STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	**619 LAUREL LAKE DRIVE COLUMBUS, NC 28722**

(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) COMPLETE DATE
L 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted from 11/18/24 through 11/20/24. Event ID# 7X6S11. The following intakes were investigated: NC00208598 and NC00215311. 2 of the 2 complaint allegations resulted in deficiency.	L 000		
L 049	.2210(A) REPORTING, INVESTIGATING ABUSE, NEGLECT 10A-13D.2210 (a) A facility shall take measures to prevent patient abuse, patient neglect, or misappropriation of patient property, including orientation and instruction of facility staff on patients' rights and the screening of and requesting of references for all prospective employees. This Rule is not met as evidenced by: Based on observations, record review, and Medical Director, resident and staff interviews, the facility failed to prevent an employee from utilizing a resident's personal finances for personal gain (Resident # 65) and failed to protect residents' right to be free from misappropriation of controlled medications (Resident #63, Resident #68, and Resident #69) for 4 of 4 residents reviewed for misappropriation of resident property. Findings included: 1. Resident #65 was admitted to the facility on	L 049	Upon notification of the two missing credit cards, investigation started immediately. Initial allegation (24 hour) report sent to the Healthcare Personnel Registry (9/29/2023), Polk County Sheriff�s Department contacted and deputy on campus to file report (9/29/2023). On 9/29/2023, audit conducted of alert and oriented residents residing on assisted living. Audit included complaints of missing items and feeling of security. Audit conducted by the administrator and the sheriff�s deputy.	12/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ____ B. WING ____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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L 049	Continued From page 1 07/13/22. A Resident Status and Health History Quarterly Nursing Assessment dated 10/02/24 revealed Resident #65 was alert and oriented. Review of the facility's investigation report dated 10/04/23 revealed on 09/29/23 the facility became aware of an allegation of misappropriation of property for Resident #65 and an investigation was initiated. The report revealed in part, Resident #65 reported she noticed two credit cards were missing from her room "a while ago" and did not report it because she thought she had misplaced them. "[Resident #65] stated she kept the cards in the dresser in her bedroom but took them out and placed them on the table bedside her recliner to take to an appointment with her. The next morning, she cancelled the appointment and didn't think of the cards again. When the credit card statements arrived, they realized that both cards had been used at a [retail store] with approximately $500 charged on each card." The report revealed the accused employee was identified as Nurse Aide (NA) #1. A review of NA #1's employee file revealed she had been screened before hire and on upon hire, she completed training modules on abuse, neglect and exploitation. During a telephone interview on 11/18/24 at 2:56 PM, NA #1 confirmed she had taken two credit cards from Resident #65's room, without Resident #65's consent, and made purchases totaling approximately $500 on each card. When asked why she had taken Resident #65's credit cards without her consent, NA #1 stated at the time, she was off her medication and was having a manic episode which caused her to not think	L 049	Education on policy of misappropriation of resident□s property started on 9/29/2023 for staff on assisted living by the nursing home administrator (NHA) and director of assisted living (DAL). Education was completed on 10/20/2023. This education is also conducted annually and on hire. Re-education on the policy of misappropriation of resident property to be conducted for staff on assisted living. Re-education will be provided by the nursing home administrator and completed by 12/17/2024. Staff will not be allowed to work after this date until education is completed. Education is also received upon hire, annually and as needed. Residents on assisted living will be notified of the availability of lock boxes, at their request, during the next resident council meeting on 12/12/2024. Audits will be conducted with three alert and oriented residents, to include interviews asking about missing items and misappropriation. Audits will occur three times weekly for two weeks, then weekly for 4 weeks, then randomly and conducted by the NHA and DAL. Results from these audits will be presented at the January 2025 and April 2025 quality assurance meetings. Completion date 12/17/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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L 049	Continued From page 2 clearly or make good decisions. During a telephone interview on 11/20/24 at 9:40 AM, the Law Enforcement Captain stated he spoke with NA #1 and she had admitted to taking the two credit cards from Resident #65 without consent and making purchases on both credit cards with a combined total of $1,021.24. He stated NA #1 never gave a reason as to why she took the credit cards from Resident #65, just that she did. He stated charges against NA #1 were filed, warrants for arrest were issued and NA #1 turned herself in to law enforcement. During an interview on 11/19/24 at 2:34 PM with the Director of Nursing present, the Administrator revealed she received a grievance report on 09/29/23 regarding Resident #65 reporting two credit cards were missing from her room and an investigation was initiated. The Administrator recalled Resident #65 could not recall the last time she had seen the credit cards only that she had taken them out of the drawer where they were kept to take with her to an appointment but then the appointment was cancelled and she forgot about the credit cards. The Administrator stated Resident #65 did not realize the credit cards were missing and thought she had just misplaced them until her family member received the credit card statements and noticed charges had been made on both cards at a retail store approximately one month prior (08/2023) to her reporting them missing on 09/29/23. The Administrator stated on 10/02/23 while the facility investigation was ongoing, NA #1 voluntarily came to her office and confessed to taking the two credit cards without Resident #65's consent but never provided a reason why. She stated NA #1 was immediately suspended. The Administrator stated based on NA #1's	L 049		

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	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 3	L 049		

confession, the allegation of misappropriation of property was substantiated and NA #1's employment was officially terminated on 10/04/23.

2. The facility's Abuse, Neglect, or Misappropriation of Resident property policy, last revised on July 31, 2023, revealed in part the facility would safeguard and protect all residents from any form of abuse or misappropriation of their property.

Resident #63 was admitted to the facility on 09/18/23 with diagnoses including low back pain and fibromyalgia. She expired in the facility on 04/12/24.

A review of the physician's order dated 03/18/24 revealed Resident #63 had an order to receive 0.5 milliliters (ml) of liquid morphine sulfate 100 milligrams (mg)/5 ml once every 1 hour as needed for pain or short of breath.

The quarterly Minimum Data Set (MDS) dated 03/21/24 coded Resident #63 with an intact cognition.

A review of the pharmacy delivery receipt dated 03/27/24 revealed the pharmacy had delivered 2 bottles of liquid morphine sulfate (an opioid analgesic for the relief of moderate to severe acute and chronic pain) 100 mg/5 ml that contained 15 ml in each bottle for Resident #63. These 2 bottles of liquid morphine sulfate were received and signed by Nurse #6.

The medication administration records (MARs) revealed Resident #63 had received 1 doses of liquid morphine sulfate 2 times as needed on 03/27/24 and 03/28/24, and 3 times as needed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 4	L 049		

03/29/24. The MAR did not indicate she had received any morphine on 03/30/24.

A review of the staffing roster and MARs revealed Nurse #2, Nurse #3, Nurse #4, Nurse #6, and Nurse #7 had access to Resident #63's liquid morphine sulfate from 03/27/24 through 03/30/24 with the following timelines:

- 03/27/24 at 10:40 PM, Nurse #6 signed and received the pharmacy delivery including 2 bottles of liquid morphine sulfate. She passed the 2 bottles of liquid morphine sulfate to Nurse #7 immediately.
- 03/27/24 at 11:00 PM, Nurse #6 conducted a shift change narcotic count with Nurse #7 before taking over the medication cart.
- 03/27/24 from 11:00 PM to 03/28/24 7:00 AM - Nurse #6 had access to the medication cart.
- 03/28/24 from 7:00 AM to 11:00 PM, Nurse #3 had access to the medication cart.
- 03/28/24 from 11:00 PM to 03/29/24 7:00 AM, Nurse #6 had access to the medication cart.
- 03/29/24 from 7:00 AM to 3:00 PM, Nurse #3 had access to the medication cart.
- 03/29/24 from 3:00 PM to 11:00 PM, Nurse #4 had access to the medication cart.
- 03/29/24 around 11:00 PM, Nurse #2 relieved Nurse #4 and noticed that one bottle of liquid morphine sulfate that should contain 15 ml was almost emptied during the shift change narcotic count.

The initial allegation report dated 03/30/24 revealed the facility became aware of the misappropriation of residents' property on 03/30/24 at 12:44 AM. The incident was reported by the Administrator to the Division of Health Services Regulation (DHSR) on the same day at 12:00 noon. A bottle of liquid morphine sulfate for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ________ B. WING ________	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 5	L 049		

Resident #63 containing 15 ml was noted to be empty during a shift change narcotic count. Resident #63 had another bottle of liquid morphine sulfate for use when the incident occurred. Investigation was initiated by the Director of Nursing (DON) immediately. The Medical Director (MD) and Resident #63 were notified of the incident on 03/30/24.

The 5-day investigation report dated 04/02/24 revealed once the DON was notified of narcotic count discrepancies related to Resident #63's liquid morphine sulfate, she conducted narcotic reconciliation for all the controlled medications in the facility immediately without identifying any additional discrepancies. The DON interviewed all the nurses working from the time of receiving the medication until the incident occurred. However, she was unable to determine the person responsible for the missing liquid morphine and the allegation of drug diversion was unsubstantiated. The Administrator filed the investigation report to the local law enforcement, North Carolina Board of Nursing (NCBON), and DHSR.

During a phone interview conducted on 11/19/24 at 2:11 PM, Nurse #3 stated the 2 bottles of liquid morphine sulfate were delivered from the pharmacy on 03/27/24 evening. She had access to the medication cart when she worked on 03/28/24 and 03/29/24. During the shift change narcotic counts, she recalled seeing 2 bottles of liquid morphine sulfate in its box and assumed they were intact, sealed, and untampered. When the DON called her on 03/30/24 asking her about the incident, she admitted that she did not check both bottles of liquid morphine sulfate and assumed they were intact during shift transition. She stated she was being reprimanded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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L 049	Continued From page 6	L 049		

A phone interview was conducted with Nurse #4 on 11/19/24 at 3:06 PM. Nurse #4 stated when she took over the medication cart from Nurse #3 at shift change 03/29/24, she did not open the boxes that contained liquid morphine sulfate during shift change narcotic count as there was already an opened bottle of liquid morphine sulfate in use for Resident #63. She assumed both bottles were intact and untampered. When Nurse #2 opened the 2 boxes of liquid morphine and checked the content, one of the bottles was opened and almost emptied, with less than 1 ml remaining. The bottle had been tampered as the manufacturer's seal was missing and an adapter was seen inserted on the top of the bottle. The adapter that came with the liquid morphine sulfate remained unused in the box. Nurse #4 stated she did not have any reasons to steal Resident #63's pain medication. She offered a drug screening or lie detector test and was declined by the DON.

A phone interview was conducted with Nurse #2 on 11/19/24 at 1:53 PM. She stated she was assigned to work third shift (11:00 PM to 7:00 AM) and relieved Nurse #4 who had worked the second shift (3:00 PM to 11:00 PM) on 03/29/24. During the shift change narcotic count, she found that one bottle of Resident #63's liquid morphine sulfate had been opened. The bottle that should contain 15 ml had less than 1 ml left. It was sitting in the box with the cap on, but the seal had disappeared. The bottle had a stopper on the top while its own stopper and syringe remaining unused in the box. She called the Assistant Director of Nursing (ADON) to report the incident immediately.

During a phone interview conducted on 11/19/24 at 3:32 PM, Nurse #6 recalled receiving the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 7 medications delivered from the pharmacy on 03/27/24 evening around 10:40 PM. She signed the pink form (pharmacy delivery receipt) and passed the medications to Nurse #7 after completing the receiving process. As she was assigned to relieve Nurse #7 at 11:00 PM that night, she conducted a shift change narcotic count with Nurse #7 without opening the 2 boxes of liquid morphine sulfate. Later, she counted the 2 boxes of liquid morphine with Nurse #3 during the next shift change narcotic count without opening the boxes. Then, she left the facility on 03/28/24 in the morning. When she came back to work again on 03/28/24 in the evening, she counted the liquid morphine sulfate with Nurse #3 without checking the seals or pulling out the bottles from the boxes to ensure they were untampered. Nurse #6 stated she should have pulled the bottles out of the boxes and checked the seals during shift transitions. A phone interview was conducted with Nurse #7 on 11/19/24 at 4:37 PM. She recalled Nurse #6 passed 2 bottles of liquid morphine sulfate that were tightened up with rubber bands to her on 03/27/24 before 11:00 PM. She did not check or open the boxes before putting them into the medication cart. She stated she should have pulled the bottles out of the boxes and checked the seals to ensure they were not tampered. She did not work any other shifts after 03/27/24 night until she heard about the incident on 03/30/24. During an interview conducted on 11/20/24 at 10:08 AM, the DON stated the stopper that was left on top of the bottle of liquid morphine sulfate indicated that someone had deliberately stolen the pain medication. She went back to the facility immediately after the incident was reported and started the investigation. She traced all the way	L 049		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 8	L 049		

back to the night of delivery and receiving. None of the nurses involved admitted any wrongdoing. One of the nurses even offered to have a drug screening or lie detector test. She notified the pharmacy immediately after the incident. The pharmacy's internal investigation that included all the pharmacy staff and the delivery driver did not identify any wrongdoing along the processes from dispensing, packaging, delivery, and receiving. The facility unsubstantiated the allegation of drug diversion and started a new tracking protocol for controlled medications.

During a phone interview conducted on 11/20/24 at 11:28 AM, the Pharmacy Manager stated he was not with the pharmacy when the incident occurred on 03/30/24. He explained all the controlled medications were dispensed, packaged in a specified area in the pharmacy under the closed-circuit camera system. Only the authorized staff were allowed to be there. After all the controlled medications were dispensed, they would be labeled, packaged, put into a sealed plastic tote, and delivered by the pharmacy's own drivers to the facility.

During an interview conducted on 11/20/24 at 12:33 PM, the Administrator stated nurses in the facility did not have access to the stoppers in the building. She felt that the opened liquid morphine sulfate could have been tampered before leaving the pharmacy. However, she could not prove it as the nursing staff did not check the bottles when receiving the shipment. She called the pharmacy and was told that the shipment was secured as the totes were locked when the medications left the pharmacy.

The facility provided the following corrective action plan with a completion date of 07/15/24:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 9	L 049		

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
During shift change narcotic count on 03/30/24, a bottle of morphine sulfate (15ml) was noted to be empty. The bottle should have been full and sealed. The nurses assumed the box was sealed and the bottle unopened and they did not take the bottle out of the box and check for multiple shifts. The Director of Nursing was immediately notified and came to the facility to begin an investigation. The resident was assessed with no signs of distress or uncontrolled pain. The Director of Nursing reviewed the narcotic sign out log, and the electronic medication administration record, and confirmed that the resident did not miss any medication doses. She was using an open bottle, and the empty bottle was the backup medication.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
When the Director of Nursing arrived at the facility, she conducted a 100% audit of all narcotics, with no other discrepancies identified. A review of shift-to-shift narcotic counts completed from the time the bottle of morphine arrived at the facility, until it was observed empty. The morphine arrived at the facility and signed the cart on 03/27/24. The bottle and the box were both labeled correctly with 03/27/24, for the correct resident. The bottle had a stopper in it and was empty. The information packet, a clean stopper, and clean syringe were also in the box. All nurses identified from shift-to-shift count were interviewed and statements obtained. Interviews and statements revealed that the nurses were inconsistent in opening the box to check the liquid inside during shift-to-shift counts. They assumed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ___ B. WING ___	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 10	L 049		

it was a new, sealed bottle. Report was filed with local Sheriff's Department and initial allegation (24-hour report) was filed to the Healthcare Personnel Registry per regulation. All residents were assessed for pain and vital signs, and they were within the normal limits. Resident #63, the Responsible Party, and Medical Director were notified.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
Education was immediately started for all nurses on the correct process of counting narcotics and diversion. 100% of nurses were educated on narcotic count and diversion, including administrative nurses. This education included proper check in procedures with pharmacy regarding narcotics, checking all narcotics at shift change and not assuming a closed box means a sealed bottle, protecting oneself against allegations of diversion, process of reporting incorrect narcotic counts, investigation procedures, and the facility's policy on controlled substances. Competencies completed on 100% of nurses that work on a medication cart. Competencies included observation of correct narcotic count procedures. These education and competencies were completed between 3/30/2024 and 4/27/2024, ensuring to include nurses who work as needed, or were on vacation. Nurses were not allowed to work until education and competencies were completed. New hires receive this education and training during their orientation process.

Progressive discipline issued for the nurses identified of not following the policy on narcotic reconciliation. New "controlled substance inventory sheet" implemented. Contacted the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ____ B. WING ____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 11 Pharmacy to schedule audits and medication observation to be completed with nurses on 05/20/24. The performance improvement plan initiated to monitor its effectiveness. After the investigation (5-day) was concluded, the results were sent to the Healthcare Personnel Registry. Not enough evidence to substantiate a drug diversion. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Narcotic reconciliation audits were conducted twice weekly for two weeks, weekly for four weeks, monthly for two months, and then randomly. The audits were conducted by the Director of Nursing, Assistant Director of Nursing, and Registered Nurse Supervisor on all shifts, including weekends. The audit included observation of shift-to-shift narcotic counts, assuring bottles were checked and not just looking at boxes, and counting refrigerated narcotics. Education and competencies proved successful in identifying any discrepancies. Education, competencies, audits, and performance improvement plan reviewed during Quality Assurance and Performance Improvement Committee meeting on 4/10/2024 and 7/10/2024. Compliance Date: July 15, 2024 3. Resident #68 was admitted to the facility on 10/07/19 with diagnoses including right shoulder pain. A review of the physician's order dated 05/15/23 revealed Resident #68 had an order to receive 1 tablet of tramadol (a narcotic-like synthetic pain	L 049		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 12	L 049		

Continued From page 12

reliever that treated moderate to severe chronic pain) 50 mg 3 times daily for right shoulder pain.

The quarterly MDS dated 04/17/24 coded Resident #68 with severely impaired cognition.

A review of the MARs revealed Resident #68 had received 1 tablet of tramadol 3 times daily throughout May 2024 including 05/14/24 and 05/15/24.

Resident #69 was admitted to the facility on 07/13/23 with diagnoses including chronic pain syndrome.

A review of the physician's order dated 02/28/24 revealed Resident #69 had an order to receive 1 tablet of Norco (a combination medication consisting of an opioid pain reliever hydrocodone and a non-opioid pain reliever acetaminophen for relieve of moderate to severe pain) 7.5/325 mg once every 6 hours for pain.

The quarterly MDS dated 04/16/24 coded Resident #69 with intact cognition.

A review of the MARs revealed Resident #69 had received 1 tablet of Norco 7.5/325 mg 4 times daily throughout May 2024 including 05/14/24 and 05/15/24.

A review of the narcotic declining count sheet revealed Resident #68 had received 30 tablets of tramadol from the pharmacy on 04/13/24. The narcotic count sheet was consistent with the MARs until 05/14/24. During the shift change narcotic count on 05/14/24 morning, Resident #68 should have 10 tablets of tramadol remaining in the blister cart according to the narcotic count sheet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 13	L 049		

The narcotic declining count sheet revealed Resident #69 had received 30 tablets of Norco 7.5/325 mg from the pharmacy on 05/07/24. The narcotic count sheet was without discrepancies compared with the MARs until 05/14/24.

The initial allegation report dated 05/14/24 revealed the facility became aware of the misappropriation of residents' property on 05/14/24 at 7:45 AM. The incident was reported by the Administrator to DHSR on the same day at 3:00 PM. The DON was notified in the morning on 05/14/24 that the narcotic count sheet was incorrect at shift change for 2 residents. A total of 2 tablets of tramadol and 1 tablet of Norco were missing. Nurse #1 who was working the shift, was unable to explain what had happened. During investigations, it was noted that 2 tablets or Norco had been wasted by Nurse #1 on the same shift. The sharp container search revealed only 1 tablet of Norco was found. Nurse #1 was suspended pending investigation.

The 5-day investigation report dated 05/20/24 revealed Nurse #1 was slow to respond to the questions, having no emotion, and taking a long pause before answering questions on 05/14/24 morning after the incident. She was unable to clarify what had happened to the missing medications but consistently denied taking any medication from the facility. All the residents in the facility were monitored for increased pain or sedation due to the inability of the facility to confirm the location of those missing medications. No issues were reported according to the observation and monitoring.

An attempt to conduct a phone interview with Nurse #1 on 11/19/24 at 1:46 PM was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ________ B. WING ________	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 14	L 049		

unsuccessful. She did not return the call.

During a phone interview conducted on 11/19/24 at 3:32 PM, Nurse #5 stated she came to the facility around 7:00 AM on 05/14/24 to relieve Nurse #1. When they performed narcotic count during shift transition, she recalled Nurse #1 holding a cup and stated it contained 2 tablets of contaminated Norco 7.5/325 mg and tossed it into the sharp container before she had a chance to verify them. She was upset and planned to report the incident to the Unit Manager (UM) later. In the meantime, she continued the narcotic counting with Nurse #1. When they came to a blister card of tramadol for Resident #68, the narcotic count sheet was not in the binder with other narcotic count sheets. Nurse #1 was unable to give her a meaningful answer when she asked for the whereabouts of the narcotic count sheet. Nurse #5 was not sure if the count sheet was hidden purposely by Nurse #1. Nurse #5 found the missing narcotic count sheet later in a drawer inside the medication room. The narcotic count sheet indicated a balance of 10 tablets of tramadol should be in the blister card. However, she only found 8 tablets in the blister card. When she asked Nurse #1 about the 2 missing tablets of tramadol, she stated she had wasted both tablets. Nurse #5 notified the findings to the UM immediately. Nurse #5 stated Nurse #1 was okay when she passed over the shift to her about 12 hours ago on 05/13/24 evening. However, Nurse #1 appeared to be confused during the incident on 05/14/24 in the morning.

An interview was conducted with Resident #69 on 11/20/24 at 8:43 AM. She recalled the incident that happened in mid-May and stated she was notified of the incident, and the staff assessed her pain level on the same day. She denied having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 15	L 049		

any problems getting her pain medications so far and added the facility replaced and paid for her missing pain medications after the incident.

An attempt to conduct an interview with Resident #68 on 11/20/24 at 8:48 AM was unsuccessful. She was unable to answer questions.

During an interview conducted on 11/20/24 at 9:48 AM, the UM stated Nurse #5 texted her on 05/14/24 morning as she could not find the narcotic count sheet for Resident #68's tramadol. She and Nurse #5 searched all over the nurse station and finally found the missing narcotic count sheet in the medication storage room. A quick review of the count sheet revealed 2 tablets of tramadol were missing. Nurse #1 was unable to explain and did not try to explain why and what had happened. She recalled Nurse #1 had a flat affect, and she could not confirm whether she was under any drug influence at that time. When Nurse #5 mentioned she did not have a chance to verify the 2 tablets of Norco that Nurse #1 tossed into the sharp container in front of Nurse #5, she took a peek into the sharp container and could not see any pills inside. Then she called the DON immediately.

An interview was conducted with the DON on 11/20/24 at 10:08 AM. She recalled when she called Nurse #1 on 05/14/24 after the incident, she had a slurred speech and was slow to respond to her questions. When Nurse #1 mentioned she dropped 2 tablets of Norco on the floor and were wasted in the sharp container, she opened the sharp container with the help of the maintenance staff. There were 7 pills in the sharp container and all the pills were Tylenol except for 1 tablet of Norco. She called Nurse #1 again and she was unable to explain why and what had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 16	L 049		

happened. The DON denied Nurse #1 had separated the narcotic count sheet for tramadol purposely and explained Nurse #1 could have pulled the wrong sheet and put it at the right spot for finished controlled medications. She stated the facility might have medication errors and indicated if a nursing staff planned to divert controlled medications, they would not choose tramadol but something stronger. She explained the missing 2 tablets of tramadol might have been given by Nurse #1 to residents in the facility by mistake, and the missing 1 tablet of Norco could have been wasted and tossed in the trash but not the sharps container.

An interview was conducted with the MD on 11/20/24 at 10:35 AM. He stated he was notified of the incidents on 04/01/24 and 05/14/24 respectively and provided with the name of the residents affected. He stated Resident #63, # 68, and #69 were assessed immediately without any adverse consequences noted as the facility had adequate supply of the missing narcotic medications. He added all the missing medications were replaced and paid for by the facility later. It was his expectation for all the nursing staff to follow the facility's protocol to count and verify controlled substances when receiving them from the pharmacy or during a shift transition.

The facility provided the following corrective action plan with a completion date of 08/12/24:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
Narcotic reconciliation performance improvement plan proved successful on 05/14/24. During shift-to-shift narcotic count, two tramadol were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ____ B. WING ____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 17	L 049		

noticed missing from one resident's medication card. The off-going nurse was unable to communicate clearly what happened to medication during her shift. The Director of Nursing was immediately notified. The suspected nurse was suspended, pending the investigation. The identified resident was assessed for pain with no complaints. Her morning dose of tramadol was signed out as given on the narcotic sheet and the medication administration record. Missing medications were worth a nominal amount, and the facility paid to replace them.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
When the Director of Nursing arrived at the facility, she conducted a phone interview with the suspected nurse. The Director of Nursing noted that the suspected nurse had moments of slurred speech. She was unable to communicate what occurred with the tramadol. Before she left her shift, she wrote a statement mentioning Norco, which was not missing. Stated she had previously dropped two Norco on the floor, and wasted them in the sharps container, with the oncoming nurse. The oncoming nurse confirmed that two white pills, appearing to be Norco, were wasted during the shift-to-shift count. The Director of Nursing checked the sharps container, and only one Norco was present, and several Tylenol, which were the same shape, size, and color of Norco. No tramadol was noted in sharps container. 100% audit of all narcotics completed with no other discrepancies noted. Identified two missing tramadol and one Norco. Report filed with the local Sheriff's Department and initial allegation (24-hour report) filed with the Healthcare Personnel Registry per regulation. The affected residents, the Responsible Party, and the Medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ____ B. WING ____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	**619 LAUREL LAKE DRIVE COLUMBUS, NC 28722**

(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) COMPLETE DATE
L 049	Continued From page 18	L 049		

Director were all notified. All the residents were assessed for unusual pain, lethargy, sedation, and vital signs, and all within normal limits.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
Education immediately started for all nurses on the correct process of counting narcotics and on diversion. 100% of nurses were educated on controlled substance policy, including proper wasting of narcotics. This education was completed between 05/14/24 and 05/31/24, ensuring to include nurses who worked as needed, or were on vacation. Nurses were not allowed to work until the education was complete. The Pharmacy conducted cart audits and observed medication administration on 05/20/24, as previously scheduled. New hires receive this education and training during their orientation process.

The performance improvement plan was updated to extend the audits and include daily medication pass observations for one week on all shifts, including weekends, to ensure compliance. The audits were conducted by the Director of Nursing and Registered Nurse Supervisor.

On 05/20/24, another nurse (unrelated to this investigation) confided in the Director of Nursing that the suspected nurse was currently undergoing ketamine treatments, and the day post treatment caused her to experience unpredicted behavior changes.

The facility reviewed the investigation with the North Carolina Board of Nursing via Teams. It concluded that there was no credible evidence that diversion occurred, and it was unnecessary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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L 049	Continued From page 19	L 049		

to file a report to the North Carolina Board of Nursing. The local Sheriff's Department also concluded that there was no credible evidence to pursue diversion charges.

The suspected nurse was offered a personal leave (due to as needed job status, not eligible for Family Medical Leave Act) and offered support through our employer Carebridge Mental Health program. She would require a medical release to return to work.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Narcotic reconciliation audits were conducted twice weekly for two weeks, weekly for four weeks, monthly for two months, and then randomly. It was continued as with the previous performance improvement plan, on a monthly schedule, as this was an effective process. The audits were conducted by the Director of Nursing and Assistant Director of Nursing on all shifts, including weekends. Daily audit conducted for seven days that included observation of medication administration, proper narcotic and electronic medication administration record documentation. Audit conducted by the Director of Nursing and Registered Nurse Supervisor, including all shifts and weekends. This was not identified as a pattern, as the previous performance improvement plan was successful in identifying this isolated narcotic discrepancy. Ad hoc Quality Assurance and Performance Improvement committee meeting conducted on 05/15/24. Education, performance improvement plan update, and audits reviewed during Quality Assurance and Performance Improvement meeting on 07/10/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 20	L 049		

Compliance Date: August 12, 2024

The facility's corrective action plan with a correction date of 08/12/24 was validated onsite by observations and interviews with the DON and nursing staff.

An observation was conducted when a nurse was receiving medications delivered from the pharmacy. The nurse checked each medication by matching the name of medication, strength, quantity, and expiration date before signing the pink sheet. The delivery did not include any controlled medications in the liquid form. No concerns noted.

An observation was conducted during a shift transition for a medication cart between 2 nurses. Nurses started by counting the total number of blister cards that contained controlled medications in thedouble-locked compartment in the medication cart and verified the balance in the narcotic count sheet. Then, they counted each blister card of controlled medication to ensure the quantity listed in the narcotic count sheet was consistent with the actual counts. All the liquid controlled medications were pulled from the box to ensure it was untampered and the volume of liquid consistent with the narcotic count sheet. After all the counts were completed without any issues, the incoming nurse signed the controlled medication count sheet before the outgoing nurse passed the medication cart key to her.

Medication pass observations were conducted from 11/18/24 to 11/19/24. It consisted of 25 medications, 6 different residents, and 2 different Nurses. The nurses were observed storing controlled medications in the double-locked compartment in the medication cart, documenting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 21	L 049		

the retrieval of controlled medication according to the facility's protocol, and using the correct technique as ordered when administering controlled medications. No medication errors were identified during the observation.

Nursing staff confirmed they had received in-service trainings related to controlled substance policy and procedures, including proper wasting of narcotics, correct process of counting narcotics, proper check in procedures with pharmacy regarding narcotics, appropriate process to count all narcotics at shift change, protecting oneself against allegations of diversion, and process of reporting incorrect narcotic counts. Nursing staff were assigned to review the policy and procedures handout prior to the training. The training was conducted in-person by DON and ADON, and it included multiple examples and scenarios.

Interview with the DON revealed she launched an in-service immediately after the first incident to re-educate all the licensed nurses about proper receiving procedures with delivery from the pharmacy, proper procedures to check all controlled medications during shift change, and proper process of handling and reporting incorrect narcotic counts. After the second incident, she introduced a new narcotic tracking sheet for proper documentation of controlled medications. She re-educated all the nursing staff for proper procedures of wasting controlled medications and the proper ways of disposing empty blister card for narcotic. The facility audited the medication cart and observed medication pass randomly to ensure all controlled medication counts were conducted appropriately and the count sheets were documented properly. She stated the 2 incidents were isolated case and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 049	Continued From page 22 interventions were successful as the facility did not have any more incident after 05/14/24. The compliance date of 8/12/24 was validated.	L 049		
L 098	.2306(D)(8) MEDICATION ADMINISTRATION 10A-13D.2306 (d) The facility shall ensure that procedures aimed at minimizing medication error rates include, but are not limited to, the following: (8) The facility shall maintain an accountability of controlled substances as defined by the North Carolina Controlled Substances Act, G.S. 90, Article 5. This Rule is not met as evidenced by: Based on record review and interviews with resident, staff, and the Medical Director (MD), the facility failed to verify the quantity and integrity of 2 bottles of controlled medications when receiving them from the pharmacy and during shift change narcotic counts. The facility also failed to keep an accurate record of controlled medications and failed to follow proper procedures when wasting contaminated controlled medications. As a result, a bottle of liquid morphine sulfate was found almost empty 3 days after receiving it from the pharmacy and 3 tablets of controlled medications went missing from a medication cart for 3 of 3 residents reviewed for pharmacy services (Resident #63, Resident #68 and Resident #69). The findings included:	L 098	Upon identification of unaccounted for liquid morphine, investigation started immediately by the Director of Nursing (DON). Initial allegation (24 hour) report sent to the Healthcare Personnel Registry (3/30/2024). Polk County Sheriff□s Department contacted and deputy on campus to file report (3/30 /2024). The pharmacy and medical director were notified. On 3/30/2024 around 1230am, an audit was conducted by the DON on 100% of narcotics. No further discrepancies identified. Education on policy of appropriate handling of controlled substances, and	12/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 098	Continued From page 23 1. Resident #63 was admitted to the facility on 09/18/23 with diagnoses including low back pain and fibromyalgia. She expired in the facility on 04/12/24. A review of the physician's order dated 03/18/24 revealed Resident #63 had an order to receive 0.5 milliliters (ml) of liquid morphine sulfate 100 milligrams (mg)/5 ml once every 1 hour as needed for pain or short of breath. The quarterly Minimum Data Set (MDS) dated 03/21/24 coded Resident #63 with an intact cognition. A review of the pharmacy delivery receipt dated 03/27/24 revealed the pharmacy had delivered 2 bottles of liquid morphine sulfate (an opioid analgesic for the relief of moderate to severe acute and chronic pain) 100 mg/5 ml that contained 15 ml in each bottle for Resident #63. These 2 bottles of liquid morphine sulfate were received and signed by Nurse #6. The medication administration records (MARs) revealed Resident #63 had received 1 doses of liquid morphine sulfate 2 times as needed on 03/27/24 and 03/28/24, and 3 times as needed on 03/29/24. The MAR did not indicate she had received any morphine on 03/30/24. A review of the staffing roster and MARs revealed Nurse #2, Nurse #3, Nurse #4, Nurse #6, and Nurse #7 had access to Resident #63's liquid morphine sulfate from 03/27/24 through 03/30/24 with the following timelines: - 03/27/24 at 10:40 PM, Nurse #6 signed and received the pharmacy delivery including 2 bottles of liquid morphine sulfate. She passed the 2	L 098	use of new narcotic sign in sheet was started on 3/30/2024 for nurses. Education was conducted by the DON and assistant director of nursing (ADON) and completed on 4/27/2024. Education on appropriate handling of controlled substances was also conducted by the DON and ADON and completed on 4/27/2024. Reeducation on the policy of appropriate handling of controlled substances to be conducted for nurses. Re-education will be provided by the DON and ADON and completed by 12/17/2024. Nurses will not be allowed to work after this date until education is completed. Education is also received upon hire, annually, and as needed. Audits on narcotic reconciliation and appropriate handling of narcotics were conducted twice weekly for four weeks, weekly for four weeks, and monthly for three months by the DON and ADON. Audits included direct observations of the handling of narcotics and shift-to-shift transitions. These audits started 3/30/24 and concluded 8/12/24. Audits and findings were discussed at QAPI meetings on 4/10/24, Ad HOC QAPI meeting on 5/15/24, and 7/10/24. Audits including observations of signing in and the handling of narcotics will be conducted twice weekly for two weeks, then weekly for four weeks, then randomly. Audits will be conducted by the DON and ADON. Results from these audits will be presented at the January	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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L 098	Continued From page 24 bottles of liquid morphine sulfate to Nurse #7 immediately. - 03/27/24 at 11:00 PM, Nurse #6 conducted a shift change narcotic count with Nurse #7 before taking over the medication cart. - 03/27/24 from 11:00 PM to 03/28/24 7:00 AM - Nurse #6 had access to the medication cart. - 03/28/24 from 7:00 AM to 11:00 PM, Nurse #3 had access to the medication cart. - 03/28/24 from 11:00 PM to 03/29/24 7:00 AM, Nurse #6 had access to the medication cart. - 03/29/24 from 7:00 AM to 3:00 PM, Nurse #3 had access to the medication cart. - 03/29/24 from 3:00 PM to 11:00 PM, Nurse #4 had access to the medication cart. - 03/29/24 around 11:00 PM, Nurse #2 relieved Nurse #4 and noticed that one bottle of liquid morphine sulfate that should contain 15 ml was almost empty during the shift change narcotic count. During a phone interview conducted on 11/19/24 at 2:11 PM, Nurse #3 stated the 2 bottles of liquid morphine sulfate were delivered from the pharmacy on 03/27/24 evening. She had access to the medication cart when she worked on 03/28/24 and 03/29/24. During the shift change narcotic counts, she recalled seeing 2 bottles of liquid morphine sulfate in its box and assumed they were intact, sealed, and untampered. When the DON called her on 03/30/24 asking her about the incident, she admitted that she did not check both bottles of liquid morphine sulfate and assumed they were intact during shift transition. She stated she was being reprimanded. A phone interview was conducted with Nurse #4 on 11/19/24 at 3:06 PM. Nurse #4 stated when she took over the medication cart from Nurse #3 at shift change 03/29/24, she did not open the	L 098	2025 and April 2025 quality assurance meetings. Completion date 12/17/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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L 098	Continued From page 25	L 098		

boxes that contained liquid morphine sulfate during shift change narcotic count as there was already an opened bottle of liquid morphine sulfate in use for Resident #63. She assumed both bottles were intact and untampered. When Nurse #2 opened the 2 boxes of liquid morphine and checked the content, one of the bottles was opened and almost emptied, with less than 1 ml remaining. The bottle had been tampered as the manufacturer's seal was missing and an adapter was seen inserted on the top of the bottle. The adapter that came with the liquid morphine sulfate remained unused in the box. Nurse #4 stated she did not have any reasons to steal Resident #63's pain medication. She offered a drug screening or lie detector test and was declined by the DON.

A phone interview was conducted with Nurse #2 on 11/19/24 at 1:53 PM. She stated she was assigned to work third shift (11:00 PM to 7:00 AM) and relieved Nurse #4 who had worked the second shift (3:00 PM to 11:00 PM) on 03/29/24. During the shift change narcotic count, she found that one bottle of Resident #63's liquid morphine sulfate had been opened. The bottle that should contain 15 ml had less than 1 ml left. It was sitting in the box with the cap on, but the seal had disappeared. The bottle had a stopper on the top while its own stopper and syringe remaining unused in the box. She called the Assistant Director of Nursing (ADON) to report the incident immediately.

During a phone interview conducted on 11/19/24 at 3:32 PM, Nurse #6 recalled receiving the medications delivered from the pharmacy on 03/27/24 evening around 10:40 PM. She signed the pink form (pharmacy delivery receipt) and passed the medications to Nurse #7 after completing the receiving process. As she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

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WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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L 098	Continued From page 26	L 098		

assigned to relieve Nurse #7 at 11:00 PM that night, she conducted a shift change narcotic count with Nurse #7 without opening the 2 boxes of liquid morphine sulfate. Later, she counted the 2 boxes of liquid morphine with Nurse #3 during the next shift change narcotic count without opening the boxes. Then, she left the facility on 03/28/24 in the morning. When she came back to work again on 03/28/24 in the evening, she counted the liquid morphine sulfate with Nurse #3 without checking the seals or pulling out the bottles from the boxes to ensure they were untampered. Nurse #6 stated she should have pulled the bottles out of the boxes and checked the seals during shift transitions.

A phone interview was conducted with Nurse #7 on 11/19/24 at 4:37 PM. She recalled Nurse #6 passed 2 bottles of liquid morphine sulfate that were tightened up with rubber bands to her on 03/27/24 before 11:00 PM. She did not check or open the boxes before putting them into the medication cart. She stated she should have pulled the bottles out of the boxes and checked the seals to ensure they were not tampered. She did not work any other shifts after 03/27/24 night until she heard about the incident on 03/30/24.

During an interview conducted on 11/20/24 at 10:08 AM, the DON stated the stopper that was left on top of the bottle of liquid morphine sulfate indicated that someone had deliberately stolen the pain medication. She went back to the facility immediately after the incident was reported and started the investigation. She traced all the way back to the night of delivery and receiving. None of the nurses involved admitted any wrongdoing. One of the nurses even offered to have a drug screening or lie detector test. She notified the pharmacy immediately after the incident. The

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	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 098	Continued From page 27	L 098		

pharmacy's internal investigation that included all the pharmacy staff and the delivery driver did not identify any wrongdoing along the processes from dispensing, packaging, delivery, and receiving. The facility unsubstantiated the allegation of drug diversion and started a new tracking protocol for controlled medications.

During a phone interview conducted on 11/20/24 at 11:28 AM, the Pharmacy Manager stated he was not with the pharmacy when the incident occurred on 03/30/24. He explained all the controlled medications were dispensed, packaged in a specified area in the pharmacy under the closed-circuit camera system. Only the authorized staff were allowed to be there. After all the controlled medications were dispensed, they would be labeled, packaged, put into a sealed plastic tote, and delivered by the pharmacy's own drivers to the facility.

During an interview conducted on 11/20/24 at 12:33 PM, the Administrator stated nurses in the facility did not have access to the stoppers in the building. She felt that the opened liquid morphine sulfate could have been tampered before leaving the pharmacy. However, she could not prove it as the nursing staff did not check the bottles when receiving the shipment. She called the pharmacy and was told that the shipment was secured as the totes were locked when the medications left the pharmacy.

2. Resident #68 was admitted to the facility on 10/07/19 with diagnoses including right shoulder pain.

A review of the physician's order dated 05/15/23 revealed Resident #68 had an order to receive 1 tablet of tramadol (a narcotic-like synthetic pain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ____ B. WING ____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

(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) COMPLETE DATE
L 098	Continued From page 28	L 098		

reliever that treated moderate to severe chronic pain) 50 mg 3 times daily for right shoulder pain.

The quarterly MDS dated 04/17/24 coded Resident #68 with severely impaired cognition.

A review of the MARs revealed Resident #68 had received 1 tablet of tramadol 3 times daily throughout May 2024 including 05/14/24 and 05/15/24.

Resident #69 was admitted to the facility on 07/13/23 with diagnoses including chronic pain syndrome.

A review of the physician's order dated 02/28/24 revealed Resident #69 had an order to receive 1 tablet of Norco (a combination medication consisting of an opioid pain reliever hydrocodone and a non-opioid pain reliever acetaminophen for relieve of moderate to severe pain) 7.5/325 mg once every 6 hours for pain.

The quarterly MDS dated 04/16/24 coded Resident #69 with intact cognition.

A review of the MARs revealed Resident #69 had received 1 tablet of Norco 7.5/325 mg 4 times daily throughout May 2024 including 05/14/24 and 05/15/24.

A review of the narcotic declining count sheet revealed Resident #68 had received 30 tablets of tramadol from the pharmacy on 04/13/24. The narcotic count sheet was consistent with the MARs until 05/14/24. During the shift change narcotic count on 05/14/24 morning, Resident #68 should have 10 tablets of tramadol remaining in the blister cart according to the narcotic count sheet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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L 098	Continued From page 29 The narcotic declining count sheet revealed Resident #69 had received 30 tablets of Norco 7.5/325 mg from the pharmacy on 05/07/24. The narcotic count sheet was without discrepancies compared with the MARs until 05/14/24. An attempt to conduct a phone interview with Nurse #1 on 11/19/24 at 1:46 PM was unsuccessful. She did not return the call. During a phone interview conducted on 11/19/24 at 3:32 PM, Nurse #5 stated she came to the facility around 7:00 AM on 05/14/24 to relieve Nurse #1. When they performed narcotic count during shift transition, she recalled Nurse #1 holding a cup and stated it contained 2 tablets of contaminated Norco 7.5/325 mg and tossed it into the sharp container before she had a chance to verify them. She was upset and planned to report the incident to the Unit Manager (UM) later. In the meantime, she continued the narcotic counting with Nurse #1. When they came to a blister card of tramadol for Resident #68, the narcotic count sheet was not in the binder with other narcotic count sheets. Nurse #1 was unable to give her a meaningful answer when she asked for the whereabouts of the narcotic count sheet. Nurse #5 was not sure if the count sheet was hidden purposely by Nurse #1. Nurse #5 found the missing narcotic count sheet later in a drawer inside the medication room. The narcotic count sheet indicated a balance of 10 tablets of tramadol should be in the blister card. However, she only found 8 tablets in the blister card. When she asked Nurse #1 about the 2 missing tablets of tramadol, she stated she had wasted both tablets. Nurse #5 notified the findings to the UM immediately. Nurse #5 stated Nurse #1 was okay when she passed over the shift to her about 12	L 098		

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WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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L 098	Continued From page 30	L 098		

hours ago on 05/13/24 evening. However, Nurse #1 appeared to be confused during the incident on 05/14/24 in the morning.

An interview was conducted with Resident #69 on 11/20/24 at 8:43 AM. She recalled the incident that happened in mid-May and stated she was notified of the incident, and the staff assessed her pain level on the same day. She denied having any problems getting her pain medications so far and added the facility replaced and paid for her missing pain medications after the incident.
An attempt to conduct an interview with Resident #68 on 11/20/24 at 8:48 AM was unsuccessful. She was unable to answer questions.

During an interview conducted on 11/20/24 at 9:48 AM, the UM stated Nurse #5 texted her on 05/14/24 morning as she could not find the narcotic count sheet for Resident #68's tramadol. She and Nurse #5 searched all over the nurse station and finally found the missing narcotic count sheet in the medication storage room. A quick review of the count sheet revealed 2 tablets of tramadol were missing. Nurse #1 was unable to explain and did not try to explain why and what had happened. She recalled Nurse #1 had a flat affect, and she could not confirm whether she was under any drug influence at that time. When Nurse #5 mentioned she did not have a chance to verify the 2 tablets of Norco that Nurse #1 tossed into the sharp container in front of Nurse #5, she took a peek into the sharp container and could not see any pills inside. Then she called the DON immediately.

An interview was conducted with the DON on 11/20/24 at 10:08 AM. She recalled when she called Nurse #1 on 05/14/24 after the incident, she had a slurred speech and was slow to

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	NH0559	A. BUILDING: ______ B. WING ______	C 11/20/2024

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WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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L 098	Continued From page 31	L 098		

respond to her questions. When Nurse #1 mentioned she dropped 2 tablets of Norco on the floor and were wasted in the sharp container, she opened the sharp container with the help of the maintenance staff. There were 7 pills in the sharp container and all the pills were Tylenol except for 1 tablet of Norco. She called Nurse #1 again and she was unable to explain why and what had happened. The DON denied Nurse #1 had separated the narcotic count sheet for tramadol purposely and explained Nurse #1 could have pulled the wrong sheet and put it at the right spot for finished controlled medications. She stated the facility might have medication errors and indicated if a nursing staff planned to divert controlled medications, they would not choose tramadol but something stronger. She explained the missing 2 tablets of tramadol might have been given by Nurse #1 to residents in the facility by mistake, and the missing 1 tablet of Norco could have been wasted and tossed in the trash but not the sharps container.

An interview was conducted with the MD on 11/20/24 at 10:35 AM. He stated he was notified of the incidents on 04/01/24 and 05/14/24 respectively and provided with the name of the residents affected. He stated Resident #63, # 68, and #69 were assessed immediately without any adverse consequences noted as the facility had adequate supply of the missing narcotic medications. He added all the missing medications were replaced and paid for by the facility later. It was his expectation for all the nursing staff to follow the facility's protocol to count and verify controlled substances when receiving them from the pharmacy or during a shift transition and followed the facility's procedures for proper documenting and wasting of controlled medications.

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WILLOWBROOKE COURT SC CTR AT TRYON ESTATE	619 LAUREL LAKE DRIVE COLUMBUS, NC 28722

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