| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185266 | A. BUILDING _____ B. WING _____ | 10/13/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| ELIZABETHTOWN NURSING AND REHABILITATION CENTER | 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0224<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to ensure an effective system was in place to identify and report diversion of medications for five (5) of nine (9) sampled residents (Residents #1, #2, #3, #5, #6) and two (2) of two (2) unsampled residents (Unsampled Residents A and B). The facility failed to identify and report misappropriation of resident property, and diversion of medications/narcotics when staff found tape on the back side of narcotic blister packs, and the narcotics ([MEDICATION NAME]/narcotic [MEDICATION NAME]) were replaced with other unidentified medications. In addition, staff borrowed [MEDICATION NAME] (anti-anxiety), [MEDICATION NAME] (anti-depressant), for other residents' use, even though staff had been trained in June 2014 not to borrow medications. (Refer to F431) On 08/31/14, during shift change (7:00 PM - 7:00 AM) review of Resident #1's narcotic blister packs revealed [MEDICATION NAME] (narcotic pain medication) tablets were missing, and/or the pack was opened with a small slit. The [MEDICATION NAME] tablets were replaced with tablets that were a different size and the pack was then taped back. Licensed Practical Nurse (LPN) #2 and LPN #6 recognized there was tape on the back side of the whole narcotic blister pack, but they failed to report this immediately to a supervisor. The staff made copies of the narcotic blister packs and gave them to the Director of Nursing (DON) under her office door. Review of Resident #1's narcotic count sheet revealed they continued to administer six (6) doses of the unknown tablets, that were in the blister pack of [MEDICATION NAME] 15 milligrams (mg), for Resident #1. The DON revealed Resident #1's [MEDICATION NAME] had been replaced with a different medication of which the resident was not ordered. On 09/05/14, LPN #3 and Registered Nurse (RN) #4 discovered Resident #1 received three (3) doses of [MEDICATION NAME], 15 mg, on 09/04/14 which was not Resident #1's normal pattern for taking this medication. Review of LPN #3's note provided to the DON revealed the resident's normal pattern was one tablet at night time. It was also determined Resident #1 had eighteen (18) tablets available on one medication card (this card had tape on the back and the [MEDICATION NAME] had been replaced) yet RN #1 documented she removed doses from Resident #1's untampered pack of [MEDICATION NAME]. Interview on 09/26/14 at 1:29 PM, with the DON, revealed she was not sure if someone had tampered with the [MEDICATION NAME] 1 mg, and the [MEDICATION NAME] 5 mg. The DON stated she was instructed by pharmacy on 09/09/14 to destroy these medications. However, these medications were not destroyed until 09/15/14, after Resident #5 had received three (3) doses of these medications on 09/10/14, 09/11/14 and 09/13/14. In addition, Resident #2 had two (2) [MEDICATION NAME], 2.5 mg, narcotic sheets and two blister packs. The second [MEDICATION NAME] 2.5 mg narcotic blister pack had paper tape behind more than half of the blisters. Resident #3's physician order [REDACTED]. Review of the first narcotic sheet, dated 08/01/14, and a second narcotic sheet dated 08/06/14, revealed RN #1 removed three (3) narcotics on 08/03/14 at 10:00 AM, 12:00 PM and 2:00 PM. RN #1 documented this medication was removed from the blister pack every two (2) hours instead of every (4) hours as ordered. Resident #6 was ordered to receive [MEDICATION NAME], 50 mg, at night. Review of the Medication Administration Record (MAR) documentation revealed multiple missed doses or the medication was not available to administer. However, the pharmacy was sending the medication routinely. Unsampled Resident A received or was documented as given six (6) doses of [MEDICATION NAME] 5/325 mg, in a six (6) hour period instead of every two (2) hours as ordered. RN #1 had documentation on the two (2) narcotic count sheets for Unsampled Resident B's [MEDICATION NAME] 5 mg as being removed from the narcotic blister packs at the same time on the same date. The facility's failure to ensure an effective system was in place to identify and report misappropriation/drug diversion and tampering of resident medications and controlled substances placed residents at risk in a situation that has caused or was likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 10/02/14 and determined to exist on 08/31/14. The facility provided an acceptable Allegation of Compliance on 10/09/14 that alleged removal of the Immediate Jeopardy on 10/09/14. However, the State Survey Agency determined the Immediate Jeopardy was removed on 10/11/14, after training of facility staff was verified completed 10/10/14, at 42 CFR 483.13 Resident Behavior and Facility Practices (F224) with a scope and severity lowered to an E while the facility monitors the effectiveness of the implemented plan of correction. The findings include: Review of the facility's policy titled Recognizing Signs and Symptoms of Abuse, revised April 2011, revealed the facility would not condone any form of resident abuse. To aid in abuse prevention, all personnel were to report any signs and symptoms of abuse to their supervisor, or to the Director of Nursing Services immediately. Signs of actual physical neglect would be improper use/administration of medications. Review of the facility's policy, Inventory Control of Controlled Substances, revised 01/01/13, revealed the facility would ensure staff immediately reported suspected theft or loss of controlled substances to their supervisor/manager for appropriate documentation, investigation and timely follow-up in accordance with facility policy. Upon receipt of such a report, the facility would ensure the appropriate facility personnel confirmed the discrepancy and followed facility policy and applicable laws regarding documentation of the incident. The facility would also conduct an investigation to determine: if a dose was in fact administered; and, if so, the reason the administration was not charted and if a dose was refused. Review of the facility's Loss and Theft policy effective 12/01/07, revealed when facility staff suspected theft or loss of medications, the facility staff would take such actions as required by applicable laws and facility policy. Appropriate actions may include: immediately reporting suspected theft or loss of drugs to a supervisor/manager or the Director of Nursing for appropriate investigation and follow-up. Investigating and reconciling discrepancies and notifying the appropriate facility Administrator of the controlled substance discrepancies and if such discrepancies were not reconciled, notifying the appropriate law enforcement agencies according to applicable laws and facility policy. 1. Review of Resident #1's [MEDICATION NAME] IR (immediate release), 15 mg, narcotic blister pack with a quantity of thirty (30) tablets, revealed tablets number twenty-four (24) through thirty (30) were empty, tablet number twenty-one (21) was also empty; and, blister number one (1) through twenty (20), twenty-two (22) and twenty-three (23) were full. Review of the 08/31/14 documentation on the [MEDICATION NAME] IR 15 mg narcotic count sheet, revealed LPN #2 and LPN #6 had signed and verified blister #21 was missing a pill. Review of a photo copy of the back of the [MEDICATION NAME] IR, 15 mg blister pack revealed all thirty (30) tablets' foil backing had been cut with a tiny slit, the tablets removed, and replaced with an unknown medication and taped across the back of the card. Continued review of the photo copy revealed two (2) [MEDICATION NAME] IR 15 mg blister packs. One (1) of the blister packs was ordered on [DATE] with a remaining correct count of eighteen (18) tablets. The second [MEDICATION NAME] blister pack was ordered on [DATE] with a remaining correct count of twenty-seven (27) tablets. Post survey interview with the Pharmacy General Manager (GM), on 11/05/14 at 9:30 AM, revealed if the facility was reordering the medication through the computer system Pharmacy would not know if it was reordered too soon. The facility had an automated system which generated a fax to the facility notifying the facility the medication was reordered too soon. However, per interview, if the DON signed the fax Pharmacy would fill the reorder without question. Interview with the DON, on 09/25/14 at 2:18 PM, revealed |

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

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

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F 0224

**Level of harm -** Immediate jeopardy

**Residents Affected -** Some

(continued... from page 1)
she did sign the too soon reorder notices to get the medications delivered. Further interview with the DON, on 09/24/14 at 3:48 PM, revealed the two (2) [MEDICATION NAME] IR blister packs were destroyed on 09/10/14 because she suspected someone had tampered with the medications. 2. Review of the Narcotic count sheets revealed two (2) of Resident #5's [MEDICATION NAME] 1 mg liquid and one (1) of [MEDICATION NAME] ([MEDICATION NAME]), 5 mg, liquid had been destroyed on 09/15/14 for
fear the medication had been tampered. Interview with the DON, on 09/26/14 at 1:29 PM, revealed the DON asked the pharmacy consultant if there was any other possible narcotics that could be tampered with and the pharmacist stated in the refrigerator. RN #1 had documented she administered this medication and the DON and the pharmacist could not tell if the liquid had been replaced with another liquid. Although pharmacy had instructed the DON to destroy this medication on 09/09/14, the facility administered three (3) more doses of these medications on 09/10/14, 09/11/14, and 09/13/14 to Resident #5. However, post survey interview with the DON, on 11/04/14 at 2:07 PM, revealed she could not remember when the pharmacist told her to destroy these medications and thought it was on 09/15/14 the day she destroyed the medications. 3. Observation of Resident #2's [MEDICATION NAME] 2.5 mg, narcotic blister packs revealed there were two (2) narcotic cards. The first [MEDICATION NAME] 2.5 mg, revealed Resident #2 had received a total of twelve (12) of thirty (30) half tablets that had no evidence they were tampered. The second [MEDICATION NAME] 2.5 mg, narcotic card, had paper tape behind more than half of the blisters. It was determined Resident #2 did not receive any of these narcotic because the blister pack still had unknown tablets taped inside the card. Interview on, 09/24/14 at 3:48 PM, the DON stated the medication looked like [MEDICATION NAME] and [MEDICATION NAME]. 4. Review of Resident #3's narcotic count sheet for [MEDICATION NAME] 2 mg,
ordered every 4 hours as needed, for the month of August, dated 08/01/14 with signatures dated 08/01/14 through 08/06/14 and a second narcotic sheet dated 08/06/14 with signature dates of 08/06/14 through 08/11/14, revealed RN #1 removed three (3) [MEDICATION NAME] tablets, one (1) each on 08/03/14 at 10:00 AM, 12:00 PM and 2:00 PM. In addition, RN #1 removed the last [MEDICATION NAME] tablet on 08/06/14 at 12:00 PM, on the second sheet. RN #1 removed one (1) [MEDICATION NAME] tablet
on 08/06/14 at 10:00 AM and then again at 2:00 PM, which was every two (2) hours instead of the every four (4) hours as needed, as the medication was ordered. Review of the MAR revealed the administration times were listed as 2:00 AM, 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, and 10:00 PM. The 12:00 PM dose was not documented as administered. In addition, the RN removed narcotics from two (2) different blister packs on the same date at the same time and documented they were administered to Resident #3. On the same two narcotic count sheets, RN #1 documented on the first count sheet she removed the last tablet on 08/06/14 at 10:00 AM leaving a balance of zero. She then removed one tablet from the second count sheet at 10:00 AM on 08/06/14. She then scratched out her initials for 10:00 AM on the first sheet and documented she removed a tablet at 12:00 PM as a PRN dose leaving a balance of zero on an already zero balanced count sheet. The RN documented she removed a medication from a narcotic count sheet that already had a zero balance. Review of the clinical record for Resident #3 revealed a 06/13/14 Quarterly Assessment that indicated Resident #3 had a Brief Interview for Mental Status (BIMS) score of fifteen (15). Interview with Resident #3, on 09/23/14 at 8:57 AM, revealed the facility had ran out of multiple medications for him/her and had to reorder them early, he/she further stated he/she suffered from pain all the time and wondered if he/she was receiving the pain medications. Review of Resident #3's, [MEDICATION NAME], 2 mg, revealed two narcotic sheets. The first narcotic count sheet, dated 08/27/14 through 09/01/14; and, the second narcotic count sheet dated 08/31/14 through 09/06/14. The first narcotic count sheet, revealed RN #1 removed narcotics on 08/30/14 at 10:00 AM, 2:00 PM and 6:00 PM, which left six (6) available tablets in the narcotic blister pack. Then on the second narcotic count sheet, RN #1 removed narcotics on 08/30/14 at 10:00 AM and 2:00 PM. RN #1 documented she removed tablets on the same date at the same time from two separate blister packs. [MEDICATION NAME] was removed from the blister packs without documentation of administration on the MAR. 5. Review of Unsampled Resident A's Physician Orders, dated 08/09/14, revealed an order for [REDACTED]. The narcotic count sheet, revealed on 09/04/14 at 12:00 PM, RN #1 removed two (2) tablets leaving a total of two (2) tablets in the blister pack. RN #1 then removed two (2) [MEDICATION NAME] APAP 5/325 mg at 6:00 PM on 09/04/14 and
finished the blister pack. RN #1 then removed [MEDICATION NAME] APAP 5/325 mg from a new narcotic count sheet on 09/04/14
at 6:00 PM. RN #1 documented on the Medication Administration Record and the narcotic count sheet that Unsampled Resident A received a total of six (6) tablets within six (6) hours. 6. Review of Unsampled Resident B's narcotic sheet for the month of July dated 07/24/14 through 07/26/14, revealed Unsampled Resident B was ordered [MEDICATION NAME] IR, one 5 mg tablet every four (4) hours, as needed. On 07/26/14 at 7:30 PM, RN #1 removed one (1) tablet, the last narcotic, from the blister pack. On a new narcotic sheet for the same drug, RN #1 removed two (2) tablets on 07/26/14 at 7:30 PM from the second narcotic count sheet: for a total of three (3), 5 mg tablets at the same time. 7. Review of Resident #6's, MAR for the month of May 2014, revealed Resident #6's [MEDICATION NAME] [MEDICATION]), 50 mg, was not given on 05/01/14, 05/02/14,
05/04/14, 05/05/14, 05/06/14, 05/07/14, 05/08/14, 05/09/14, 05/10/14, 05/13/14, 05/15/14, 05/16/14, 05/24/14, and 05/29/14. There was no documentation for the reason the medication was not given, except for 05/10/14, 05/14/14, 05/24/14, when it was documented the medication was not available and on 05/06/14, 05/07/14 and 05/24/14 when it was documented the resident refused the medication. Review of Resident #6's MAR for the month of June 2014, revealed Resident #6's [MEDICATION NAME], 50 mg, was not given on 06/07/14, 06/11/14, 06/14/14, 06/15/14, 06/16/14, 06/17/14, 06/18/14, 06/19/14, 06/20/14, 06/21/14, 06/22/14, and 06/24/14. There was no documentation to indicate why the medications were circled for the days of the 05/07/14, 05/19/14, 05/21/14, and 05/24/14. The dates of 05/11/14 and 05/14/14 were blank with no initials or documentation as why the boxes were left blank. Review of Resident #6's, MAR for the month of July 2014, revealed Resident #6's [MEDICATION NAME], 50 mg, was not given on 07/02/14, 07/03/14, 07/04/14, 07/05/14, 07/06/14 and 07/07/14. There was no documentation as to why this medication was not administered except for 07/02/14 and 07/05/14 it was indicated the medication was not available and pharmacy was notified. Review of the Work Order Fill form, not dated, revealed this medication was replaced by pharmacy at the facility's expense. 8. Review of the narcotic count sheets, the corresponding blister packs, and the contents of two sharps containers (labeled men and women) confiscated by the local Police Department, on 10/01/14 at 8:10 AM, revealed slits were cut into the foil backing of the blister packs, taped closed with paper tape and contained all sizes of tablets cut in half. These tablets could not be identified because of their size and the manufacture's marking was obliterated. In addition, there were two (2) Sharps boxes, one labeled Men's and one Women's Sharps that had also been confiscated by the police and determined to be used by RN #1. The Women's Sharps box was observed to have paper tape, clear pill crusher sleeves with white residue, nine (9) opened, empty blister packs of [MEDICATION NAME] (diuretic) 20 mg, clear plastic cigarette wrapper with white residue in it, a partial pill (unidentifiable) and straws, one of which was found still in a clear pill crusher sleeve. The Men's Sharps box was observed to have four (4) straws, clear pill crusher sleeves with powder residue in them and two (2) partial pills to small to identify. Unsuccessful attempts were made to interview RN #1, on 09/24/14 at 2:29 PM; and, on 09/25/14 at 9:18 AM on her home phone and, at 9:20 AM on her cell phone. Messages were left three (3) times to call back. No return calls were received. Interview with LPN #2, on 10/10/14 at 9:30 AM, revealed he did not know when he found the narcotic blister packs with tape across the back for Resident #1 at the end of August that it was misappropriation of property. However, the Loss and Theft of Medications policy indicated the facility staff should immediately report suspected theft or loss of drugs to a supervisor/manager or Director of Nursing. Interview with LPN #6, on 10/10/14 at 3:30 PM, revealed she was not aware the missing narcotics was misappropriation of property at the time. Interview with LPN #3, on 10/01/14 at 2:02 PM, revealed at the time she did not consider the medication being given more than one time to be abuse. She identified it to be more of a medication error. She was aware to report abuse immediately and now she recognized that she should have reported the incident sooner. LPN #3 stated she knew the residents' pain probably was not being addressed and could cause increased pain for the residents. LPN #3 stated the resident could have also had an allergy to the unknown medication which could lead to an allergic reaction or death. Interview with the Unit Manager, on 09/30/14 at 10:00 AM, revealed it did not cross her mind that the medication had been tampered. She stated she should have immediately informed the DON of the paper tape to the back of the medication blister pack because of possible misappropriation; however, she was not aware at the time that it was neglect. Interview with the DON, on 09/25/14 at 2:37 PM, revealed she was not thinking about abuse at the time, she was trying to figure everything out in her mind. The DON stated she did not notify the Administrator at the time, because she was trying to wrap her brain around the use of tape. Continued interview with the DON, on 09/25/14, revealed when she went to interview the staff, the staff stated they were borrowing medications from other residents, so the residents without medications could have their medications. The DON stated she had repeatedly informed the staff not to borrow medications from residents. At that time, the DON stated she could not see the bigger picture. She was not thinking about abuse at the time, she was trying to figure everything out in her mind. Interview with the Administrator, on 09/25/14 at 4:06 PM, revealed she was made aware of the diversion of medication on 09/08/14 and not before that time. The Administrator and the DON initiated an

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| F 0224<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 2)<br>investigation on 09/08/14 and determined Resident #1 received all the medication as ordered, terminated RN #1 for failure to document on the MAR that the [MEDICATION NAME] had been administered, not completing a pain assessment prior to administering the pain medication, nor indicating the pain medication was effective or not. Interview with the Administrator on 10/02/14 at 4:58 PM, revealed taking of resident medication was misappropriation of property. Interview with the Medical Director, on 09/25/14 at 3:47 PM, revealed he was made aware of the [MEDICATION NAME] medication error, but not the narcotic concerns. He was not notified of the misappropriation of property until 09/08/14. The facility provided an acceptable Allegation of Compliance (AOC) on 10/09/14 alleging the Immediate Jeopardy was removed 10/09/14; however, the State Survey Agency verified that staff training was completed on 10/10/14 and the Immediate Jeopardy was removed on 10/11/14. The facility took the following steps to remove the Immediate Jeopardy. 1. Residents #1, #2, #3, #5 and #6 were assessed and interviewed, with no negative outcomes. RN #1 was immediately suspended on 09/08/14 pending the investigation. 2. Licensed staff was interviewed and the allegation reported to the Office of Inspector General (OIG), Kentucky Board of Nursing (KBN), the Department of Community Based Services (DCBS) and Law Enforcement. 3. All medications<br>found to be tampered with were reordered at the facility's expense. 4. Resident #1's tampered medications were pulled from circulation on 09/08/14 by the DON and destroyed on 09/10/14. 5. Resident #2's medications were pulled on 09/03/14 and locked up, when the resident was admitted to the hospital. Upon the resident's return on 09/10/14, the narcotics were determined to have been tampered with and the Police were immediately notified. Narcotics and their containers were turned over to the local Police Department. Medications were reordered at the facility's expense. 6. On 09/16/14, the Pharmacist auditing the medication carts suggested to the DON and the ADON, that Resident #5's narcotics should be destroyed. 7. The DON and facility Administrator conducted 100 % audit of narcotic orders and reconciliation sheets for any discrepancies that may indicate diversion on 09/08/14. The DON continued to complete audits daily to ensure there has been no breach of narcotic medication administration, documentation, reconciliation and or tampering of packages. 8. The Consultant Manager from the pharmacy (facility contracted), on 10/03/14, reviewed and analyzed narcotic medications dispensed and being administered for any discrepancies of tampered packaging, documentation of narcotic sheets, medication administration records for reconciliation and the Emergency Drug Kit (EDK). In addition, all Consulting Pharmacists visits starting 10/03/14 will include at a minimum a review of the entire narcotic dispensing system and analyzing narcotic counts, records, MARs, labels and packaging which will be compared to current orders to ensure there has been no tampering. 9. Education provided to the nursing staff by the DON included medication misappropriation (tampering of medication packaging or appearance of falsification of narcotic sheets), immediate notification to the DON, supervisor or the Administrator. 10. The DON was educated by the Regional Nurse Consultant for Preferred Care Partners Management Group on 09/12/14, on Misappropriation and Diversion of Narcotics, EDK Process, Pharmacy Training Guide, Notification to Administration and Pharmacy, Destruction of Narcotics, Pain Assessment, Accuracy of Notes, Change of Condition, Abuse and Neglect and the Narcotic Balance. 11. All licensed staff was educated by the Nursing Consultants on 10/07/14, which was attended by fourteen (14) licensed nursing staff. This includes seven (7) RNs and seven (7) LPNs, the Director of Nursing and the Unit Manger. In-services provided on the 7th were taken to QA on the 7th. 12. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following programs: Pain Assessment and Management; Accuracy of Notes, Documenting change of Condition; PRN Medication Management; Medication Pass-Indicators, Side Effects, reporting errors; Prevent/Recognize and Reporting Patient abuse; Pharmacy Training Guide; EDK Process; and, State Regulations controlled substance Notification. This training was completed by all nursing staff on the computer program SilverChair by 09/28/14. 13. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following Policies: Adverse Reaction to Medications; Controlled Substances- Misappropriation; Adverse Consequences and Medication Errors; Accepting Delivery of Medications; Administering Medications; Loss or Theft of Medications; Discarding or Destroying of Medications; and, Security of the Medication Carts. This training was provided by the DON and completed by all nursing staff by 10/06/14. 14. The Quality Assurance Committee consisted of the Administrator, DON, Unit Managers, Social Services, Activities Director, Dietary Director, Medical Director and Consulting Pharmacist, met Monday through Friday, in which the DON and or the Administrator reported on Narcotic Count Records as well as the MAR and reviewed narcotic medications. If suspicion was identified, the DON would immediately contact the Pharmacy and begin an internal investigation. All proper Authorities would be notified including OIG, DCBS, local police and/or KBN. This practice would continue 5 x weekly and/or PRN as needed through 10/31/14. 15. Any discrepancies discovered on the weekend, the weekend nurse would immediately notify the nurse on call, the nurse on call would notify the Administrator or DON. 16. The Pharmacy Consultant would also review for any possible administration of narcotics that may elude a suspicious activity and review the list of destroyed narcotics with each visit. Also a copy of current narcotic orders would be provided from pharmacy for the consultant pharmacist to reconcile with the current orders on the resident's chart to ensure ordering accuracy from pharmacy. 17. The Administrator contacted the Corporate Regional Team on 09/08/14. She and the DON organized the collection of narcotics, and narcotic count sheets on 09/08/14. The DON contacted local law enforcement agency. The Administrator reviewed policies and procedures on 09/08/14 with no revisions. Through observation, interview and record review the State Survey Agency (SSA) validated the Allegation of Compliance with removal of Immediate Jeopardy on 10/11/14 prior to exit on 10/13/14. 1. Interview with Resident #1, on 09/23/14 at 11:30 AM and Resident #3, on 09/23/14 at 8:57 AM, revealed no negative outcomes. Review of Residents #1, #2, #3, #5, and #6's clinical record revealed no adverse outcomes. Review of RN #1's employee file, revealed the facility terminated RN #1 on 09/12/14. Interview with the DON, 09/24/14 at 3:48 PM, revealed RN #1 had not worked since 09/04/14, was suspended on 09/08/14 and was officially terminated on 09/12/14. 2. Review of the facility's investigation, dated 09/08/14, revealed the facility faxed a report to the Office of Inspector General (OIG) and the Department of Community Based Services (DCBS) on 09/08/14. The Local Police Department (opened case #14-2423) was also notified regarding misappropriation of controlled medications. The Kentucky Board of Nursing was notified of the allegation in regards to RN #1 on 09/11/14. 3. Review of the facility's charges from the Pharmacy revealed the facility purchased the reordered medications that were destroyed. Review of the Product Destruction Summary, dated 09/26/14, revealed medications were being destroyed as of 09/17/14. Interview on 09/26/14 at 1:29 PM, with the DON revealed the facility replaced the narcotic medications that were destroyed. 4. Review of Resident #1's Controlled Substance Inventory Form, revealed two (2) bottles of [MEDICATION NAME] were destroyed on 09/10/14 by the DON and Assistant Director of Nursing (ADON). Interview with the ADON, on 09/25/14 at 9:28 AM, revealed she was present when Resident #1's medication was being destroyed. Interview with the DON, on 09/24/14 at 3:48 PM, revealed she destroyed any medications that appeared tampered. 5. Interview with the DON, on 09/24/14 at 3:48 PM, revealed the police were given Resident #2's medication cards. Review of Resident #2's two (2) [MEDICATION NAME] narcotic cards, which were in police custody at the Police Department, revealed one card was tampered; however, this medication was not dispensed to Resident #1. The other [MEDICATION NAME] narcotic card showed no evidence that it had been tampered. Review of the facility's charges from the Pharmacy, revealed the facility purchased the re-ordered medications which were destroyed. 6. Review of Resident #5's [MEDICATION NAME] and [MEDICATION NAME] narcotic sheets, revealed the two (2) medications were destroyed on 09/15/14 by the DON. Interview with the DON, on 09/26/14 at 1:29 PM, revealed the DON had destroyed [MEDICATION NAME] and [MEDICATION NAME] on 09/15/14. 7.<br>Record review of audits of narcotic orders and reconciliation sheets for discrepancies, revealed they started to be completed on 09/15/14. Interview with the DON, on 09/26/14 at 2:37 PM, revealed she began to audit MARs and physician orders [REDACTED]. Interview with the DON, on 10/13/14 at 10:29 AM, revealed every morning she reviewed the controlled substances, to ensure the narcotic counts were right and would report that to the QA team every morning, 10/06/14 through 10/10/14. 8. Review of the Pharmacy Clinical Manager MAR to Cart Audit Form, dated 10/03/14, revealed she completed a 100% audit to look at all orders, verified the MAR matched the orders, and that the pink narcotic sheets matched the drug labels. Then all narcotic counts were verified. The review revealed no signs of diversion for any of the residents.<br>Interview with the Pharmacy Clinical Manager, on 10/13/14 at 11:34 AM, via telephone, revealed she came into the facility to review controlled substances orders, make sure the directions of the orders matched the narcotic sheets. She did an inventory with nursing and inspected the medications and ensured that the narcotic counts matched. The Pharmacy Clinical Manager stated she did not identify any concerns except the orders did not match the directions on the narcotic cards, especially when the medication changed from routine to PRN. She stated she reviewed all four (4) medication carts and looked at the Emergency Drug Kit (EDK) box, which revealed no concerns with the shift change counts. She then provided the facility with a report. Interview with the Administrator, on 10/13/14 at 2:02 PM, revealed on 10/03/14 the Pharmacy Clinical Manager came in and did a 100% audit and would provide oversight until 11/30/14. 9. Review of the education content confirmed the education was completed on 09/30/14 by the DON for eleven (11) LPNs, and five (5) RNs, there was no |

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| F 0224<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 3)<br>PRN staff, none on FMLA (Family Medical Leave Act) or vacation and the facility did not use contract staffing. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3 on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7 on 10/13/14 at 1:26 PM; and ,RN #4, on 10/10/14 at 10:36 AM revealed all were knowledgeable of what abuse and misappropriation was and how to report to the DON or Administrator immediately. 10. Interview with the DON, on 10/13/14 at 10:29 AM, revealed she received training on 09/12/14 by the Regional Nurse Consultant. She was educated on medication pass, audits, what information she needed to obtain from the pharmacy, such as a record of all the items that needed to be ordered by pharmacy and then use the information to audit the MAR and compare to what was in the drawer and the physician's orders [REDACTED]. Interview with the Regional Nurse Consultant, on 10/13/14 at 3:42 PM, revealed she completed education on 09/08/14 and 09/12/14 with the DON and Administrator. She went over documentation, narcotic sheets and the protocol for nursing. She also compared MARs and the Pain assessment sheets. The DON was educated on not throwing away evidence. The DON was educated on abuse and misappropriation of medications. The Regional Nurse Consultant stated she talked to the DON about replacing all medications because it was the resident's property. The DON was educated on monitoring the narcotic sheets, MARs and Pain assessment sheets daily. The destruction of medication a |
| F 0275<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Completely assess the resident at least every twelve months.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review and review of the Minimum Data Set (MDS) 3.0, it was determined the facility failed to ensure an assessment was completed every twelve (12) months for one (1) of nine (9) sampled residents (Resident #9). The facility failed to complete an Annual MDS assessment due in August, 2014. The findings include: Interview with the MDS Coordinator, on 10/08/14 at 10:00 AM, revealed the facility did not have a policy on MDS assessments, the facility used the MDS Manual 3.0 as their policy. Review of the Resident Assessment Instrument, (RAI), MDS Manual 3.0, Chapter 2, page 2-15, RAI OBRA-required Assessment Summary revealed an annual comprehensive assessment was to be completed no later than the Assessment Reference Date (ARD) of the previous Omnibus Budget Reconciliation Act (OBRA) Comprehensive Assessment plus<br>366 calendar days and the ARD of the previous OBRA Quarterly Assessment plus 92 calendar days. Review of Resident #9's clinical record, revealed the facility admitted the resident on 03/28/13 and then readmitted him/her on 03/01/14, with [DIAGNOSES REDACTED]. Review of Resident #9's assessments, revealed Resident #9 had an Admission Assessment completed on<br>07/27/13 and a most recently Quarterly Assessment on 06/06/14. The Annual assessment was due to be completed 08/11/14, making the assessment sixty (60) days late. Observation of Resident #9, on 10/08/14 at 8:38 AM, revealed Resident #9 was asleep in the bed with covers pulled up. A wheelchair was at bedside with a chair alarm attached to wheelchair. On 10/08/14 at 10:15 AM, Resident #9 was sitting up at the dining room table drinking coffee independently. Interview with the MDS Coordinator, on 10/08/14 at 10:00 AM, revealed she had been in the role as an MDS Coordinator since April of 2014. The MDS Coordinator stated the Regional Manager wanted her to utilize the computer system to track when the assessments needed to be completed and not her own record. The MDS Coordinator stated obviously the backup system which was the computer was not working because it missed Resident #9's assessment. The MDS Coordinator stated when assessments were late; there was obviously some sort of penalty in which she was not familiar. The MDS Coordinator stated for now she was going to use her personal schedule with the computer schedule for accuracy. The missing assessment tool utilized in the computer did not pick up Resident #9 as due the month of September or October. The Interdisciplinary Team did not complete the full assessment and this could have affected Resident #9 in the care planning process. Interview with Social Services, on 10/09/14 at 1:03 PM, revealed she was aware of a resident's assessment coming up missing before, but it had been months since something like that occurred. Social Services stated she was aware the facility was transitioning into the new computer system. Social Services stated she saw that she could look into the computer system and see when the next assessment was due; however, she did not notice Resident #9 had not received an assessment. She stated Resident #9 had not changed very much since his/her last assessment because she monitored the resident's behaviors every day and looked at the Accue Nurse System in the computer for changes. Interview with the Director of Nursing, on 10/13/14 at 10:29 AM, revealed she was not aware the MDS Coordinator had missed an assessment. If a resident was to have an annual assessment completed, the MDS Coordinator would send a schedule and Social Services would coordinate with the Activities Director and Dietary Manager. They made sure the Nurse Aids capture the Activities of Daily Living (ADL)'s for the Resident for two (2) weeks. The DON stated the difference between a full assessment and a quarterly assessment was the oral health and there was about five (5) or six (6) more different assessments than the quarterly. The care plan was also assessed for accuracy. The DON stated as far as she was aware Resident #9 did not have any changes in condition. Interview with the Regional Reimbursement Nurse Specialist, on 10/13/14 at 11:40 AM, revealed she came into the facility to identify if there were any concerns with the system. The Specialist stated in the meantime the MDS Coordinator would use her paper calendar as well as the computer system to ensure no other assessments would come up missing. If an assessment was missed, it could affect the payment and stated the resident would be monitored everyday in the morning meeting. The Regional Reimbursement Nurse Specialist stated she had re-educated the MDS Coordinator on how to schedule, recalculate OBRA assessments and see what was due and compare to the paper calendar. |
| F 0431<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review and review of the facility's policies, Pharmacy job descriptions and Pharmacy contract, it was determined the facility failed to ensure the Consultant Pharmacist established an effective system for monitoring, reconciliation and destruction of medications and failed to ensure Pharmacy determined drug records were in order, maintained and reconciled. In addition, the facility failed to ensure resident medications were not borrowed for the use of another resident even though staff had been inserviced on not borrowing medication in [DATE]. These failures affected five (5) of nine (9) sampled residents (Residents #1, #2, #3, #5 and #6); and, two (2) of two (2) unsampled residents (Unsampled Residents A and B). Interview and record review revealed narcotic blister packs were tampered with for Residents #1 and Resident #2. On [DATE] during shift change, Licensed Practical Nurse (LPN) #6 and LPN #2 completed a narcotic review of the narcotic lock box on the medication cart for Lincoln Lane. The review included one (1) Morphine Sulfate (narcotic pain medicine) narcotic blister pack, for Resident #1, containing thirty (30) tablets which revealed twelve (12) blisters were empty or missing, and eighteen (18) blisters contained a tablet; however, these tablets were not the same size as the Morphine 15 milligrams (mg) tablets. The back of the narcotic blister pack contained paper tape to hold the pill inside the foil enclosure. The nursing staff recognized there was tape on the back side of the whole narcotic blister pack; however, they failed to report this immediately to a supervisor, as per policy. Instead, LPN #6 and LPN #2 made copies of the narcotic blister pack and placed it under the door of the Director of Nursing (DON). Staff administered six (6) doses of the unidentified tablets that were in the Morphine Sulfate 15 milligrams (mg) blister pack, to Resident #1. Interview with the DON revealed Resident #1's Morphine Sulfate had been replaced with a different medication the resident was not ordered. The DON stated after the Morphine was replaced with an unknown tablet by Registered Nurse (RN) #1, she did not remove any more tablets from that blister pack and started removing tablets from a second blister pack. Staff interview revealed on [DATE], they discovered three (3) doses of Morphine Sulfate 15 mg that was removed on [DATE]; however, this was not Resident #1's normal pattern for taking this medication. Interview with Resident #1 revealed the Morphine was only taken one time at night and he/she had never requested three doses. Resident #2 had a Oxycodone 2.5 mg, narcotic blister pack with paper tape across more than half of the tablets. Interview and record review revealed the narcotic count sheet balances did not reconcile and entries indicated double dosing for Resident #3, Unsampled Resident A and Unsampled Resident B. Review of the narcotic count sheets for the Hydromorphone 2.5 mg revealed doses were removed on the same date and at the same time on two different narcotic count sheets for administration to Resident #3. Unsampled Resident A had Oxycodone ,[DATE] mg, ordered two tablets every six (6) hours; however, it was documented as four (4) tablets administered at 6:00 PM. RN #1 documented the removal of Oxycodone 5 mg on two different narcotic count sheets for the same day at the same time. Unsampled Resident B had Oxycodone IR 5 mg, every four (4) hours; however, RN #1 documented on [DATE] at 7:30 PM that three (3) tablets were administered for a total of 15 mg. Interview and record review revealed Resident #5 was administered three doses of a narcotic after the pharmacy instructed the facility to destroy it. Interview with the DON revealed Resident #5's Lorazepam 1 mg, and Morphine 5 mg, may have been tampered. Pharmacy instructed the DON on [DATE] to destroy these medications; however, they were not destroyed until [DATE]. Resident #5 received three (3) doses |

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| F 0431<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 4)<br>of these medications on [DATE], [DATE] and [DATE]. In addition, Buspirone and Escitolopram were reordered too soon for Resident #3 and Resident #6 who received Primidone. The documentation on the Medication Administration Record [REDACTED]. The facility's failure to ensure an effective system was in place to prevent/detect misappropriation/drug diversion and tampering of resident medications including controlled substances placed residents at risk in a situation that has caused or likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was identified on [DATE] and determined to exist of [DATE]. The facility provided an acceptable Allegation of Compliance on [DATE] that alleged removal of Immediate Jeopardy on [DATE]. However, the State Survey Agency determined the Immediate Jeopardy was removed on [DATE],<br>after training of facility staff was verified completed [DATE], at 42 CFR 483.60 Pharmacy Services (F431) with a scope and severity lowered to an E while the facility monitors the effectiveness of the implemented plan of correction. The findings include: Review of the facility's policy regarding Inventory Control for Controlled Substances, revised [DATE], revealed the facility would ensure staff immediately reported suspected theft or loss of controlled substances to their supervisor/manager for appropriate documentation, investigation and timely follow-up in accordance with facility policy. Upon receipt of such a report, the facility would ensure the appropriate facility personnel confirmed the discrepancy and followed facility policy and applicable laws regarding documentation of the incident. The facility would also conduct an investigation to determine: if a dose was in fact administered and, if so, the reason the administration was not charted and if a dose was refused. A facility representative would regularly check the inventory records to reconcile inventory. The facility would regularly reconcile the current and discontinued inventory of controlled substances against the log used in the facility's controlled medication inventory system. The current inventory should be compared to the controlled medication declining inventory record and to the residents' Medication Administration Record [REDACTED]. Review of the facility's policy regarding Loss and Theft, effective [DATE], revealed when facility staff suspect theft or loss of medication, the facility staff would take such actions as required by applicable laws and facility policy. Appropriate actions may include: immediately reporting suspected theft or loss of drugs to a supervisor/manager or the Director of Nursing for appropriate investigation and follow-up. Investigating and reconciling discrepancies and notifying the appropriate Administration of controlled substance discrepancies and if such discrepancies are not reconciled, notifying the appropriate law enforcement agencies according to applicable laws and facility policy. Review of the facility's policy, regarding Documentation of Medication Administration, revised [DATE], revealed a nurse or Certified Medication Aide would document all medications administered to each resident's Medication Administration Record [REDACTED]. Review of the facility's policy, regarding Administering Medications, revised [DATE], revealed medications must be administered within one (1) hour of their prescribed time, unless otherwise specified. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication would initial and circle the MAR indicated [REDACTED]. If a resident used an as needed (PRN) medication frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist, as needed, would re-evaluate the situation, examine the individual as needed, determine if there was a clinical reason for the frequent PRN use, and consider whether a standing dose of medication was clinically indicated. Review of the Consultant Pharmacist's job description, effective [DATE], revealed the consultant pharmacist's key responsibilities included: ensure facility remains compliant with federal regulations; clinical reviews as required by federal and state regulations; own issue resolution and communicate early warning signs of potential issues; conduct executive reviews and other customer meetings as required; perform medication regimen reviews and provide written reports of these reviews; utilize the MDS 3.0 to identify specific residents needing targeted focus; complete the quality improvement consultant pharmacist summary report for all facilities; provide quarterly reports reflecting facility-level drug utilization; attend quarterly Quality Assurance Committee meetings and provide written reports; and, coordinate or perform review of controlled substance utilization, reconciliation and documentation. Review of the Consultant Extender job description (referred to self as the Quality Assurance Technician QAT), effective date [DATE], revealed the QAT inspects medication storage and medication pass audits; conducts inspections of all drug storage areas per Federal and State regulations and requirements; review narcotic proof of use sheets and narcotic change of shift logs for completeness; provides education to licensed staff; and, reports to the Consultant Pharmacist. Review of the Pharmacy contract, effective [DATE], revealed the pharmacy would maintain a drug profile on each facility resident serviced by pharmacy; make a representative of pharmacy available for attendance at facility's quality assurance committee, infection control committee and other committee meetings that relate to pharmacy products and services; provide drug information and consultation to the facility's licensed professional staff regarding pharmacy products ordered; provide pharmacy policy and procedures; and, collaborate with the facility to coordinate pharmacy documentation processes. The contract further stated Required Consultant Services included: the consultant shall provide consultation regarding all material aspects of providing pharmaceutical services to the facility; a written report regarding the provision of pharmaceutical services would be provided to the facility quarterly; the consultant shall collaborate with the Medical Director; shall conduct a medication regimen review for each facility resident at least once a month; shall identify any irregularities as defined in the State Operations Manual (SOM); shall within three (3) business days of conducting a medication regimen review, provide the facility with a written report; shall assist the facility in reviewing the safe and secure storage of medications in locked compartments; and, shall assist the facility in developing and implementing safeguards and systems to control, account for, and periodically reconcile controlled medications. Optional Consultant Services included: medication observation evaluations; non-financial audits relating to the provisions of medications; potential narcotic diversion investigation; drug utilization and/or evaluation activities; narcotic and/or drug destruction, regardless of whether such task is required by applicable law; and, services provided by consultant as part of corrective action plans. 1. Interview and record review revealed the narcotic blister packs were tampered with for Residents #1 and Resident #2. Review of Resident #1's clinical record, revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. Review of Resident #1's Minimum Data Set (MDS) Admission Assessment, dated [DATE], revealed the facility assessed Resident #1 with a Brief Interview of Mental Status (BIMS) score of twelve (12), which indicated Resident #1 was interviewable. Resident #1 was also identified on the Admission Assessment to have pain. Review of Resident #1's Morphine Sulfate IR, (immediate release) 5 mg, narcotic card with a quantity of thirty (30) tablets, revealed tablet number twenty-one (21) and number twenty-four (24) through thirty (30) were empty. Further review of the medication revealed blister number one (1) through twenty (20), twenty-two (22) and twenty-three (23) were full. Documentation on the Morphine Sulfate IR, 15 mg, Narcotic Sheet, for [DATE] revealed LPN #2 and LPN #6 had signed and verified blister #21 was missing a pill. Review of the back of the Morphine Sulfate IR, 15 mg, card revealed all thirty (30) tablets had been cut; replaced with an unknown medication; and, paper tape placed across the back of the card. Interview with LPN #2, on [DATE] at 8:38 AM, revealed LPN #2 and LPN #6 were counting narcotics (could not give a time frame), when LPN #2 discovered a tablet had fallen out of Resident #1's Morphine Sulfate Narcotic Card (tablet number twenty-one (21)). LPN #2 stated he then addressed it with the Unit Manager and the Unit Manager had him make a copy of the narcotic card. LPN #2 stated the Unit Manager told him she would have the DON take care of it. Interview with LPN #6, on [DATE] at 2:33 PM, revealed around [DATE], she and LPN #2 were counting Resident #1's Morphine Sulfate card and noticed a missing tablet at the bottom of the card and LPN #2 noticed a small slit in the foil backing. LPN #6 informed LPN #2 she just noticed the discrepancy and it was a mistake because there was no pill in the blister at all and there was a micro cut in the foil backing. LPN #6 stated sometimes the pills would get out and if someone so much as rubbed against the card it would push a pill out and then she would just re-enforce the foil with tape. LPN #6 stated she did not observe tape a lot and never really looked at the back of the medication cards. Interview with the Unit Manager, on [DATE] at 10:00 AM, revealed it was at the end of August, 2014 when LPN #2 and LPN #6 had brought to her attention Resident #1's narcotic card. The staff seemed to think the medication had come from pharmacy taped. The Unit Manager stated she did not remove the narcotic card to ensure non-use of the medication. She stated she was not aware if the staff continued to give the narcotic after she was informed of the missing medications. Further interview with the Unit Manager revealed she did not observe the narcotic card, nor did it cross her mind that the narcotic had been tampered. The Unit Manager stated she had been a nurse since 2007 and never witnessed the pharmacy deliver narcotics with paper tape to the back of the narcotic card. She stated she should have pulled the narcotic card right then and there and destroyed the medication. The Unit Manager stated she thought she sent word through a text to the DON to inform her of Resident #1's medication, but she should have immediately informed the DON of the paper tape to the back of the narcotic card. However, interview with the DON, on [DATE] at 6:00 PM, revealed she had no evidence of a text from the UM only the information placed under her office door by LPN #2 on [DATE]. Review of Resident #1's Morphine Sulfate IR, 15 mg, narcotic count sheet, dated [DATE], revealed it originally contained thirty (30) tablets that were taped across the back of the blister pack and |

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| F 0431<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 5)<br>seven (7) tablets had been removed with number 21 missing. Interview with Registered Nurse (RN) #4 revealed the DON was notified on [DATE] by LPN #3 and RN #4 of the suspicious blister packs with tape; however, the facility continued to administer three (3) additional doses of the unidentified medication on [DATE], [DATE], and [DATE], for a total of eleven (11) unknown tablets being administered. There were eighteen (18) tampered narcotics left on the card. In addition to record review, an interview with LPN #3, on [DATE] at 3:20 PM, revealed that on [DATE], while LPN #3 and RN #4 were completing their narcotic count, it was discovered RN #1 had removed three (3) doses of Morphine Sulfate IR, 15 mg, on [DATE] at 10:00 AM, 2:00 PM; and, at 6:00 PM on a separate Morphine Sulfate IR, 15 mg Narcotic Count Sheet (the new narcotic card that had not been tampered). Interview with LPN #3, on [DATE] at 3:20 PM, revealed she was aware Resident #1 liked to receive his/her pain medications at night. When she and RN #4 went to count the narcotic sheet at the beginning of her shift on [DATE], she realized that both narcotic cards for Morphine Sulfate, 15 mg, had been used. LPN #3 stated RN #1 had pulled three (3) doses of Morphine Sulfate, 15 mg, all on [DATE] at 10:00 AM, 2:00 PM and 6:00 PM while using a new narcotic card for Resident #1. LPN #3 stated this was really odd for Resident #1 to obtain three (3) doses in one day, so she made a copy of both of the Morphine Sulfate, 15 mg, narcotic sheets and slid the copies under the DON's door for review. Interview with the DON, on [DATE] at 3:48 PM, revealed on [DATE] when she came to work, she found the copies and was wondering why RN #1 would pull narcotics from a different narcotic card. Interview with Resident #1, on [DATE] at 11:30 AM, revealed he/she had always asked for pain medication at night because he/she suffered from pain to the right leg. Resident #1 stated he/she had five (5) surgeries to his/her leg. Resident #1 stated he/she did not receive the pain medications that the nurse documented he/she had received on [DATE]. Interview with the Minimum Data Set (MDS) Coordinator, on [DATE] at 2:45 PM, revealed while she was conducting an assessment of Resident #1, she was reviewing Resident #1's Medication Administration Record [REDACTED]. Resident #1 had verbalized to her he/she did not like to take his/her pain medication because it made him/her sleepy. The MDS Coordinator stated she suggested to Resident #1 to take his/her Tylenol (pain medication) as this medication would not make him/her sleepy and he/she could participate in therapy and become stronger. Sometime during the week of [DATE] the MDS Coordinator informed the DON of what she had found and the DON stated she was doing an investigation and instructed her to obtain a statement from Resident #1. The MDS Coordinator stated Resident #1 verbalized he/she did not receive any of the medication. Continued interview with the DON, on [DATE] at 3:48 PM revealed the DON discovered on [DATE] that Resident #1's narcotic cards had been cut open, narcotics replaced and then taped closed. The DON stated she felt she had to call the police and start an investigation to identify how many residents had been affected. Closed record review for Resident #2 revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. Review of Resident #2's MDS Admission Assessment, dated [DATE], revealed the facility assessed Resident #2 with a Brief Interview of Mental Status score of fifteen (15) which meant the resident was interviewable. Review of Resident #2's Nurses Notes, revealed on [DATE] at 6:30 PM, Resident #2 had complained about having pain everywhere. Resident #2 complained that his/her pacemaker was burning him/her and he/she was having left side hand and neck pain. The nurse administered Diazepam and Oxycodone for pain as prescribed, but Resident #2 continued to have pain. At 6:45 PM and 7:40 PM, the doctor was notified and orders were written to send Resident #2 to the hospital for evaluation and treatment. Interview with the DON, on [DATE] at 3:48 PM, revealed she locked Resident #2's Oxycodone cards and narcotic sheets in a locked box, so that when Resident #2 came back to the facility Resident #2's pain medication would be available. Further interview with the DON, on [DATE] at 3:48 PM, revealed when Resident #2 came back to the facility on [DATE], she went to remove Resident #2's narcotics from the locked box and discovered tape to the back of the Oxycodone 2.5 mg, narcotic card. Review of Resident #2's, Oxycodone, 2.5 mg, revealed there were two (2) narcotic cards. The first Oxycodone 2.5 mg, revealed Resident #2 had received a total of twelve (12) of thirty (30) half tablets that had no evidence of cuts in the foil backing or any tape applied. The second Oxycodone, 2.5 mg, narcotic card, had paper tape behind more than half of the blisters. Per interview with the DON, on [DATE], it was determined by the DON Resident #2 did not receive any of the the Oxycodone because the blister pack still had an unknown tablet taped inside the card. The DON stated the medication looked like Lexapro (antidepressant medication) and Lasix (diuretic). Continued interview with the DON, on [DATE] at 3:48 PM, revealed when she interviewed the nurses, the nurses verbalized the narcotic cards were coming from pharmacy with tape on the back of the narcotic cards. Interview with LPN #2, on [DATE] at 3:29 PM, revealed he told the DON during the investigation he thought pharmacy was delivering the narcotic cards with the tape on the back of them because it began to seem like a normal thing to him. LPN #2 stated he felt it had been going on for a couple of months. He also stated he always observed a few narcotics taped, though he never studied the backs of the narcotic cards. LPN #2 stated he was not aware that diversion of drugs should be reported immediately to a supervisor, as stated in the policy. Interview with LPN #7, on [DATE] at 4:42 PM, revealed she saw the tape on the back of the narcotic cards ever since she started at the facility in [DATE]. LPN #7 stated she had not questioned the paper tape behind the narcotics. Interview with LPN #3, on [DATE] at 2:02 PM, revealed she had noticed the tape on the backs of the narcotic cards as early as [DATE]. LPN #3, stated she attempted to remove a narcotic from the blister and had a hard time pushing the medication through the foil backing. LPN #3 stated she did not think the narcotics were coming from pharmacy taped, she just thought the staff was placing the tape too tight to the back of the card. LPN #3 stated she had not observed any others blister packs with tape, but she was not looking either to identify if there were anymore packs with tape. Interview with the DON, on [DATE] at 3:48 PM, revealed she reviewed the narcotics on all four (4) medication carts and could not identify any concerns with tampering of the medications on the Heritage Hall. The DON stated Residents #1 and #2 all lived on the Lincoln Hall and received medications from the odd hall cart utilized by RN #1. The DON stated she then destroyed any narcotics cards that looked like they were bent to prove a point to staff that the narcotic cards did not come from pharmacy in that condition. The DON stated she then informed the staff that if they saw tape on the back side of a narcotic card, they needed to report to her immediately. Further interview with the DON, on [DATE] at 2:37 PM, revealed the Consulting Pharmacist came into the building on [DATE] and [DATE] to review carts and narcotics for any discrepancies. The DON began to check the orders and narcotic administration records to ensure the orders and MARs matched what was in the computer. Also to ensure the narcotics matched the count by the end of the month. The DON stated she asked the Consulting Pharmacist to pay special attention to the Lincoln Lane medication carts on [DATE] even though the pharmacist completed monthly medication checks. However, review of the Pharmacy Quality Assurance Summary Report, dated [DATE] revealed there was a special focus on the Heritage Hall carts (which was not identified to be the hall in question). The controlled substances on Heritage Hall were observed to be: double locked; controlled substances were not tampered; controlled substances were within date; timed orders were completed and pulled; the controlled substances were signed by two (2) nurses when the narcotics were counted at the end of shift; and, the controlled substance count matched the count sheets on Heritage Hall. However, there was no documented evidence that Lincoln Hall's Controlled Substance Storage/Documentation or carts had been checked. Post survey interview with the DON, on [DATE] at 2:07 PM, revealed she informed the Consulting Pharmacist to look at both halls when the diversion occurred. However, the DON did not monitor the Pharmacist to ensure the audit was completed, nor did she know what the Pharmacist actually reviewed. 2. Interview and record review revealed Resident #5 was administered three (3) doses of a narcotic after the pharmacy instructed the facility to destroy it. Review of Resident #5's record, revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. Review of Resident #5's Physician Orders, dated [DATE], revealed Resident #5 had an order for [REDACTED]. Review of the Narcotic sheets revealed two (2) of Resident #5's Lorazepam, 1 mg; and, one (1) Morphine (Roxanol), 5 mg had been destroyed on [DATE] for fear the medication had been tampered. Although pharmacy had instructed the DON to destroy this medication on [DATE], the facility continued to administer this medication to Resident #5; three (3) doses were given, one on [DATE], [DATE], and [DATE]. Review of the Quality Improvement: Consultant Pharmacist Summary, period covered [DATE] through [DATE], revealed Consultant Pharmacist checked the remaining controlled medication for tampering. She suggested for Resident #5 that one (1) thirty (30) milliliters (ml) Morphine be destroyed and also one (1) Lorazepam thirty (30) ml, as both of the medications were open and the contents could not be verified. Interview with the Consulting Pharmacist, on [DATE] at 8:35 AM, revealed on [DATE], the DON decided she wanted a sense of security to ensure what was remaining in the medication carts had not been tampered. There was some Morphine that had been opened for Resident #5. The Consulting Pharmacist stated the Morphine liquid was blue and the Lorazepam liquid was clear. The Consulting Pharmacist stated she informed the DON to dispose of the medications because she was unaware if the medication had been tampered. The Consultant Pharmacist did not destroy the medication with the DON. Post survey interview with the DON, on [DATE] at 2:07 PM, revealed she could not remember when the pharmacist told her to destroy these medications and thought it was on [DATE] the day she destroyed the medications. 3. Interview and record review revealed the facility staff was reordering medications too soon due to not being available for use for |

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| F 0431<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 6)<br>Resident #3 and Resident #6 although the pharmacy had sent the medications. In addition, review of Resident #6's MAR indicated [REDACTED]. Review of Resident #3's record revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. Review of Resident #3's MDS Quarterly Assessment, dated [DATE], revealed the facility assessed Resident #3 with a BIMS score of fifteen (15), which meant Resident #3 was interviewable. Review of Resident #3's May, 2014 Physician orders, revealed orders for Buspirone HCL (anti-anxiety) 15 mg, by mouth three times a day (TID); Escitalopram, (anti-depressant) 20 mg, by mouth daily; and, Dilaudid, (narcotic pain analgesic) 2 mg, by mouth every four (4) hours as needed. Review of Resident #3's September, 2014 Physician Orders, revealed Resident #3 was currently taking: Buspirone HCL, 15 mg, by mouth three times a day; Dilaudid, 2 mg, by mouth every four hours per resident request; Lorazepam, (anti-anxiety) 0.5 mg, by mouth three times a day; and, Benadryl, (anti-histamine) 25 mg, by mouth every six hours for itching. Review of a pharmacy invoice for the months of April, May and [DATE], revealed the facility had to reorder multiple doses of Buspirone and Escitalopram. Review of the [DATE], invoice revealed Resident #3's Buspirone HCL, 15 mg, and Escitalopram, 20 mg, had to be reordered and paid for by the facility. Review of Resident #6's record revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. Review of Resident #6's physician orders [REDACTED].<br>Review of Resident #6's, MAR for the month of [DATE], revealed Resident #6's Primidone, 50 mg, was not given on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Review of the<br>MAR indicated [REDACTED]. There was no documentation to indicate why the medications were not administered on the other dates. Review of the pharmacy's Work Order Fills form, for Resident #6 for the month of [DATE], revealed the Pharmacy sent a total of thirty (30), Primidone tablets on [DATE] and again on [DATE], for a total of sixty (60) tablets. However, review of Resident #6's MAR indicated [REDACTED]. Review of Resident #6's, MAR for the month of [DATE], revealed Resident #6's Primidone, 50 mg, was not given on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]<br>and on [DATE]. There was no documentation to indicate why the medications were not administered. Review of the pharmacy's Work Order Fills form, for Resident #6 for the month of [DATE], revealed the Pharmacy sent a total of thirty (30) Primidone tablets on [DATE]. However, review of Resident #6's MAR indicated [REDACTED]. Review of Resident #6's, MAR for the month of<br>[DATE], revealed Resident #6's Primidone, 50 mg, was not given on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. Review<br>of the MAR indicated [REDACTED]. There was no documentation to indicate why the medications were not administered on the other dates. Review of Resident #6's, Advanced Practice Registered Nurse (APRN) worksheet, dated [DATE], revealed upon review of the MARs it was identified that Resident #6 had been without Primidone (anti-seizure medication) medication for the entire month because the pharmacy had failed to send the medication. The plan was to call the pharmacy to send the Primidone to the facility. Attempted interview with the APRN, on [DATE] at 11:00 AM, revealed a refusal to interview because she did not work for the facility any longer. Review of the pharmacy's Work Order Fills Form, for Resident #6 for the month of [DATE], revealed the Pharmacy sent nine (9) tablets of Primidone on [DATE] and nine (9) tablets on [DATE]. Interview with LPN #6, on [DATE] at 2:33 PM, revealed she kept reordering the Primidone, because it would be there one day and not the next. Post survey interview with the Medical Director, on [DATE] at 2:38 PM, revealed if he had identified that Resident #6 was not receiving h |
| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Be administered in an acceptable way that maintains the well-being of each resident .**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review and review of the facility's policies and the Administrator's job description it was determined the Administrator failed to use available resources to ensure an effective system was in place to ensure staff was knowledgeable of the facility's policies and procedures for narcotic and medication administration and to prevent misappropriation/drug diversion and tampering of resident medications and controlled substances for five (5) of nine (9) sampled residents (Residents #1, #2, #3, #5 and #6); and, two (2) of two (2) unsampled residents (Unsampled Residents A and B). The Administrator failed to ensure medications and narcotics were administered, reconciled, and monitored. (Refer to F224, F431, F514 and F520) The Administrator had a concern with reordering medications in June and July of 2014; this was taken to Quality Assurance (QA) and considered resolved as of 07/28/14. This was the last QA meeting on record. However, it was never identified by QA that narcotics were being diverted during this time. The Administrator was not made aware on 08/31/14 of the narcotic blister packs, that were identified by Licensed Practical Nurse (LPN) #2, #3 and #6, as having been tampered and taped. She became aware of this on 09/08/14, by the Director of Nursing and initiated audits to determine how many residents were effected. The audits determined twenty-five (25) additional residents were effected; however, this was never taken to QA for review, monitoring or resolution. Although the Administrator contacted the pharmacy for assistance, the Administrator never reviewed the audits for 09/09/14 and 09/15/14 to ensure it covered the suspected medication cart on Lincoln Lane. In addition, the Administrator did not make sure all of the licensed staff was educated on the facility's policy and procedures for reconciling and documenting narcotic counts. The Administrator did not ensure the Abuse education provided to staff after 09/08/14, clarified that theft/diversion of resident drugs was defined as misappropriation of resident property and should be reported immediately, per the facility's policy. The failure of the Administrator to effectively use available resources to detect misappropriation/diversion of medications and narcotics, ensure the Quality Assurance Committee developed action plans and monitored the reconciliation of narcotics, and administration of medications placed residents at risk in a situation that has caused or was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was identified on 10/02/14 and determined to exist on 08/31/14. The facility provided an acceptable Allegation of Compliance on 10/09/14 that alleged removal of Immediate Jeopardy on 10/09/14. However, the State Survey Agency determined the Immediate Jeopardy was removed on 10/11/14, after training of facility staff was verified completed 10/10/14, at 42 CFR 483.75 Administration (F490) with a scope and severity lowered to an E while the facility monitors the effectiveness of the implemented plan of correction. The findings include: Review of the job description for the Administrator, not dated or signed, revealed the purpose of the position was to direct the day to day functions of the facility in accordance with current federal, state and local standards, guidelines, and regulations that govern nursing facilities. The essential function of the position was: compliance management; to ensure excellent care for residents is maintained by overseeing and monitoring patient care services delivered; works with and supervises personnel to ensure complete understanding of responsibilities; and, to ensure maintenance of accurate medical records for billing, auditing, and regulatory compliance. Review of the Inventory Control of Controlled Substances Policy, revised 01/01/13, revealed the facility representative should regularly check the inventory records to reconcile inventory. The Facility should regularly reconcile: Current and discontinued inventory of controlled substances to the log used in the facility's controlled medication inventory system: Current inventory to the controlled medication declining inventory record and to the residents' Medication Administration Record (MAR) and unused controlled substances held in storage destruction to the declining inventory record. Review of the Loss and Theft Policy, effective 12/01/07, revealed appropriate actions may include: immediately reporting suspected theft or loss of drugs to a supervisor/manager or the Director of Nursing for appropriate investigation and follow-up. Investigating and reconciling discrepancies; and, notifying the appropriate Facility Administrator of controlled substance discrepancies and if such discrepancies are not reconciled, notifying the appropriate law enforcement agencies according to applicable law and facility policy. Review of the facility's policy, Recognizing Signs and Symptoms of Abuse, revised April 2011, revealed the facility would not condone any form of resident abuse. To aid in abuse prevention, all personnel were to report any signs and symptoms of abuse to their supervisor or to the Director of Nursing Services immediately. Signs of actual physical neglect would be improper use/administration of medications. Review of the facility's policy, Documentation of Medication Administration, revised April 2007, revealed a nurse or Certified Medication Aide would document all medications administered on each resident's Medication Administration Record (MAR). Administration of medication must be documented immediately after (never before) it was given. Review of the facility's policy, Medical Records, revised August 2006, revealed a medical/clinical record was maintained for each resident admitted to the facility. All data contained in the resident's chart maintained at the nurses's station reflects the medical history of [REDACTED]. Review of the facility's policy regarding Adverse Consequences and Medication Error, revised February 2014, revealed the interdisciplinary team reviews the resident's medication regimen for efficiency and actual or potential medication-related problems on an ongoing basis. The QA Committee would conduct a root cause analysis of medication administration errors to determine the source of errors, implement process improvement steps, and compare results over time to determine that system improvements were effective in reducing errors. Review of the training records revealed licensed staff borrowing medications was not included in either training conducted on 06/04/14 or 06/10/14. Education provided on 09/17/14 after the drug diversion was suspected |

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| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 7)<br>did not cover misappropriation of resident property. Review of the computer education regarding Abuse revealed it did not cover drug diversion as misappropriation of resident property. (Refer to F224) The Administrator did not ensure education provided on 06/04/14, 06/10/14, and 09/17/14 addressed identification of diversion of medications/narcotics, monitoring narcotics, reporting suspicion of diversion of drugs, or following the facility policies. (Refer to F431) The Administrator did not ensure narcotic count sheets were monitored for irregularities or inaccurate documentation. The Administrator did not ensure Pharmacy was reviewing the narcotic count sheets for accuracy. The Administrator did not ensure education provided on 06/04/14, 06/10/14 and 09/17/14 addressed monitoring the accuracy of the medication/narcotic documentation. (Refer to 514) Interview, on 09/25/14 at 4:06 PM, with the Administrator, revealed the facility did not monitor, reconcile and/or destroy medications according to policy. Interview with the Director of Nursing (DON), on 09/24/14 at 3:48 PM, revealed she destroyed evidence (narcotic blister packs and liquids) when diversion of drugs was suspected and continued to destroy evidence once law enforcement had initiated an active case. From 09/15/14 until 10/13/14 twenty-five (25) additional residents were identified as possible victims of the drug diversion. The Administrator failed to ensure a QA meeting was held to develop a plan of action and monitor the investigation process after she was notified of the suspected diversion of drugs on 09/08/14. (Refer to 520) Interview with the Administrator, on 09/25/14 at 4:06 PM, revealed she was made aware of the diversion on 09/08/14 by the DON. She stated there was no QA meeting held after 09/08/14 to address the magnitude of the diversion of drugs; however, there was a QA meeting scheduled for the week after 09/25/14. In addition, she did not make contact with the pharmacy consultant about the information discovered on 09/08/14 due to the pharmacist had been working with the DON. Continued interview with the Administrator, on 10/01/14 at 3:01 PM, revealed she was alerted to medication errors before and they were addressed. As of now and looking at them today and knowing what has happened, she would look at the medication errors differently. The Administrator stated she was not aware the DON was not looking at the narcotic sheets or the empty blister packs. She stated she was aware there were some concerns with pharmacy and the delay of medications, but she felt the facility was at fault because the time lines in which medications were given. The facility provided an acceptable Allegation of Compliance (AOC) on 10/09/14 alleging the Immediate Jeopardy was removed 10/09/14; however, the State Survey Agency verified that staff training was completed on 10/10/14 and the Immediate Jeopardy was removed on 10/11/14. The facility took the following steps to remove the Immediate Jeopardy. 1. Residents #1, #2, #3, #5 and #6 were assessed and interviewed, with no negative outcomes. RN #1 was immediately suspended on 09/08/14 pending the investigation. 2. Licensed staff was interviewed and the allegation reported to the Office of Inspector General (OIG), Kentucky Board of Nursing (KBN), the Department of Community Based Services (DCBS) and Law Enforcement. 3. All medications<br>found to be tampered with were reordered at the facility's expense. 4. Resident #1's tampered medications were pulled from circulation on 09/08/14 by the DON and destroyed on 09/10/14. 5. Resident #2's medications were pulled on 09/03/14 and locked up, when the resident was admitted to the hospital. Upon the resident's return on 09/10/14, the narcotics were determined to have been tampered with and the Police were immediately notified. Narcotics and their containers were turned over to the local Police Department. Medications were reordered at the facility's expense. 6. On 09/16/14, the Pharmacist auditing the medication carts suggested to the DON and the ADON, that Resident #5's narcotics should be destroyed. 7. The DON and facility Administrator conducted 100 % audit of narcotic orders and reconciliation sheets for any discrepancies that may indicate diversion on 09/08/14. The DON continued to complete audits daily to ensure there has been no breach of narcotic medication administration, documentation, reconciliation and or tampering of packages. 8. The Consultant Manager from the pharmacy (facility contracted), on 10/03/14, reviewed and analyzed narcotic medications dispensed and being administered for any discrepancies of tampered packaging, documentation of narcotic sheets, medication administration records for reconciliation and the Emergency Drug Kit (EDK). In addition, all Consulting Pharmacists visits starting 10/03/14 will include at a minimum a review of the entire narcotic dispensing system and analyzing narcotic counts, records, MARs, labels and packaging which will be compared to current orders to ensure there has been no tampering. 9. Education provided to the nursing staff by the DON included medication misappropriation (tampering of medication packaging or appearance of falsification of narcotic sheets), immediate notification to the DON, supervisor or the Administrator. 10. The DON was educated by the Regional Nurse Consultant for Preferred Care Partners Management Group on 09/12/14, on Misappropriation and Diversion of Narcotics, EDK Process, Pharmacy Training Guide, Notification to Administration and Pharmacy, Destruction of Narcotics, Pain Assessment, Accuracy of Notes, Change of Condition, Abuse and Neglect and the Narcotic Balance. 11. All licensed staff was educated by the Nursing Consultants on 10/07/14, which was attended by fourteen (14) licensed nursing staff. This includes seven (7) RNs and seven (7) LPNs, the Director of Nursing and the Unit Manger. In-services provided on the 7th were taken to QA on the 7th. 12. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following programs: Pain Assessment and Management; Accuracy of Notes, Documenting change of Condition; PRN Medication Management; Medication Pass-Indicators, Side Effects, reporting errors; Prevent/Recognize and Reporting Patient abuse; Pharmacy Training Guide; EDK Process; and, State Regulations controlled substance Notification. This training was completed by all nursing staff on the computer program SilverChair by 09/28/14. 13. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following Policies: Adverse Reaction to Medications; Controlled Substances- Misappropriation; Adverse Consequences and Medication Errors; Accepting Delivery of Medications; Administering Medications; Loss or Theft of Medications; Discarding or Destroying of Medications; and, Security of the Medication Carts. This training was provided by the DON and completed by all nursing staff by 10/06/14. 14. The Quality Assurance Committee consisted of the Administrator, DON, Unit Managers, Social Services, Activities Director, Dietary Director, Medical Director and Consulting Pharmacist, met Monday through Friday, in which the DON and or the Administrator reported on Narcotic Count Records as well as the MAR and reviewed narcotic medications. If suspicion was identified, the DON would immediately contact the Pharmacy and begin an internal investigation. All proper Authorities would be notified including OIG, DCBS, local police and/or KBN. This practice would continue 5 x weekly and/or PRN as needed through 10/31/14. 15. Any discrepancies discovered on the weekend, the weekend nurse would immediately notify the nurse on call, the nurse on call would notify the Administrator or DON. 16. The Pharmacy Consultant would also review for any possible administration of narcotics that may elude a suspicious activity and review the list of destroyed narcotics with each visit. Also a copy of current narcotic orders would be provided from pharmacy for the consultant pharmacist to reconcile with the current orders on the resident's chart to ensure ordering accuracy from pharmacy. 17. The Administrator contacted the Corporate Regional Team on 09/08/14. She and the DON organized the collection of narcotics, and narcotic count sheets on 09/08/14. The DON contacted local law enforcement agency. The Administrator reviewed policies and procedures on 09/08/14 with no revisions. Through observation, interview and record review the State Survey Agency (SSA) validated the Allegation of Compliance with removal of Immediate Jeopardy on 10/11/14 prior to exit on 10/13/14. 1. Interview with Resident #1, on 09/23/14 at 11:30 AM and Resident #3, on 09/23/14 at 8:57 AM, revealed no negative outcomes. Review of Residents #1, #2, #3, #5, and #6's clinical record revealed no adverse outcomes. Review of RN #1's employee file, revealed the facility terminated RN #1 on 09/12/14. Interview with the DON, 09/24/14 at 3:48 PM, revealed RN #1 had not worked since 09/04/14, was suspended on 09/08/14 and was officially terminated on 09/12/14. 2. Review of the facility's investigation, dated 09/08/14, revealed the facility faxed a report to the Office of Inspector General (OIG) and the Department of Community Based Services (DCBS) on 09/08/14. The Local Police Department (opened case #14-2423) was also notified regarding misappropriation of controlled medications. The Kentucky Board of Nursing was notified of the allegation in regards to RN #1 on 09/11/14. 3. Review of the facility's charges from the Pharmacy revealed the facility purchased the reordered medications that were destroyed. Review of the Product Destruction Summary, dated 09/26/14, revealed medications were being destroyed as of 09/17/14. Interview on 09/26/14 at 1:29 PM, with the DON revealed the facility replaced the narcotic medications that were destroyed. 4. Review of Resident #1's Controlled Substance Inventory Form, revealed two (2) bottles of [MEDICATION NAME] were destroyed on 09/10/14 by the DON and Assistant Director of Nursing (ADON). Interview with the ADON, on 09/25/14 at 9:28 AM, revealed she was present when Resident #1's medication was being destroyed. Interview with the DON, on 09/24/14 at 3:48 PM, revealed she destroyed any medications that appeared tampered. 5. Interview with the DON, on 09/24/14 at 3:48 PM, revealed the police were given Resident #2's medication cards. Review of Resident #2's two (2) [MEDICATION NAME] narcotic cards, which were in police custody at the Police Department, revealed one card was tampered; however, this medication was not dispensed to Resident #1. The other [MEDICATION NAME] narcotic card showed no evidence that it had been tampered. Review of the facility's charges from the Pharmacy, revealed the facility purchased the re-ordered medications which were destroyed. 6. Review of Resident #5's [MEDICATION NAME] and [MEDICATION NAME] narcotic sheets, revealed the two (2) medications were destroyed on 09/15/14 by the DON. Interview with the DON, on 09/26/14 at 1:29 PM, revealed the DON had destroyed [MEDICATION NAME] and [MEDICATION NAME] on 09/15/14. 7. |

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| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 8)<br>Record review of audits of narcotic orders and reconciliation sheets for discrepancies, revealed they started to be completed on 09/15/14. Interview with the DON, on 09/26/14 at 2:37 PM, revealed she began to audit MARs and physician orders [REDACTED]. Interview with the DON, on 10/13/14 at 10:29 AM, revealed every morning she reviewed the controlled substances, to ensure the narcotic counts were right and would report that to the QA team every morning, 10/06/14 through 10/10/14. 8. Review of the Pharmacy Clinical Manager MAR to Cart Audit Form, dated 10/03/14, revealed she completed a 100% audit to look at all orders, verified the MAR matched the orders, and that the pink narcotic sheets matched the drug labels. Then all narcotic counts were verified. The review revealed no signs of diversion for any of the residents. Interview with the Pharmacy Clinical Manager, on 10/13/14 at 11:34 AM, via telephone, revealed she came into the facility to review controlled substances orders, make sure the directions of the orders matched the narcotic sheets. She did an inventory with nursing and inspected the medications and ensured that the narcotic counts matched. The Pharmacy Clinical Manager stated she did not identify any concerns except the orders did not match the directions on the narcotic cards, especially when the medication changed from routine to PRN. She stated she reviewed all four (4) medication carts and looked at the Emergency Drug Kit (EDK) box, which revealed no concerns with the shift change counts. She then provided the facility with a report. Interview with the Administrator, on 10/13/14 at 2:02 PM, revealed on 10/03/14 the Pharmacy Clinical Manager came in and did a 100% audit and would provide oversight until 11/30/14. 9. Review of the education content confirmed the education was completed on 09/30/14 by the DON for eleven (11) LPNs, and five (5) RNs, there was no PRN staff, none on FMLA (Family Medical Leave Act) or vacation and the facility did not use contract staffing. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3 on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7 on 10/13/14 at 1:26 PM; and ,RN #4, on 10/10/14 at 10:36 AM revealed all were knowledgeable of what abuse and misappropriation was and how to report to the DON or Administrator immediately. 10. Interview with the DON, on 10/13/14 at 10:29 AM, revealed she received training on 09/12/14 by the Regional Nurse Consultant. She was educated on medication pass, audits, what information she needed to obtain from the pharmacy, such as a record of all the items that needed to be ordered by pharmacy and then use the information to audit the MAR and compare to what was in the drawer and the physician's orders [REDACTED]. Interview with the Regional Nurse Consultant, on 10/13/14 at 3:42 PM, revealed she completed education on 09/08/14 and 09/12/14 with the DON and Administrator. She went over documentation, narcotic sheets and the protocol for nursing. She also compared MARs and the Pain assessment sheets. The DON was educated on not throwing away evidence. The DON was educated on abuse and misappropriation of medications. The Regional Nurse Consultant stated she talked to the DON about replacing all medications because it was the resident's property. The DON was educated on monitoring the narcotic sheets, MARs and Pain assessment sheets daily. The destruction of medication and ensuring two (2) nurses were present. Also, monitoring the EDK box and ensuring the serial numbers matched everyday. The DON was also educated on different methods of tampering with medication and not having tape placed on the back of narcotic cards. 11. Interview with LPN #3, on 10/10/14 at 1:20 PM, revealed she was not educated by the Clinical Services Nurse. LPN #3 stated she was not in the building on 10/06/14, 10/07/14 or 10/08/14 in which the Consulting Pharmacists were present in the building. LPN #3 stated she did not obtain a packet from the DON, but had obtained 1:1 training with the DON. LPN #3 had been working the whole shift on 10/10/14 without being educated. Review of the In-service Education on 10/08/14, by the Clinical Services Nurse from pharmacy for the loss/theft of medications, revealed only six (6) LPNs were educated, one (1) RN, and the ADON was educated out of a total of sixteen (16) licensed staff members. LPN #3 was not on the sign in list as being educated. Interview with the Regional Nurse Clinician for pharmacy, revealed she completed a quick training with the staff because she was told the staff had already been in-serviced. The training was supposed to be a quick reference tool. She stated she observed a shift to shift narcotic count. The Regional Nurse Clinician stated she wanted to ensure the nurses, when counting narcotics, monitored the card numbers and looked at the narcotic sheets to ensure they matched. The DON stated she knew LPN #3 was not trained and was going to train LPN #3 at the end of her shift. The DON stated LPN #3, knew she had been trained on most of the information; however, she was not trained on how to destroy narcotic medication and who was responsible to destroy the medications. Everything the Regional Nurse Clinician educated staff on, the DON had already went over with the staff. So though the Regional Nurse Clinician did not get the opportunity to educate all the nursing staff, all nurses were provided the same information. Review of the daily QA meetings on 10/06/14 through 10/10/14, revealed no documented evidence that the training went to QA; however, there was evidence on the 10/07/14 QA meeting where they talked about the pharmacy and their role and participation in the correction of the deficiency. Interview with the Regional Director of Operations, on 10/10/14 at 2:21 PM, revealed staff was not to work unless they had been educated. He stated he was not aware LPN #3 was on the floor the whole shift. He stated he was at fault for this. The Regional Director of Operations (RDO) stated he knew he stated in the Allegation of Compliance (AOC), all the nursing staff was educated, but he meant to say the staff could not work if all were not educated and would fix it immediately. Interview with the RDO, on 10/10/14 at 2:04 PM, revealed he had the information in the AOC wrong. Review of the training for loss or theft of medications revealed an additional six (6) nurses were educated on 10/10/14 by the DON. 12. Review of the Pain Assessment and Management training provided from 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-served on pain medications. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of pain assessments and the fact they had to be completed before and after administration of pain medications. The trainings were completed on 09/27/14. Review of the training on the Ins and Outs of Documentation, provided 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-serviced on documentation. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of accurate documentation of the MAR's and narcotic sheets. The training was completed for all nursing staff by 09/28/14. Review of the training on PRN Medication Management, provided on 09/01/14 through 10/05/14, revealed all licensed staff, eleven (11) LPNs and five (5) RNs had been in-serviced on PRN medication management and ensuring an assessment was completed on all residents before and after PRN medication was given. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of PRN medication management. The training was completed by all nursing staff by 09/29/14. Review of the training on Medication Pass, provided on 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-serviced on the proper way to perform a medication pass, side effects of giving the wrong medications and reporting errors immediately to the DON or Administrator. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable about the Medication Pass requirements. The training was completed on 09/29/14. Review of the training on Preventing, Recognizing and Reporting Resident Abuse, provided on 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs were educated on abuse, misappropriation and the importance of notifying the DON and Administrator as soon as abuse was observed. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable of identifying and reporting abuse. The training was completed by all nursing staff by 09/30/14. Review of the training on the Pharmacy Training Guide, EDK Process and KAR's Controlled Substance Notification, provided on 09/17/14, revealed nine (9) LPN's and five (5) RN's were educated and two LPN's were educated on a later date. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable of the physician order [REDACTED]. The training was completed by all nursing staff by 10/10/14. 13. Review of a training provided by the Regional Nurse Clinician and the DON on Policies and Procedures with copies provided on the following: loss and theft of medications; adverse consequences; medication destruction and disposal of controlled substances; security of the medication cart; documentation medication administration; administering medications; and, accepting delivery of medications and controlled substances. Review revealed all eleven (11) LPNs and five (5) RNs were inserviced from 10/07/14 through 10/10/14. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable of the policies and procedures for narcotics and medication administration. The training was completed by all nursing staff on 10/10/14. 14. Review of the QA meetings minutes and sign in sheets, dated 10/06/14, 10/07/14, 10/08/14, 10/09/14 and 10/10/14, revealed the Administrator, DON, Unit Manger, Medical Director, Consulting Pharmacist and |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185266 | A. BUILDING _____ B. WING _____ | 10/13/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| ELIZABETHTOWN NURSING AND REHABILITATION CENTER | 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 9)<br>Regional Director of Operations had attended daily meetings Monday through Friday. Interview with the DON, on 10/13/14 at 10:29 AM, revealed there was a QA meeting every morning. Review of the Controlled Substance Audit, dated 10/06/14 through 10/10/14, revealed the audits were completed without concerns. The DON stated she would report back to the QA committee with any diversion they would initiate an investigation immediately and report to all agencies. Interview with the Regional Director of Operations, on 10/13/14 at 2:28 PM, revealed he would attend QA daily while he was in the facility. 15. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable to call the DON immediately if they observed any discrepancies with narcotics. The staff was also aware to report to the DON if they had witnessed tape behind a narcotic medication card. 16. Review of the Pharmacy consults, dated 10/03/14, revealed the MARs were verified to match the pharmacy delivery tickets; and, matched the labels. All counts, and all tablets were verified to be accurate and no signs of diversion. Direction change stickers (to be placed on the Narcotic count sheets when the directions for administering the narcotics is changed) were applied. Interview with the Pharmacy Consultant Manager, on 10/13/14 at 11:34 AM, revealed on 10/13/14, she came in and reviewed 100% of the control substance orders, made sure the directions matched the narcotic pinks sheets. She conducted an inventory of what narcotics were available, with the nursing staff. Interview with the Pharmacy Regional Manager, on 10/13/14 at 9:31 AM, revealed to his understanding the new Consultant Pharmacist would be completing 100% audits, looking at narcotic cards and narcotic count sheets. The Regional Manager, stated the Consultant would ensure the narcotic count was accurate and there had been no tampering with the medications. The Consultant was expected to exit with the facility, attend QA meetings monthly and quarterly and review weekly Narcotic delivery worksheets. 17. Interview with the Regional Director of Operations, on 10/13/14 at 2:28 PM, revealed the Administrator notified him on 09/08/14. A conference call with the Regional Nurse Consultant took place on 09/08/14, to discuss Resident #1 in which it was stated it was pretty evident Resident #1 did not receive all of his/her medications. Review of the narcotic count sheets revealed a collection of count sheets on the DON's desk. Interview with Detective #1, 09/22/14 at 3:23 PM, revealed the facility had contacted them to report the allegation of drug diversion. Review of the signature section of the policies and procedures revealed they were reviewed by the DON and ADON on 10/06/14 with no changes to the policies and procedures. |
| F 0514<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Keep accurate, complete and organized clinical records on each resident that meet professional standards**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to maintain accurate clinical records and have an effective system in place for monitoring narcotics sheets and monitoring Medication Administration Records (MARs) for four (4) of nine (9) sampled residents (Residents #1,#2, #3 and #6); and two (2) of two (2) unsampled residents (Residents A and B). (Refer to F431) RN #1 altered narcotic count sheets to make the balance appear accurate on paper although the actual narcotic tablets had been removed from the blister packs and substituted with an unknown medication. In addition, RN #1 did not sign for the narcotics as they were removed from the blister pack, she would complete the documentation as the shift to shift count occurred. RN #1 made changes on the narcotic count sheets by obliterating her signature, date and time, without a witness or supervisor review. RN #1 documented the removal of narcotic tablets for the same date and time on two (2) separate count sheets. The Medication Administration Records (MARS) did not reflect the administration of the narcotics removed by RN #1. The MAR reflected missing doses or medications that were not available. There was no documented evidence of follow up with the pharmacy for the missing medications. The narcotic count sheets were filed in medical records when completed without any review by the Director of Nursing, Assistant Director of Nursing, Administrator, Medical Records Director or Pharmacy. The facility's failure to have an effective system in place to ensure narcotic and medication administration records were accurately documented placed residents at risk in a situation that has caused or was likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 10/02/14 and determined to exist on 08/31/14. The facility provided an acceptable Allegation of Compliance on 10/09/14 that alleged removal of Immediate Jeopardy on 10/09/14. However, the State Survey Agency determined the Immediate Jeopardy was removed on 10/11/14, after training of facility staff was verified completed 10/10/14, at 42 CFR 483.75 Administration (F514) with the scope and severity lowered to an E while the facility monitors the effectiveness of the implemented plan of correction. The findings include: Review of the facility's policy, Inventory Control of Controlled Substances, revised 01/01/13, revealed the facility's representative would regularly check the inventory records to reconcile inventory. The facility would regularly reconcile: current and discontinued inventory of controlled substances against the log used in facility's controlled medication inventory system; current inventory against the controlled medication declining inventory record; and, to the residents' Medication Administration Record (MAR) and unused controlled substances held in storage destruction to the declining inventory record. Review of the facility's policy, Documentation of Medication Administration, revised April 2007, revealed a nurse or Certified Medication Aide would document all medications administered to each resident's medication administration record (MAR). Administration of medication must be documented immediately after (never before) it was given. Review of the facility's policy regarding Medical Records, revised August 2006, revealed a medical/clinical record was maintained for each resident admitted to the facility. All data contained in the resident's chart maintained at the Nurses's Station should reflect the medical history of [REDACTED]. 1. Review of Resident #1's [MEDICATION NAME] IR, (immediate release) 15 mg, narcotic blister pack with a quantity of thirty (30) tablets, revealed blisters number twenty-four (24) through thirty (30) were empty and blister number twenty-one (21) was empty, blisters number one (1) through twenty (20), twenty-two (22) and twenty-three (23) were full. Documentation on the [MEDICATION NAME] IR, 15 mg, narcotic sheet, on 08/31/14 revealed, LPN #2 and LPN #6 had signed<br>and verified blister #21 was missing a pill. Review of the back of the [MEDICATION NAME] IR, 15 mg, card revealed all thirty (30) tablets had been cut, replaced with an unknown medication and paper tape placed across the back of the card. Review of the [MEDICATION NAME] IR, 15 mg, from the untampered narcotic card, dated 09/04/14, revealed Resident #1 received medication at 10:00 AM, 2:00 PM and 6:00 PM all by RN #1 when there was eighteen (18) tablets available on the first narcotic sheet of [MEDICATION NAME] IR, 15 mg. Interview with LPN #6, on 09/26/14 at 2:33 PM, revealed she was informed to always use up all the medication on the first narcotic card and then move to the second narcotic card. This would be keeping an accurate clinical record. If she had seen where the nurse was pulling from one narcotic sheet and then pulling from another when narcotics were available on the first sheet, she would have notified her supervisor. Interview with LPN #3, on 09/24/14 at 3:20 PM, revealed she was aware Resident #1 liked to receive his/her pain medications at night. So when LPN #3 reviewed the narcotic count sheet it revealed RN #1 had pulled three (3) doses of [MEDICATION NAME] 15 mg all on 09/04/14 at 10:00 AM, 2:00 PM and 6:00 PM while utilizing a new medication card for Resident #1. LPN #3 stated this was really odd for Resident #1 to receive three (3) doses in one day. She stated this was not reported to the supervisor on duty, she just made a copy placed it under the DON's door for review on Monday. Interview with Resident #1, on 09/23/14 at 11:30 AM, revealed he/she had always asked for pain medication at night because he/she suffered from pain to the right leg. Resident #1 stated he/she had five (5) surgeries to his/her leg. Resident #1's right leg was observed to be lying to the right severely and contracted. Resident #1 stated he/she did not receive the pain medications that the nurse documented he/she had received on 09/04/14. 2. Review of Resident #2's [MEDICATION NAME], 2.5 mg, every eight (8) hours as needed revealed out of a total of thirty (30) tablets, #13 and #4 tablets were removed from the medication card, with no signature as to what happened to the medications. Signature space for #28 had one (1) line through the error with one signature and it was not witnessed by two (2) nurses. Further review of the narcotic count sheet revealed the dates of removal were out of order. Tablet #5 was removed at 6:30 AM on 08/28/14 with a balance of 4, tablet #4 was noted as empty with a balance of 3, and tablet #3 was removed on 08/27/14 at 10:30 AM, after it was documented tablet #5 was removed on 08/28/14. Interview with the DON, on 09/25/14 at 6:00 PM, revealed she had a concern with the tape on the blister packs; however, she did not have any concerns with narcotic counts because she had not reviewed the narcotic count sheets and had focused on pharmacy from 09/01/14 through 09/08/14 as the source of the tape being on the back of the blister packs. On 09/05/14, she received a copy of a second set of narcotic count sheets with a note from LPN #3. The narcotic count sheet revealed three (3) doses were removed on 09/04/14 by RN #1; however, the note stated Resident #1 never takes three (3) doses in one day. 3. Review of Resident #3's [MEDICATION NAME], 0.5 mg, by mouth three (3) times a day as needed, dated from 05/27/14 through 06/29/14, revealed tablets #11, #13, two (2) #22's, and #23 were scribbled through with multiple lines. Tablet #23, two #22's and #11 |

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|---|---|---|---|
| | 185266 | A. BUILDING _____ B. WING _____ | 10/13/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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|---|---|
| F 0514<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 10)<br>were observed to have been scribbled through by RN #1. Error was documented on signature line for tablets #11 and #13. Review also revealed there was no documentation of two (2) nurses to witness the error, as per policy. Review of Resident #3's [MEDICATION NAME] 2 milligrams (mg) every four (4) hours as needed for pain, narcotic sheet, revealed there were two (2) narcotic cards, one for the month of June dated 06/15/14 through 06/20/14; and, a second narcotic dated 06/19/14 through 06/25/14. The first sheet had multiple lines going through 06/17/14 over RN #1's name, date and time of medication. There was no error documented above RN #1's name, nor an initial to document the error. Interview with the DON, on 09/26/14 at 3:18 PM, revealed nurses were to draw a line through the error, write error above the line and initial with a witness. Interview with LPN #2, on 09/26/14 at 3:29 PM, revealed the poor documentation on the narcotic count sheets had become routine and acceptable over time. He further stated he was not aware of the procedure for correcting the narcotic count sheets. Interview with LPN #3, on 10/01/14 at 2:02 PM, revealed when she would do the shift to shift count of narcotics, she did not recognize the scratching out of the signatures as a concern. Review of Resident #3's physician's orders [REDACTED]. Review of the first narcotic sheet, dated 08/01/14, and a second narcotic sheet dated 08/06/14, revealed RN #1 removed three (3) narcotics on 08/03/14 at 10:00 AM, 12:00 PM and 2:00 PM. RN #1 documented this medication was removed from the blister pack every two (2) hours instead of every (4) hours as ordered. Interview with Resident #3, on 09/23/14 at 8:57 AM, revealed the facility ran out of multiple medications before, such as his/her pain medications and [MEDICATION NAME]. Resident #3 stated it had occurred ever since he/she got out of the hospital in December 2013. Resident #3 stated he/she suffered from pain all the time. Interview with LPN #2, on 09/26/14 at 3:29 PM, revealed a lot of times when he and RN #1 would count the narcotic sheets and blister packs, RN #1 would have to either sign the narcotic sheet to balance the total tablets or she would scribble her signature due to signing on the wrong line of the narcotic sheet. LPN #2 stated when a nurse passes out a narcotic medication they should sign the narcotic out immediately. LPN #2 stated RN #1 would have to correct the narcotic sheets frequently and he did not suspect any thing was wrong at the time; although he was aware the narcotic was to be signed for when removing the tablet. Interview with the DON, on 09/25/14 at 6:00 PM, revealed she pulled narcotic count sheets and focused on RN #1's documentation and she identified through her audits that RN #1 had given medications too close, there were transcription errors noted, and narcotics were given at the same time. Additional interview with the DON, on 09/26/14 at 3:18 PM, revealed when the nurse had an error, the nurse was to document a line through the narcotic sheet and then write error above the line and sign with an initial. The nurse was to also have a nurse witness the error and notify her of any errors or inconsistencies in documentation. 4. Review of Resident #6's, MAR for the month of May 2014, revealed Resident #6's [MEDICATION NAME], 50 mg, was not given on 05/01/14, 05/02/14, 05/04/14, 05/05/14, 05/06/14, 05/07/14, 05/08/14, 05/09/14, 05/10/14, 05/13/14, 05/15/14, 05/16/14, 05/24/14, 05/29/14 and, days 05/04/14, and 05/29/14 had no initial in the day provided. There was no documentation for the reason the medication was not given, except for 05/10/14, 05/14/14, 05/24/14, it was documented the medication was not available; and, on 05/06/14, 05/07/14 and 05/24/14 it was documented the resident refused the medication. Review of Resident #6's Nurses Notes, dated 05/06/14, revealed Resident #6 had refused to take the [MEDICATION NAME], and no other documentation was provided. Review of Resident #6's pharmacy Work Order Fills form, for the month of May 2014, revealed the pharmacy sent a total of thirty (30), [MEDICATION NAME] tablets on 05/05/14; and again on 05/30/14, which meant the medications were available for use. Review of Resident #6's, MAR for the month of June 2014, revealed Resident #6's [MEDICATION NAME], 50 mg, were not given on<br>06/07/14, 06/11/14, 06/14/14, 06/15/14, 06/16/14, 06/17/14, 06/18/14, 06/19/14, 06/20/14, 06/21/14, 06/22/14, 06/24/14. There was no documentation to indicate why the medications were circled for the days of the 05/07/14, 05/19/14, 05/21/14, and 05/24/14. The dates of 05/11/14 and 05/14/14 were blank with no initials or documentation as why the boxes were left blank. Review of Resident #6's Nurses Notes, dated 06/05/14, revealed Resident #6 had refused all medications for the day. No other documentation was provided as to why the medication was refused. Review of Resident #6's pharmacy Work Order Fills form, for the month of June 2014, revealed the Pharmacy sent a total of thirty (30) [MEDICATION NAME] tablets on 06/24/14. Review of Resident #6's, MAR for the month of July 2014, revealed Resident #6's [MEDICATION NAME], 50 mg, were circled as not given on 07/02/14, 07/03/14, 07/04/14, 07/05/14, 07/06/14 and 07/07/14. There was no documentation as to why this medication was not administered except for 07/02/14 and 07/05/14 it was indicated the medication was not available and pharmacy was notified. Interview with LPN #6, on 09/26/14 at 2:33 PM, revealed she received counseling for circling the [MEDICATION NAME] because she had circled for a couple of days in a row and then some days her initials did not have circles. LPN #6 stated she would call pharmacy and would be notified that it was too early to reorder. Further interview with LPN #6, on 09/30/14 at 3:17 PM, revealed she could remember at one point the medication had come in and then she would come in at a later date and see that the medication was being circled again. LPN #6 stated this had occurred for a long time. LPN #6 stated she did not know why she did not inform the DON of this occurrence. Interview with the DON, on 10/01/14 at 12:30 PM, revealed not one nurse had ever talked to her about the medication coming up missing. The DON stated she talked to the nurses and informed them that someone was stealing the medication and was not sure if this concern had went to QA. 5. Review of Unsampled Resident A's [MEDICATION NAME], 5/325 mg, revealed it was ordered two (2) tables every six (6) hours for pain. Review of the narcotic count sheet for 09/04/14 at 12:00 PM revealed two (2) tablets had been removed by RN #1. Two (2) more tablets were then given at 6:00 PM on 09/04/14, which was the last pill on the narcotic sheet. On a new narcotic sheet, RN #1 then removed two (2) more medications on 09/04/14 at 6:00 PM. Thus RN #1 appeared to have administered four (4) tablets at 6:00 PM which was not how the medication was ordered. 6. Review of Unsampled Resident B's [MEDICATION NAME], 5 mg, revealed it was ordered one (1) to two (2) tablet every four (4) hours as needed for pain. Review of the narcotic count sheet for 07/26/14 at 7:30 PM revealed RN #1 had removed the last one (1) tablet and finished the narcotic sheet. On a new sheet, same medication, RN #1 then removed two (2) tablets at the same time. Interview with the DON, on 09/25/14 at 6:00 PM, revealed she recognized RN #1 had given medication too close and there were transcription errors noted when she completed her audits. Further interview with the DON, on 10/02/14 at 4:58 PM, revealed there were improvements needed for the nurses at this time in regards to making the nurses document changes in the Nurses Notes. The DON stated she always strived to have an accurate clinical record. In reviewing of the narcotic sheets, she recognized the nurses were documenting times to close, documenting giving medications at the same time and appearing to double dose the resident. She stated she was not sure if the staff was stealing or giving the wrong medications. The DON stated scribbling on the narcotic sheets was not appropriate as well and she could not understand how anyone could miss it. Interview with the Administrator, on 10/01/14 at 3:01 PM, revealed she was alerted to medication errors before and they were addressed. As of now and looking at them today and knowing what has happened, she would look at the medication errors differently. The Administrator stated she was not aware the DON was not looking at the narcotic sheets or the empty blister packs. The Administrator stated she was aware there were some concerns with pharmacy and the delay of medications, but felt the facility was at fault because the time lines in which medications were given. The facility provided an acceptable Allegation of Compliance (AOC) on 10/09/14 alleging the Immediate Jeopardy was removed 10/09/14; however, the State Survey Agency verified that staff training was completed on 10/10/14 and the Immediate Jeopardy was removed on 10/11/14. The facility took the following steps to remove the Immediate Jeopardy. 1. Residents #1, #2, #3, #5 and #6 were assessed and interviewed, with no negative outcomes. RN #1 was immediately suspended on 09/08/14 pending the investigation. 2. Licensed staff was interviewed and the allegation reported to the Office of Inspector General (OIG), Kentucky Board of Nursing (KBN), the Department of Community Based Services (DCBS) and Law Enforcement. 3. All medications found to be tampered with were reordered at the facility's expense. 4. Resident #1's tampered medications were pulled from circulation on 09/08/14 by the DON and destroyed on 09/10/14. 5. Resident #2's medications were pulled on 09/03/14 and locked up, when the resident was admitted to the hospital. Upon the resident's return on 09/10/14, the narcotics were determined to have been tampered with and the Police were immediately notified. Narcotics and their containers were turned over to the local Police Department. Medications were reordered at the facility's expense. 6. On 09/16/14, the Pharmacist auditing the medication carts suggested to the DON and the ADON, that Resident #5's narcotics should be destroyed. 7. The DON and facility Administrator conducted 100 % audit of narcotic orders and reconciliation sheets for any discrepancies that may indicate diversion on 09/08/14. The DON continued to complete audits daily to ensure there has been no breach of narcotic medication administration, documentation, reconciliation and or tampering of packages. 8. The Consultant Manager from the pharmacy (facility contracted), on 10/03/14, reviewed and analyzed narcotic medications dispensed and being administered for any discrepancies of tampered packaging, documentation of narcotic sheets, medication administration records for reconciliation and the Emergency Drug Kit (EDK). In addition, all Consulting Pharmacists visits starting 10/03/14 will include at a minimum a review of the entire narcotic dispensing system and analyzing narcotic counts, records, MARs, labels and packaging which will be compared to current orders to ensure there has been no tampering. 9. Education provided to the |

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| F 0514<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 11)<br>nursing staff by the DON included medication misappropriation (tampering of medication packaging or appearance of falsification of narcotic sheets), immediate notification to the DON, supervisor or the Administrator. 10. The DON was educated by the Regional Nurse Consultant for Preferred Care Partners Management Group on 09/12/14, on Misappropriation and Diversion of Narcotics, EDK Process, Pharmacy Training Guide, Notification to Administration and Pharmacy, Destruction of Narcotics, Pain Assessment, Accuracy of Notes, Change of Condition, Abuse and Neglect and the Narcotic Balance. 11. All licensed staff was educated by the Nursing Consultants on 10/07/14, which was attended by fourteen (14) licensed nursing staff. This includes seven (7) RNs and seven (7) LPNs, the Director of Nursing and the Unit Manger. In-services provided on the 7th were taken to QA on the 7th. 12. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following programs: Pain Assessment and Management; Accuracy of Notes, Documenting change of Condition; PRN Medication Management; Medication Pass-Indicators, Side Effects, reporting errors; Prevent/Recognize and Reporting Patient abuse; Pharmacy Training Guide; EDK Process; and, State Regulations controlled substance Notification. This training was completed by all nursing staff on the computer program SilverChair by 09/28/14. 13. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following Policies: Adverse Reaction to Medications; Controlled Substances- Misappropriation; Adverse Consequences and Medication Errors; Accepting Delivery of Medications; Administering Medications; Loss or Theft of Medications; Discarding or Destroying of Medications; and, Security of the Medication Carts. This training was provided by the DON and completed by all nursing staff by 10/06/14. 14. The Quality Assurance Committee consisted of the Administrator, DON, Unit Managers, Social Services, Activities Director, Dietary Director, Medical Director and Consulting Pharmacist, met Monday through Friday, in which the DON and or the Administrator reported on Narcotic Count Records as well as the MAR and reviewed narcotic medications. If suspicion was identified, the DON would immediately contact the Pharmacy and begin an internal investigation. All proper Authorities would be notified including OIG, DCBS, local police and/or KBN. This practice would continue 5 x weekly and/or PRN as needed through 10/31/14. 15. Any discrepancies discovered on the weekend, the weekend nurse would immediately notify the nurse on call, the nurse on call would notify the Administrator or DON. 16. The Pharmacy Consultant would also review for any possible administration of narcotics that may elude a suspicious activity and review the list of destroyed narcotics with each visit. Also a copy of current narcotic orders would be provided from pharmacy for the consultant pharmacist to reconcile with the current orders on the resident's chart to ensure ordering accuracy from pharmacy. 17. The Administrator contacted the Corporate Regional Team on 09/08/14. She and the DON organized the collection of narcotics, and narcotic count sheets on 09/08/14. The DON contacted local law enforcement agency. The Administrator reviewed policies and procedures on 09/08/14 with no revisions. Through observation, interview and record review the State Survey Agency (SSA) validated the Allegation of Compliance with removal of Immediate Jeopardy on 10/11/14 prior to exit on 10/13/14. 1. Interview with Resident #1, on 09/23/14 at 11:30 AM and Resident #3, on 09/23/14 at 8:57 AM, revealed no negative outcomes. Review of Residents #1, #2, #3, #5, and #6's clinical record revealed no adverse outcomes. Review of RN #1's employee file, revealed the facility terminated RN #1 on 09/12/14. Interview with the DON, 09/24/14 at 3:48 PM, revealed RN #1 had not worked since 09/04/14, was suspended on 09/08/14 and was officially terminated on 09/12/14. 2. Review of the facility's investigation, dated 09/08/14, revealed the facility faxed a report to the Office of Inspector General (OIG) and the Department of Community Based Services (DCBS) on 09/08/14. The Local Police Department (opened case #14-2423) was also notified regarding misappropriation of controlled medications. The Kentucky Board of Nursing was notified of the allegation in regards to RN #1 on 09/11/14. 3. Review of the facility's charges from the Pharmacy revealed the facility purchased the reordered medications that were destroyed. Review of the Product Destruction Summary, dated 09/26/14, revealed medications were being destroyed as of 09/17/14. Interview on 09/26/14 at 1:29 PM, with the DON revealed the facility replaced the narcotic medications that were destroyed. 4. Review of Resident #1's Controlled Substance Inventory Form, revealed two (2) bottles of [MEDICATION NAME] were destroyed on 09/10/14 by the DON and Assistant Director of Nursing (ADON). Interview with the ADON, on 09/25/14 at 9:28 AM, revealed she was present when Resident #1's medication was being destroyed. Interview with the DON, on 09/24/14 at 3:48 PM, revealed she destroyed any medications that appeared tampered. 5. Interview with the DON, on 09/24/14 at 3:48 PM, revealed the police were given Resident #2's medication cards. Review of Resident #2's two (2) [MEDICATION NAME] narcotic cards, which were in police custody at the Police Department, revealed one card was tampered; however, this medication was not dispensed to Resident #1. The other [MEDICATION NAME] narcotic card showed no evidence that it had been tampered. Review of the facility's charges from the Pharmacy, revealed the facility purchased the re-ordered medications which were destroyed. 6. Review of Resident #5's [MEDICATION NAME] and [MEDICATION NAME] narcotic sheets, revealed the two (2) medications were destroyed on 09/15/14 by the DON. Interview with the DON, on 09/26/14 at 1:29 PM, revealed the DON had destroyed [MEDICATION NAME] and [MEDICATION NAME] on 09/15/14. 7.<br>Record review of audits of narcotic orders and reconciliation sheets for discrepancies, revealed they started to be completed on 09/15/14. Interview with the DON, on 09/26/14 at 2:37 PM, revealed she began to audit MARs and physician orders [REDACTED]. Interview with the DON, on 10/13/14 at 10:29 AM, revealed every morning she reviewed the controlled substances, to ensure the narcotic counts were right and would report that to the QA team every morning, 10/06/14 through 10/10/14. 8. Review of the Pharmacy Clinical Manager MAR to Cart Audit Form, dated 10/03/14, revealed she completed a 100% audit to look at all orders, verified the MAR matched the orders, and that the pink narcotic sheets matched the drug labels. Then all narcotic counts were verified. The review revealed no signs of diversion for any of the residents.<br>Interview with the Pharmacy Clinical Manager, on 10/13/14 at 11:34 AM, via telephone, revealed she came into the facility to review controlled substances orders, make sure the directions of the orders matched the narcotic sheets. She did an inventory with nursing and inspected the medications and ensured that the narcotic counts matched. The Pharmacy Clinical Manager stated she did not identify any concerns except the orders did not match the directions on the narcotic cards, especially when the medication changed from routine to PRN. She stated she reviewed all four (4) medication carts and looked at the Emergency Drug Kit (EDK) box, which revealed no concerns with the shift change counts. She then provided the facility with a report. Interview with the Administrator, on 10/13/14 at 2:02 PM, revealed on 10/03/14 the Pharmacy Clinical Manager came in and did a 100% audit and would provide oversight until 11/30/14. 9. Review of the education content confirmed the education was completed on 09/30/14 by the DON for eleven (11) LPNs, and five (5) RNs, there was no PRN staff, none on FMLA (Family Medical Leave Act) or vacation and the facility did not use contract staffing. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3 on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7 on 10/13/14 at 1:26 PM; and ,RN #4, on 10/10/14 at 10:36 AM revealed all were knowledgeable of what abuse and misappropriation was and how to report to the DON or Administrator immediately. 10. Interview with the DON, on 10/13/14 at 10:29 AM, revealed she received training on 09/12/14 by the Regional Nurse Consultant. She was educated on medication pass, audits, what information she needed to obtain from the pharmacy, such as a record of all the items that needed to be ordered by pharmacy and then use the information to audit the MAR and compare to what was in the drawer and the physician's orders [REDACTED]. Interview with the Regional Nurse Consultant, on 10/13/14 at 3:42 PM, revealed she completed education on 09/08/14 and 09/12/14 with the DON and Administrator. She went over documentation, narcotic sheets and the protocol for nursing. She also compared MARs and the Pain assessment sheets. The DON was educated on not throwing away evidence. The DON was educated on abuse and misappropriation of medications. The Regional Nurse Consultant stated she talked to the DON about replacing all medications because it was the resident's property. The DON was educated on monitoring the narcotic sheets, MARs and Pain assessment sheets daily. The destruction of medication and ensuring two (2) nurses were present. Also, monitoring the EDK box and ensuring the serial numbers matched everyday. The DON was also educated on different methods of tampering with medication and not having tape placed on the back of narcotic cards. 11. Interview with LPN #3, on 10/10/14 at 1:20 PM, revealed she was not educated by the Clinical Services Nurse. LPN #3 stated she was not in the building on 10/06/14, 10/07/14 or 10/08/14 in which the Consulting Pharmacists were present in the building. LPN #3 stated she did not obtain a packet from the DON, but had obtained 1:1 training with the DON. LPN #3 had been working the whole shift on 10/10/14 without being educated. Review of the In-service Education on 10/08/14, by the Clinical Services Nurse from pharmacy for the loss/theft of medications, revealed only six (6) LPNs were educated, one (1) RN, and the ADON was educated out of a total of sixteen (16) licensed staff members. LPN #3 was not on the sign in list as being educated. Interview with the Regional Nurse Clinician for pharmacy, revealed she completed a quick training with the staff because she was told the staff had already been in-serviced. The training was supposed to be a quick reference tool. She stated she observed a shift to shift narcotic count. The Regional Nurse Clinician stated she wanted to ensure the nurses, when counting narcotics, monitored the card numbers and looked at the narcotic sheets to ensure they matched. The DON stated she knew LPN #3 was not trained and was going to train LPN #3 at the end of her shift. The DON stated LPN #3, |

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| F 0514<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 12)<br>knew she had been trained on most of the information; however, she was not trained on how to destroy narcotic medication and who was responsible to destroy the medications. Everything the Regional Nurse Clinician educated staff on, the DON had already went over with the staff. So though the Regional Nurse Clinician did not get the opportunity to educate all the nursing staff, all nurses were provided the same information. Review of the daily QA meetings on 10/06/14 through 10/10/14, revealed no documented evidence that the training went to QA; however, there was evidence on the 10/07/14 QA meeting where they talked about the pharmacy and their role and participation in the correction of the deficiency. Interview with the Regional Director of Operations, on 10/10/14 at 2:21 PM, revealed staff was not to work unless they had been educated. He stated he was not aware LPN #3 was on the floor the whole shift. He stated he was at fault for this. The Regional Director of Operations (RDO) stated he knew he stated in the Allegation of Compliance (AOC), all the nursing staff was educated, but he meant to say the staff could not work if all were not educated and would fix it immediately. Interview with the RDO, on 10/10/14 at 2:04 PM, revealed he had the information in the AOC wrong. Review of the training for loss or theft of medications revealed an additional six (6) nurses were educated on 10/10/14 by the DON. 12. Review of the Pain Assessment and Management training provided from 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-served on pain medications. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of pain assessments and the fact they had to be completed before and after administration of pain medications. The trainings were completed on 09/27/14. Review of the training on the Ins and Outs of Documentation, provided 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-serviced on documentation. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, |
| F 0520<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, record review and review of the facility's policies and job descriptions, it was determined the facility failed to have an effective Quality Assurance Committee (QA) to ensure the identification of quality deficiencies, implementation of plans of action, and monitoring of the plans of action to prevent misappropriation/drug diversion and tampering of resident medications and controlled substances, for five (5) of nine (9) sampled residents (Residents #1, #2, #3, #5 and #6); and, two (2) of two (2) unsampled residents (Residents A and B). The facility failed to identify and report diversion of medications/narcotics when staff found tape on the back side of narcotic cards. Narcotics were replaced with other medications, and staff borrowed resident medications for other residents' use. The facility failed to monitor, reconcile and destroy medications according to standards of practice. The facility failed to ensure the resident's clinical record was maintained in an accurate format to detail the care provided. The facility further failed to include Pharmacy in the QA Committee meetings to assist with the investigation of drug diversion. (Refer to F224, F431, F490 and F514) The facility staff identified suspicion of diversion of drugs; however, failed to report this to the Administrative staff. Once the Administrative staff was made aware of the suspicion of drug diversion they did not take this information to QA for review and possible plan of action. The staff continued to borrow medication from residents after education was provided by the Director of Nursing in June 2014, and the borrowing of medications was not reviewed by the QA Committee. Pharmacy provided the QA Committee with reports; however, they did not identify borrowing of medications or diversion of narcotics as a concern. The QA Committee did not review the narcotic reconciliation process to determine if the process met the facility's policy. The QA committee did not identify, monitor, or develop plans of action to ensure the accuracy of the medical record. The facility's failure to ensure an effective QA Committee was in place to identify quality deficiencies, develop action plans and monitor the effectiveness of the plans for narcotic reconciliation, monitoring of medication administration, and accurate documentation to prevent misappropriation/drug diversion and tampering of resident medications and controlled substances placed residents at risk in a situation that has caused is likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 10/02/14 and determined to exist on 08/31/14. The facility provided an acceptable Allegation of Compliance on 10/09/14 that alleged removal of Immediate Jeopardy on 10/09/14. However, the State Survey Agency determined the Immediate Jeopardy was removed on 10/11/14, after training of facility staff was verified completed 10/10/14, at 42 CFR 483.75 Administration (F520) with the scope and severity lowered to an E while the facility monitors the effectiveness of the implemented plan of correction. The findings include: Review of the facility's policy, Adverse Consequences and Medication Error, revised February 2014, revealed the interdisciplinary team reviews the resident's medication regimen for efficiency and actual or potential medication-related problems on an ongoing basis. The QA Committee would conduct a root cause analysis of medication administration errors to determine the source of errors, implement process improvement steps, and compare results over time to determine that system improvements were effective in reducing errors. Interview with the Assistant Director of Nursing (ADON), on 09/25/14 at 9:28 AM, revealed such drugs as [MEDICATION NAME] and [MEDICATION<br>NAME] were reordered too soon. The ADON stated she discovered it was easy to see on the Pharmacy System the drugs that needed to be reordered and the drugs the facility had to pay for reimbursement. The ADON stated she could not remember which residents were effected. She further stated she did not monitor anything, just the medications which needed to be reordered. The ADON stated the nurses had to be trained and the circumstance did not go to the QA Committee. The ADON stated it should have gone. Interview with the Director of Nursing (DON), on 09/24/14 at 3:48 PM, revealed she had repeatedly educated the staff about not borrowing medications and acknowledged she had educated the staff back in June 2014. The DON stated she began to complete medication checks, sometimes triple checks of the house drugs and was wondering why the facility was being charged for drugs. The DON stated she really did not know what to do with the information that was being presented to her. The DON stated she called a Pharmacy Representative and asked how could the facility be ordering multiple medications. However, post survey interview with the DON, on 11/04/14 at 2:07 PM, revealed there was no conversation with the pharmacy on how the pharmacy would help resolve the reordering of medications. Per interview, the pharmacy always faxed over a reorder to soon document in which the DON or Administrator would have to sign to receive the medications. The DON stated no one from pharmacy called her to inform her about too many drugs being reordered by the facility. Interview with the Consulting Pharmacist, on 09/25/14 at 5:01 PM, revealed she had a phone conversation with the DON regarding the review of delivery tickets for [MEDICATION NAME] by the DON, but could not recall the [MEDICATION NAME]<br>([MEDICATION NAME]) and [MEDICATION NAME] ([MEDICATION NAME]) (both are anti-depressants) being in the conversation.<br>Continued interview with the DON on 09/24/14 at 3:48 PM, revealed the issue was taken to QA; however, she could not specify a date. The action plan instructed the DON to check the orders to see if they match what was on the narcotic cards. Also check to see if the amount of medication ordered balanced with the MARs. Further interview with the DON, on 09/25/14 at 2:37 PM, revealed she did not receive empty narcotic cards or narcotic sheets, as all of the narcotic sheets went to Medical Records to be filed; however, this was not reviewed in QA. Interview with the Administrator, on 09/25/14 at 4:06 PM, revealed the DON had brought to her attention the facility had to replace medications which were coming up missing and this information was taken to the QA committee on 06/06/14. The plan at that time was to monitor and triple check the nurses documentation of the MAR to ensure there was enough medications available. The Unit Manager was responsible to check the AHT (medical record in the computer system) to make sure the medication orders were placed on the MAR and AHT. The DON was responsible to update the care plans and educate the nursing staff on the importance of reviewing the five (5) rights and three (3) checks of the medication pass as well as the importance of ensuring the accuracy of the transcription of medication orders. Interview with the Medical Director, on 09/25/14 at 3:47 PM, revealed the facility had to reorder medications. The Medical Director stated there was a plan of action to get to the bottom of the problem on 06/06/14. He stated the QA talked about possible diversion of medication and foul play. The Medical Director stated he felt the action plan was consistent with the goals of the facility, but he could not specify the plan. Interview with the Consulting Pharmacist, on 09/25/14 at 5:01 PM, revealed she did not attend QA meetings; however, provided a QA report on what she had found quarterly. The Consulting Pharmacist stated she did not complete a 100% audit, but did complete a 10% spot check in which she did not identify any concerns with narcotics or control sheets. Based on the facility's census on 09/23/14, this would only be six (6) residents reviewed related to narcotics and control sheets. However, per the Consultant Pharmacist's job description, the Pharmacist would conduct a Medication Regimen Review on each resident in the facility monthly and |

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| F 0520<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 13)<br>would coordinate or perform review of controlled substance utilization, reconciliation and documentation. Although the Pharmacist's job description did not specify a measured quantity to review, it stated the Pharmacist should follow the regulations and per post survey interview with the Pharmacy General Manager, on 11/05/14 at 9:30 AM, the Pharmacist was to look at 100% of the 30 day reviews. The Pharmacy General Manager stated there was no rule that a Pharmacist had to look at ten (10) percent of the census for additional audits. They normally looked at enough residents to determine if there was a pattern to their concerns. Interview with the Administrator, on 09/25/14 at 4:06 PM, revealed she followed up on 06/30/14 in the QA meeting and what was reported was the in-service had been completed and the DON had worked individually with nurses who had issues with medication errors and there had been great improvements. Pharmacy came and checked their records to see if the nurses were reordering and comparing the information to the MARs. The Administrator stated she thought in July 2014, the Consulting Pharmacist stated to her the medications looked really really good. The Administrator stated then on July 28th the QA Committee discontinued monitoring the reordering of medication concerns; however, never discussed the diversion of narcotics. Further interview with the Administrator, on 09/25/14 at 4:06 PM, revealed the DON reported the monitoring would continue and the licensed nursing staff would be educated as issues arose. No other QA meetings after the 07/28/14 meeting was provided; although diversion of narcotics was identified on 08/31/14. Post survey interview with the Administrator, on 11/04/14 at 1:37 PM, revealed she talked to the Pharmacy when the reordering concern was brought to QA. The Administrator stated she talked to the pharmacy in regards to the new orders and the mix up on quantities of medications available. She stated she was trying to figure out what was sent and not sent for the residents. The Administrator stated she thought the problem was fixed when she asked the Pharmacy to send resident medications at their cost. She further stated the facility took on the responsibility to fix the reordering problem. Pharmacy was not identified as a source to help with the monitoring process or help the QA Committee find the root cause of the reordering concern. However, review of the Consultant Pharmacist's job description, effective 03/09/11, revealed the consultant pharmacist's key responsibilities included attending the facility's quarterly QA Committee meetings. Review of the pharmacy contract, effective 07/01/12, revealed the pharmacy would make a representative of pharmacy available for attendance at the facility's QA Committee meetings. Post survey interview with the Pharmacy General Manager (GM), on 11/05/14 at 9:30 AM, revealed if there was any correspondence between the pharmacy and the facility regarding assistance with QA they would have come to him. However, review of his correspondences revealed there were none from the facility. Through facility audit reviews of narcotic sheets after 08/31/14, it was identified by the facility that twenty-five (25) additional residents were involved in the possible diversion of medications. However, the additional information was not discussed in the QA meetings, per interview with the Administrator, on 09/25/14, as there had been no QA meetings since 07/28/14. The facility provided an acceptable Allegation of Compliance (AOC) on 10/09/14 alleging the Immediate Jeopardy was removed 10/09/14; however, the State Survey Agency verified that staff training was completed on 10/10/14 and the Immediate Jeopardy was removed on 10/11/14. The facility took the following steps to remove the Immediate Jeopardy. 1. Residents #1, #2, #3, #5 and #6 were assessed and interviewed, with no negative outcomes. RN #1 was immediately suspended on 09/08/14 pending the investigation. 2. Licensed staff was interviewed and the allegation reported to the Office of Inspector General (OIG), Kentucky Board of Nursing (KBN), the Department of Community Based Services (DCBS) and Law Enforcement. 3. All medications<br>found to be tampered with were reordered at the facility's expense. 4. Resident #1's tampered medications were pulled from circulation on 09/08/14 by the DON and destroyed on 09/10/14. 5. Resident #2's medications were pulled on 09/03/14 and locked up, when the resident was admitted to the hospital. Upon the resident's return on 09/10/14, the narcotics were determined to have been tampered with and the Police were immediately notified. Narcotics and their containers were turned over to the local Police Department. Medications were reordered at the facility's expense. 6. On 09/16/14, the Pharmacist auditing the medication carts suggested to the DON and the ADON, that Resident #5's narcotics should be destroyed. 7. The DON and facility Administrator conducted 100 % audit of narcotic orders and reconciliation sheets for any discrepancies that may indicate diversion on 09/08/14. The DON continued to complete audits daily to ensure there has been no breach of narcotic medication administration, documentation, reconciliation and or tampering of packages. 8. The Consultant Manager from the pharmacy (facility contracted), on 10/03/14, reviewed and analyzed narcotic medications dispensed and being administered for any discrepancies of tampered packaging, documentation of narcotic sheets, medication administration records for reconciliation and the Emergency Drug Kit (EDK). In addition, all Consulting Pharmacists visits starting 10/03/14 will include at a minimum a review of the entire narcotic dispensing system and analyzing narcotic counts, records, MARs, labels and packaging which will be compared to current orders to ensure there has been no tampering. 9. Education provided to the nursing staff by the DON included medication misappropriation (tampering of medication packaging or appearance of falsification of narcotic sheets), immediate notification to the DON, supervisor or the Administrator. 10. The DON was educated by the Regional Nurse Consultant for Preferred Care Partners Management Group on 09/12/14, on Misappropriation and Diversion of Narcotics, EDK Process, Pharmacy Training Guide, Notification to Administration and Pharmacy, Destruction of Narcotics, Pain Assessment, Accuracy of Notes, Change of Condition, Abuse and Neglect and the Narcotic Balance. 11. All licensed staff was educated by the Nursing Consultants on 10/07/14, which was attended by fourteen (14) licensed nursing staff. This includes seven (7) RNs and seven (7) LPNs, the Director of Nursing and the Unit Manger. In-services provided on the 7th were taken to QA on the 7th. 12. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following programs: Pain Assessment and Management; Accuracy of Notes, Documenting change of Condition; PRN Medication Management; Medication Pass-Indicators, Side Effects, reporting errors; Prevent/Recognize and Reporting Patient abuse; Pharmacy Training Guide; EDK Process; and, State Regulations controlled substance Notification. This training was completed by all nursing staff on the computer program SilverChair by 09/28/14. 13. All Registered Nurses (RN) and Licensed Practical Nurses (LPN), who handle a medication cart have been in-serviced on the following Policies: Adverse Reaction to Medications; Controlled Substances- Misappropriation; Adverse Consequences and Medication Errors; Accepting Delivery of Medications; Administering Medications; Loss or Theft of Medications; Discarding or Destroying of Medications; and, Security of the Medication Carts. This training was provided by the DON and completed by all nursing staff by 10/06/14. 14. The Quality Assurance Committee consisted of the Administrator, DON, Unit Managers, Social Services, Activities Director, Dietary Director, Medical Director and Consulting Pharmacist, met Monday through Friday, in which the DON and or the Administrator reported on Narcotic Count Records as well as the MAR and reviewed narcotic medications. If suspicion was identified, the DON would immediately contact the Pharmacy and begin an internal investigation. All proper Authorities would be notified including OIG, DCBS, local police and/or KBN. This practice would continue 5 x weekly and/or PRN as needed through 10/31/14. 15. Any discrepancies discovered on the weekend, the weekend nurse would immediately notify the nurse on call, the nurse on call would notify the Administrator or DON. 16. The Pharmacy Consultant would also review for any possible administration of narcotics that may elude a suspicious activity and review the list of destroyed narcotics with each visit. Also a copy of current narcotic orders would be provided from pharmacy for the consultant pharmacist to reconcile with the current orders on the resident's chart to ensure ordering accuracy from pharmacy. 17. The Administrator contacted the Corporate Regional Team on 09/08/14. She and the DON organized the collection of narcotics, and narcotic count sheets on 09/08/14. The DON contacted local law enforcement agency. The Administrator reviewed policies and procedures on 09/08/14 with no revisions. Through observation, interview and record review the State Survey Agency (SSA) validated the Allegation of Compliance with removal of Immediate Jeopardy on 10/11/14 prior to exit on 10/13/14. 1. Interview with Resident #1, on 09/23/14 at 11:30 AM and Resident #3, on 09/23/14 at 8:57 AM, revealed no negative outcomes. Review of Residents #1, #2, #3, #5, and #6's clinical record revealed no adverse outcomes. Review of RN #1's employee file, revealed the facility terminated RN #1 on 09/12/14. Interview with the DON, 09/24/14 at 3:48 PM, revealed RN #1 had not worked since 09/04/14, was suspended on 09/08/14 and was officially terminated on 09/12/14. 2. Review of the facility's investigation, dated 09/08/14, revealed the facility faxed a report to the Office of Inspector General (OIG) and the Department of Community Based Services (DCBS) on 09/08/14. The Local Police Department (opened case #14-2423) was also notified regarding misappropriation of controlled medications. The Kentucky Board of Nursing was notified of the allegation in regards to RN #1 on 09/11/14. 3. Review of the facility's charges from the Pharmacy revealed the facility purchased the reordered medications that were destroyed. Review of the Product Destruction Summary, dated 09/26/14, revealed medications were being destroyed as of 09/17/14. Interview on 09/26/14 at 1:29 PM, with the DON revealed the facility replaced the narcotic medications that were destroyed. 4. Review of Resident #1's Controlled Substance Inventory Form, revealed two (2) bottles of [MEDICATION NAME] were destroyed on 09/10/14 by the DON and Assistant Director of Nursing (ADON). Interview with the ADON, on 09/25/14 at 9:28 AM, revealed she was present when Resident #1's medication was being destroyed. Interview with the DON, on 09/24/14 at 3:48 PM, revealed she destroyed any medications that appeared |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185266 | A. BUILDING _____ B. WING _____ | 10/13/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| ELIZABETHTOWN NURSING AND REHABILITATION CENTER | 1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0520<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 14)<br>tampered. 5. Interview with the DON, on 09/24/14 at 3:48 PM, revealed the police were given Resident #2's medication cards. Review of Resident #2's two (2) [MEDICATION NAME] narcotic cards, which were in police custody at the Police Department, revealed one card was tampered; however, this medication was not dispensed to Resident #1. The other [MEDICATION NAME] narcotic card showed no evidence that it had been tampered. Review of the facility's charges from the Pharmacy, revealed the facility purchased the re-ordered medications which were destroyed. 6. Review of Resident #5's [MEDICATION NAME] and [MEDICATION NAME] narcotic sheets, revealed the two (2) medications were destroyed on 09/15/14 by the DON. Interview with the DON, on 09/26/14 at 1:29 PM, revealed the DON had destroyed [MEDICATION NAME] and [MEDICATION NAME] on 09/15/14. 7.<br>Record review of audits of narcotic orders and reconciliation sheets for discrepancies, revealed they started to be completed on 09/15/14. Interview with the DON, on 09/26/14 at 2:37 PM, revealed she began to audit MARs and physician orders [REDACTED]. Interview with the DON, on 10/13/14 at 10:29 AM, revealed every morning she reviewed the controlled substances, to ensure the narcotic counts were right and would report that to the QA team every morning, 10/06/14 through 10/10/14. 8. Review of the Pharmacy Clinical Manager MAR to Cart Audit Form, dated 10/03/14, revealed she completed a 100% audit to look at all orders, verified the MAR matched the orders, and that the pink narcotic sheets matched the drug labels. Then all narcotic counts were verified. The review revealed no signs of diversion for any of the residents.<br>Interview with the Pharmacy Clinical Manager, on 10/13/14 at 11:34 AM, via telephone, revealed she came into the facility to review controlled substances orders, make sure the directions of the orders matched the narcotic sheets. She did an inventory with nursing and inspected the medications and ensured that the narcotic counts matched. The Pharmacy Clinical Manager stated she did not identify any concerns except the orders did not match the directions on the narcotic cards, especially when the medication changed from routine to PRN. She stated she reviewed all four (4) medication carts and looked at the Emergency Drug Kit (EDK) box, which revealed no concerns with the shift change counts. She then provided the facility with a report. Interview with the Administrator, on 10/13/14 at 2:02 PM, revealed on 10/03/14 the Pharmacy Clinical Manager came in and did a 100% audit and would provide oversight until 11/30/14. 9. Review of the education content confirmed the education was completed on 09/30/14 by the DON for eleven (11) LPNs, and five (5) RNs, there was no PRN staff, none on FMLA (Family Medical Leave Act) or vacation and the facility did not use contract staffing. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3 on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7 on 10/13/14 at 1:26 PM; and ,RN #4, on 10/10/14 at 10:36 AM revealed all were knowledgeable of what abuse and misappropriation was and how to report to the DON or Administrator immediately. 10. Interview with the DON, on 10/13/14 at 10:29 AM, revealed she received training on 09/12/14 by the Regional Nurse Consultant. She was educated on medication pass, audits, what information she needed to obtain from the pharmacy, such as a record of all the items that needed to be ordered by pharmacy and then use the information to audit the MAR and compare to what was in the drawer and the physician's orders [REDACTED]. Interview with the Regional Nurse Consultant, on 10/13/14 at 3:42 PM, revealed she completed education on 09/08/14 and 09/12/14 with the DON and Administrator. She went over documentation, narcotic sheets and the protocol for nursing. She also compared MARs and the Pain assessment sheets. The DON was educated on not throwing away evidence. The DON was educated on abuse and misappropriation of medications. The Regional Nurse Consultant stated she talked to the DON about replacing all medications because it was the resident's property. The DON was educated on monitoring the narcotic sheets, MARs and Pain assessment sheets daily. The destruction of medication and ensuring two (2) nurses were present. Also, monitoring the EDK box and ensuring the serial numbers matched everyday. The DON was also educated on different methods of tampering with medication and not having tape placed on the back of narcotic cards. 11. Interview with LPN #3, on 10/10/14 at 1:20 PM, revealed she was not educated by the Clinical Services Nurse. LPN #3 stated she was not in the building on 10/06/14, 10/07/14 or 10/08/14 in which the Consulting Pharmacists were present in the building. LPN #3 stated she did not obtain a packet from the DON, but had obtained 1:1 training with the DON. LPN #3 had been working the whole shift on 10/10/14 without being educated. Review of the In-service Education on 10/08/14, by the Clinical Services Nurse from pharmacy for the loss/theft of medications, revealed only six (6) LPNs were educated, one (1) RN, and the ADON was educated out of a total of sixteen (16) licensed staff members. LPN #3 was not on the sign in list as being educated. Interview with the Regional Nurse Clinician for pharmacy, revealed she completed a quick training with the staff because she was told the staff had already been in-serviced. The training was supposed to be a quick reference tool. She stated she observed a shift to shift narcotic count. The Regional Nurse Clinician stated she wanted to ensure the nurses, when counting narcotics, monitored the card numbers and looked at the narcotic sheets to ensure they matched. The DON stated she knew LPN #3 was not trained and was going to train LPN #3 at the end of her shift. The DON stated LPN #3, knew she had been trained on most of the information; however, she was not trained on how to destroy narcotic medication and who was responsible to destroy the medications. Everything the Regional Nurse Clinician educated staff on, the DON had already went over with the staff. So though the Regional Nurse Clinician did not get the opportunity to educate all the nursing staff, all nurses were provided the same information. Review of the daily QA meetings on 10/06/14 through 10/10/14, revealed no documented evidence that the training went to QA; however, there was evidence on the 10/07/14 QA meeting where they talked about the pharmacy and their role and participation in the correction of the deficiency. Interview with the Regional Director of Operations, on 10/10/14 at 2:21 PM, revealed staff was not to work unless they had been educated. He stated he was not aware LPN #3 was on the floor the whole shift. He stated he was at fault for this. The Regional Director of Operations (RDO) stated he knew he stated in the Allegation of Compliance (AOC), all the nursing staff was educated, but he meant to say the staff could not work if all were not educated and would fix it immediately. Interview with the RDO, on 10/10/14 at 2:04 PM, revealed he had the information in the AOC wrong. Review of the training for loss or theft of medications revealed an additional six (6) nurses were educated on 10/10/14 by the DON. 12. Review of the Pain Assessment and Management training provided from 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-served on pain medications. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of pain assessments and the fact they had to be completed before and after administration of pain medications. The trainings were completed on 09/27/14. Review of the training on the Ins and Outs of Documentation, provided 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-serviced on documentation. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of accurate documentation of the MAR's and narcotic sheets. The training was completed for all nursing staff by 09/28/14. Review of the training on PRN Medication Management, provided on 09/01/14 through 10/05/14, revealed all licensed staff, eleven (11) LPNs and five (5) RNs had been in-serviced on PRN medication management and ensuring an assessment was completed on all residents before and after PRN medication was given. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable of PRN medication management. The training was completed by all nursing staff by 09/29/14. Review of the training on Medication Pass, provided on 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs had been in-serviced on the proper way to perform a medication pass, side effects of giving the wrong medications and reporting errors immediately to the DON or Administrator. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable about the Medication Pass requirements. The training was completed on 09/29/14. Review of the training on Preventing, Recognizing and Reporting Resident Abuse, provided on 09/01/14 through 10/05/14, revealed eleven (11) LPNs and five (5) RNs were educated on abuse, misappropriation and the importance of notifying the DON and Administrator as soon as abuse was observed. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable of identifying and reporting abuse. The training was completed by all nursing staff by 09/30/14. Review of the training on the Pharmacy Training Guide, EDK Process and KAR's Controlled Substance Notification, provided on 09/17/14, revealed nine (9) LPN's and five (5) RN's were educated and two LPN's were educated on a later date. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable of the physician order [REDACTED]. The training was completed by all nursing staff by 10/10/14. 13. Review of a training provided by the Regional Nurse Clinician and the DON on Policies and Procedures with copies provided on the following: loss and theft of medications; adverse consequences; medication destruction and disposal of controlled substances; security of the |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **185266** | A. BUILDING _____ B. WING _____ | **10/13/2014** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **ELIZABETHTOWN NURSING AND REHABILITATION CENTER** | **1101 WOODLAND DRIVE ELIZABETHTOWN, KY 42701** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0520<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 15)<br>medication cart; documentation medication administration; administering medications; and, accepting delivery of medications and controlled substances. Review revealed all eleven (11) LPNs and five (5) RNs were inserviced from 10/07/14 through 10/10/14. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were all knowledgeable of the policies and procedures for narcotics and medication administration. The training was completed by all nursing staff on 10/10/14. 14. Review of the QA meetings minutes and sign in sheets, dated 10/06/14, 10/07/14, 10/08/14, 10/09/14 and 10/10/14, revealed the Administrator, DON, Unit Manger, Medical Director, Consulting Pharmacist and Regional Director of Operations had attended daily meetings Monday through Friday. Interview with the DON, on 10/13/14 at 10:29 AM, revealed there was a QA meeting every morning. Review of the Controlled Substance Audit, dated 10/06/14 through 10/10/14, revealed the audits were completed without concerns. The DON stated she would report back to the QA committee with any diversion they would initiate an investigation immediately and report to all agencies. Interview with the Regional Director of Operations, on 10/13/14 at 2:28 PM, revealed he would attend QA daily while he was in the facility. 15. Interview with LPN #2, on 10/10/14 at 9:30 AM, LPN #3, on 10/10/14 at 1:20 PM, LPN #4, on 10/13/14 at 1:50 PM, LPN #6 on 10/10/14 at 3:30 PM, and LPN #7, on 10/13/14 at 1:26 PM and RN #4, on 10/10/14 at 10:36 AM, revealed they were knowledgeable to call the DON immediately if they observed any discrepancies with narcotics. The staff was also aware to report to the DON if they had witnessed tape behind a narcotic medicat |