STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE HEALTH AND REHABILITATION OF ASHEBORO	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 survey and complaint investigation were conducted 02/19/2024 through 02/22/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# KI6S11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation were conducted 02/19/2024 through 02/22/2024. The following intakes were investigated. NC00213620, NC00199693, NC00213129, NC00213462, NC00201891. Event ID# KI6S11. 3 of the 13 allegations resulted in a deficiency.	F 000		
F 602 SS=B	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, staff, resident and family interviews, the facility failed to protect the residents right to be free from misappropriation of a narcotic medication (Oxycodone) prescribed to treat pain for Resident #46 and Resident #47. This was for 2 of 6 residents reviewed for misappropriation. The findings included: 1a. Resident #46 was admitted on 9/14/23 with diagnoses of polymyalgia rheummatica	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 02/29/2024

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F 602	Continued From page 1	F 602		

(inflammatory disorder that causes muscle pain and stiffness) and osteomyelitis (inflammation of bone tissue that can result in an infection) to his left foot.

Review of Resident #46's Physician cumulative orders included an order dated 12/11/23 for Oxycodone 5 milligrams (mg) one tablet four times daily for pain.
Review of Resident #46's medication administration record for February 2024 documented he received his Oxycodone as ordered four times daily on 2/6/24.
1b. Resident #47 was admitted on 9/29/23 with a diagnosis of dementia.
Review of Resident #47's cumulative Physician orders included an order dated 12/19/23 for Oxycodone 5 milligrams (mg) I tablet as needed for pain.

Review of Resident #47's February medication administration record did not include any documented evidence that she received any Oxycodone during the month of February prior to 2/6/24.

An initial allegation report dated 2/6/24 documented that Medication Aide (MA) #1 discovered 3 missing Oxycodone tablets for Resident #46 on audit, 2 missing Oxycodone tablets for Resident #47.

The investigation report dated 2/12/24 documented Nurse #1 removed 3 Oxycodone tablets from Resident #46's narcotic bubble pack and 2 Oxycodone tablets from Resident #47's narcotic bubble pack. Both narcotic bubble packs were resealed with scotch tape after replacing what was later determined to be Claritin tablets.

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The investigation included interviews with nurses and medication aides who worked the week prior leading up to 2/6/24. The investigation read the police and the board of nursing were notified. Nurse #1 was met at the facility on 2/6/24 at the start of her shift by the Director of Nursing (DON) and Unit Manager #1. Nurse #1 was questioned regarding diversion of narcotics discovered on 2/6/24 and requested she perform a drug test. Nurse #1 refused and was terminated at this time.

An interview was completed with MA #1 on 2/21/24 at 2:00 PM. She stated she relieved Nurse #1 on 2/6/24 and a narcotic count was completed. There was no evidence of missing narcotics until she was preparing to administer Resident #46's schedule Oxycodone when she noticed the back of the bubble pack had been tampered with. She immediately notified the DON and Administrator.

A telephone interview was attempted on 2/21/24 at 2:50 PM with Nurse #1 with no return calls at the time of survey exit.

The DON was unavailable for interview during the survey.

An interview was completed on 2/22/24 at 9:20 AM with Unit Manager #1. She stated she assisted the DON with a completing narcotic audit on 2/6/24 which included the narcotic count logs, the medication administration records for residents who had narcotics signed out as administered and evidence of tampering of the bubble packs. She stated only two residents were affected. Unit Manager #1 stated she was present on 2/6/24 when Nurse #1 was questioned about

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the missing narcotics. She stated Nurse #1 denied the allegation and refused to be drug tested with the understanding that she would be terminated.

An interview was completed on 2/22/24 at 2:25 PM with Resident #46. He stated he did not have any untreated pain and the medication regime he was prescribed was effective. Resident #46 stated he had been questioned about his pain control earlier this month by the DON and Administrator.

An interview was completed on 2/22/24 at 2:40 PM with Resident #47 and a family member. She stated she occasionally experienced back pain but when she told the nurse, she got a pain pill that helped her back. There were no observed signs or symptoms of untreated pain during the interview with Resident #47. The family member stated there were no concerns with Resident #47's care or pain management.

An interview was completed on 2/21/24 at 3:20 PM with the Administrator. He stated when he was made aware on 2/6/24 of the tampering of Resident #46's and Resident #47's narcotics, he submitted his initial report and notified the state agency on 2/6/24. He stated the DON and Unit Manager #1 completed an audit of all narcotic medications for the correct medication count and evidence of tapering. He stated it was determined that Nurse #1 was the only staff member who worked both medication carts missing the narcotics in recent days. He stated Nurse #1 refused to submit to a drug test on 2/6/24 and was terminated. The Administrator

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stated Nurse #1 was hired in October 2023 and had already received disciplinary actions in November and in December 2023 for administering discontinued narcotics to residents. He stated an action plan also included the completion of education with the nurses and the medication aides regarding diversion and proper documentation with ongoing monitoring. He stated the investigation dated 2/12/24 substantiated the diversion of narcotics

The facility action plan dated 2/6/24 documented the immediate actions the facility took on 2/6/24 included a complete narcotic audit, interviews and pain assessments with Resident #46 and Resident #47. The action plan also read completion of the initial allegation report was forwarded to the state agency on 2/6/24. The action plan read all nurses and medication aides were interviewed for the week leading up to 2/6/24. He stated the police were also notified and notified the board of nursing. The facility replaced the diverted narcotics for Resident #46 and Resident #47 for a total of .65 cents. The action plan detailed the education was provided by the Staff Development Coordinator (SDC) to all nurses and medication aides staff regarding diversion, narcotics counts to include any evidence of tampering, documentation correctly on narcotics count sheets and medication administration records. This education was completed by 2/9/24. The facility started Quality Monitoring 5 times a week for 4 weeks on 2/6/24 to ensure there was no evidence of narcotic diversion. The audits were to be completed by the DON and SDC to include narcotic count sheets, medication administration records and any evidence of tampering with the narcotic bubble packs. An ad hoc Quality Assurance and

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F 602	Continued From page 5 Performance Improvement (QAPI) team meeting was completed on 2/6/24 to review and discuss the action plan. The results of the Quality Monitoring will be discussed at the monthly QAPI meeting and further concerns will be addressed by the team. The date of completion was 2/12/24. The action plan was validated by reviewing the education provided to the staff, reviewing the interviews with staff and residents, and reviewing the daily Quality Monitoring documentation. Residents were interviewed during the survey, and none reported untreated pain. Staff were interviewed and they had all received education narcotic diversion. The facility completion date of 2/12/24 was validated.	F 602		