated the Director of Nursing (DON) became aware of the incident at 11:20 AM when the Dining Assistant notified her that Resident #212's breakfast tray was still in the warmer in the kitchen. The DON went to inquire about the tray with Nursing Assistant #1 (NA #1) who was assigned to care for Resident #212 on 5/15/24 7:00 AM - 3:00 PM shift and NA #1 stated she forgot. During an interview on 11/13/24 at 11:40 AM with the Dining Assistant, she stated nursing assistants were responsible for obtaining trays from the food cart or kitchen for residents that ate meals in their rooms and required feeding	F 600	extent of the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Preparation and submission of this Plan of Correction is in response to CMS 2567 from November 12-14, 2024. Wesley Pines' response to this statement of deficiencies and plan of correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Wesley Pines reserves the right to refute any deficiency on this statement of deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative legal procedures. F600 Free from Abuse and Neglect SS=D CFR(s): 483.12 (a)(1) I. Resident #212 did not experience any negative consequences from the alleged deficient practice. It is the practice of Wesley Pines to ensure residents are provided with their meal trays. II. All residents have the potential to be affected. No other residents were identified as having missed a meal tray. III. The Assistance with Meals Policy was reviewed on November 13, 2024 by the Administrator and Director of Nursing and was found to meet clinical standards. In addition, the Abuse and Neglect Policy and the Abuse, Neglect, Exploitation, or	

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F 600	Continued From page 2 assistance. The Dining Assistant stated she found Resident #212's tray in the warmer in the kitchen on 5/15/24 at around 11:20 AM and notified Nurse #1 that the tray was still in the kitchen. During an interview on 11/13/24 at 11:55 AM with Nurse #1, she stated she became aware that Resident #212 did not receive a breakfast tray on 5/15/24 when she was notified by the Dining Assistant at around 11:20 AM that Resident #212's tray was still in the kitchen. When she asked NA #1 about the tray, NA #1 stated she forgot about the tray. Nurse #1 explained that Resident #212 was dependent on staff for feeding and NA #1 should have obtained the tray from the kitchen to feed the Resident. She further stated that if NA #1 was busy she should have informed her that she needed assistance and she would have obtained the tray and fed Resident #212 herself. Attempts to interview NA #1 were unsuccessful. An Interview was conducted with the Director of Nursing (DON) on 11/13/24 at 12:06 PM. The DON stated that breakfast was normally served between 7:30 AM and 9:00 AM. She indicated that NA #1 stated she had forgotten to feed Resident #212 and when asked why she did not ask for assistance, NA #1 stated she was not running behind and that she got sidetracked and forgot about the tray. The DON verbalized Resident #212 ate her meals in her room with feeding assistance and NA #1 should have retrieved the breakfast tray from the kitchen and fed the Resident or asked for assistance from another staff member.	F 600	Misappropriation Policy were reviewed by the Administrator and Director of Nursing on November 13, 2024 and found to meet clinical standards. Education was provided by the Director of Nursing and the Assistant Director of Nursing to Health Center Nursing Staff, and education to Health Care Food and Beverage Staff was provided by the Food and Beverage Director on the timely service of meal trays in resident rooms and assistance with meals, including for dependent residents on November 13-14, 2024. All Health Center Nursing and Food and Beverage staff education was completed by November 14, 2024. Additional systemic changes are being addressed through our quality assurance process described below. IV. The Director of Nursing or designee will: Audit compliance with service of meal trays in resident rooms, three times weekly for 6 weeks, then weekly for 4 weeks, then monthly for a total duration of 6 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review.	

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F 600	Continued From page 3	F 600	V. The facility will be in and remain in compliance by: November 14, 2024.	
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of property when a staff member (Nurse #2) took a Duragesic pain patch that was ordered for a Resident. The deficient practice was reviewed for 1 of 3 residents for misappropriation of residents' property (Resident #29). Finding included: Resident #29 was admitted to the facility on 04/24/2019 with diagnosis including chronic back pain. The quarterly Minimum Data Set (MDS) dated 10/29/2024 had Resident#29 coded as cognitively intact. The care plan dated 11/07/2024 had focus of pain due to chronic back pain, osteoarthritis, and muscle spasms. The interventions included to please give me my pain medication as ordered.	F 602	Past noncompliance: no plan of correction required.	

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Monitor for narcotic overdose and follow protocol as ordered.

The Initial Allegation Report dated 11/30/2023 completed by the Director of Nursing (DON) was reviewed. On 11/30/2023 staff notified the DON that Nurse #2 came into the facility during his off hours. Nurse #2 entered Resident #29's room to utilize a Duragesic patch. Later, Nurse #2 became pale, blood pressure 70/50, with low oxygenation.

The Investigation Report dated 12/07/2023 completed by the DON was reviewed. On 11/30/2023 Nurse #2 provided enough information to substantiate allegation of deviating medication from Resident #29. The employee was terminated and support for professional assistance was provided. The North Carolina Board of Nursing (NCBON) and local police department were performing their own investigations. The employee was terminated. The staff had an in-service on communication, reporting, medication administration, and protecting your license.

The Lumberton Police Department Incident Report dated 12/01/2023 by Officer #1 was reviewed. On 11/30/2023 the complainant (DON) reported Nurse #2 for larceny by employee of Fentanyl patch $1.00 value. The employee allegedly deviated Duragesic. Soon after, he became hypotensive with a low oxygen saturation. The emergency medical services (EMS) were notified but the employee refused transport. He later agreed to go to the emergency department (ED) with his parents. The allegation had been emailed to the NCBON.

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The November narcotic dosage form for Fentanyl 75mcg/hour for Resident #29 revealed all the medications for November were signed out as given and there were no patches missing.

The November 2023 Medication Administration Record (MAR) for Resident #29 revealed an order for Duragesic (Fentanyl) 75 MCG/hour topical every other day for chronic pain syndrome was given as directed.

Nurse #2 was not available for interview.

An interview with Resident #29 was conducted on 11/12/2024 at 3:40 PM. The Resident stated he has been using pain patches for a while now and they are helping to control his pain. He has always received his patches and did not recall ever missing any doses.
An interview with Officer #1 was conducted on 11/13/2024 at 10:16 AM. The officer stated he was the officer that responded to the report of larceny by an employee at the nursing home. Nurse #2 was accused of taking a Duragesic patch from the resident at the facility. The District Attorney (DA) did not press charges because the employee went to get treatment at a center for substance abuse.

An interview with Nurse #3 was conducted on 11/13/2024 at 12:25 PM. The nurse stated she was the nurse working with Resident #29 on 11/30/2023. That morning, Nurse #2 was at the facility, and she thought he was still there from the prior shift. He came to her cart with Resident #29's old patch in a cup. The Nurse thought it had come off because she saw Nurse #2 go into Resident #29's room to check the resident because his light was on. She and Nurse #2

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disposed of the old patch properly and signed out a new patch and she then gave the patch to Nurse #2 to place on Resident #29. She continued her medication pass and was told Nurse #2 was about to pass out. She thought about the patch he was supposed to change and went into the residents' room and did not see the replacement patch on the Resident. She reported it to the Assistant Director of Nursing (ADON).

A telephone interview with Nurse #4 was conducted on 11/13/2024 at 2:04 PM. The nurse stated she worked 11/29/2023 third shift and Resident #29's patch was in place the last time she saw him at around 6:30 to 7:00 AM.

An interview with ADON was conducted on 11/13/2024 at 3:04 PM. The ADON stated the morning of 11/30/2023 she was coming in to work around 7:30 AM and received a report that nurse #2 was going to the hosp. EMS was there but Nurse #2 would not allow them to perform a drug test. She was updated by Nurse #3 that Nurse #2 had gone into Resident #29's room to answer a call light and came out with a patch in a cup. The Nurse thought it had come off. The nurses discarded the old patch and Nurse #3 gave Nurse #2 a new patch to apply to the Resident and saw him go in Resident #29's room. The nurse did not think anything of it because Nurse #2 would work third shift regularly and answer call lights while charting. The ADON also stated she assisted in assessing residents that had patches and there were no complaints of pain from the residents. The Nurse Practitioner (NP) was in the facility and a one-time order for Resident #29 to have another patch was ordered and applied.

An interview with the NP was conducted on

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11/13/2024 at 3:20 PM. The NP was called to supply room because Nurse #2 was not acting right. He looked lethargic and 911 was called because his bp was low. She started an IV of normal saline and let it hang with gravity. She placed him in the Trendelenburg position, and he became more aware and coherent. When EMS arrived, he started walking and signed a waiver to not go to hospital. She thought he was tired at first and she did not know what was going on with him but was concerned about low bp. She then was updated on the missing Duragesic patch and ordered a one-time order for a new patch to be placed, and the nursing staff applied for the patch without any issues. The missing patch was long acting and there were no adverse reactions or pain while the patch was missing.

An interview with the DON was conducted on 11/13/2024 at 3:37 PM. The morning of 11/30/2024 she received a call from her ADON stating Nurse #2 came in when he was not scheduled and helped Nurse#2 dispose of an old patch and was supposed to apply a new patch to Resident #29. The old patch that Nurse #2 brought to Nurse #3 was disposed of by the two nurses. Nurse #3 did not think anything of it when Nurse #2 was in the facility in the morning because he often would do double shifts. Nurse #2 became ill and found to have low blood pressure. He refused to go with the EMS to the hospital. He was escorted to the car at the back door, and she asked Nurse #2 if he remembers taking a patch from Resident #29, and Nurse #2 stated he did take the patch. After Nurse #2 left the facility, the police were called, and an investigation began. They assessed the three residents with pain patches and there were no complaints of pain. The police were called, and

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they also reported this incident to North Carolina Department of Health and Human Services (NCDHHS) and the NCBON. Nurse #2 was terminated, and staff were educated.

An interview with the Administrator was conducted on 11/13/2024 at 4:08 PM. The Administrator stated it was an unfortunate incident with Nurse #2. He was loved by all staff and Residents. This was a shock that he had a problem. He had just gone through a bad break up with his significant other and they felt that was what sparked this incident. He had since gone to a rehab facility. They completed a Plan of Correction (POC) and there was no harm to any residents or pain voiced due to the removal of the patch. The Residents were assessed and there were no missing patches found during the count of narcotics and all patches were signed as administered as ordered.

POC
Problem: On 11/30/2023 Nurse #2 was supposed to replace a Duragesic (Fentanyl) 75 microgram (mcg) patch for Resident #29, but the patch was not replaced.

o Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice include:

Resident #29 was assessed, and the pain patch was missing. Resident #29 was interviewed and assessed and there were no reports of pain or any memory of him going without the patch in the past. A new Duragesic patch for Resident the resident was placed.
It is the practice of Wesley Pines to ensure that resident's pain medication patches are

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administered as ordered and residents are free from medication diversion.

o Address how the facility will identify other residents having the potential to be affected by the same deficient practice include:

All three of the Residents in the facility with Duragesic patches had the potential to be affected and all residents were assessed and assured the patches were placed as ordered.

The Medication Administration Records (MAR) and narcotic medication sheets of the three Residents with Duragesic patches were checked for accuracy.

o Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur include:

The police were called 11/30/2023.
A report was filed with NCDHHS on 11/30/2023.
NCBON was made aware of the incident on 11/30/2023.
The DON will in-service the nursing staff on 11/30/2023 and/or prior to working the next scheduled shift. Topics to include Communication, Reporting, Medication Administration, and Protecting Your license.
Terminate Nurse #2.

o Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The DON/Designee will monitor all MARs and controlled medication count sheets from 11/30/2023 to 12/30/2023 with audits to ensure all

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F 602	Continued From page 10 Duragesic patches are accounted for and in place. An Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the interdisciplinary team on December 1, 2023, concerning the drug diversion and this plan of correction that was developed and implemented. The facility's QAPI Committee will review this POC for the next 3 months. The Administrator stated she was responsible for this POC. Corrective action completion date: December 6, 2023 Validation On 11/15/2024 the facility's plan of correction was validated by the following: Audits conducted by the facility were reviewed and were found to be completed according to the plan of correction. Auditing started 11/30/2023 and was completed on 12/30/2023. No issues found. Reviewed all narcotic medications for the three residents that received a Duragesic patch in November and December to assure the count was equal. No issues noted. All residents on the Duragesic patch in November and November 2023 were checked to make sure they received their patches, and the residents received their doses as ordered. The Lumberton City Police Department report dated 11/30/2023 was reviewed and the police officer that conducted the investigation was interviewed on 11/13/2024 and stated the case was investigated and closed without prosecution. NCDHHS 24-hour report was submitted on 11/30/2023.	F 602		

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F 602	Continued From page 11 11/30/2023 to 12/06/2023 signed in-services were held for nursing staff by DON with topics including Communication, Reporting, Medication Administration, and Protecting Your license. Nursing staff voiced understanding of education. The training check-off sheets were noted to have DON's signature as the instructor. A review of the certified letter dated 12/01/2023 indicated Nurse #2s termination was sent out by the Human Resources Director. The DON stated she completed the auditing of the narcotic sheets and the MARs of the three Residents during the months of November and December 2023 and did not find any discrepancies. She completed the education for all nurses prior to their next shift. The Administrator stated she ensured the DON audited the MARs and narcotic controlled sheets and in-serviced all nursing staff including communication; to especially include knowing what staff that are on the schedule and not allowing any other nurse to administer any medications for them. They completed their monitoring of this medication deviation in March 2023. Reviewed NCBON complaint form dated 12/01/2023. The facility's plan of correction was validated to be completed as of 12/06/2023.	F 602		