STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345449	A. BUILDING ______ B. WING ______	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	**115 WHITE ROAD KING, NC 27021**

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 02/28/24 through 02/29/24. Event ID# H41111. The following intakes were investigated: NC00213183 and NC00213023. 1 of 6 complaint allegations resulted in a deficiency.	F 000		
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 reviews and staff interviews, the facility failed to protect the rights of 1 of 2 residents (Resident #2) to be free from misappropriation of a narcotic medication (Oxycodone) prescribed to treat pain. Findings included: Resident #2 was admitted to the facility on 9/26/23 and re-admitted on 2/2/24 with the diagnoses which included: surgical aftercare following surgery on the nervous system, spinal stenosis, osteoarthritis, chronic pain, and post-traumatic stress syndrome (PTSD). Review of the quarterly Minimum Data Set dated 2/9/24 indicated Resident #2 was cognitively intact and received opioid medication.	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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 602	Continued From page 1	F 602		

Review of Resident #2's physician cumulative orders included an order dated 2/2/24 for Oxycodone hydrochloride, immediate release 5 milligrams (mg), one tablet every four hours as needed for pain for seven days (stop date 2/9/24).

On 2/29/24 the Administrator was away from the facility and unavailable for interview.

During an interview with the Director of Nursing (DON) on 2/29/24 at 3:00 p.m. and review of the initial allegation report submitted to the state agency on 2/4/24 revealed that the hall nurse made the weekend supervisor and the DON aware that approximately 16 Oxycodone IR 5mg were missing. The contracted agency nurse who worked the night before had documented that a narcotic bubble card was removed from the medication cart, but the bubble card and the narcotic sheet were not turned in. Initial efforts made to contact the nurse were unsuccessful by the facility and the contracted agency at that time. Full audits were completed of all the medication carts to ensure no other narcotics were missing. The medication room was also searched for missing narcotics. Staff were educated about misappropriation of medication. The police were notified.

During the survey on 2/29/24 at 3:58 p.m., attempts made to contact the accused contracted agency nurse via telephone were unsuccessful.

The facility's investigation report submitted to the state agency on 2/9/24 included the return telephone call from the contracted agency nurse insisting she was not sure what happened to the

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missing bubble card of Oxycodone and the narcotic sheet. The contracting agency also notified the facility that the contracting agency nurse was immediately suspended, pending investigation, and the nurse submitted to a drug test the next morning of which the results were negative. The police were notified, and statements were gathered from other staff members.

Summary of the facility's investigation documented Resident #2 received her medications and had an adequate supply until the missing medication was replaced by the pharmacy. The contracted agency was notified and the contracted agency nurse responsible for the incorrect count was suspended by the contracting agency pending investigation. The contracted agency nurse was designated "do not return" by the facility. The medication (Oxycodone) was not located. Law enforcement, Drug Enforcement Agency (DEA), Department of Social Services (DSS), and the North Board of Nursing were notified.

A Quality Assurance and Performance Improvement (QAPI) Action Plan of the identified misappropriation of the 16 Oxycodone IR 5mg tablets was reviewed and signed by the Administrator, DON, and the Medical Director on 2/5/24.

The facility's corrective actions following the incident included: nurses, medication aides, including contract associates were educated on misappropriation of resident property/narcotic medications. The contracted agency was notified to take disciplinary action. The pharmacy was notified. The DON conducted a 100% review of

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all the facility's medication carts' narcotic drawers (carts on Hall A, 2 on Hall B, Hall C, Hall D, and Hall E) paired with the residents' individual narcotic count sheets, medication containers, and the change of shift-controlled substance count sheets. All medication carts and medication rooms were audited by the DON to ensure all medication counts were accurate. No further discrepancies were identified. The DON would report all findings of audits to the QAPI Committee monthly for 3 months for any needed improvement to prevent a reoccurrence. The date of completion was 2/6/24.

The action plan was validated by reviewing the education provided to the staff, reviewing the interviews with staff and residents, and reviewing the daily Controlled Substance Count Sheet/Card Audits. Staff were interviewed and confirmed receiving education on misappropriation of residents' property/medications. Resident #2 was discharged from the facility on 2/20/24.