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	345339	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR REHABILITATION AND HEALTHCARE CENTER	1306 SOUTH KING STREET WINDSOR, NC 27983

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 4/09/25 through 4/10/25. Event ID# U2YR11. The following intakes were investigated NC00224378, NC00224874, NC00226648, NC00227930, NC00228904, and NC00228958. 1 of the 15 complaint allegations resulted in deficiency.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		4/26/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/24/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 607	Continued From page 1 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Medical Director interviews, the facility failed to implement their policy for abuse, neglect, and misappropriation of property in the areas of reporting and investigating when Nurse #2 and Nurse #3 reported to the Unit Manager, Assistant Director of Nursing, and Director of Nursing allegations that Resident #1's liquid morphine appeared to be tampered with and Nurse #1 appeared impaired. These allegations were not reported to the State Agency, law enforcement, or Adult Protective Services (APS) and were not thoroughly investigated. This deficient practice affected 1 of 4 residents (Resident #1) reviewed for misappropriation of property and placed all facility residents who were ordered narcotic medication at risk of misappropriation of property. The findings included: Review of the facility policy Compliance with Reporting Allegations of Abuse, Neglect, Exploitation last reviewed on 4/01/24 revealed it was the policy to report all allegations including misappropriation of resident property to the Administrator and other appropriate agencies in accordance with current state and federal regulations within the prescribed timeframes. The policy further noted that when allegations were reported the following procedures would be initiated which included the Director of Nursing, Administrator, or designee notifying the appropriate agencies within specific time frames, obtain statements from direct care staff, suspend	F 607	1. Resident #1 no longer resides at the facility. Facility report for Resident #1 was submitted on 4/10/25. 2. All residents have the ability to be affected by the deficient practice. 3. All staff will be receive mandatory retraining on the facility's abuse prevention policies, reporting protocols and their obligation under state and federal law to report abuse or misappropriation by 4/26/2025 by the Administrator or designee. This will include signs of abuse, reporting timeframes, and anonymity protections. The Administrator and DON were in-serviced on 4/10/2025 on the state and federal laws to report abuse and misappropriation by the Vice President of Clinicals. New hires will receive training upon hire. An audit was conducted of the grievance log for 3 months prior for any complaints or allegations that may have been missed. None were found. 4. The Administrator or designee will conduct monthly audits of incident reports and investigations for three months, then quarterly, to ensure that all reports are logged, investigated promptly, and reported to approoriate agencies as required. Results of these audits will be presented	

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F 607	Continued From page 2 the accused team member pending completion of the investigation, and report the results of the investigation. Resident #1 was admitted to the facility on 7/02/24 with a history of prostate cancer and was on comfort measures. Resident #1 expired at the facility on 4/02/25. The Minimum Data Set (MDS) quarterly assessment dated 3/05/25 revealed Resident #1 had severe cognitive impairment and received opioid medication. Resident #1 had a physician order dated 3/19/25 for morphine sulfate solution (opioid/narcotic analgesic medication) 20 mg/mL (milligrams per milliliter). Give 0.25 ml by mouth every 4 hours for pain and air hunger. Review of the Medication Administration Record (MAR) for March 2025 revealed Resident #1 was administered his ordered morphine sulfate as scheduled and it was noted as effective. Review of the morphine sulfate narcotic count down sheets revealed no missed doses, no discrepancies with the administration record, and no doses removed without signatures of nurses. Review of the nursing progress notes for March 2024 revealed Resident #1 did not show any pain or distress and continued with the morphine sulfate administration. An interview was conducted with Nurse #2 on 4/09/25 at 10:41 am who revealed she worked at the facility on 3/23/25 during the 7:00 pm through 7:00 am shift and was assigned to Resident #1.	F 607	to the Quality Assurance and Performance Improvement (QAPI)Committee for three months for review and, if warranted, further action. 5. Alleged Date of Compliance 4/26/2025.	

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Nurse #2 stated when she received the shift report from Nurse #1 that evening it took her (Nurse #1) hours to complete the report and Nurse #1 was unable to stand, talk, she kept falling asleep and appeared impaired. Nurse #2 stated she made multiple attempts to contact the Unit Manager and Director of Nursing (DON) by phone to report her observations and request someone come to the facility but she was not successful reaching them. Nurse #2 stated she then called the Assistant Director of Nursing (ADON) who stated she would come to the facility. Nurse #2 stated the Unit Manager returned her call and when she reported her concerns regarding her observations of Nurse #1 the Unit Manager told her that Nurse #1 was on prescription medication and she did not need to be drug tested. Nurse #2 stated Nurse #1's family came to pick her up and Nurse #3 had to help get Nurse #1 to the car because she was unable to walk. Nurse #2 stated when she began her medication pass she poured Resident #1's liquid morphine into the medication cup and it appeared to be diluted and a different shade of blue than it normally was. Nurse #2 stated she had Nurse #3 come look at the medication and she agreed the morphine did not look "right". She stated she then went to the cart and went to open the new bottle of morphine and noticed there was a small section of the seal that was open and it appeared to have been tampered with. Nurse #2 stated she contacted the pharmacy regarding her concern about the possible tampering of the medication and requested to obtain Resident #1 a new bottle of morphine but the pharmacy was unable to dispense without a new prescription since the medication had just been received on 3/19/25. Nurse #2 stated when the ADON arrived at the facility she observed the liquid morphine

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and agreed that it did not look the same. Nurse #2 stated the ADON assisted her to obtain a new prescription from the Medical Director for a new bottle of morphine for Resident #1. Nurse #2 stated she wrote a written statement for the DON on 3/24/25 regarding the state of Nurse #1 and the possible tampering of Resident #1's liquid morphine and was told that since she did not see Nurse #1 take any medication it was defamation of character.

A telephone interview was conducted on 4/09/25 at 2:40 pm with Nurse #3 who revealed Nurse #1 appeared to be impaired during shift report on 3/23/25 and she needed to help her get to the car when she left work. She stated when Nurse #2 asked her to look at Resident #1's morphine sulfate solution she agreed that the color and viscosity (how thick or sticky a fluid is) did not seem the same as normal morphine. Nurse #3 stated they went to open Resident #1's new bottle and she noticed at that time that there was a small slit in the seal on the bottle and it was wet on top. She stated she and Nurse #2 compared Resident #1's morphine to another resident's bottle and they did not look to be the same color so Nurse #2 did not feel comfortable administering the medication so she called the pharmacy. Nurse #3 stated the ADON arrived at the facility and assisted with getting Resident #1 a new bottle of morphine and spoke to Nurse #1 but she was not sure of the outcome of that conversation. She stated she notified the DON and wrote a written statement on 3/24/25 to the DON regarding the state of Nurse #1 and Resident #1's morphine but she never received a call from the DON or Administrator to ask any further questions.

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An interview was conducted with the Assistant Director of Nursing on 4/9/25 at 2:05 pm who revealed she received a call from Nurse #2 on the night on 3/23/25 and she reported the concern regarding Nurse #1 and Resident #1's morphine. The ADON stated she was not on call but since Nurse #2 was unable to reach the Unit Manager, who was on call, she went to the facility. She stated when she was on the way to the facility when she received a call from the DON regarding the report and she notified the DON that she was on her way to the facility. The ADON stated when she arrived at the facility Nurse #1 was still present and she agreed that Nurse #1 appeared to be different in some way but she was unable to say for sure if she was impaired. She stated she spoke to Nurse #1 who reported she was tired and stressed about a personal family illness. The ADON stated she observed Resident #1's morphine and she confirmed that the medication did not appear to be the same color blue as it normally was and she notified the DON of her observations. The ADON stated she asked the DON if a drug test should be completed for Nurse #1 and she was told by the DON if they tested Nurse #1 they would need to test all the staff and she was told that Nurse #1 did not need to be tested. The ADON stated she called the Medical Director and notified him of the concern of tampering with Resident #1's morphine and the need for a new prescription so the facility could pull a new bottle from the medication dispensing machine. She stated the Medical Director sent a prescription right over to the pharmacy and they were able to remove a new bottle for Resident #1. The ADON stated the DON instructed her to place Resident #1's morphine bottles that were possibly tampered with in a plastic bag with her name across the opening and she would look at

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them the next day when she returned to work. The ADON stated she was not sure if the DON completed an investigation regarding Nurse #2's and Nurse #3's reported concerns about Resident #1's morphine and Nurse #1.

A telephone interview was conducted with Nurse #1 on 4/10/25 at 10:50 am who revealed she did not recall anything out of ordinary on her shift on 3/23/25. Nurse #1 stated she did recall the DON left her voicemail on 3/24/25 but she was not available to speak at that time and she never actually spoke to her. She stated she was under a tremendous amount of stress at the facility related to work hours and family illness and decided to resign from the facility effective immediately to focus on her health and family illness. Nurse #1 stated her last day of work was 3/23/25 and she sent a letter of resignation to the facility. She stated the DON may have sent her a text and asked her to come talk to her after she found out she was resigning but she was out of town and was not able to go to the facility. Nurse #1 stated the DON did not say anything about having to talk about Resident #1's medications or any concerns about work. Nurse #1 stated she did not receive another call from the DON or Administrator and she was not aware there was a concern regarding Resident #1's morphine.

An interview was conducted with the Unit Manager on 4/10/25 at 12:20 pm who confirmed she received a call from Nurse #2 who reported that Resident #1's morphine was tampered with and that Nurse #1 was impaired. The Unit Manager stated she notified the DON of the report from Nurse #2 and was told by the DON that the ADON was on the way to the facility. The Unit Manager stated she was not sure about an

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investigation regarding Resident #1's morphine or Nurse #1's reported impairment.

A telephone interview was conducted with the Medical Director on 4/10/25 at 10:56 am who revealed he was called by the facility on the evening of 3/23/25 maybe around 11:00 pm and was told that there were concerns regarding Resident #1's morphine being tampered with. He stated if the facility nurse had a concern then he had a concern so his first concern was to get Resident #1 a new bottle of morphine so he would not experience pain. The Medical Director stated he would have expected the facility to complete a full investigation for the reported tampering of Resident #1's morphine medication but he was not sure if the concern was investigated.

An interview was conducted with the DON on 4/09/25 at 1:50 pm who revealed she was called by Nurse #2 and was told that Resident #1's morphine did not look the same, that it looked watered down and that the new bottle of morphine looked like the seal was lifted up without being opened all the way. She was unable to recall the exact date or the exact time of the call. The DON stated Nurse #2 reported that Nurse #1 was sleeping during the shift and that Nurse #1 may have taken Resident #1's morphine. The DON stated she spoke to the ADON when she (the ADON) was on the way to the facility but did not speak to her regarding her observations of the medication or Nurse #1 at the facility. She stated she instructed the ADON to place Resident #1's morphine bottles in a sealed bag and she would look at them the next day. The DON stated she did not recall that Resident #1's medications looked different. The DON

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stated she did call Nurse #1 to come in and talk but was not able to speak to her. She stated Nurse #1 resigned her position and did not return to work after 3/23/25 due to a family medical issue. She stated the staff did not see Nurse #1 take any medications and the narcotic sheets did not have discrepancies when she checked. The DON stated she was not sure of the policy regarding drug testing staff and she was not sure if the facility was able to drug test a staff member if impairment was reported. The DON stated she notified the VP of Clinical Services and the Administrator but did not know if the Administrator reported the allegations to the required people.

An interview was conducted with the Vice President (VP) of Clinical Services for the facility on 4/09/25 at 2:55 pm who revealed she was notified about Resident #1's morphine when she came to the facility for a planned visit on 3/24/25. She stated she did look at Resident#1's morphine bottles on 3/24/25 and she did not notice a significant difference in color from each bottle. She stated there was no documentation that Resident #1's morphine was not effective when administered. The VP of Clinical Services stated she did an audit to confirm that all narcotics sent to the facility were accounted for on 3/24/25 when she visited the facility.

An interview was conducted with the Administrator on 4/10/25 at 11:22 am who revealed she did not report the allegation of misappropriation of resident property for Resident #1 because the facility did not feel it was substantiated because all the medication was accounted for. The Administrator stated that in hindsight she should have completed the appropriate steps to investigate the allegation and

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