STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(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 was conducted on 10/24/2024. Event ID # JSBP11. The following intakes were investigated NC00223262, NC00223116, and NC00219706. One of the three 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 review and staff interview the facility failed to protect the resident's right to be free from misappropriation of controlled medication for 1 (Resident #5) of 2 residents reviewed for misappropriation of controlled medication. Findings included: Documentation on the facility abuse, neglect, exploitation and misappropriation policies and procedures, dated as last revised on 11/16/2022, revealed misappropriation of resident property included the diversion of resident's medication, including, but not limited to, controlled substances for staff use or personal gain. The same policy and procedure indicated employees were not at any time to commit misappropriation of property against any resident. Resident #5 had diagnoses of vascular dementia,	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 10/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(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 602	Continued From page 1	F 602		

hemiplegia, and osteoarthritis.

Documentation in a quarterly Minimum Data Set assessment dated 7/27/2024 coded Resident #5 as having moderately impaired cognition and received pain medication on an as needed basis.

Documentation on physician orders for July 2024 revealed Resident #5 had an order renewed on 7/17/2024 for 5 milligrams (mg) Oxycodone HCL to be administered as one tablet by mouth every 8 hours as needed for moderate to severe pain. Oxycodone HCL is a controlled medication stored securely because it may be abused or cause addiction.

Documentation on a pharmacy shipment summary dated 7/12/2024 revealed thirty (5 mg) tablets of Oxycodone were filled and delivered to the facility for Resident #5.

There was no documentation on the July Medication Administration record for Resident #5 of her being administered Oxycodone pain medication after 7/12/2024.

An interview was conducted with Nurse #1 on 10/24/2024 at 10:27 AM. Nurse #1 revealed the following information during the interview. Nurse #1 had worked from 11:00 PM beginning on 7/17/2024 to 7:00 AM on 7/18/2024 on the hallway for which Resident #5 resided. Nurse #1 knew Resident #5 had a medication card with 30 tablets of Oxycodone in the medication cart on that shift because Resident #5 rarely requested pain medication. On the morning of 7/18/2024 at 7:00 AM, Nurse #1 counted the controlled medication in the cart with Nurse #6 and confirmed it matched the amount of medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(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 602	Continued From page 2	F 602		

documented on the declining controlled medication inventory sheets for each resident, to include the 30 tablets of Oxycodone for Resident #5. Nurse #6 worked from 7:00 AM until 11:00 PM on 7/18/2024 repeating the reconciliation of the controlled medication on the medication cart with Nurse #1 at 11:00 PM. Nurse #1 stated she counted the controlled medication for each resident on the cart while Nurse #6 confirmed the count matched the declining controlled medication inventory sheets for each resident. Nurse #1 confirmed all the controlled medication in the drawer correctly matched the declining controlled medication count sheets for each resident that evening. Nurse #6 left the facility at the end of her shift on 7/18/2024. Nurse #1 began her nursing duties and after passing out medication to residents who needed controlled medication, she noted the full card of 30 Oxycodone for Resident #5 was missing from the medication cart along with the declining controlled medication count inventory sheet for the Oxycodone for Resident #5. Nurse #1 stated she immediately notified the evening shift supervisor, Nurse #3, and they together searched the likely places the Oxycodone for Resident #5 may have been placed along with the corresponding declining controlled medication inventory sheet. Nurse #3 called the Director of Nursing (DON). Nurse #1 stated they were instructed by the DON to tell the morning shift supervisors so the pharmacy and Nurse #6 could be contacted to locate the 30 Oxycodone. In the morning Nurse #1 and Nurse #3 informed Nurse #2 and Nurse #4 of the missing Oxycodone for Resident #5. Nurse #1 further revealed she was drug tested prior to leaving on the morning of 11/19/2024.

The evening shift supervisor, Nurse #3, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	**6590 TRYON ROAD CARY, NC 27518**

(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 602	Continued From page 3	F 602		

interviewed on 10/24/2024 at 1:02 PM. Nurse #3 confirmed Nurse #1 let him know on the 11:00 PM to 7:00 AM shift that began on 7/18/2024 of the missing Oxycodone medication card and declining controlled medication inventory sheet for Resident #5. Nurse #3 confirmed they looked everywhere for the medication and could not find it, so they notified the Director of Nursing. Nurse #3 also stated he notified the morning shift supervisors on 7/19/2024 so the pharmacy could be contacted along with Nurse #6.

Nurse #2 and Nurse #4 were simultaneously interviewed on 10/24/2024 at 1:52 PM. The following information was revealed. On the morning of 7/19/2024 Nurse #1 notified Nurse #2 of the missing 30 tablets of Oxycodone for Resident #5 and the missing corresponding declining controlled medication inventory sheet. Nurse #2 knew the 30 tablets of Oxycodone could not have been administered to Resident #5 because she very rarely complained of pain. Nurse #1 was drug tested prior to leaving at the end of her shift on 7/19/2024 and the test came back negative. Nurse #2 called the pharmacy and confirmed the Oxycodone was not sent back to the pharmacy. Nurse #2, along with Nurse #4, called Nurse #6 because she was the only nurse to have control of the medication cart prior to Nurse #1. Nurse #2 requested Nurse #6 come back to the facility to help find the missing Oxycodone for Resident #5, and Nurse #6 initially agreed she would. Nurse #6 did not call back or come to the facility and after half an hour had passed, Nurse #2 and Nurse #4 again called Nurse #6. Nurse #6 relayed to Nurse #2 and Nurse #4 she would call back later because she was talking to her family. Nurse #4 stated Nurse #6 called her back and while on the speaker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(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 602	Continued From page 4	F 602		

phone admitted she was taking responsibility for taking the Oxycodone from the cart. Nurse #2 and Nurse #4 requested Nurse #6 bring the Oxycodone back to the facility but were told by Nurse #6 she was unable to do so. Nurse #2 and Nurse #4 relayed to Nurse #6 the consequences for her actions involved notification of the police, the board of nursing, and state officials as well as likely termination of her employment.

Nurse #6 was interviewed on 10/24/2024 at 2:52 PM and provided the following information. Nurse #6 confirmed she removed the medication card with 30 Oxycodone for Resident #5 along with the corresponding declining controlled medication inventory sheet from the building. Nurse #6 called the Board of Nursing letting them know of her actions and was currently working with the Board of Nursing to seek help. Nurse #6 confirmed she was contacted by the police as well but, only on one occasion about the diversion of the medication.

The DON was interviewed on 10/24/2024 at 1:02 PM. The DON confirmed she was called by Nurse #3 on 7/18/2024 after 11:00 PM letting her know a controlled medication card for Resident #5 was missing. The DON related she told Nurse #3 to have the day shift supervisors, Nurse #2 and Nurse #4, call the pharmacy in the morning and Nurse #6 to help locate the missing medication. The DON also confirmed Nurse #2 let her know in the morning on 7/19/2024 of the confession of Nurse #6 to diversion of the controlled medication. The DON said the diversion of the medication was reported to the state offices of health and human services, the board of nursing, the police, and the pharmacy. The DON said an immediate corrective action plan was started on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(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 602	Continued From page 5	F 602		

7/19/2024. The DON felt the diversion of the narcotic by the trusted employee was unexpected and has not happened again since that occasion in July.

The facility provided the following action plan with a completion date of 7/20/2024.

1. Corrective action for resident's affected by the alleged deficient practice:
On 7/19/2024 upon learning of the missing Oxycodone, the Unit Managers notified the Director of Nursing and the Facility Administrator/Executive Director. Nurse #6, who was assigned to Resident #5 and the cart for the prior 16-hour shift (7:00 AM to 11:00 PM) on 7/18/2024 was called to come into the facility. Nurse #1 who was assigned to Resident #5 for the 11:00 PM to 7:00 AM shift ending on 7/19/2024 was drug tested and the test was negative. After 30 minutes without arrival or contact from Nurse #6, the Unit Manager reached back out to her, and she stated that she would be on her way shortly but was speaking with her family. Approximately 15 minutes later, Nurse #6 confessed that she took both the card of Oxycodone and the declining controlled medication inventory sheet. The Facility Administrator notified the North Carolina Board of Nursing, local police department, and submitted an allegation of drug diversion to North Carolina Division of Health and Human Services. The facility pharmacy was contacted, and the Oxycodone for Resident #5 was replenished by the facility. It was confirmed Resident #5 had not suffered any negative outcome as a result of the missing narcotic. The Medical Director, the clinical team, and the responsible party for Resident #5 were all notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(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 602	Continued From page 6	F 602		

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
A full audit of all declining controlled medication inventory sheets was reconciled with controlled medication of all residents on 7/19/2024 to ensure no other discrepancies. On 7/19/2024 a quality review was conducted by the unit managers/designee of the manifest from the pharmacy from 7/1/2024 until current to validate all controlled medications were accounted for to confirm the medication was present, sent back to the pharmacy, sent home with the resident, or administered to the resident with none remaining. Interviews and statements were obtained from all nurses that administered medication about missing controlled medications. Pain assessments were completed on 7/19/2024 on current residents to ensure pain medication was being received and pain was being controlled.

3. Measures/systematic changes to prevent reoccurrence of deficient practice:
Education was provided to all staff on all shifts by the unit managers on 7/19/2024 on the abuse policy with emphasis on misappropriation of resident property. Education was provided on 7/19/2024 by the unit managers to all licensed nursing staff on the drug diversion policy, the acceptance of controlled drugs upon arrival from the pharmacy, the controlled drug count, controlled drug disposal and wasting, and managing a drug diversion. All the licensed nurses signed the zero-tolerance policy of misappropriation of medications on 7/19/2024 which detailed the expectation and the consequences for non-compliance. Staff and Licensed Nursing staff were not allowed to work

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(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 602	Continued From page 7	F 602		

until education about misappropriation of resident property and/or drug diversion was provided.

On 7/19/2024 the Executive Director presented the allegation of diversion of medication, plan, education, and findings to Quality Assurance Performance Improvement (QAPI) committee members in an ad hoc meeting.

The Executive Director and the Director of Nursing and/or Nursing Supervisor oversee the Quality Improvement Monitoring. The Director of Nursing or Nursing Supervisor will complete Quality Improvement monitoring on medication carts 2 times weekly for 4 weeks then weekly for 12 weeks to ensure all medications are accounted for with count correct with nurses counting and documenting total cards and total count sheets. The Quality Improvement Monitoring was started on 7/19/2024.

The results of the Quality Improvement Monitoring were reported to the QAPI committee by the Executive Director and/or Director of Nursing to ensure compliance was achieved and maintained monthly for three months and then quarterly for two quarters. The QAPI committee members consisted of but were not limited to the following members of the Interdisciplinary team: Executive Director/Administrator, Director of Nursing, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director, and Minimum Data Set Assessment Nurse and at least one direct care staff member.

The correction date was 7/20/2024.

The facility corrective action plan was reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	**6590 TRYON ROAD CARY, NC 27518**

(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 602	Continued From page 8 on 10/24/2024. Interviews with nursing staff confirmed all staff were provided with training on abuse policies and procedures for misappropriation of resident property. Interviews with the licensed nursing staff confirmed re-education was provided on entire process of documentation and handling of controlled medication from the receipt of medication from the pharmacy to the storage, disposal, administration, or return of medication to the pharmacy. Licensed nursing staff interviews also confirmed each was required to sign a copy of the diversion of drugs zero-tolerance policy. Monitoring tools, staff education, and performance improvement plan were reviewed. The corrective action plan was verified as completed on 7/20/2024.	F 602		