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	185028	A. BUILDING _____ B. WING _____	C 09/02/2021

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JOHNSON MATHERS NURSING HOME	2323 CONCRETE ROAD CARLISLE, KY 40311

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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY00033997, KY00034103, KY00034127, KY00034202, KY00034203, and KY00034222 was initiated on 07/26/2021. After supervisory review with the State Survey Agency (SSA), the survey transitioned to a Standard Recertification/Extended and Abbreviated Survey, on 08/09/2021, which concluded on 09/02/2021. In addition, a COVID-19 Focused Infection Control Survey was conducted, which identified the facility was not in compliance with 42 CFR 483.80, Infection Control, F 880, and had not implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 93 at the start of the Abbreviated Survey; total census 88 at the start of the Standard Recertification Survey. Complaints KY00034103 and KY00034127 were unsubstantiated with no deficient practice identified. Complaints KY00033997, KY00034202, KY00034203, and KY00034222 were substantiated with deficient practice identified. On 01/26/2021 at 6:30 PM, Resident #242 suffered a cardiopulmonary arrest and Licensed Practical Nurse (LPN) #15 called a Code Blue for full CPR to be given. The Staff Development Coordinator/Quality Improvement (SDC/QI) nurse initiated CPR for approximately two (2) minutes. Then, LPN #15 assessed Resident #242 to have a pulse and stated to stop CPR. However, the previous Administrator directed the SDC/QI nurse	F 000	Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/19/2021

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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Hydrocodone (Scheduled II narcotic), and Gabapentin (Scheduled III anticonvulsant). Additionally, LPN #1 was found to have Primidone (non-controlled anticonvulsive) on her person, which she admitted she used to replace Resident #32's and Resident #84's controlled narcotic medications, which she had misappropriated.

Ten (10) additional residents had a total of fourteen (14) controlled medications missing and not signed out properly, on 07/18/2021, some of which were the same type of medications found on LPN #1 by the Police: Resident #71, #8, #56, #1, #79, #47, #34, #60, #48, and #65.

Review of a Uniform Citation, dated 07/18/2021, revealed LPN #1 was charged with two (2) counts of Wanton Endangerment in the First Degree; thirteen (13) counts of Theft by Unlawful Taking, Controlled Substance; three (3) counts of Possession of a Controlled Substance; and two (2) counts of Abuse and Neglect of an Adult Person.

On 07/20/2021, the Director of Nursing (DON) determined, in an audit, the Shift Change Count Sheet signed by LPN #2 had one (1) less in the count of narcotic skids from the previous Shift Change Count Sheet. The facility determined Resident #9 had a missing skid of Percocet, and LPN #2 was suspended.

The facility's failure to take immediate action and to follow their policies to prevent further abuse and to ensure all residents were free from abuse and to prevent further misappropriation of residents' property so that their controlled medications were available to the residents per

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F 000	Continued From page 4 Services, F-755 at a S/S of an "E"; and 42 CFR 483.70 Administration, F-835 and F-837 at a S/S of an "E" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. Additional deficiencies were cited at 42 CFR 483.10 Resident Rights F-550 at a S/S of a "D" and F-571 at a S/S of a "E"; 42 CFR Resident Assessment F-641 at a S/S of a "G"; 42 CFR 483.21 Comprehensive Resident Centered Care Plans F-656 at a S/S of a "G" and F-657 at a S/S of an "E"; 42 CFR 483.25 Quality of Care F-688 and F-689 both at a S/S of a "G"; 42 CFR 483.60 Food and Nutrition Services F-801 at a S/S of a "D" and F-812 at a S/S of an "F"; and 42 CFR 483.80 Infection Control F-880 at a S/S of an "E".	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550	F 550 1. Residents #13 and #31 were assessed by the Registered Nurse, Staff Development Coordinator (SDC), on 09/02/21 and 09/08/21, to ensure the residents were covered and/or their privacy curtains were pulled to ensure the residents were treated with dignity while in bed. 2. All residents have the potential to be affected by the deficient practice. 3. Beginning 8/26/21, 100% of staff were educated by the SDC, Director of Nursing (DON), Administrator (ADM), Activities Director (AD) and	

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facility failed to protect and promote the rights of the residents for two (2) of forty-four (44) residents; Resident #13 and #31.

Observations, on 08/10/2021, by the State Survey Agency (SSA) Surveyor of Resident #13 revealed the resident was lying in bed with his/her bare legs exposed; the resident was wearing only a brief from the waist down and was uncovered. Observations, on 08/12/2021, by the SSA Surveyor of Resident #31 revealed the resident was lying in bed wearing only briefs with the resident's room door wide open. For Resident #13 and #31, staff entered and exited the residents' rooms without notifying nursing staff the residents were exposed or providing privacy with a cover or by pulling the privacy curtain.

The findings include:

Review of the facility's "Resident Rights" document, undated, revealed the resident had the right to live with dignity and to be treated with respect. Further, the document stated residents had the right to personal privacy.

1. Review of Resident #13's medical record revealed the facility admitted the resident, on 07/28/2017, with diagnoses including Dementia, Major Depressive Disorder, Arthritis, and Schizoaffective Disorder.

Review of Resident #13's Comprehensive Care Plan, revised on 11/06/2019, revealed the resident required assistance for dressing. The goal was the resident would be appropriately dressed. The intervention was the resident required extensive assistance of one (1) staff for dressing.

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Bed B's bed remote with his back to Resident #13. He then opened the privacy curtain by pushing the curtain back between the beds to the wall. Resident #13 was lying in bed, with his/her legs bare from the waist down and uncovered; the resident was wearing only a brief from the waist down. Further observation revealed RN #3 stood outside Resident #13's room on the medication cart preparing medications for administration and walked past Resident #13's door two (2) times. Maintenance staff #1 exited the resident's room and did not notify nursing staff the resident was exposed.

Interview with Maintenance staff #1, on 08/10/2021 at 12:15 PM, revealed he had worked at the facility for eleven (11) years. Per the interview, he had been provided Resident Rights training by the facility. Additionally, he stated he usually would knock on residents' doors before entering, ensure privacy curtains were pulled, and would let nursing staff know if a resident needed to be covered up; however, he said he forgot to do it that today. Further, he stated he was aware those things ensured Resident Rights of dignity and privacy.

Interview with RN #3, on 08/10/202 at 12:24 PM, revealed she had worked at the facility for two (2) months. Per the interview, she was aware of Resident Rights to include dignity and privacy. Additionally, she stated all staff should ensure Resident Rights and knock on doors before entering, ensure privacy curtains were closed, and ensure residents were dressed appropriately or covered up. Further, RN #3 stated she would continuously round on the hallways and watch the residents; however, today she was passing medications and did not notice Resident #13 was

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should have been covered or the curtain pulled for privacy, and it was a dignity issue.

Interview with SRNA #14, North Unit, on 08/12/2021 at 1:40 PM, revealed Resident #31 should have been covered or the curtain pulled for privacy. SRNA #14 stated Resident #31 had a history of playing with his/her briefs or kicking off the blankets. SRNA #14 stated it was a dignity issue with staff passing by and not covering up or pulling the curtain.

Interview with Licensed Practical Nurse (LPN) #9, on 08/12//2021 at 1:45 PM, revealed Resident #31 should have been covered up or the curtain pulled. LPN #9 stated, first, staff should have knocked at the door and asked to cover up the resident; and it was a dignity concern. In addition, LPN #9 stated staff should be educated to cover the resident, pull curtains, dress the resident in pants, or close the resident's door.

Interview with Registered Nurse (RN) Quality Improvement/Infection Control Preventionist/Staff Development Coordinator, on 08/16/2021 at 10:30 AM, revealed Resident #31 uncovered himself/herself. She stated staff should cover the resident or pull the curtain. Further she stated she expected staff to round and check on Resident #31 and keep him/her covered due to the concern for his/her dignity.

Interview with the Director of Nursing (DON), on 08/16/2021 at 10:54 AM, revealed Resident #31 should have been covered or the curtain pulled. She stated SRNA # 22 could have covered or pulled the curtain after the staff member brought the roommate into the resident's room. Further, the DON stated this was a dignity issue.

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F 571 SS=E	Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii)	F 571	F 571	

§483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)
(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services:
(A) Nursing services as required at §483.35.
(B) Food and Nutrition services as required at §483.60.
(C) An activities program as required at §483.24(c).
(D) Room/bed maintenance services.
(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and

F 571

1. Residents #30, #34, and #36 patient trust fund accounts were reimbursed by the corporate business office on 07/27/21. Resident #77's patient trust fund account was reimbursed by the corporate business office on 08/18/21.
2. Regional business office personnel and corporate compliance staff conducted audits of all residents' patient trust fund accounts and items purchased on 07/22/21 and 08/19/21. Any items purchased which were identified as facility responsibility were reimbursed to the residents' patient trust accounts.
3. The Administrator and Business Office Manager (BOM) were educated on 07/22/21 and 07/23/21, by the Regional Vice President (RVP) and Corporate Business Office, on what items cannot be purchased with resident funds and must be provided by the facility. General accounting principles are utilized which includes separation of duties. The Administrator and BOM will have oversight of the RFMS accounts. Residents were provided written information related to their

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control).
(L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.
(1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60.
(2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.
(iii) Requests for items and services.
(A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.
(B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.
(C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's documents and policy, it was determined the facility failed to have an effective system in place to limit charges on residents' personal funds. In addition, the facility failed to protect residents' personal funds from unnecessary purchasing of items for residents using Stimulus money and for any item not

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Review of 42 CFR 483.10(f)(11) revealed the facility must not impose a charge against the personal funds of a resident for any item or service for which payment was made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). In addition, the regulation stated the facility could only charge a resident for any non-covered item or service if such item or service was specifically requested by the resident. Further review revealed the facility must inform, orally and in writing, the resident requesting an item or service for which a charge would be made that there would be a charge for the item or service and what the charge would be.

Review of the facility's document Guideline: Stimulus and Representative Payee Responsibilities, dated 05/29/2020 and updated 07/21/2021, revealed Stimulus money was to be used solely at the discretion of the resident or responsible party. Under no circumstances should the Stimulus money be used to pay resident liability at the facility. The Stimulus money did not count as resources to affect federal programs like Medicaid for a year and any attempt by the facility to seize the money was unlawful. Further, the Guideline stated that an Interdisciplinary Team (IDT) meeting should be held with residents and responsible parties to discuss what could/could not be purchased with the Stimulus monies, who should be invited, and what to do if the facility staff became aware of misuse of the monies.

Review of the Quality Assurance Performance Improvement (QAPI) Meeting minutes, dated 07/21/2021, revealed Corporate became aware the RTA Stimulus checks were used to purchase

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Representative, authorized payment of $3,334.74 for personal items that included a forty inch television for $482.99 and an Optima Evolution Chair for $2,522.99; that authorization form was signed by the previous Administrator.

Review of Resident #77's progress notes, dated October 2020 until March 2021, revealed no documented evidence the POA was contacted related to the television or chair. There were multiple notes where the POA was notified of positive COVID results and testing for COVID. Review of Occupational Therapy notes revealed no documented evidence of an assessment of the evolutionary chair. Interview, on 08/18/2021 at 10:48 AM, with the DON revealed there were no therapy notes about the resident's evolutionary chair. Review of Resident #77's care plan, dated 10/2019, revealed the evolutionary chair was for comfort and positioning.

Review of Resident #77's financial statements, dated 08/13/2021, revealed a total of $2,853.42 was refunded to Resident #77's RTA account. This amount included the cost of the chair, taxes, shipping, and interest for April-July 2021.

Attempts to reach Resident #77's Power-of-Attorney (POA) via phone, on 08/11/2021 at 10:15 AM and 08/18/2021 at 9:30 AM, were unsuccessful; the voice mail was not set up.

2. Review of Resident #36's RTA revealed he/she received Stimulus monies on 04/07/2021 for $1400. On 06/09/2021, authorization for miscellaneous payments from patient trust accounts revealed the facility, as Resident/Legal Representative, authorized payment of $1,286.82

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Interview with the Minimum Data Set (MDS) Registered Nurse (RN) #7, on 08/17/2021 at 9:20 AM, revealed that typically mattresses were used as a fall interventions and was unaware Resident #36 had issues with the winged mattress. She stated a resident getting a new mattress would not be a decision she would make by herself because there were different factors involved. She stated Resident #36 had not been on the air mattress for a day before he/she fell out of the bed, and it was again replaced by the winged mattress. Per the interview, she stated the decision to replace the mattress was made by the former Administrator, and she was uncertain of her reasoning.

Interview with Staff Development Coordinator/Quality Improvement (SDC/QI) nurse, on 08/17/2021 at 10:21 AM, revealed all she knew was that the former Administrator ordered Resident #36 the air mattress for comfort. However, she stated Resident #36 had not complained the bed was uncomfortable nor had requested a new mattress.

Review of Resident #36 financial statements, dated 07/27/2021, revealed $970.83 was refunded to Resident #36's RTA account.

3. Review of Resident #30's RTA revealed he/she received Stimulus money on 05/03/2020 for $1200, on 01/04/2021 for $600, and on 04/07/2021 for $1400. On 03/26/2021, authorization for miscellaneous payments from patient trust accounts revealed Resident #30, as the Resident/Legal Representative, authorized payment, by signature, of $1245.49 for personal items that included a forty inch television for $482.99 and a Lift Chair for $617.00.

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personal items that included a forty inch television for $482, a microAIR MA500 alternating pressure low air loss mattress system for $892.99, a Matrix 4100 bed frame for $932.99, a 4-drawer chest for $390.00, and a 3-drawer bedside cabinet for $237.00.

Interview with Resident #34, 08/19/2021 at 10:20 AM revealed he/she "ordered'em" but was not able to say how he/she knew to order those specific items and did not look at a catalogue.

Observation of Resident #34's room, with the DON at the same time, revealed the cabinet, chest and television were in Resident #34's room. However, per observation, the bedframe was not in his/her room.

Interview with the DON, on 08/19/2021 at 10:20 AM, revealed the mattress was on his/her bed but was unaware of where the bedframe was. The DON stated she would get with Maintenance and locate the bed frame. She also stated she was unaware of any items ordered for residents because the former Administrator kept staff out of the loop as to what she was doing with the Stimulus money.

Interview with the Maintenance Director, on 08/19/2021 at 1:40 PM, revealed he inspected all resident electrical items for safety. He stated Resident #34 did receive a new bed frame and mattress, which was ordered by the former Administrator. However, he stated, the bed did not have a headboard nor a footboard. In addition, he stated the wheel locking mechanism did not meet safety standards for locking tightly enough to prevent the bed from slipping if a resident tried to get out of the bed. Therefore, he

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called her after several items had been purchased.

Review of the Stimulus Payment Tracking Report revealed the facility reimbursed Resident #246's RTA account $1657.60 on 07/13/2021.

Interview with the Accounts Receivable/Resident Trust Accounts Clerk, on 08/13/2021 at 2:05 PM, revealed the facility was given information in 05/2020, she thought from Corporate, that Resident Stimulus checks would not affect RTA for a year. She stated Stimulus monies were not used until this year (2021) to buy residents durable medical equipment (DME). She stated the former Administrator initiated using RTA for DME that should have been paid for by facility.

Additional interview with the Accounts Receivable/Resident Trust Accounts (RTA) Clerk, on 08/19/2021 at 9:15 AM, revealed when she questioned the former Administrator about using Stimulus monies, the Administrator told her purchased items could be used or were needed by the residents. The Clerk stated she signed the requisition slips as a witness for all the ordered items because she was told by the former Administrator she was always the witness. Further, she stated when she showed the former Administrator the 05/2020 Corporate documentation regarding RTA's and purchases, the former Administrator told her that as long as they could use the purchased items at the facility, it was okay. Further interview revealed the Clerk did not report the former Administrator's actions to the Regional Vice President or the Corporate Compliance Hotline because the former Administrator had told her it was okay to use the monies. She stated, after Corporate was aware

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Administrator. He stated, until July, there was no awareness the former Administrator had used RTA's money to purchase items the facility should have furnished and that this had happened as early as January or February 2021. He stated the facility needed a more regular audit of the business office, and this was going to be put in place. He stated the facility did have audits that looked into those things that were usually done annually, or sometimes semi-annually. He stated there were different price levels where the RVP was triggered to look at a purchase. He stated he expected if the Administrator was using resident money for DME purchases, someone would call Corporate. He stated he believed staff had been intimidated by the former Administrator. He stated he wished the incidents had been reported earlier to someone.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed there was a letter sent out in 06/2021 regarding how Stimulus checks should be spent and Stimulus monies would not affect resident Medicaid status for at least a year. An additional update was sent 07/21/2021 reiterating Stimulus expenditures and the public health emergency was in effect until October 2021. He stated he was not aware Stimulus monies were used inappropriately and that is something that is taken very seriously. He stated the facility had addressed it through a review, going back, and looking at processes from a Quality Assurance standpoint. The facility had made some refunds of purchased items that the facility should or would have normally purchased. He stated those items were not expensive enough to require prior approval. The RVP stated he did not have a great answer regarding what system should have caught this,

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F 600	Continued From page 28 (anti-convulsive) and taped into the Roxicodone blister pack. Review of a Uniform Citation (police report), dated 07/18/2021, revealed LPN #1 was charged with two (2) counts of Wanton Endangerment, First Degree. LPN #1 admitted to the police that she switched out medications for Primidone fifty (50) milligrams (mg), not caring what effects it would have on the residents. The facility's failure to take immediate action to prevent further abuse and to follow their policy to ensure all residents were free from abuse has caused or is likely to cause serious injury, serious harm or death to other residents in the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 08/20/2021, and were determined to exist on 07/18/2021, in the area of 42 CFR 483.12 Freedom from Abuse, F-600, Free from Abuse. The facility was notified of the IJ and SQC on 08/20/2021. Additionally, it was determined the facility failed to protect residents from abuse for an additional four (4) residents (Residents #21, #45, #28, and #63). On 05/18/2021, Resident #28 pushed Resident #63 down, resulting in a hematoma to Resident #63's head. On 06/27/2021, Resident #45 attacked Resident #21, resulting in multiple scratches and abrasions to Resident #21. The facility provided an acceptable Immediate Jeopardy Removal Plan on 09/01/2021, with the facility alleging removal of the Immediate Jeopardy, on 08/31/2021. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 08/31/2021, prior to exit on 09/02/2021. The facility's remaining	F 600	meeting will be completed, five times a week for two weeks, then weekly for four weeks, then monthly for two months, to ensure any allegation of abuse or misappropriation was reported. Resident concerns will be reviewed in the IDT meeting to ensure any concern regarding abuse or misappropriation was reported and action was taken to ensure the resident(s) was protected. On 07/20/21, the DON, SDC, MDS nurses, Social Services Director (SSD) and Activities Director (AD) or support RN nurse began interviewing 3 random residents with a BIMs of 9 or higher, weekly for four weeks, then monthly for two months, to ensure they have no concerns with when or how their controlled substances are administered. Abuse and narcotic audits continue as per the abatement plan. Data will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting monthly for additional recommendations. Compliance Date: 11/24/2021	

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mg tablet along with three (3) empty packs; one (1) Oxycodone 10/325 mg tablet; one (1) Tramadol 50 mg tablet; two (2) Hydrocodone 10/325 mg tablets; three (3) Gabapentin 600 mg tablets; five (5) Gabapentin 300 mg tablets; one (1) empty skid (a blister pack when full contained thirty (30) tablets) of Roxicodone labeled for Resident #32; and, one (1) pack of birth control pills labeled for LPN #1.

Continued review of the report, revealed LPN #1 admitted to taking medications from the facility, as well as changing some narcotics out and replaced them with Primidone 50 mg, without regard for how this would affect the involved residents. LPN #1 stated, if the police drug tested her, she would have Hydrocodone, Percocet, Gabapentin, and Marijuana in her system. Per the report, LPN #1 stated she did not document narcotics removed from her medication cart until the end of the shift and stated this was common practice among nurses at the facility. Therefore, the medication could be missing and even taken by the resident but not yet signed out on the narcotic record. The report stated LPN #1 was charged with two (2) counts of Wanton Endangerment in the First Degree; thirteen (13) counts of Theft by Unlawful Taking (TBUT), Controlled Substance; three (3) counts of Possession of a Controlled Substance; and two (2) counts of Abuse and Neglect of an Adult Person.

Interview with the Registered Nurse (RN) Facility Consultant, on 07/27/2021 at 1:15 PM, and again, on 08/18/2021 at 2:32 PM, revealed she had been brought in from corporate as a result of the facility's issues that needed to be addressed. She stated there had been an audit, on

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#17. She stated the first she heard of missing Percocets was when pharmacy determined a skid was missing, which belonged to Resident #17, in an audit conducted on 07/09/2021. She revealed she had reported this to the Administrator and sent the information in a self-report to the police on 07/09/2021. Continued interview revealed when police came to the facility, she never spoke with them, the Administrator did. She stated pharmacy had delivered three (3) skids of thirty (30) Percocet 50 mg tablets for Resident #17, on 06/28/2021; however, LPN #1 stated she only received two (2) skids. The DON stated she thought there was a trigger call that day, but she was not on the trigger call. The DON stated neither LPN #1 nor LPN #2 were suspended.

Interview with the Ombudsman, on 07/26/2021 at 3:15 PM, revealed she interviewed the DON following an incident, on 07/09/2021, after a skid of Percocet tablets was reported missing. She stated, when asked about suspending staff implicated in drug diversion on 07/09/2021, the DON replied she was not sure which of the two (2) nurses was responsible. The Ombudsman stated, when the DON was asked why she did not suspend both staff members, the DON shrugged her shoulders.

Continued interview with the RN Facility Consultant, on 07/27/2021 at 1:15 PM, revealed, on 07/18/2021, she was contacted by the DON, who informed her LPN #2 had found two (2) pills taped into a Roxicodone skid belonging to Resident #32 which were not Roxicodone, followed by a second resident, Resident #84, who also had two (2) pills taped into a Roxicodone skid which were not Roxicodone. She stated the pills used to replace the Roxicodone were

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the narcotics sheet, but the Administrator and DON had taken the Shift Change Count Sheet, which tracked the number of controlled substance skids in the cart. LPN #2 stated she started another sheet and counted forty-two (42) sheets.

Interview with SRNA #20, on 08/11/2021 at 4:13 PM, revealed LPN #2 showed him, on 07/18/2021, taped skids belonging to Resident #32 of two (2) Roxicodone tablets that had been replaced with something else. He revealed, due to that, she wanted to check the rest of the narcotics in the drawer, and they found Resident #84 also had two (2) Roxicodone tablets removed from a skid and replaced with something else. He revealed LPN #2 reported this to the DON, and he knew they had looked at LPN #2's cart while he was still on the floor.

Interview with the DON, on 08/04/2021 at 8:28 AM, revealed she received a call from LPN #2, on the night of 07/18/2021 at 7:30 PM. She stated LPN #2, stated that she had found two (2) of Resident #32's narcotics that had been replaced with other pills. She stated she also received a text, on 07/18/2021 at 7:47 PM from LPN #2, that she had found a second resident, Resident #84, who had two (2) narcotics replaced with other pills. The DON stated she alerted the Administrator. The Administrator then had a trigger call, at 7:52 PM, with the Facility Consultant, the Clinical Director, and the Regional Vice President.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed she and the Administrator came in a little after 9:00 PM on 07/18/2021; police and the SSCI were already present in the facility. She stated they did cart audits, and the

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09/11/2020, with diagnoses that included End Stage Renal Disease, Dementia in Other Diseases Classified Elsewhere without Behavioral Disturbance, and Dependence on Renal Dialysis.

Record review revealed the facility assessed Resident #84, in a Quarterly Minimum Data Set (MDS) Assessment, dated 04/26/2021, as fourteen (14) of fifteen (15) on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. Continued review of Resident #84's medical record revealed a Physician's Order, dated 03/23/2021, for Neurontin (Gabapentin, an anti-seizure medication also used for nerve pain) 100 mg at bedtime. The record revealed another Physician's Order, on 05/10/2021 for Roxicodone (Oxycodone) 5 mg every eights (8) hours as needed for pain.

Review of Resident #84's Controlled Substance Count Record for Roxicodone 5 mg, delivered on 06/10/2021, revealed frequent use once a day, with use twice a day on multiple occasions. LPN #1 had signed out eight (8) tablets on the record, with two (2) tablets documented as replaced with Primidone on 07/18/2021.

Interview with Resident #84, on 07/28/2021 at 2:45 PM, revealed he/she received his/her medications on time, and whenever he/she experienced pain, staff provided him/her with pain medications. Resident #84 stated he/she had never received the wrong medications, as far as he/she was aware.

Interview with LPN #6, on 08/10/2021 at 2:40 PM, revealed she had observed, on Resident #84's Medication Administration Record (MAR) that Resident #84 did routinely receive pain

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Review of Resident #32's Controlled Substance Count Record for Roxicodone 5 mg, initiated on 06/15/2021, revealed the last two (2) medications on the skid had been replaced with Primidone on 07/18/2021.

Additional interview with LPN #6, on 08/19/2021 at 8:39 AM, revealed there had been no evidence Resident #32 was not receiving his/her pain medication or getting another medication in place of it. She revealed Resident #32 did not ask for pain medication often. LPN #6 stated Resident #32 had frequent UTI's, which would be exhibited in Resident #32 by confusion, saying off-the-wall things, having delusions, and sometimes fatigue, which were behaviors exhibited by Resident #32 around 07/18/2021.

Interview with LPN #9, on 08/19/2021 at 8:50 AM, revealed when Resident #32 had a UTI, he/she would be confused, might not know where he/she was or why, and yell out. She revealed Resident #32 did not use many as needed pain medications.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed when medications were not administered as prescribed, it could lead to problems; and, in the case of residents with pain medications, it could lead to untreated pain. Regarding Resident #32, he stated he had ordered lab work because he was concerned Resident #32 might have been overdosed but found that was not the case. The Medical Director stated the DON had been keeping him informed on issues surrounding the drug diversion situation at the facility, as well as their plans to address the issues.

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allegations.

2. Review of a Long Term Care Facility Self-Reported Incident Form, dated 06/27/2021, revealed, on 06/27/2021, Resident #21 alleged Resident #45 attacked him/her when Resident #21 tried to stop Resident #45 from pulling flowers in the courtyard. Continued review revealed the facility made appropriate contacts and initiated an investigation. Report of the five day follow-up revealed Resident #21 was assessed and treated, and Resident #45 was placed and remained on one-to-one (1:1) supervision until he/she was sent to another facility for psychiatric evaluation and treatment.

Review of Resident #45's medical record revealed the facility admitted the resident, on 03/12/2020, with diagnoses that included Unspecified Dementia with Behavioral Disturbance, Paranoid Personality Disorder, and Psychotic Disorder due to Known Physiological Condition. The facility assessed Resident #45, in a Quarterly MDS Assessment, dated 06/15/2021, as three (3) of fifteen (15) on the BIMS, indicating severe cognitive impairment.

Review of Resident #45's Comprehensive Care Plan, dated 05/04/2020, revealed a care plan for verbal/physical aggression with interventions for staff to include not invading the resident's personal space and removing the resident to a quiet area during periods of anger or if appropriate. Further review revealed that staff was not present in the courtyard at the time of the incident, and other residents invaded Resident #45's personal space in response to his/her behaviors.

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pulling flowers up because Resident #45 thought they were weeds. RN #4 stated, "I guess (he/she) didn't like being yelled at. I do not know what they did after that incident, besides the usual. Anything like that, we always get the abuse training."

Interview with LPN #3, on 07/29/2021 at 9:23 AM, revealed Resident #21 came up to the nurse's station after the incident on 06/27/2021, and she bandaged the resident and called the doctor. She stated Resident #21 had skin tears all the way up his/her right arm, an abrasion on his/her leg, redness to his/her neck, and a scratch under one (1) of his/her eyes. LPN #3 stated the residents were all out in the courtyard and had been making comments to Resident #45 all day, as he/she was pulling up flowers. LPN #3 stated staff had encouraged the residents to come and get them if Resident #45 started pulling up flowers again, but instead, per her interview with Resident #21, Resident #1 was making gestures at Resident #45, trying to get him/her to stop pulling up flowers. Continued interview revealed when Resident #45 "went after" Resident #1, who was not touched by Resident #45, Resident #21 intervened. LPN #3 revealed Resident #45 had exhibited aggression toward staff before, but not toward other residents. She stated Resident #45 was placed on one-to-one (1:1) supervision, and she took care of Resident #21, calling the doctor and the family. LPN #3 stated Resident #45's nurse and the Assistant Director of Nursing (ADON), took care of initiating the investigation. Further, she stated the facility had transferred Resident #45 to another facility, for psychiatric care, and since his/her return to the facility, the resident had been well behaved.

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the interview, she stated a Personal Care Assistant (PCA) was in the courtyard with her, and the CA told her to go get a nurse. When the nurse came out, she stated, the nurse took Resident #21 inside and told the CA to take Resident #45 to his/her room for one-to-one (1:1) supervision, which she did until 11:00 PM, when her shift ended. She stated, after the incident, Resident #45 calmed down.

Interview with Registered Nurse (RN) #2, on 08/03/2021 at 3:33 PM, revealed she was in the dining room with a State Registered Nurse Assistant (SRNA), on 06/27/2021, at the time of the incident, feeding residents. She stated, they heard a commotion at the inside door to the courtyard, and the SRNA went out first. She stated the SRNA came and got her to go to the courtyard. She stated she saw Resident #21, who was upset, crying, and bloody. In addition, she said she saw several SRNA's and staff members in the courtyard, and she was told Resident #45 had gone to the courtyard and was pulling up flowers. Then, she stated, when other alert and oriented residents, in the courtyard, told Resident #45 to stop, he/she turned and became violent. RN #2 revealed she was told Resident #45 choked Resident #21, twisted his/her arm, and kicked him/her. She stated there was a "marking" around Resident #21's neck, multiple skin tears to the right arm, and a skin tear or laceration to either the right or left leg. RN #2 stated Resident #21 was pretty upset, and other residents out there were also upset. Per the interview, RN #2 said she told CA #1 to take Resident #45 back to his/her room, to separate him/her from everybody else.

Continued interview with RN #2, on 08/03/2021 at

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3. Review of a Long Term Care Facility Self-Reported Incident Form, dated 05/18/2021, revealed on 05/18/2021, on the secure dementia unit, the DON witnessed Resident #28 push Resident #63, causing Resident #63 to fall. Continued review of the facility's five-day final report revealed Resident #28 was agitated, and Resident #63 was in his/her path. Resident #28 said some profanities to Resident #63, and before staff could intervene, Resident #28 pushed Resident #63, who fell backwards and struck his/her head on the floor. Per the report, Resident #28 was placed on one-to-one (1:1) supervision. Resident #63 was assessed, and complained of left lower back pain. Further review revealed Resident #63 was determined to have a hematoma to the left back side of the head. The report stated Resident #63 was transferred to the Emergency Room (ER), where computed tomography (CT) scans showed normal results.

Review of Resident #28's medical record revealed the facility admitted the resident, on 10/21/2019, with diagnoses to include Alcohol Dependence with Alcohol Induced Persistent Dementia, Unspecified Dementia with Behavioral Disturbance, and Restlessness and Agitation. The facility assessed Resident #28, in a Quarterly MDS Assessment, dated 05/27/2021, as three (3) of fifteen (15) on the BIMS, indicating severe cognitive impairment.

Review of Resident #28's care plan, dated 10/25/2019, revealed a behavioral care plan for anxiety and anger when others were in his/her personal space. Interventions included documenting behaviors and notifying the

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Interview with SRNA #6, on 07/28/2021 at 11:20 AM, revealed she routinely worked on the secure unit and had been there consistently for the past five (5) months. She revealed Resident #28 could "sometimes get in a mood", but it was not typical behavior for Resident #28 to push somebody out of his/her way.

Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, revealed the ADON observed Resident #28 push Resident #63, on 05/18/2021, resulting in a fall with injury. She stated Resident #28 was placed on one-to-one (1:1) supervision, which gradually went to every fifteen (15) minute checks and was finally discontinued, on 06/04/2021, as there had been no further incidents.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, that alleged removal of the Immediate Jeopardy (IJ) on 08/31/2021. The facility implemented the following:

1. On 07/09/2021, a Performance Improvement Plan (PIP) was initiated related to Missing Narcotics which was reported to the Office of Inspector General- Division of Health Care (State Survey Agency), at 4:30 PM on 07/09/2021.

2. On 07/09/2021, the Unit Manager and MDS Nurses audited narcotics in the remaining medication carts as the North back hall had a blister pack missing. All count sheets were found to match the number of skids. Staff signing in and out of a medication cart was expected on controlled substance check sheets.

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to review the additional action steps with the interdisciplinary team (IDT). The IDT was comprised of the Administrator, DON, Quality Improvement Nurse/Staff Development Coordinator (SDC/QI), Minimum Data Set (MDS) Nurse, Unit Manager, Activity Director, Social Services Director, and Dietary Manager. The IDT agreed actions taken would include abuse/neglect education, abuse/neglect monitoring via progress note review, safe surveys with residents, and staff surveys regarding abuse/neglect.

9. On 07/19/2021, the DON, Unit Manager, Administrator, Corporate RN, or a support RN began reconciling the narcotic packing slips to the narcotics received. The reconciliation would be completed three (3) times per week to ensure the correct number of delivered narcotics were logged into the narcotic count book and the number of declining count sheets were updated. Any discrepancies would be reported immediately to the DON and/or administration.

10. On 07/19/2021, staff nurses performed assessments on all residents, including assessing pain. For residents with a BIMS of eight (8) or below, the assessment included observation of non-verbal signs of pain to include: breathing, facial expression, body language, and consolability. No concerns were identified.

11. On 07/19/2021, the APRN assessed Residents #32 and #84.

12. On 07/20/2021, the Administrator suspended LPN #2.

13. On 07/20/2021, the DON, ADON, SDC, MDS

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sheets and found Licensed Practical Nurse (LPN #2) had recorded on the log sheet a reduced number of sheets counted. The nurse documented four (4) less sheets than the previous shift. There was no documented explanation why there were four (4) less sheets than the previous shift. The facility suspended the nurse and reported the information to the OIG, APS (Adult Protective Services), and police.

15. On 07/20/2021 to 07/21/2021, the Social Worker and Admissions Coordinator completed interviews with all residents with a BIMS above 8. Residents were asked about concerns with how and when medications were administered. Any concerns, which included but was not limited to pain, were documented and reported to the Administrator.

16. On 07/21/2021, the DON, ADON, Unit Manager, SDC/QI, Weekend Supervisor, MDS Nurses, the Corporate RN, and/or a support RN would audit the storage and documentation of narcotics when checking medication carts to ensure narcotics were stored appropriately and documentation was correct. The audits included: locking carts, MAR's, shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids, skid cards in numerical order, no missing skids, all narcotics accounted for, and/or pharmacy packing slips. Audits would occur five (5) times per week until the QAPI committee determined frequency could be reduced. Any concern regarding documentation or storage of narcotic administration would be addressed at the time of the audit and reported to the DON or Administrator. All new concerns would be reviewed in the morning IDT meeting. Any

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not witness for a nurse.) Nurses and KMA's could not tape a medication to hold it in a card. If a narcotic came loose, it must be wasted, and two (2) signatures must be present. This education also included signing the Shift Change Controlled Substance Count Check sheet at the beginning and end of the shift. This education included that the signature was the nurse's affirmation that the count was correct and must be signed when counting. It could not be signed early or late. Nurses and KMA's were also educated regarding deliveries of multiple cards of narcotics. The nurse receiving the narcotics and the nurse whose medication cart would hold the narcotics must both sign for the receipt. If the same nurse was both receiving and had the medication cart, a second nurse must sign also.

20. On 07/26/2021, the DON, Unit Manager, SDC, Nurse Supervisor, MDS Nurse, and Corporate RN consultants began administering a medication administration post-test to all licensed nurses and KMA's. The quiz covered both medication administration and physician notification and validated the licensed nurses and the KMA's continued competency in a written form. Any licensed nurse or KMA not scoring one-hundred percent (100%) on the quiz would receive additional education.

21. On 07/27/2021, the DON and SDC began abuse/neglect monitoring via nursing progress note review. The past twenty-four (24) hours of nursing notes were printed off and read, looking for any indication of abuse/neglect/exploitation.

22. On 07/27/2021, the DON, SDC, Unit Manager, RN's, and Administrators from "sister facilities", and RN Corporate nurses continued

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30. On 08/19/2021 the DON facilitated a Medical Director update telephone call.

31. On 08/20/2021, the DON notified the Medical Director of eight (8) IJ tags and the PIP's that were being worked on.

32. On 08/20/2021, the Administrator, DON, SDC, and Corporate Support staff began additional Code of Conduct in-servicing. The in-service included a quiz. The quiz questions included employees following laws, reporting systems, when to report, who to report to, and where to find more information. The employees were able to verbalize their role in protecting residents and preventing abuse, neglect, and exploitation.

33. On 08/20/2021, the facility verified the facility rebilled and/or paid for the misappropriated medications.

34. On 08/25/2021, the Regional Vice President announced the transition to the new Administrator. The Regional Vice President and Interim Administrator provided education to the new Administrator, including the requirements of the tags F-600 Abuse/Neglect/Exploitation and F-610 Investigate/Prevent/Correct Alleged Violation.

35. On 08/26/2021, the DON facilitated a Medical Director update telephone meeting, including the DON, Regional Vice President, Medical Director, Interim Administrator, new Administrator, and RN Consultant. The discussion included the facility's immediate jeopardy (IJ) status, including the tag F-610 Investigate/Prevent/Correct Alleged

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40. On 08/29/2021, the DON, four (4) Support RN Nurses, and a Corporate RN Nurse interviewed staff and residents, inspected medication carts, and reviewed narcotic documentation. No new staff concerns were received. No new resident concerns were received, as residents stated they were receiving their medications. No narcotic medications were identified as missing.

41. Starting 08/29/2021, the facility's IDT would have a meeting five (5) times a week to review concerns. The Administrator or DON would identify an investigator to conduct the investigation. The Cardinal IDT tool would be utilized to track the investigation and ensure the investigation was completed timely and thoroughly.

42. The Pharmacy Consultant would visit the facility at least monthly to validate narcotics were being monitored and counted per standard of practice.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

1. Review of a Quality Assurance (PIP), dated 07/09/2021, revealed, as a result of the missing blister pack of thirty (30) Percocet identified in a pharmacy audit, the facility identified only one (1) staff was signing for narcotics arriving at the facility, and initiated education on controlled substances, to include having a second person sign for controlled substances arriving at the facility.

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South and North halls of the building, observing staff providing care, and talking with staff. She revealed she assessed and interviewed for evidence of abuse. She revealed she also conducted chart reviews and validated the facility was continuing audits and doing everything they were supposed to be doing. The Clinical Director stated she had made surprise visits to the facility at 2:00 AM, as well as on weekends, to determine any resident concerns and ensure staff was following procedures they had been educated on.

5. Review of Complete In-Service Training Report with Staff Attending, dated 07/12/2021, confirmed the DON initiated staff education for licensed nursing staff and KMA's. Education covered (1) All PRN (as needed) medications must be signed on the back of the MAR, (2) all narcotics no longer in use must stay locked up in the medication cart until they could be given to the DON, and (3) declining count sheet must be labeled with room numbers at the top of the sheet.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed it had been determined not everything was signed out consistently on the back of the MAR, so the education initiated, on 07/12/2021, emphasized to staff the need to do this, including documenting the effectiveness of pain medication administered to residents.

6. Review of a Kentucky Incident Based Reporting System (KYIBRS) Report, dated 07/18/2021, revealed LPN #1 had been arrested and charged with thirteen (13) counts of Theft by Unlawful Taking, three (3) counts of Possession of Controlled Substances, two (2) counts of Wanton Endangerment, and two (2) counts of

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Interview with the DON, on 09/02/2021 at 9:10 AM, revealed when reviewing packing slips, she confirmed there were two (2) signatures and checked to ensure everything listed on the packing slips was on the medication cart; then she would initial the packing slips to show she reviewed them.

10. Review of Pain Assessments revealed Pain Assessments were completed for all facility residents on 07/19/2021. No concerns were identified. Additionally, Resident Interview Medication Administration papers were reviewed, with no concerns identified.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed no new or untreated pain was identified through the pain assessments conducted on 07/19/2021.

11. Review of Ambulatory Nursing Home Report confirmed APRN #1 assessed Resident #84 on 07/19/2021. No concerns were identified with the assessment of Resident #84.

Review of the physician visit by the Medical Director (MD) with Resident #32, on 07/20/2021, revealed possible indicators Resident #32's opiates had been replaced with Primidone. MD documentation revealed Resident #32's condition improving at the time of documentation. MD documentation further revealed APRN #2 had visited with Resident #32 on 07/19/2021.

12. Review of a Long Term Care Facility - Self-Reported Incident Form, dated 07/20/2021, confirmed LPN #2 had been suspended from the facility.

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questioned the Regional Vice President by the Social Services Director or the Admissions Coordinator about whether or not they had concerns regarding administration of their medications. If residents indicated concerns, this was explored further, to include to whom the residents reported concerns and when. No issues were identified during documentation review.

16. Review of Narcotic Cart Audit forms, dated 07/21/2021 confirmed the DON audited the storage and documentation of all facility medication carts. Continued review of audits revealed audits were occurring five (5) or more times each week. Review of Narcotic Cart Audit forms revealed required education was given, on 07/22/2021, for a KMA who had pulled narcotics but did not sign at the time the narcotics were given.

17. Interview with the Regional Vice President, on 09/02/2021 at 7:07 PM, confirmed the previous Administrator had been suspended on 07/21/2021, as a result of concerns regarding the way the Administrator handled the drug diversion ue. The Regional Vice President stated he present at the facility acting in the capacity of strator from 07/21/2021 through 21, with an Interim Administrator present , beginning 07/27/2021, until a new started on 08/26/2021.

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narcotics.

Interviews, on 09/02/2021 with LPN #11, at 3:03 PM, and RN #3 at 3:14 PM, revealed both had been educated on the proper way to do a narcotic count at shift change, counting skids, comparing to the number of controlled substance sheets, and wasting medications, with another nurse witnessing and signing, in the Drug Buster kept in the medication rooms. Both stated education also covered the importance of signing and completing pain assessments on the back of the MAR for PRN (as needed) medications and signing with another nurse when narcotics arrived. LPN #11 also stated, if a skid was damaged, to report it to the DON, and if a medication was in danger of falling out of a damaged skid, it was to be wasted with another nurse witnessing and signing. LPN #11 revealed she had seen and experienced management staff, including the DON, going around doing medication cart audits, and she stayed with her medication cart while was being audited.

Interview with SRNA #20, on 09/02/2021 at 3:39 PM, a KMA, revealed he received the same education nursing staff received. He revealed he had received multiple educations. The KMA stated the education included the importance of signing out narcotics when he gave them and not waiting until the end of shift to sign them out. He revealed he signed them out right after they were given, and if a resident refused, he would mark it as a refusal and have a nurse witness and sign the medication as wasted. He stated, if a pill or skid was compromised, or if anything looked tampered with, he would alert the DON so she could assess and determine if medications needed to be wasted. He revealed corporate

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continuing. Review of a sign in sheet, dated 08/10/2021, revealed the Medical Director was in attendance at the meeting.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed the DON had been in contact with him two (2) to three (3) times a week and had provided him all the PIP's that had been planned out. The Medical Director revealed he was extremely pleased at the progress the facility had made addressing their problems.

26. Review of the Narcotic Cart Audit sheets used for facility narcotic cart audits revealed staff were auditing to ensure (1) All staff were signing the Controlled Substance Count Sheet (CSCS) at shift change, (2) All narcotic sheets had been counted, (3) the number of narcotic count sheets matched the number of skids on the cart, (4) Skids on the cart did not have tape on their backs, (5) Skids were checked to ensure there were no missing skids, (6) CSCS were being logged in and out of the cart on the Shift Change Controlled Substance Count Check form as the sheet count number changed (new skids arrived, skids were completed), and (6) All narcotics were signed out and accounted for.

Review of a Narcotic Cart Audit completed, on 08/11/2021 at 11:42 AM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken. The Corporate RN Consultant noted the front-north narcotic drawer had a screw sticking out that caused tears/punched holes in the back of multiple narcotic skids: The screw was covered.

27. Review of Narcotic Cart Audit completed, on

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report an allegation to their supervisor and did not feel like it was being addressed, they could contact the DON and Administrator, as well as call or fax the Corporate Compliance line.

33. Review of facility documentation, not labeled or dated, revealed a total of one hundred and eight (108) narcotics were documented as missing, which included three (3) skids of thirty (30) medications each that were missing, and four (4) non-controlled medications that were documented as missing. The document listed residents by name, along with discrepancies noted, the cost for each individual dose, resident payors, and the total cost of all medications reimbursed, which was three hundred and four dollars and ninety-seven ($304.97) cents.

34. Review of an Appointment Letter as facility Administrator revealed appointment of a new Administrator, on 08/26/2021, with an Administrator job description, reporting to the Regional Vice President, who also signed the letter on 08/28/2021.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed he spoke with the Interim Administrator and the Regional Vice President over the phone, on 08/25/2021, and they discussed with him the IJ tags the facility had been cited, to include abuse and misappropriation tags. He stated they wanted to make sure he was aware of the situation he would be coming into. He stated the Regional Vice President had stressed the importance of reporting allegations and keeping him informed.

35. Review of the document Communication with Medical Director, signed by the Medical Director

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at 9:10 AM, revealed she, the SDC, and a sister facility nurse went to each medication cart, on 08/28/2021 at shift change with their audit tools, and went through the packet of audit tools with medication cart staff, asking questions about documentation and reporting. She revealed this process was repeated on 08/29/2021 with a nurse from a different sister facility. She revealed there had been no concerns with the audits.

39. Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed the Clinical Director had thoroughly reviewed with him abuse reporting and investigating.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed she reviewed an investigation file with the Administrator on 08/29/2021. She revealed they went down the Action Checklist, reviewed the process, and the Administrator made notes to himself on what he needed to do and on what he could do at that time. The Clinical Director stated the Administrator had interviewed residents, called residents' representatives, and was very thorough in his investigation of misappropriation.

40. Review of the facility's Weekend Audits, dated 08/28/2021, confirmed the Administrator and a support RN interviewed staff and residents regarding abuse, code of conduct, and medication administration. Staff members were able to answer questions accurately, and residents did not express any concerns during interviews. Further, nursing staff conducted an audit of narcotic documentation and did not determine any concerns.

41. Review of the Cardinal IDT Meeting minutes

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F 602	Continued From page 74 (14) of forty-four (44) sampled residents. On 07/09/2021, two Licensed Practical Nurses (LPN #1 and #2) were implicated in stealing a skid of thirty (30) tablets of Resident #17's Percocet (a narcotic opioid used to treat pain) 5/325 milligram (mg). Despite this, neither nurse was suspended pending investigation, nor did the facility take other action to prevent misappropriation. On 07/18/2021, an additional ten (10) sampled residents had controlled medications taken, (Residents #1, #8, #34, #47, #48, #56, #60, #65, #71, and #79); and two (2) residents had controlled medications taken and replaced with a non-prescribed medication (Resident #32 and Resident #84). On 07/20/2021, it was discovered Resident #9 had a missing skid of thirty (30) tablets of Percocet. LPN #2 was suspended pending investigation. The facility's failure to take immediate action to prevent further misappropriation of residents' property; and failure to follow their policy has caused or is likely to cause serious injury, serious harm or death to other residents in the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 08/20/2021 and were determined to exist on 07/09/2021, in the area of 42 CFR 483.12 Freedom from Abuse, F-602 Free from Misappropriation/Exploitation. The facility was notified of the IJ and SQC on 08/20/2021. In addition, the facility failed to protect residents' personal funds, using their Stimulus money, from	F 602	2. On 7/19/21, staff nurses completed pain assessments on all residents with no concerns identified. On 7/21/21, corporate business office staff audited stimulus monies spent. Any additional residents found to have had stimulus monies spent on items the facility should have provided had the monies refunded. Residents were allowed to keep any items purchased. 3. On 07/09/21, 07/12/21, 07/20/21, 07/22/21, 07/23/212, 07/24/21, and 07/25/21 the DON, SDC, RN consultants and corporate nurses conducted various in-services on the facility's abuse policy, abuse/misappropriation investigations, and narcotic administration, documentation and reconciliation. (See abatement plan for details). On 07/21/21 the RN consultant educated the DON on the investigation process and the use of checklists to ensure all appropriate actions are taken when misappropriation/exploitation occurs. This education is part of new employee orientation, and agency orientation, as appropriate.	

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Review of the facility Drug Free Workplace Policy (DFWP), revised 12/2018, revealed the company recognized the need for a safe and healthy work environment free from the use of prohibited drugs and alcohol. The policy stated employees who abused drugs or alcohol posed a serious risk to the safety, security, and welfare of residents and the company. The policy revealed all applicants for Registered Nurse (RN), Licensed Practical Nurse (LPN), or Medication Aide were required to submit a urine sample as a condition of employment. The policy defined Prohibited Conduct as possessing or using any prohibited drug or alcohol while at the workplace, while at work, or during working hours. Further Prohibited Conduct, per the policy, included refusing to submit to a drug or alcohol test required by the policy, or failing a drug or alcohol test administered in accordance with the policy. The Drug and Alcohol Testing Policy, as documented in the DFWP, revealed employees could be asked to submit to various testing for drugs and alcohol, and included the company's right to test employees in situations such as, but not limited to, a workplace injury, following an incident that resulted in an investigation such as instances of resident abuse or medication diversion, or any time at the sole discretion of the company. The policy required employees consent to the Drug Free Workplace Policy (DFWP), by signing an acknowledgement of receipt of the policy.

Review of the employee file for LPN #1 revealed a DFWP Acknowledgement of Receipt of Policy, signed on 04/07/2021.

Review of the employee file for LPN #2 revealed a DFWP Acknowledgement of Receipt of Policy,

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Percocet 5/325 mg missing for Resident #17 and provided that information to the facility in her report.

Review of a Packing Slip, dated 06/28/2021, revealed LPN #2 signed for ninety (90) Percocet 5/325 mg tablets, three (3) skids, for Resident #17.

Interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed, on the night of 06/28/2021, LPN #1 had approached her repeatedly to let her know when the pharmacy arrived to deliver medications, as LPN #2 was working on the South Unit, and the South Unit nurse was responsible for signing for deliveries from pharmacy. LPN #2 stated she signed for three (3) skids of thirty (30) tablets each of Percocet 5/325 mg for Resident #17, on the night of 06/28/2021. However, she stated she was informed, after the discovery of a missing skid on 07/09/2021, that LPN #1 alleged only receiving two (2) skids.

Review of Resident #17's Controlled Substance Count Record for Percocet 5/325 mg revealed a sheet, 2 of 3, delivered on 06/28/2021, with a receiving signature and date on the sheet. Despite repeated requests, the facility was unable to provide either sheet 1 of 3, or a Controlled Substance Count Record for Percocet 5/325 mg covering the time frame 06/19/2021 through 07/08/2021. Sheet 3 of 3 was the sheet missing as identified by pharmacy on 07/09/2021. Review of sheet 2 of 3 revealed LPN #1 signed the first tablet out, at 12:00 AM on 07/09/2021, with LPN #7 replacing her on the medication cart on the morning of 07/09/2021. Review of Resident #17's MAR for 07/2021 revealed eighty-two (82) doses of Percocet 5/325 mg had been

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LPN #1 was actively stealing resident medications at the facility. The Police report revealed LPN #1 was asked to empty her pockets and had an unmarked pill bottle with several different types of pills inside, along with several loose pills in her pocket. Review of the evidence revealed the following were found on LPN #1: one (1) Primidone 50 mg tablet along with three (3) empty packs, one (1) Oxycodone 10/325 mg, one (1) Tramadol 50 mg, two (2) Hydrocodone 10/325 mg, three (3) Gabapentin 600 mg, five (5) Gabapentin 300 mg, one (1) empty skid of Roxicodone labeled for Resident #32, and one (1) pack of birth control pills labeled for LPN #1. Continued review of the report revealed LPN #1 admitted to taking medications from the facility, as well as changing some narcotics out and replacing them with Primidone 50 mg, without regard for how this would affect the residents. When asked by officers what drugs would be found in her system upon drug testing her, LPN #1 revealed she would have Hydrocodone, Percocet, Gabapentin, and Marijuana (a recreational psychoactive drug) in her system. LPN #1 stated she did not document narcotics removed from her medication cart until the end of the shift and stated this was common practice among nurses at the facility. LPN #1 was charged with two (2) counts of Wanton Endangerment in the First Degree; thirteen (13) counts of Theft by Unlawful Taking, Controlled Substance; three (3) counts of Possession of a Controlled Substance; and two (2) counts of Abuse and Neglect of an Adult Person.

Interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed she was working the night of 07/18/2021, and was administering medications, when she noted Resident #32's narcotic skid had

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together and all medication carts were audited by 2:00 AM on 07/19/2021, when she left the facility. The DON revealed she did not have a full record of what was wasted on the evening of 07/18/2021 through the morning of 07/19/2021.

Interview with RN #4, on 07/28/2021 at 1:20 PM, revealed she was called to the facility, on the night of 07/18/2021, by the DON to help audit medication carts. She revealed several narcotics were missing from the cart belonging to LPN #1.

Interview with LPN #12, on 08/13/2021 at 8:21 AM, revealed she was working, on the night of 07/18/2021, when another nurse and the SSCI came around checking medication carts. She revealed her cart had no problems, and the only cart she thought had an issue was LPN #1's cart.

A) Review of Resident #65's medical record revealed the facility assessed Resident #65, in a Quarterly MDS Assessment, dated 06/29/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review revealed orders for Neurontin (Gabapentin) 200 mg three times per day, dated 06/04/2021; and Roxicodone 5 mg every six (6) hours, dated 06/21/2021.

Review of Resident #65's Controlled Substance Count Record for Roxicodone 5 mg revealed a missing (not documented) tablet on 07/18/2021.

B) Review of Resident #34's medical record revealed Resident #34 was admitted by the facility, on 12/09/2019, and was assessed in a Quarterly MDS Assessment, dated 06/29/2021, as fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued

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#1 signed out eight (8) tablets on the record, with two (2) tablets documented as replaced with Primidone on 07/18/2021. Review of the MAR for 07/2021 revealed a dose of Roxicodone 5 mg was administered on 07/08/2021, but not documented on the controlled Substance Count Record. Further review revealed ten (10) documented administrations during 07/2021 on the MAR, with only six (6) documented on the back of the MAR. Review of the 06/2021 MAR revealed, of twenty-two (22) doses administered, only six (6) were documented on the back of the MAR. The last dose administered on the MAR was, on 07/18/2021 at 8:00 PM, by LPN #2.

Interview with LPN #6, on 08/10/2021 at 2:40 PM, revealed she had observed, on the MAR, that Resident #84 did routinely receive pain medications with LPN #1 at night, although he did not routinely receive them when LPN #6 was working during the day.

E) Review of Resident #32's medical record revealed the resident was admitted by the facility, on 04/01/2020, and was assessed in the Quarterly MDS Assessment, dated 06/01/2021, as a seven (7) of fifteen (15) on the BIMS, indicating severely impaired cognition. Continued review revealed an order for Roxicodone 5 mg every eight (8) hours PRN, dated 04/01/2020.

Review of Resident #32's Controlled Substance Count Record for Roxicodone 5 mg, initiated on 06/15/2021, revealed the last two (2) medications on the skid had been replaced with Primidone. Review of Resident #32's MAR for 07/2021 revealed two (2) doses of Roxicodone 5 mg documented as given for 07/03/2021; however, the back of the MAR only listed one (1) dose was

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H) Review of Resident #8's medical record revealed the resident was admitted by the facility, on 03/12/2020, and was assessed in the Significant Change of Status Assessment, dated 05/05/2021, as three (3) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order for Hydrocodone 5 mg four (4) times per day, dated 05/26/2021.

Review of Resident #8's Controlled Substance Count Record for Hydrocodone 5 mg revealed one (1) dose missing, on 07/18/2021, and not documented as given.

I) Review of Resident #47's medical record revealed the resident was readmitted by the facility, on 09/01/2020, and was assessed in a Quarterly MDS Assessment, dated 06/15/2021, as four (4) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order for Ultram (Tramadol) 50 mg every eight (8) hours PRN, dated 05/28/2021.

Review of Resident #47's Controlled Substance Count Record for Ultram 50 mg revealed one (1) dose missing, on 07/18/2021, and not documented as given.

J) Review of Resident #56's medical record revealed the resident was admitted by the facility, on 11/25/2013 and was assessed in the Quarterly MDS Assessment, dated 06/28/2021, as six (6) of fifteen (15) on the BIMS, indicating severe cognitive impairment. Continued review revealed an order for Percocet 10/325 mg every four (4) hours PRN, dated 04/19/2021.

Review of Resident #56's Controlled Substance

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facility, on 05/03/2021, and was assessed in the Admission MDS Assessment, dated 05/09/2021, as a fifteen (15) of fifteen (15) on the BIMS, indicating no cognitive impairment. Continued review of Resident #9's medical record revealed an order for Klonopin (a nerve pain reliever) 1 mg twice a day PRN, dated 05/05/2021 (was changed to twice a day, on 07/08/2021); an order for Neurontin (Gabapentin) 600 mg four (4) times a day, dated, 05/05/2021; and an order for Percocet 7.5/325 mg every eight (8) hours PRN, dated 05/27/2021 (was changed to twice a day, on 07/12/2021).

Interview with Resident #9, on 07/28/2021 at 3:01 PM, revealed one morning he/she had asked for pain medication, and staff informed him/her they could not provide it as they had been administered at 2:30 AM. The resident shared he/she had not received pain medication, at 2:30 AM, and that LPN #1 had been working the night the medication was allegedly administered. Resident #9 stated he/she consistently had pain medication signed out and not given to him/her when LPN #1 worked. Resident #9 stated he/she had reported it to other staff, but remembered reporting it to SRNA #9, who was also a Kentucky Medication Aide (KMA), able to administer medications.

Interview with SRNA #9, on 08/02/2021 at 2:55 PM, revealed Resident #9 had one (1) scheduled Percocet and one (1) scheduled as a PRN pain medication. She stated she did not recall any instance in which Resident #9 shared with her not getting a medication, but if he/she had, she would check the MAR, and if Resident #9 stated he/she had not received something documented on the MAR, she would share this information with her

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of two (2), was delivered on 07/15/2021.

Review of a Shift Change Controlled Substance Count Check form for resident rooms 136 to 149 revealed an incomplete form with LPN #2 not signing in on form next to LPN #6 on 07/18/2021 at 6:30 PM, which indicated forty-six (46) count sheets remaining. There was still room at the bottom of the sheet for two more changes of shift. Review of the following form revealed LPN #2 indicated the sheet count was 42, and completed two sheets on the 07/18/2021 at 7 PM to 07/19/2021 at 7 AM shift, bringing the count to 40 sheets.

Interview with LPN #5 on 08/03/2021 at 4:20 PM revealed when she came in on the morning of 07/20/2021, the DON had asked her to go through a med cart with her. She stated they noted a narcotic skid was on skid two (2) of two (2) for a medication that had just been delivered a week before for Resident #9. She revealed there was also a discrepancy in the Shift Change Count Sheets, however, looking at the cart she would not have known that, as the previous Shift Change Count Sheet had been removed from the cart. She revealed after the previous Shift Change Count Sheet had been located, it was determined there was a discrepancy of four (4) skids unaccounted for. She revealed one (1) skid was missing for Resident #9.

Continued interview with LPN #2 revealed, following the arrival of the DON and Administrator, they identified multiple narcotic skids with tape on them, and were busy wasting medications on the night of 07/18/2021 through the morning of 07/19/2021. She revealed some skids had tape all over them, and had to be

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pain.

Interview with Advanced Registered Nurse Practitioner (ARNP) #1, on 08/11/2021 at 11:44 AM, revealed her concern with residents not receiving their controlled pain medication would be residents not having their pain controlled.

The previous Administrator was not available during the course of the survey, and did not return calls, the last of which was attempted on 08/20/2021 at 9:48 AM.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed his expectation was the facility would have a good investigation program, a good audit program, and a good count program for narcotics that started when they come in to the facility, to limit the possibility of drug diversion occurring, which resulted in misappropriation of residents' medications.
4. Review of the facility's policy titled, "Resident Fund Management System," no date, revealed that each resident that entered the facility had the opportunity to establish a Resident Trust account (RTA). There was no minimum or maximum deposit to open the account, and it was solely for the convenience of the resident. Per the policy, it stated to protect the integrity of the RTA and minimize the risk of embezzlement, there was a division of duties in the facility. The Administrator was the primary check signer, along with the Director of Nursing (DON); and the Business Office Manager (BOM) should monitor the balance report monthly to identify any Medicaid recipient whose balance was within two hundred dollars ($200) of the State's limit.

Review of 42 CFR 483.10(f)(11) revealed the

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have been supplied by the facility. On 07/22/2021, per the minutes, the Regional Business Office (RBO) and Corporate Compliance (CC) conducted an investigation and audits of accounts and items purchased. Items identified that the facility should have paid for were to be reimbursed by 07/27/2021. RBO and CC would conduct monthly audits of RTA's for two (2) months to validate purchases met regulations. On 07/23/2021 a QAPI meeting was held to discuss the process improvement plan (PIP) of self-identified issuesand all actions taken. The Investigation Summary dated 07/21/2021 revealed that facility staff, in good faith, was assisting residents to "spend down" their RTA in order to maintain Medicaid eligibility. Continued review revealed education was provided in May 2020 to assist facilities with understanding the current guidelines for spending down the RTA. The Summary stated the facility believed they were following the guidance correctly.

Review of the Stimulus Payment Tracking Report, dated 01/01/2021 through the present, revealed all four (4) sampled residents received Stimulus money that was added to their RTA's. Continued review revealed that at various times in 2021, there were large sums of money authorized to be disbursed from their RTA to pay for personal items.

1. Review of Resident #77's RTA revealed he/she received Stimulus money, on 05/28/2020 for $1200, 01/04/2021 for $600, and 04/07/2021 for $1400. On 02/08/2021, authorization for miscellaneous payments from patient trust accounts revealed the facility, as Resident/Legal Representative, authorized payment of $3,334.74

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television for $299.99 and a microAIR MA500 alternating pressure low air loss mattress system for $894.99; that authorization form was signed by the previous Administrator.

Interview with Resident #36, on 08/17/2021 at 8:48 AM, revealed he/she was resting in bed, winged mattress observed, head of bed elevated, when asked about the previous mattress (air mattress), the resident stated he/she had told them he/she did not want the mattress. Resident #36 stated he/she was unable to remember who he/she told, just "the one that brought it." The resident also stated the winged mattress was comfortable. Resident #36, per the interview, stated there had not been the need for a new television, and he/she did not request it. Although, Resident #36 stated, this one was bigger, he/she could see better, and it could be given to his/her daughter.

Interview with Licensed Practical Nurse (LPN) #7, on 08/14/2021 at 10:29 AM, revealed she did not know whose idea it was to get Resident #36 the air mattress. She stated she was confused as to why because the resident had a winged mattress to prevent falling out of bed, and an air mattress made it easier to slide out of bed. The winged mattress was taken off the bed, and the air mattress was put on the bed. LPN #7 stated Resident #36 slid out of the bed three (3) times that night, with no serious injuries, and night shift staff took it upon themselves to remove the air mattress and put the winged mattress back on the bed. Per LPN #7, Resident #36 never complained that the winged mattress was uncomfortable.

Interview with the Minimum Data Set (MDS)

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Review of an authorization, dated 08/09/2021, signed by the previous Administrator and co-signed by Resident #30, revealed an order for a floor lamp, top of the line bedside table, and a case of pillow covers.

Interview with Resident #30, on 08/10/2021 at 3:50 PM, revealed when the resident was asked about the RTA and who bought items such as clothing for him/her, the resident stated he/she did not need anything. Resident #30 seemed a little confused.

Attempt to interview Resident #30, on 08/19/2021 at 11:52 AM, was unsuccessful. Resident #30 ignored the State Survey Agency (SSA) Surveyor's conversation and stared blankly, straight ahead. Resident #30's roommate stated Resident #30 would ignore someone if he/she did not want to talk. Observation of Resident #30's room, at this time, revealed the floor lamp, lift chair, television, and top of the line bedside table in the room.

Review of Resident #30's financial statements, dated 07/23/2021, revealed a total of $507.61 was refunded to Resident #30's RTA account.

4. Review of Resident #34's RTA revealed he/she received Stimulus monies on 04/29/2020 for $1200, on 01/04/2021 for $600, and on 04/02/2021 for $1400. On 02/10/2021, an authorization for miscellaneous payments from patient trust accounts revealed Resident #34 as his/her Resident/Legal Representative, with his/her signature,. and it was co-signed by the former Administrator. Further review revealed the authorization was for payment of $3639.85, for personal items that included a forty inch television

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said she would take care of making it right, and the bed frame was still in the Maintenance storage area. The Maintenance Director stated the former Administrator acted alone when ordering the resident items.

Review of Resident #34's financial statements, dated 07/23/2021, revealed a total of $3238.88 was refunded to Resident #34's RTA account.

5. Telephone interview with Resident #246's daughter/POA, on 08/19/2021 at 10:36 AM, revealed the resident had been a patient at the facility but was now deceased. She stated the facility said they had to do something with the resident's Stimulus money and had to spend down the RTA within the year, and several items were purchased. Further, she stated, after Resident #246 passed away, his/her sister did pick up the television that had been purchased, but the resident already had one, and she did not know why the facility bought a new one. Additionally, she stated the family was able to take home the lightweight wheelchair ($129.31) that was used to take Resident #246 out of the facility for visits, and she did not know about RoHo cushion ($75.00) purchase. She stated the lift chair ($617.00) and the Panacea Reclining Wheelchair ($363.99), which had been purchased, were left at the facility because they were too heavy for the family to move. She stated the family was not reimbursed for the $1700 spent. The interview ended by Resident #246's daughter stating that if facility staff felt like the resident needed those items, that was fine, but she did not sign anything nor was the RTA reimbursed any monies. She stated the facility called her after several items had been purchased.

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reimbursed.

Interview with the DON, on 08/13/2021 at 4:20 PM, revealed she had no direct knowledge of Stimulus purchases or reimbursements. She did remember, in a daily morning meeting (unable to remember when, formal notes not taken), the Administrator talked about using Stimulus monies to buy residents special air mattresses that the facility should supply. The DON stated when the former Administrator was questioned if she was allowed to do that, the Administrator stated it was okay as long as a resident would be using it. The DON stated staff did not question her again about anything with resident financials. She stated she did not report this to anyone because she had not been notified of the Principal (Corporate) directive regarding Stimulus checks, and therefore, did not know to notify Corporate Compliance or the Regional Vice President.

Interview with the DON and Interim Administrator, on 08/16/2021 at 2:30 PM, revealed they were unaware of what system or process was in place that caught the DME purchases. The Interim Administrator stated he did not arrive at facility until 07/26/2021 and that was one reason he did not know.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed the Administrator did not have any ability to move money or access the general accounting ledger. Administrators could order stuff but could not move money around or take money out of a resident trust. He stated the Regional Vice President (RVP) was oversight manager for the Administrator. He stated, until July, there was no awareness the former Administrator had used

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worked her way around the system.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, that alleged removal of the Immediate Jeopardy (IJ) on 08/31/2021. The facility implemented the following:

1. On 07/09/2021, a Performance Improvement Plan (PIP) was initiated related to Missing Narcotics which was reported to the Office of Inspector General- Division of Health Care (State Survey Agency), at 4:30 PM on 07/09/2021.

2. On 07/09/2021, the Unit Manager and MDS Nurses audited narcotics in the remaining medication carts as the North back hall had a blister pack missing. All count sheets were found to match the number of skids. Staff signing in and out of a medication cart was expected on controlled substance check sheets.

3. On 07/09/2021, the Staff Development Coordinator (SDC) initiated staff education. The topics included narcotic count, counting sheets added and subtracted, signing packing slips, and logging narcotics into the narcotic books.

4. On 07/12/2021, 07/13/2021, 07/20/2021 to 07/22/2021, 07/24/2021 to 08/13/2021, and 08/22/2021 to 08/29/2021, an RN Corporate (Facility) Consultant worked in the facility. An RN Corporate Nurse would continue to be at the facility five (5) days a week through September 2021, ensuring residents remained free from abuse, neglect, and exploitation, and policy and procedures were followed, including the active plan of correction. An RN Corporate Nurse could complete any audit in place of the assigned

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completed three (3) times per week to ensure the correct number of delivered narcotics were logged into the narcotic count book and the number of declining count sheets were updated. Any discrepancies would be reported immediately to the DON and/or administration.

10. On 07/19/2021, staff nurses performed assessments on all residents, including assessing pain. For residents with a BIMS of eight (8) or below, the assessment included observation of non-verbal signs of pain to include: breathing, facial expression, body language, and consolability. No concerns were identified.

11. On 07/19/2021, the APRN assessed Residents #32 and #84.

12. On 07/20/2021, the Administrator suspended LPN #2.

13. On 07/20/2021, the DON, ADON, SDC, MDS Nurses, Weekend Supervisor, Social Services Director (SSD), Activities Director (AD), and/or support RN nurses began interviewing three (3) random residents, with a BIMS of nine (9) or above, weekly to ensure they had no concerns related to when or how their narcotic medications were administered. Any concern regarding narcotic administration would be reported to the DON or Administrator for review at the morning interdisciplinary team (IDT) meeting. The three (3) audits would continue five (5) times a week until the Quality Assurance Performance Improvement (QAPI) committee determined a reduction could be made. The results of these audits would be reviewed in the monthly QAPI meeting. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist,

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Administrator.

16. On 07/21/2021, the DON, ADON, Unit Manager, SDC/QI, Weekend Supervisor, MDS Nurses, the Corporate RN, and/or a support RN would audit the storage and documentation of narcotics when checking medication carts to ensure narcotics were stored appropriately and documentation was correct. The audits included: locking carts, MAR's, shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids, skid cards in numerical order, no missing skids, all narcotics accounted for, and/or pharmacy packing slips. Audits would occur five (5) times per week until the QAPI committee determined frequency could be reduced. Any concern regarding documentation or storage of narcotic administration would be addressed at the time of the audit and reported to the DON or Administrator. All new concerns would be reviewed in the morning IDT meeting. Any concerns and trending would be reviewed and discussed weekly on Fridays.

17. On 07/21/2021, the Regional Vice President interviewed and suspended the facility's Administrator.

18. On 07/20/2021 through 07/25/2021, the RN Corporate Nurses provided education on Abuse, Neglect, and the Misappropriation of Resident Property Policy. The education included: screening of employees, training of employees, prevention, identification, investigation, protection, and reporting/response. One hundred five (105) of one hundred eight (108) employees completed the education at that time. The three (3) remaining employees have since received the

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20. On 07/26/2021, the DON, Unit Manager, SDC, Nurse Supervisor, MDS Nurse, and Corporate RN consultants began administering a medication administration post-test to all licensed nurses and KMA's. The quiz covered both medication administration and physician notification and validated the licensed nurses and the KMA's continued competency in a written form. Any licensed nurse or KMA not scoring one-hundred percent (100%) on the quiz would receive additional education.

21. On 07/27/2021, the DON and SDC began abuse/neglect monitoring via nursing progress note review. The past twenty-four (24) hours of nursing notes were printed off and read, looking for any indication of abuse/neglect/exploitation.

22. On 07/27/2021, the DON, SDC, Unit Manager, RN's, and Administrators from "sister facilities", and RN Corporate nurses continued safe surveys, with residents, and staff surveys regarding abuse/neglect.

23. On 07/29/2021, the DON facilitated a Medical Director Update telephone call.

24. On 08/01/2021, the DON e-mailed the narcotic abuse/neglect PIP to the Medical Director.

25. On 08/10/2021, the DON facilitated a QAPI Committee meeting with the Medical Director present. The committee discussed the facility's survey status, including the abuse/neglect PIP. Review of actions taken and audit results concluded in the recommendation for the facility to: 1) continue with the narcotics PIP; 2) provide

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exploitation.

33. On 08/20/2021, the facility verified the facility rebilled and/or paid for the misappropriated medications.

34. On 08/25/2021, the Regional Vice President announced the transition to the new Administrator. The Regional Vice President and Interim Administrator provided education to the new Administrator, including the requirements of the tags F-600 Abuse/Neglect/Exploitation and F-610 Investigate/Prevent/Correct Alleged Violation.

35. On 08/26/2021, the DON facilitated a Medical Director update telephone meeting, including the DON, Regional Vice President, Medical Director, Interim Administrator, new Administrator, and RN Consultant. The discussion included the facility's Immediate jeopardy (IJ) status, including the tag F-610 Investigate/Prevent/Correct Alleged Violation. Review of actions taken and audit results concluded in the recommendation for the facility to: 1) provide continued education and 2) continue auditing.

36. On 08/26/2021, the SDC and RN Corporate Nurse provided education to three (3) new dietary employees, including abuse/ neglect, and Investigate/Prevent/Correct Alleged Violation if they saw abuse.

37. On 08/26/2021, the SDC monitored and audited the north-front medication cart and verbally quizzed the medication cart nurse related to preventing and protecting residents from further misappropriation of property (controlled medications). The medication cart nurse passed

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investigation was completed timely and thoroughly.

42. The Pharmacy Consultant would visit the facility at least monthly to validate narcotics were being monitored and counted per standard of practice.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

1. Review of a Quality Assurance (PIP), dated 07/09/2021, revealed, as a result of the missing blister pack of thirty (30) Percocet identified in a pharmacy audit, the facility identified only one (1) staff was signing for narcotics arriving at the facility, and initiated education on controlled substances, to include having a second person sign for controlled substances arriving at the facility.

Review of a Long Term Care Facility Self-Reported Incident Form, dated 07/09/2021, confirmed the facility reported the incident of misappropriation to all appropriate parties, to include the Office of Inspector General (State Survey Agency) on 07/09/2021.

2. Review of documentation confirmed facility staff audited narcotics in all medication carts on 07/09/2021. Review of audits revealed no other missing narcotics.

3. Review of a Complete In-Service Training Report with Staff Attending, dated 07/09/2021, confirmed the SDC initiated staff education, attended by licensed nursing staff and KMA's. Education covered the need for both the off going

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must be signed on the back of the MAR, (2) all narcotics no longer in use must stay locked up in the medication cart until they could be given to the DON, and (3) declining count sheet must be labeled with room numbers at the top of the sheet.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed it had been determined not everything was signed out consistently on the back of the MAR, so the education initiated, on 07/12/2021, emphasized to staff the need to do this, including documenting the effectiveness of pain medication administered to residents.

6. Review of a Kentucky Incident Based Reporting System (KYIBRS) Report, dated 07/18/2021, revealed LPN #1 had been arrested and charged with thirteen (13) counts of Theft by Unlawful Taking, three (3) counts of Possession of Controlled Substances, two (2) counts of Wanton Endangerment, and two (2) counts of Abuse and Neglect of an Adult Person.

Review of LPN #1's employee file confirmed LPN #1 had been terminated from employment on 07/18/2021.

7. Review of the Narcotic PIP confirmed, as a result of the 07/18/2021 incident in which two (2) residents had narcotics replaced with non-prescribed medications, a PIP addendum was in place to identify the scope of residents affected, as well as further staff education on controlled substances and monitoring by management staff.

8. Review of meeting minutes, dated 07/18/2021, confirmed the IDT met and were in

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identified through the pain assessments conducted on 07/19/2021.

11. Review of Ambulatory Nursing Home Report confirmed APRN #1 assessed Resident #84 on 07/19/2021. No concerns were identified with the assessment of Resident #84.

Review of the physician visit by the Medical Director (MD) with Resident #32, on 07/20/2021, revealed possible indicators Resident #32's opiates had been replaced with Primidone. MD documentation revealed Resident #32's condition improving at the time of documentation. MD documentation further revealed APRN #2 had visited with Resident #32 on 07/19/2021.

12. Review of a Long Term Care Facility - Self-Reported Incident Form, dated 07/20/2021, confirmed LPN #2 had been suspended from the facility.

13. Review of Resident Interview Medication Administration confirmed facility staff interviewed three (3) or more residents each week beginning on 07/20/2021 regarding any concerns with medication administration, and if so who they reported to and when. No concerns were noted in review of resident interviews.

Review of Shift Change Narcotic Review sheets, also used to document nurse and KMA concerns regarding narcotics administration, revealed no forms had been completed, indicating no concerns had been reported as of the review date of 09/02/2021.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed she frequently interviewed residents

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07/22/2021, for a KMA who had pulled narcotics but did not sign at the time the narcotics were given.

17. Interview with the Regional Vice President, on 09/02/2021 at 7:07 PM, confirmed the previous Administrator had been suspended on 07/21/2021, as a result of concerns regarding the way the Administrator handled the drug diversion issue. The Regional Vice President stated he was present at the facility acting in the capacity of Administrator from 07/21/2021 through 07/23/2021, with an Interim Administrator present at the facility, beginning 07/27/2021, until a new Administrator started on 08/26/2021.

18. Review of Complete In-Service Training Report with Staff Attending, with a start date of 07/20/2021, revealed staff was educated on the facility Abuse, Neglect, and Misappropriation of Resident Property Policy, revised 03/10/2017. The focus of the training appeared to be on reporting and following the chain of command in reporting if the situation had not been addressed. The chain of command consisted of the employee's supervisor, the DON, the Administrator, and followed by the Corporate Compliance line or the Regional Vice President. The training also noted calls to the Corporate Compliance line could be anonymous. Review of sign in sheets for training revealed the last employee completed the training, on 08/10/2021.

Interviews, on 09/02/2021, with Housekeeper #4, at 2:27 PM; the Admissions Coordinator, at 2:48 PM; RN #3, at 3:14 PM; and SRNA #23, at 3:21 PM, revealed they all had received education on abuse/neglect and misappropriation. In addition, each was able to identify their immediate

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damaged skid, it was to be wasted with another nurse witnessing and signing. LPN #11 revealed she had seen and experienced management staff, including the DON, going around doing medication cart audits, and she stayed with her medication cart while was being audited.

Interview with SRNA #20, on 09/02/2021 at 3:39 PM, a KMA, revealed he received the same education nursing staff received. He revealed he had received multiple educations. The KMA stated the education included the importance of signing out narcotics when he gave them and not waiting until the end of shift to sign them out. He revealed he signed them out right after they were given, and if a resident refused, he would mark it as a refusal and have a nurse witness and sign the medication as wasted. He stated, if a pill or skid was compromised, or if anything looked tampered with, he would alert the DON so she could assess and determine if medications needed to be wasted. He revealed corporate nurses had audited his drug cart recently.

20. Review of the facility's Narcotic Administration Quiz revealed licensed nurses and KMA's completed written quizzes, beginning on 07/26/2021. Quiz responses reviewed were appropriate, with no concerns identified during review of them.

21. Interview with the DON, on 09/02/2021 at 9:10 AM, revealed the DON and the SDC printed and reviewed all resident progress notes, highlighting anything potentially indicative of abuse or neglect. She revealed, in addition to reviewing any incidents and accidents, they looked for any documentation of resident injuries or behaviors. She stated this was an ongoing

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shift change, (2) All narcotic sheets had been counted, (3) the number of narcotic count sheets matched the number of skids on the cart, (4) Skids on the cart did not have tape on their backs, (5) Skids were checked to ensure there were no missing skids, (6) CSCS were being logged in and out of the cart on the Shift Change Controlled Substance Count Check form as the sheet count number changed (new skids arrived, skids were completed), and (8) All narcotics were signed out and accounted for.

Review of a Narcotic Cart Audit completed, on 08/11/2021 at 11:42 AM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken. The Corporate RN Consultant noted the front-north narcotic drawer had a screw sticking out that caused tears/punched holes in the back of multiple narcotic skids: The screw was covered.

27. Review of Narcotic Cart Audit completed, on 08/12/2021 at 5:10 PM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken.

28. Review of the Narcotic Cart Audit completed, on 08/13/2021 at 2:25 PM, by the DON revealed the audit was completed with no issues noted or corrective action required or taken.

29. Review of the Narcotic Cart Audit completed, on 08/18/2021 at 10:30 AM, by the SDC revealed the audit was completed with no issues noted or corrective action required or taken.

30. Documentation review confirmed the DON provided the Medical Director an update call on 08/19/2021.

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34. Review of an Appointment Letter as facility Administrator revealed appointment of a new Administrator, on 08/26/2021, with an Administrator job description, reporting to the Regional Vice President, who also signed the letter on 08/26/2021.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed he spoke with the Interim Administrator and the Regional Vice President over the phone, on 08/25/2021, and they discussed with him the IJ tags the facility had been cited, to include abuse and misappropriation tags. He stated they wanted to make sure he was aware of the situation he would be coming into. He stated the Regional Vice President had stressed the importance of reporting allegations and keeping him informed.

35. Review of the document Communication with Medical Director, signed by the Medical Director on 08/28/2021, confirmed the Medical Director was provided an update by the DON on the Immediate Jeopardy (IJ) citations and corrective actions the facility was taking to address the citations.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, revealed he was present for the phone call with the Medical Director, on 08/26/2021, in which the jeopardy citations were discussed, as well as the audits the facility had been doing and the education the facility had provided. He revealed they went down each one of the tags, discussing issues and what was being done to address issues.

36. Review of three (3) Employee Affirmation

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investigation file with the Administrator on 08/29/2021. She revealed they went down the Action Checklist, reviewed the process, and the Administrator made notes to himself on what he needed to do and on what he could do at that time. The Clinical Director stated the Administrator had interviewed residents, called residents' representatives, and was very thorough in his investigation of misappropriation.

40. Review of the facility's Weekend Audits, dated 08/28/2021, confirmed the Administrator and a support RN interviewed staff and residents regarding abuse, code of conduct, and medication administration. Staff members were able to answer questions accurately, and residents did not express any concerns during interviews. Further, nursing staff conducted an audit of narcotic documentation and did not determine any concerns.

41. Review of the Cardinal IDT Meeting minutes for 08/30/2021, 08/31/2021, and 09/01/2021 revealed evidence the facility had initiated five (5) times weekly IDT meetings.

42. Interview with the Consultant Pharmacist confirmed she visited the facility monthly and conducted a narcotics audit during her monthly visits.

Interview with the DON, on 09/02/2021 at 9:10 AM, confirmed the Consultant Pharmacist conducted monthly visits, reviewed charts, and conducted a medication administration audit. She stated the only time the Consultant Pharmacist was not coming were times, during the last year, when the facility was in lock-down due to the pandemic.

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property (controlled medications), after residents made allegations of not receiving medications and that staff were taking the medications for fifteen (15) of forty-four (44) sampled residents. The residents affected were: Resident #1, #8, #9, #17, #32, #34, #47, #48, #56, #60, #65, #71, #79, #82, and #84.

On 06/25/2021, Resident #82 alleged in a written grievance that he/she had not received controlled pain medications documented as given by Licensed Practical Nurse (LPN) #1. The Director of Nursing (DON) stated the Administrator asked her to monitor and investigate for any concerns regarding PRN controlled pain medications; there was no documented evidence the facility conducted a thorough investigation into the allegation.

On 07/08/2021, Resident #9 confronted LPN #1; alleging LPN #1 was stealing his/her controlled medications. A formal grievance was initiated; however, LPN #1 was not investigated as result of this allegation.

On 07/09/2021, a pharmacy audit revealed a missing skid of thirty (30) Percocet (Scheduled II narcotic) belonging to Resident #17. LPN #2 signed for three (3) skids of thirty (30) Percocet each, for a total of ninety (90) Percocet for Resident #17, on 06/28/2021; however, LPN #1 alleged only receiving two (2) skids of thirty (30) Percocet each, for a total of sixty (60) Percocet. The facility allowed both nurses to continue to work with residents despite being in an allegation of missing controlled medications.

On 07/18/2021, LPN #2 discovered Resident #32 and Resident #84 both had two (2) Roxicodone

F 610 misappropriation is alleged occurs. Refer to the abatement plan for the facility's systemic change.

4. Beginning 11/1/21, completed investigations will be reviewed in the IDT meeting, weekly for four weeks, then monthly for two months, to ensure the investigation was complete and followed checklists as appropriate. Abuse and narcotic audits continue as per the abatement plan. Refer to the abatement plan for facility's systemic change. Data will be reviewed at the Quality Assurance Performance Improvement (QAPI) meeting monthly for additional recommendations.

Compliance Date: 11/24/2021

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a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

The findings include:

Review of the facility's policy titled, "Abuse, Neglect, or Misappropriation of Resident Property Policy," last revised 03/10/2017, revealed the facility would do whatever was in its control to prevent abuse and misappropriation of resident property. The policy stated the Administrator was responsible to ensure complaints were investigated and to report allegations to the appropriate agencies. Under the section on Prevention, the policy stated staff would investigate allegations in a timely manner and develop corrective measures as indicated. Under the section on Investigation, the policy stated the Administrator was responsible to direct the investigation and to ensure appropriate agencies were notified.

Interview with the Social Services Director (SSD), on 07/27/2021 at 10:29 AM, and again, on 07/29/2021 at 3:45 PM, revealed staff reported allegations to their supervisor, which were then reported to the Administrator. The Administrator did the reporting to state agencies and initiated an investigation. The SSD revealed her role in investigations was typically interviewing other facility residents and sometimes conducting follow up interviews with the residents involved. Regarding grievances, the SSD shared any staff or resident could complete one, with the Administrator determining which individual/department would receive the grievance, and the SSD logging them in the grievance log. She revealed some staff and

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four (4) of which were on consecutive days.

Interview with Registered Nurse (RN) #1, on 08/02/2021 at 3:52 PM, revealed she had reported to the Administrator, on 08/21/2021, a concern over narcotics. She stated she asked Resident #82 how he/she was doing, the resident revealed he/she was doing well, but told her a couple of nurses thought he/she was dying because he/she had received a lot of narcotics over the weekend which the resident said did not occur. Resident #82 reported he/she was not hurting and had not needed any pain medications in a few days. RN #1 stated she examined Resident #82's narcotic sheet and found LPN #1 had signed out for two (2) pain pills on Saturday and two (2) pain pills for Sunday, which Resident #82 stated he/she had not received. She revealed she sent a text to the previous Administrator regarding Resident #82's concern with narcotics. She revealed she showed the Administrator the MAR, and the Administrator stated "this was becoming a problem" and that Resident #9 had already "called state on us." She revealed the Administrator met with Resident #82 for about twenty (20) minutes, after which Resident #82 stated the Administrator told him/her she would get to the bottom of it, but as he/she had heard that before, knew they "weren't going to do crap" about it. Continued interview with RN #1 revealed Resident #82 typically took three (3) or four (4) pain pills a month for breakthrough pain.

Review of a Facility Concern/Grievance Form, dated 08/25/2021, initiated by Resident #82 with RN #1 who received the grievance, revealed uncertainty voiced by the resident if he/she had received pain medication over the weekend. RN

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Interview with the SDC/QI, on 08/05/2021 at 12:22 PM, revealed she was uncertain when Resident #82 first identified an issue, although she thought it was early to mid-July. She revealed no one reported anything directly to her about Resident #82, although there had been a grievance regarding him/her believing he/she was not getting pain medications that had been signed out during the night. She stated if someone had reported anything to her, she would have reported it to the DON. She stated, if a nurse had a suspicion of drug diversion, he/she should contact the DON immediately and initiate a grievance form. The SDC/QI shared she would expect staff to follow the chain of command in reporting concerns, which would be nursing staff, herself, and the DON, as there was currently (as of the date of this interview) no Assistant Director of Nursing (ADON).

Interview with the DON, on 08/04/2021 at 8:28 AM, and again, on 08/05/2021 at 12:35 PM, revealed the Administrator approached her, after the grievance by Resident #82, and told her that Resident #82 might not have received his/her medication. She stated the Administrator told her she needed to start watching LPN #1. The DON revealed, in her review of MAR's, she was unable to identify LPN #1 was signing out more PRN medications than other night shift staff. The DON revealed she did not document her review of the residents' MAR's.

2. Review of Resident #9's medical record revealed the resident was readmitted to the facility, on 05/03/2021, with diagnoses to include Paraplegia Unspecified, Nicotine Dependence Unspecified Uncomplicated, Other Specified Anxiety Disorders, and Other Chronic Pain. The

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Resident #9 confronted LPN #1, saying he/she did not appreciate not getting his/her medication when the nurse said he/she did receive them.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed she stayed late, on 07/08/2021, to speak with LPN #1, who revealed she had been giving PRN pain medications to residents to ensure they were able to sleep. The DON stated she instructed LPN #1 not to do that.

Interview with LPN #5, on 08/03/2021 at 4:20 PM, revealed, on 07/06/2021, Resident #9 had indicated to her that he/she was not receiving his/her medications. She revealed Resident #9 wanted his/her pain medication, but she was unable to give it as Resident #9's pain pill had been signed out the previous evening. She revealed she alerted the DON at that time via text message of Resident #9's allegation. She stated Resident #9 was not in any pain that morning. However, she stated Resident #9's routine was to receive his/her PRN pain medication in the morning.

Interview with Resident #9, on 07/28/2021 at 3:01 PM, revealed one morning he/she had asked for pain medication, and staff informed him/her they could not provide it as they had been administered at 2:30 AM. Resident #9 shared he/she had not received pain medication at 2:30 AM, and LPN #1 had been working the night the medication was allegedly administered. Resident #9 stated he/she consistently had pain medications signed out and not given to him/her when LPN #1 worked. Resident #9 stated he/she had reported this to other staff, but remembered reporting to SRNA #9, who was also a Kentucky Medication Aide (KMA) and able to administer

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him/her. The previous Administrator received and responded to the grievance, with action taken, which included: interviewed Resident #9, interviewed nurses (did not indicate who), reviewed MAR's, and ongoing investigation with facility and law enforcement. The form was signed as resolved by the previous Administrator on 07/09/2021. This information was not used to initiate an investigation into misappropriation.

3. Interview with the Facility Consultant, on 07/27/2021 at 1:15 PM, and again, on 08/18/2021 at 2:32 PM, revealed she had been brought in from corporate as a result of facility issues that needed to be addressed. She revealed there had been an audit, on 07/09/2021, by pharmacy which determined there was a missing skid of Percocet 5/325 mg belonging to Resident #17. The investigation revealed three (3) skids of thirty (30) tablets each of Percocet 5/325 mg had been delivered by pharmacy, on 06/28/2021 as documented by Licensed Practical Nurse (LPN) #2; however, LPN #1 stated she had received only two (2) skids of thirty (30) tablets each of Percocet 5/325 mg.

Interview with the Consultant Pharmacist, on 08/13/2021 at 10:31 AM, revealed any time she noted a concern or anything that raised her attention, she included it in her pharmacy report. She revealed on 07/09/2021, she noted a skid of Percocet missing and provided that information in her report to administrative staff.

Review of a Packing Slip, dated 06/28/2021, revealed LPN #2 signed for three (3) skids of thirty (30) tablets each of Percocet 5/325 mg, for a total of ninety (90) Percocet 5/325 mg for Resident #17.

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second skid only contained twenty-nine (29) Percocet tablets, but only one (1) had been signed out by LPN #1. She stated she reported this to the SDC/QI, but was uncertain of the date, and did not say anything to LPN #1. She stated the DON was auditing her medication cart later, and the DON told her she was doing the audit because a whole skid of Percocet was missing.

Review of Resident #17's Controlled Substance Count Record revealed a sheet two (2) of three (3), delivered, on 06/28/2021, with a receiving signature and date on the sheet. Despite repeated requests, the facility was unable to provide either sheet one (1) of three (3), or a Controlled Substance Count Record for Percocet 5/325 mg covering the time frame of 06/19/2021 through 07/08/2021. Sheet three (3) of (3) was the missing sheet, as identified by pharmacy on 07/09/2021. Sheet 2 of 3 revealed LPN #1 signed the first tablet of Percocet out at midnight on 07/09/2021, with LPN #7 replacing her on the cart on the morning of 07/09/2021. Review of Resident #17's MAR for 07/2021 revealed eighty-two (82) doses (tablets) of Percocet 5/325 mg had been administered. However, review of the back of the MAR revealed no staff had signed, indicating administration or results of the medication on the resident's pain level.

There was no documented evidence Resident #17's missing single tablet of Percocet 5/325 mg, as reported by LPN #7 on 07/08/21 to the SDC/QI, was investigated.

Interview with the SDC/QI, on 08/03/2021 at 9:29 AM, and again, on 08/13/2021 at 4:00 PM, revealed staff had suspicions about LPN #1, and she and the DON had interviewed her on a

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diversion. She stated she would have to suspect without a doubt someone was under the influence, and she had never suspected LPN #1, and staff had never reported to her LPN #1 was under the influence. She stated the decision was made as a team by corporate and administration to suspend or drug test an employee. She stated she agreed on the importance of suspending staff to prevent further potential drug diversion.

Interview with the Ombudsman, on 07/26/2021 at 3:15 PM, revealed she interviewed the DON following the 07/09/2021 incident with drug diversion and asked what the facility had done to address the issue. She stated the DON said they were unable to determine which of two (2) nurses was guilty of drug diversion. When asked why both were not suspended, the Ombudsman stated the DON shrugged her shoulders, indicating she did not know.

Review of the facility Drug Free Workplace Policy (DFWP), revised 12/2018, revealed the company recognized the need for a safe and healthy work environment free from the use of prohibited drugs and alcohol. The policy stated employees who abused drugs or alcohol posed a serious risk to the safety, security, and welfare of residents and the company. The policy revealed all applicants for Registered Nurse (RN), Licensed Practical Nurse (LPN), or Medication Aide were required to submit a urine sample as a condition of employment. The policy defined Prohibited Conduct as possessing or using any prohibited drug or alcohol while at the workplace, while at work, or during working hours. Further Prohibited Conduct, per the policy, included refusing to submit to a drug or alcohol test required by the policy, or failing a drug or alcohol test

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Interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed she was working the night of 07/18/2021, and was administering medications when she noted Resident #32's narcotic skid had tape on it, and the medications taped inside were thicker than the other medications in the skid. She revealed she contacted the DON and had SRNA #20 witness as she searched the rest of the medication cart and found two more medications taped in place of Resident #84's narcotics. She stated she contacted Adult Protective Services, and was advised by Social Services Clinician I (SSCI) to have other staff witness her medication administration involving any narcotics, which she did by having SRNA #8 and SRNA #20 witness every narcotic pulled.

Continued interview with LPN #2, on 07/29/2021 at 4:29 PM, revealed the DON and Administrator identified multiple narcotic skids with tape on them and were busy wasting medications on the night of 07/18/2021 through the morning of 07/19/2021. She stated some skids had tape all over them and had to be wasted, while others just had pills removed due to tape. She stated when individual pills were taken from her medication cart, both she and the removing staff signed on the narcotics sheet.

Continued interview with the DON, on 08/04/2021 at 8:28 AM, revealed she received a call from LPN #2, on the night of 07/18/2021 at 7:30 PM, who revealed she had found two (2) of Resident #32's narcotics had been replaced with other pills. She then stated she received a text, at 7:47 PM, from LPN #2 that she had found a second resident, #84, also had two (2) narcotics replaced with other pills. The DON stated she alerted the

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an investigation was started.

Interview with the Interim Administrator, on 08/20/2021 at 10:24 AM, revealed his expectation the facility would have a good investigation program, a good audit program, and a good count program for narcotics that started when they came to the facility, to limit the possibility of drug diversion occurring.

The previous Administrator was not available during the course of the survey and did not return calls, the last of which was attempted on 08/20/2021 at 9:48 AM.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed he was part of the trigger call that occurred on 07/09/2021. He stated the facility reported the incident and also notified Police of the missing skid of thirty (30) tablets of Percocet. However, he stated, as they were unable to determine which specific nurse might have taken the medications, neither nurse was suspended at that time. He stated he had not been informed of any prior allegations that implicated LPN #1 in diverting medications, and as RVP he would have expected to be notified of those types of allegations.

The facility provided an acceptable Immediate Jeopardy Removal Plan, on 09/01/2021, that alleged removal of the Immediate Jeopardy (IJ) on 08/31/2021. The facility implemented the following:

1. On 07/09/2021, a Performance Improvement Plan (PIP) was initiated related to Missing Narcotics which was reported to the Office of Inspector General- Division of Health Care (State

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(LPN) #1 was removed from the facility and arrested by Police. LPN #1 was automatically suspended.

7. On 07/18/2021, an Addendum was added to the PIP due to findings that Percocet tablets were replaced with Primidone on Resident #84 and Resident #32 medications.

8. On 07/18/2021, an ad hoc meeting was held to review the additional action steps with the interdisciplinary team (IDT). The IDT was comprised of the Administrator, DON, Quality Improvement Nurse/Staff Development Coordinator (SDC/QI), Minimum Data Set (MDS) Nurse, Unit Manager, Activity Director, Social Services Director, and Dietary Manager. The IDT agreed actions taken would include abuse/neglect education, abuse/neglect monitoring via progress note review, safe surveys with residents, and staff surveys regarding abuse/neglect.

9. On 07/19/2021, the DON, Unit Manager, Administrator, Corporate RN, or a support RN began reconciling the narcotic packing slips to the narcotics received. The reconciliation would be completed three (3) times per week to ensure the correct number of delivered narcotics were logged into the narcotic count book and the number of declining count sheets were updated. Any discrepancies would be reported immediately to the DON and/or administration.

10. On 07/19/2021, staff nurses performed assessments on all residents, including assessing pain. For residents with a BIMS of eight (8) or below, the assessment included observation of non-verbal signs of pain to include:

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concern would include who the concern was reported to. Any resident concern regarding narcotic medication administration would be reported to the DON or Administrator for review at the morning IDT meeting. The results of these audits would be reviewed in the monthly QAPI meeting.

14. On 07/20/2021, the DON audited the Shift Change Controlled Substance Count Check sheets and found Licensed Practical Nurse (LPN #2) had recorded on the log sheet a reduced number of sheets counted. The nurse documented four (4) less sheets than the previous shift. There was no documented explanation why there were four (4) less sheets than the previous shift. The facility suspended the nurse and reported the information to the OIG, APS (Adult Protective Services), and police.

15. On 07/20/2021 to 07/21/2021, the Social Worker and Admissions Coordinator completed interviews with all residents with a BIMS above 8. Residents were asked about concerns with how and when medications were administered. Any concerns, which included but was not limited to pain, were documented and reported to the Administrator.

16. On 07/21/2021, the DON, ADON, Unit Manager, SDC/QI, Weekend Supervisor, MDS Nurses, the Corporate RN, and/or a support RN would audit the storage and documentation of narcotics when checking medication carts to ensure narcotics were stored appropriately and documentation was correct. The audits included: locking carts, MAR's, shift change count sheets, signatures, declining count sheets, wasted narcotics, back side of narcotic medication skids,

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had since returned. One (1) nurse was on Family Medical Leave Act (FMLA) and remained on FMLA. This education included the off-going nurse should have the record for comparison to actual narcotics seen by the on-coming staff member. Narcotics should be signed out at the time they were removed from the packet; a nurse must witness destruction of a dropped or refused narcotic before signing as a witness. KMA's could not be the second signature. (A KMA could not witness for a nurse.) Nurses and KMA's could not tape a medication to hold it in a card. If a narcotic came loose, it must be wasted, and two (2) signatures must be present. This education also included signing the Shift Change Controlled Substance Count Check sheet at the beginning and end of the shift. This education included that the signature was the nurse's affirmation that the count was correct and must be signed when counting. It could not be signed early or late. Nurses and KMA's were also educated regarding deliveries of multiple cards of narcotics. The nurse receiving the narcotics and the nurse whose medication cart would hold the narcotics must both sign for the receipt. If the same nurse was both receiving and had the medication cart, a second nurse must sign also.

20. On 07/26/2021, the DON, Unit Manager, SDC, Nurse Supervisor, MDS Nurse, and Corporate RN consultants began administering a medication administration post-test to all licensed nurses and KMA's. The quiz covered both medication administration and physician notification and validated the licensed nurses and the KMA's continued competency in a written form. Any licensed nurse or KMA not scoring one-hundred percent (100%) on the quiz would receive additional education.

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cart audits on each of the five medication carts. Audit result: no issues.

28. On 08/13/2021, the SDC completed narcotic cart audits on each of the five (5) medication carts. Audit result: no issues.

29. On 08/18/2021, the SDC completed narcotic cart audits on each of the five medication carts. Audit result: no issues.

30. On 08/19/2021 the DON facilitated a Medical Director update telephone call.

31. On 08/20/2021, the DON notified the Medical Director of eight (8) IJ tags and the PIP's that were being worked on.

32. On 08/20/2021, the Administrator, DON, SDC, and Corporate Support staff began additional Code of Conduct in-servicing. The in-service included a quiz. The quiz questions included employees following laws, reporting systems, when to report, who to report to, and where to find more information. The employees were able to verbalize their role in protecting residents and preventing abuse, neglect, and exploitation.

33. On 08/20/2021, the facility verified the facility rebilled and/or paid for the misappropriated medications.

34. On 08/25/2021, the Regional Vice President announced the transition to the new Administrator. The Regional Vice President and Interim Administrator provided education to the new Administrator, including the requirements of the tags F-600 Abuse/Neglect/Exploitation and

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investigations, preventing, and correcting any alleged violations. Review of the Action Checklist for abuse/neglect was also included. This continued on 08/29/2021, at which time the Administrator was able to verbalize the importance of, and timeline for, reporting any allegation of misappropriation of property. The Administrator also articulated corrective actions to protect, thoroughly investigate, and resolve alleged violations.

40. On 08/29/2021, the DON, four (4) Support RN Nurses, and a Corporate RN Nurse interviewed staff and residents, inspected medication carts, and reviewed narcotic documentation. No new staff concerns were received. No new resident concerns were received, as residents stated they were receiving their medications. No narcotic medications were identified as missing.

41. Starting 08/29/2021, the facility's IDT would have a meeting five (5) times a week to review concerns. The Administrator or DON would identify an investigator to conduct the investigation. The Cardinal IDT tool would be utilized to track the investigation and ensure the investigation was completed timely and thoroughly.

42. The Pharmacy Consultant would visit the facility at least monthly to validate narcotics were being monitored and counted per standard of practice.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

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a packet of education on medication administration as well as having each nurse sign for delivery of narcotics.

4. Interview, on 09/02/2021 at 9:10 AM, with the Clinical Director revealed that she, prior to her arrival, the Facility Consultant, had been in the facility on the dates documented in the IJ Removal Plan. She revealed her daily routine consisted of talking to residents on both the South and North halls of the building, observing staff providing care, and talking with staff. She revealed she assessed and interviewed for evidence of abuse. She revealed she also conducted chart reviews and validated the facility was continuing audits and doing everything they were supposed to be doing. The Clinical Director stated she had made surprise visits to the facility at 2:00 AM, as well as on weekends, to determine any resident concerns and ensure staff was following procedures they had been educated on.

5. Review of Complete In-Service Training Report with Staff Attending, dated 07/12/2021, confirmed the DON initiated staff education for licensed nursing staff and KMA's. Education covered (1) All PRN (as needed) medications must be signed on the back of the MAR, (2) all narcotics no longer in use must stay locked up in the medication cart until they could be given to the DON, and (3) declining count sheet must be labeled with room numbers at the top of the sheet.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed it had been determined not everything was signed out consistently on the back of the MAR, so the education initiated, on 07/12/2021, emphasized to staff the need to do

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indicating the slips had been reviewed by either the DON, Unit Manager, Administrator, a Corporate RN, or a Support RN.

One (1) packing slip, dated 07/22/2021, was signed for by one (1) nurse. Further review determined this nurse received consultation and reeducation by the Facility Consultant regarding the need for two (2) signatures always.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed when reviewing packing slips, she confirmed there were two (2) signatures and checked to ensure everything listed on the packing slips was on the medication cart; then she would initial the packing slips to show she reviewed them.

10. Review of Pain Assessments revealed Pain Assessments were completed for all facility residents on 07/19/2021. No concerns were identified. Additionally, Resident Interview Medication Administration papers were reviewed, with no concerns identified.

Interview with the DON, on 09/02/2021 at 9:10 AM, revealed no new or untreated pain was identified through the pain assessments conducted on 07/19/2021.

11. Review of Ambulatory Nursing Home Report confirmed APRN #1 assessed Resident #84 on 07/19/2021. No concerns were identified with the assessment of Resident #84.

Review of the physician visit by the Medical Director (MD) with Resident #32, on 07/20/2021, revealed possible indicators Resident #32's opiates had been replaced with Primidone. MD

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of two (2) for Percocet and Resident #76 was missing skid four (4) of four (4) for Norco (a narcotic pain medication). Review of Shift Change Controlled Substance Count Check sheets confirmed one (1) sheet ended at forty-six (46), while the following sheet started at forty-two (42).

15. Resident Interview Medication Administration documentation was reviewed. Residents were questioned the Regional Vice President by the Social Services Director or the Admissions Coordinator about whether or not they had concerns regarding administration of their medications. If residents indicated concerns, this was explored further, to include to whom the residents reported concerns and when. No issues were identified during documentation review.

16. Review of Narcotic Cart Audit forms, dated 07/21/2021 confirmed the DON audited the storage and documentation of all facility medication carts. Continued review of audits revealed audits were occurring five (5) or more times each week. Review of Narcotic Cart Audit forms revealed required education was given, on 07/22/2021, for a KMA who had pulled narcotics but did not sign at the time the narcotics were given.

17. Interview with the Regional Vice President, on 09/02/2021 at 7:07 PM, confirmed the previous Administrator had been suspended on 07/21/2021, as a result of concerns regarding the way the Administrator handled the drug diversion issue. The Regional Vice President stated he was present at the facility acting in the capacity of Administrator from 07/21/2021 through

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Interview with the DON, on 09/02/2021 at 9:10 AM, revealed education emphasized skids could not be taped, and discussed the proper way to waste narcotics. She revealed a nurse could sign for a KMA to waste narcotics, however, a KMA could not sign for a nurse. She stated drugs were all to be wasted in the Drug Buster, which was a chemical container that drugs were placed in for disposal. She stated staff was educated on the requirement for two (2) staff to sign for receipt of narcotics.

Interviews, on 09/02/2021 with LPN #11, at 3:03 PM, and RN #3 at 3:14 PM, revealed both had been educated on the proper way to do a narcotic count at shift change, counting skids, comparing to the number of controlled substance sheets, and wasting medications, with another nurse witnessing and signing, in the Drug Buster kept in the medication rooms. Both stated education also covered the importance of signing and completing pain assessments on the back of the MAR for PRN (as needed) medications and signing with another nurse when narcotics arrived. LPN #11 also stated, if a skid was damaged, to report it to the DON, and if a medication was in danger of falling out of a damaged skid, it was to be wasted with another nurse witnessing and signing. LPN #11 revealed she had seen and experienced management staff, including the DON, going around doing medication cart audits, and she stayed with her medication cart while was being audited.

Interview with SRNA #20, on 09/02/2021 at 3:39 PM, a KMA, revealed he received the same education nursing staff received. He revealed he had received multiple educations. The KMA stated the education included the importance of

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for Abuse and Narcotics and ongoing audits on 07/29/2021.

24. Review of an email, with the Abuse PIP and Narcotic PIP attached, confirmed it was sent to the Medical Director, on 08/01/2021.

25. Review of a QAPI Committee meeting agenda, from 08/10/2021, revealed the Abuse PIP was in the monitoring phase, with monitoring continuing. Review of a sign in sheet, dated 08/10/2021, revealed the Medical Director was in attendance at the meeting.

Interview with the Medical Director, on 08/10/2021 at 4:11 PM, revealed the DON had been in contact with him two (2) to three (3) times a week and had provided him all the PIP's that had been planned out. The Medical Director revealed he was extremely pleased at the progress the facility had made addressing their problems.

26. Review of the Narcotic Cart Audit sheets used for facility narcotic cart audits revealed staff were auditing to ensure (1) All staff were signing the Controlled Substance Count Sheet (CSCS) at shift change, (2) All narcotic sheets had been counted, (3) the number of narcotic count sheets matched the number of skids on the cart, (4) Skids on the cart did not have tape on their backs, (5) Skids were checked to ensure there were no missing skids, (6) CSCS were being logged in and out of the cart on the Shift Change Controlled Substance Count Check form as the sheet count number changed (new skids arrived, skids were completed), and (6) All narcotics were signed out and accounted for.

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the ability to make anonymous reports if desired, with the goal of ensuring all potential violations were reported and addressed.

Interview with SRNA #24 and the Occupational Therapist, on 09/02/2021 at 3:30 PM, revealed both had received training on the Code of Conduct, which included abuse, neglect, misappropriation, what to report, who to report to, and when to report. Both revealed if they were to report an allegation to their supervisor and did not feel like it was being addressed, they could contact the DON and Administrator, as well as call or fax the Corporate Compliance line.

33. Review of facility documentation, not labeled or dated, revealed a total of one hundred and eight (108) narcotics were documented as missing, which included three (3) skids of thirty (30) medications each that were missing, and four (4) non-controlled medications that were documented as missing. The document listed residents by name, along with discrepancies noted, the cost for each individual dose, resident payors, and the total cost of all medications reimbursed, which was three hundred and four dollars and ninety-seven ($304.97) cents.

34. Review of an Appointment Letter as facility Administrator revealed appointment of a new Administrator, on 08/26/2021, with an Administrator job description, reporting to the Regional Vice President, who also signed the letter on 08/26/2021.

Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed he spoke with the Interim Administrator and the Regional Vice President over the phone, on 08/25/2021, and they

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no concerns identified.

38. Review of Shift Change Narcotic Review sheets, completed by the SDC, support RN's, and corporate RN's, revealed medication carts and narcotic documentation were monitored on 08/28/2021, 08/29/2021, and 08/30/2021, with no issues identified.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed she, the SDC, and a sister facility nurse went to each medication cart, on 08/28/2021 at shift change with their audit tools, and went through the packet of audit tools with medication cart staff, asking questions about documentation and reporting. She revealed this process was repeated on 08/29/2021 with a nurse from a different sister facility. She revealed there had been no concerns with the audits.

39. Interview with the Administrator, on 09/02/2021 at 6:32 PM, confirmed the Clinical Director had thoroughly reviewed with him abuse reporting and investigating.

Interview with the Clinical Director, on 09/02/2021 at 9:10 AM, revealed she reviewed an investigation file with the Administrator on 08/29/2021. She revealed they went down the Action Checklist, reviewed the process, and the Administrator made notes to himself on what he needed to do and on what he could do at that time. The Clinical Director stated the Administrator had interviewed residents, called residents' representatives, and was very thorough in his investigation of misappropriation.

40. Review of the facility's Weekend Audits, dated 08/28/2021, confirmed the Administrator

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and review of the Centers for Medicare and Medicaid Services, "Resident Assessment Instrument (RAI) Manual 3.0", it was determined the facility failed to ensure the Minimum Data Set (MDS) Assessment accurately reflected the resident's status for two (2) of forty-four (44) residents (Residents #13 and #245).

Observation of Resident #13, on 08/09/2021, 08/10/2021, and 08/12/2021 revealed the resident had functional limitations in bilateral lower extremities: hips and knees and his/her mobility was dependent on an "Evolution" chair (a chair that addressed mobility and positioning needs).

However, review of Resident #13's Quarterly Minimum Data Set (MDS) Assessment, dated 08/10/2021, revealed the resident did not have functional limitations in Range of Motion (ROM) for lower bilateral extremities and did not use a mobility device.

Review of Resident #245's fall assessment and Progress Notes revealed the resident had two (2) falls on 02/19/2021 and 02/23/2021, prior to the Quarterly MDS Assessment, dated 02/26/2021, which only reflected one (1) fall.

The findings include:

Interview with the MDS Coordinator, on 08/13/2021 at 2:51 PM, revealed the facility utilized the Resident Assessment Instrument (RAI) Manual 3.0, as a guideline for accuracy of assessments. Additionally, she stated the Assessment process included communication with licensed and non-licensed direct care staff members, face-to-face observations and assessment of residents, and review of the

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resident assessment coding for falls on 09/03/21 thru 09/07/21. Three additional resident assessments were resubmitted with modified information. On 10/18/21, the MDS nurse, and MDS Consultants, reviewed 100% of residents to ensure ROM and limitations were correctly coded. No concerns were identified.

3. The MDS consultant educated the MDS nurses on 9/3/21, regarding the accurate coding of falls and on 9/29/21 on the accurate MDS coding of ROM and limitations utilizing the Resident Assessment Instrument Manual. The RAI manual will be utilized as a reference for MDS coding.
4. Beginning 9/6/21, the MDS consultant or an RN Consultant will audit MDS submissions weekly for 4 weeks, then monthly for two months, to ensure falls, ROM and limitations were coded correctly. In addition, on an ongoing basis the Director of Nursing will audit two MDS assessments weekly to ensure accuracy of the assessments. This will be an ongoing practice. Data collected will be taken to the monthly

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dependent on an Evolution chair (a device that addressed mobility and positioning needs).

Review of Resident #13's most current Quarterly MDS Assessment, dated 08/10/2021, Section C: Cognitive Pattern, revealed the resident had short and long term memory problems; moderately impaired cognitive skills for daily decision making. Additional review of Section G: Functional Status, revealed ambulation did not occur, and the resident did not use a mobility device. Further, the resident required extensive assistance of two (2) staff with ADL's such as bed mobility, transfer, toileting, personal hygiene, dressing, and eating. Continued review revealed the resident had no functional limitations in ROM for upper or lower bilateral extremities.

Observation of Resident #13, on 08/09/2021 at 4:11 PM, revealed the resident lying in bed. It was noted that at rest, the resident's bilateral lower extremities were bent at the knees and the resident's left leg rested on the right leg. Further observation revealed an Evolution chair at the bedside.

Observation of Resident #13, on 08/10/2021 at 11:58 AM, revealed the resident was lying in bed. Additionally, at rest, the resident's left leg was bent greater than the right leg. The resident's left calf touched the left thigh. Continued observation revealed the resident's left leg fell over the resident's right leg.

Observation of Resident #13, on 08/12/2021 at 3:06 PM, with Registered Nurse (RN) #6, revealed the resident had functional limitations in his/her bilateral lower extremities: hips and knees. The resident's right knee was bent at

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Interview with State Registered Nurse Aide (SRNA) #19 (worked at the facility for twelve (12) years), on 08/12/2021 at 11:00 AM, revealed she was often assigned to provide care to Resident #13. Per the interview, the resident was not able to put his/her legs down and he/she held them bent at all times. In addition, she stated the resident's legs had been bent for several months. SRNA #19 stated she provided passive ROM to the resident's arms and legs for one (1) hour a day during care. Further, she stated Resident #13 had an Evolution chair that he/she was assisted to daily.

However, review of the Quarterly MDS assessment, dated 08/10/2021, revealed the assessment did not capture Resident #13's functional limitations in ROM, bilateral lower extremities, or the mobility device used daily.

Further, review of Resident #13's nurse aide care plan (Kardex), dated 08/13/2021, revealed the resident was dependent on an Evolution chair for mobility.

Interview with Licensed Practical Nurse (LPN) #13/MDS Coordinator and Registered Nurse (RN) #7/MDS Coordinator (at the facility for seven (7) years), on 08/13/2021 at 2:51 PM, revealed they used the RAI guidelines to ensure accurate MDS Assessments. Per the interview, when collecting data to complete MDS Assessments, they interviewed staff and the resident; completed a face-to-face assessment of the resident, and reviewed the medical record in its entirety. In addition, they stated it was important to ensure MDS Assessments were accurate and that they reflected the current status of the resident because the MDS Assessment helped develop

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revealed the facility admitted the resident, on 01/18/2021, with diagnoses including Parkinson's Disease, Major Depression, Dementia, and Diabetes Mellitus Type 2.

Review of Resident #245's Quarterly Minimum Data Set (MDS) Assessment, dated 02/26/2021, revealed the facility assessed the resident with the Brief Interview for Mental Status (BIMS) examination. Resident #245 scored four (4) out of fifteen (15), which indicated severe cognitive impairment. Continued review revealed in Section G: the resident was a one (1) person assist for bed mobility and self-transfers. The resident used mobility devices, walker and wheelchair. Further review of Section G revealed the resident was not steady for moving from seated to standing position, walking, turning around, and surface-to-surface transfers between the bed and wheelchair. Further review of this MDS Assessment, revealed Resident #245's fall, on 02/23/2021, which occurred during the look back period, prior to the assessment, was not noted on the MDS.

Review of Resident #245's CCP, dated 01/18/2021, revealed the resident had an area of Focus for falls with interventions listed. Further review revealed the Focus area did not address the falls on 02/19/2021 or 02/23/2021 and revealed no revision of interventions after these falls. (see F-657)

Review of the incident reports for falls revealed Resident #245 had falls, on 02/19/2021 and 02/23/2021. Review of Resident #245's fall assessment and Progress Notes revealed the resident had two (2) falls, on 02/19/2021 and 02/23/2021, prior to the Quarterly MDS

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F 656 SS=G	Continued From page 182 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (I) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656 F 656	F 656 1. Residents # 13, #36, #64, #77 and #240, care plans were reviewed by the MDS nurses and MDS consultants on 9/29/21. Updates were completed as identified. 2. MDS nurses and MDS consultant completed a review of all resident care plans on 09/29-10/05/21. Any care plans needing updated, resolved, or amended were corrected. 3. On 10/19/21 the MDS consultant educated the MDS nurses, UM, and DON on the importance of updating care plans and when to initiate a care plan. MDS nurses, UM, and DON will educate licensed nurses on the importance of updating care plans and when to initiate a care plan. 4. Beginning 10/25/21, residents with new orders or changes requiring care plan updates will be reviewed by the IDT, five times a week for two weeks, then weekly for four weeks, then monthly for two months, to ensure care plans were updated/revised/developed as needed. Any concerns identified will be corrected at the time of	

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second, licensed staff member present. Resident #240 suffered a fall with serious injury on 01/27/2021.

2. The CCP for Resident #13 was not developed to include bilateral lower extremity contractures or Restorative Care with interventions, services, or treatment to maintain current functional status or prevent a decrease in function.

3. The CCP for Resident #77 was not implemented consistently related to Restorative Care interventions, services, or treatment (left palmar splint) to maintain current functional status or prevent a decrease in function.

4. The CCP for Resident #36 was not developed to include the air mattress that was purchased for the resident.

The findings include:

Review of the Centers for Medicare and Medicaid Services, "Resident Assessment Instrument (RAI) Manual 3.0", dated October 2019, revealed the Comprehensive Care Plan was an interdisciplinary communication tool and must include measurable objectives and time frames and must describe the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Additionally, the facility was responsible for assessing and addressing all care issues that were relevant to individual residents, regardless of whether or not they were covered by the RAI, including monitoring each resident's condition and responding with appropriate interventions. Further review revealed the services provided or arranged must be consistent

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and mobile x-ray was ordered of bilateral hips, pelvis, and left shoulder, which was completed on site that day. Further review revealed X-ray results were returned at 1:35 PM on 01/27/2021, with abnormal results, and Resident #240 was ordered to be transferred to the hospital. Resident #240 returned from the local hospital, on 01/27/2021 at 8:30 PM, with a diagnosis of left humeral fracture.

Review of Resident #240's CCP revealed the resident's mobility care plan, prior to 01/27/2021, had not been developed to indicate the assistance required for bed mobility, transfers, or toileting. However, all four (4) previous MDS Assessment, on 01/05/2021, 10/08/2020, 07/01/2020, and 05/29/2020, assessed the resident as requiring an assist of two (2) with bed mobility, transfers, and toileting. On 01/27/2021, the resident's CCP was updated for two (2) person assist with bed mobility.

Review of the Witness Statement from Personal Care Assistant (PCA) #2, dated 01/27/2021, revealed PCA #2 was providing incontinence care Resident #240 when the resident's hand slipped off the rail, resulting in a fall. PCA #2 revealed she notified the nurse to come and help as soon as possible.

Review of the Witness Statement from LPN #17 revealed she was called into Resident #240's room, on 01/27/2021, and noted Resident #240 on the floor on his/her back between the beds. LPN #17's statement revealed Resident #240 said "I couldn't hold on." LPN #17's statement revealed she completed a head-to-toe assessment of the resident and noted a skin tear to the right lower arm, a skin tear to the right inner

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were a reflection of the CCP, so this information would not have been reflected on the nurse aide care plan prior to 01/27/2021.

Interview with the DON, on 08/04/2021 at 8:28 AM, revealed care plans should match the MDS, which was a reflection of a resident's care needs. She stated she would expect staff to follow the care plan.

Additional interview with the DON, on 08/18/2021 at 10:48 AM, revealed MDS nurses followed the RAI manual in developing and revising care plans. She revealed the highest level of care required during the look back period was what was coded, and staff could always provide more care than the care plan specified, but could not provide less care.

2. Review of Resident #13's medical record revealed the facility admitted the resident, on 07/28/2017, with diagnoses including Dementia, Major Depressive Disorder, Arthritis, and Schizoaffective Disorder.

Review of Resident #13's Admission Minimum Data Set (MDS) Assessment, dated 08/04/2017, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3) of fifteen (15), indicating severe cognitive impairment. Additional review revealed the resident had no functional limitations in Range of Motion (ROM) for upper or lower bilateral extremities. Per the Assessment, the resident was ambulatory and did not use a mobility device. Further, the resident required extensive assistance of one (1) staff with bed mobility, transfer, dressing, toileting, and personal hygiene.

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functional status or to prevent a decrease in function.

Further observation of Resident #13, on 08/12/2021 at 3:06 PM, with Registered Nurse (RN) #6, revealed the resident had functional limitations in bilateral lower extremities: hips and knees. The resident's right knee was bent at approximately a ninety (90) degree angle, and the resident was not able to flex or extend the right knee past the resting position. The resident's left leg was bent less than forty-five (45) degrees, and the resident was not able to flex or extend the left knee beyond resting position. Per the observation, the resident's legs touched each other, and the left leg crossed the right leg. The nurse stated the bilateral quadriceps were tight and there was resistance when trying to move the resident's knees and when trying to move the resident's legs apart. Further, when RN #6 attempted to move the resident's left leg off the right leg, the resident moaned and attempted to grab the nurse's hands. When the resident was at rest, the residents left leg rolled to the right over the right leg, and Resident #13 was not able to control normal alignment of his/her legs.

Interview with RN #6, on 08/12/2021 at 3:06 PM, revealed Resident #13's legs were severely contracted. Per the interview, the resident had a decline in December of 2020 and had not been ambulatory since then. Additionally, RN #6 stated it was important to provide care to residents to meet their needs and ensure quality care. Further, RN #6 stated the CCP should have been developed to include the bilateral lower extremity contractures and appropriate interventions to assist the resident.

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revealed interventions included to encourage the resident to participate in passive ROM, dated 05/20/2020. Additional interventions included hand hygiene for the resident, prior to donning the left palmar orthotic (splint); donning of the splint for the resident to wear three (3) to four (4) hours before removing; and checking skin prior to and after removing the splint, for six (6) days a week for twelve (12) weeks, dated 03/18/2020. Further interventions included, If the resident did not participate in the splint/brace program, document the reason, dated 03/18/2020.

However, there was no documented evidence the facility consistently implemented the Restorative Care regimen with interventions, services, or treatment to maintain current functional status or to prevent a decrease in function for Resident #77.

Review of Resident #77's RNP Restorative Aide task, dated 05/23/2021 through 08/18/2021, revealed no documented evidence the resident received his/her splint three (3) to four (4) hours a day, six (6) days a week, for six (6) of the twelve (12) weeks. Additional review revealed no documented evidence passive ROM had been provided since 01/26/2021. Further review revealed no documented evidence the resident received splint skin integrity checks before and after donning of the left palmar hand splint for twelve (12) of the twelve (12) weeks.

Review of Resident #77's Annual MDS Assessment, dated 07/14/2021, revealed the facility assessed the resident to have a BIMS score of seven (7) of fifteen (15), indicating severe cognitive impairment. Additional review revealed the resident had functional limitations in

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twelve (12) weeks; however, there was no documented evidence of passive ROM, or skin integrity checks with the splint.

Interview with SRNA #5 (had worked at the facility for thirty-four (34) years), on 08/12/2021 at 11:24 AM, revealed she had been a RNP aide for eight (8) years. Per the interview, she used the CCP as a guide to know how to care for residents. Also, she stated Resident # 77 required a brace to his/her left hand for four (4) to five (5) hours a day. She stated the resident also needed his/her hand washed and his/her fingers moved around before applying the brace. SRNA #5 stated further care should be provided to residents per their CCP to ensure safe care and to ensure their needs were met. However, she revealed she did not always work as a RNP aide, and all aides were responsible to implement the Restorative care per the CCP.

Interview with RN #4, on 08/12/2021 at 3:45 PM, revealed nursing staff followed the CCP to ensure care was provided appropriately to individualized residents. Per the interview, Resident #77's Restorative interventions should be applied per his/her RNP Care Plan. In addition, she stated it was important to encourage passive ROM, provide skin integrity checks, and to apply the brace per the RNP Care Plan to decrease risk for worsening contracture, pain, and skin impairment. Additionally, she stated nurses should spot check the resident and ensure aides had provided those interventions. Further, RN #4 reported she had not identified any issues with the resident not receiving his/her Restorative interventions as care planned.

Interview with the Occupational Therapist (OT),

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needs were met and a decline in functionality was avoided. Further, she revealed Resident #13's CCP should have been developed to include his/her contractures to bilateral lower extremities, and Resident #77's CCP should have been consistently implemented related to his/her Restorative interventions to ensure safe quality care to meet the needs of the individual resident.

Interview with the Director of Nursing (DON), on 08/13/2021 at 2:31 PM, revealed she had worked at the facility as the DON for one (1) year, and she expected the RAI Manual Guidelines to be followed related to development of the CCP for functional limitations in ROM. Per the interview, she also expected the CCP for Restorative care intervention to be implemented consistently. Additionally, she stated, if a resident had a functional limitation in ROM, the CCP should be developed to include the limitations and interventions, services, or treatment to maintain current functional status or to prevent a decrease in function of ROM. Further, she stated it was important for the CCP to be developed and implemented to ensure the IDT provided necessary care to residents to prevent complications and maintain quality of care.

Interview with the Administrator, on 08/16/2021 at 3:30 PM, revealed he had worked at the facility since July 27, 2021. Per interview, he expected the CCP to be developed per the RAI guidelines and the facility's policy. Additionally, he expected residents who had functional limitations in ROM, to have a CCP developed to include interventions, services, or treatment to maintain current functional status or to prevent a decrease in function of ROM. Continued interview revealed he expected the CCP to be implemented

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8:48 AM, revealed he/she had told staff he/she did not need an air mattress when they brought it in the room. Resident #36 shared that the winged mattress he/she was currently using was comfortable, and he/she had never had an issue with his/her bed being uncomfortable.

Interview with RN #7/MDS Coordinator, on 08/17/2021 at 9:20 AM, revealed that typically, resident mattresses were fall interventions. She stated if a resident were to have a new intervention with a mattress, the previous mattress intervention would be resolved. She revealed in the case of Resident #36, the mattress had been replaced for not even a day, prior to returning the resident to his/her winged/deep dish mattress. She stated the decision to change mattresses had been entirely the decision of the previous Administrator, and she was uncertain why the previous Administrator had made the change.

Interview with the SDC/QI, on 08/17/2021 at 10:25 AM, revealed the previous Administrator had ordered the air mattress for Resident #36 for comfort, as she thought it would benefit Resident #36. The SDC/QI stated, when she came to work the following morning, Resident #36 had slid out of bed, so she had staff remove the air mattress and place the deep dish/winged mattress back on Resident #36's bed. The SDC stated she was unaware whether or not Resident #36 was assessed by therapy for needing an air mattress.

Continued interview with the DON, on 08/18/2021 at 10:48 AM, revealed residents should be assessed prior to changing mattresses, and care plans should be updated whenever there was a change.

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F 657	Continued From page 200	F 657	4. Beginning 11/1/21, residents with new orders or changes requiring care plan updates will be reviewed by the MDS nurses, UM, SDC, DON or MDS consultant five times a week for two weeks, then weekly for four weeks, then monthly for two months, to ensure care plans were updated/revised/developed as needed. Any concerns identified will be corrected at the time of discovery and reported to the DON. Concerns will be taken to the monthly Quality Assurance Performance Improvement (QAPI) committee meeting for further review and recommendation. Compliance Date: 11/24/2021	

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS), "Resident Assessment Instrument (RAI) Manual 3.0," it was determined the facility failed to ensure the Comprehensive Care Plan (CCP) was reviewed and revised by an interdisciplinary team composed of individuals who had knowledge of the resident and his/her needs for four (4) of forty-four (44) sampled residents (Resident #13, #22, #80, and #245).

1. Resident #13 had a fall, on 07/22/2021, and the Fall Incident Report noted the resident required a high low bed to prevent further falls of the same nature; however, the Comprehensive Care Plan (CCP) was not revised to reflect the resident's fall intervention of the high low bed to prevent further falls until 08/11/2021 (twenty (20) days after the fall).

Additionally, Resident #13 had a fall, on 07/23/2021, and the Fall Incident Report noted the resident required a winged mattress to prevent further falls of the same nature. However, the CCP was not revised to reflect the resident's fall intervention of the winged mattress

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arranged should be consistent with each resident's written plan of care. Continued review revealed the CCP was driven not only by identified resident issues and/or conditions, but also by a resident's unique characteristics,. strengths, and needs. Furthermore, a CCP based on a thorough assessment and effective clinical decision making, was compatible with current standards of clinical practice that provided a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. A well developed and executed assessment and CCP re-evaluated the resident's status at prescribed intervals (quarterly, annually, or if a significant change in status occurred) using the RAI, and then, the individualized CCP was modified as appropriate and necessary.

1. Review of Resident #13's medical record revealed the facility admitted the resident, on 07/28/2017, with diagnoses including Dementia, Major Depressive Disorder, Arthritis, and Schizoaffective Disorder.

Review of Resident #13's CCP, revised on 10/02/2020, revealed the resident had a history of falls with injury, and had multiple risk factors such as impaired cognition and an actual fall on 10/02/2020. The goal was the resident would be free of serious injury from falls. Further review revealed interventions, which included encourage the resident to wear glasses (07/14/2020); attempt to distract the resident with candy and/or snack (10/02/2020); have commonly used articles within easy reach (07/14/2020); keep call light within reach and answer timely (07/14/2020); winged mattress (07/29/2021); and high low bed (08/11/2021).

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on the floor. Additionally, the resident was provided perineal care by staff and was assisted by two (2) staff back to bed; a winged mattress was placed on the bed to prevent further falls from the bed.

However, Resident #13's CCP was not revised to include a winged mattress, until 07/29/2021, six (6) days after the fall occurrence, on 07/23/2021 at 5:15 AM.

C) Review of Resident #13's Fall Incident Report Form, dated 07/24/2021, signed by LPN #3, revealed on 07/24/2021 at 5:40 PM, the resident had a fall occurrence in his/her room from the Evolution chair to the floor. The resident was sitting on the floor, the lights were off, and his/her back was resting against the dresser; the Evolution chair was to the resident's right side. Additionally, the resident was unable to give a description of the event related to his/her cognitive status. Further, the report stated the immediate action taken was the resident was assisted by two (2) staff, back to his/her Evolution chair, and dycem was placed on the seat to prevent the resident from sliding out of the chair.

However, there was no documented evidence Resident #13's CCP was revised to include dycem to the chair after the fall occurrence, on 07/24/2021 at 5:40 PM.

Interview with LPN # 3, on 08/15/2021 at 3:15 PM, revealed she had worked at the facility for eleven (11) years. Per the interview, after a fall event, it was the nurse's responsibility to implement an intervention immediately to decrease the risk of another fall of the same nature. Additionally, she stated the CCP should

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before providing care, was aware the resident required the assistance of two (2) staff for mobility, and was a fall risk. Additional interview revealed she was aware Resident #13 had poor safety awareness and had a history of falling from bed and his/her Evolution chair. SRNA #19 stated it was the responsibility of the staff to ensure residents were provided a safe environment to keep the resident safe and to meet their needs. Further, she stated she was not aware the resident required dycem to the chair seat to prevent him/her from sliding out of the chair.

2. Review of Resident #22's medical record revealed the facility admitted the resident, on 04/17/2019, with diagnoses including Dementia, Anxiety Disorder, Atrial Fibrillation, Sick Sinus Syndrome, Pseudobulbar Affect, Overactive Bladder, and Hypertension.

Review of Resident #22's Significant Change MDS Assessment, dated 02/22/2021, revealed the facility assessed the resident as having short and long term memory problems; and severely impaired cognitive skills for daily decision making. Continued review of the Assessment revealed the resident required extensive assistance of two (2) staff with bed mobility and transfers; extensive assistance of one (1) staff with eating; and total assistance of two (2) staff for personal hygiene, dressing, and toilet use. Per the Assessment, the resident did not ambulate. Further review revealed the resident had two (2) non-injury falls and one (1) fall with injury since the prior Assessment.

Review of Resident #22's Fall Incident Report Form, dated 03/04/2021, signed by LPN #3,

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have been revised to include the use of dycem on the wheelchair seat. Per the interview, she did not recall why she failed to complete the evaluation or revise the CCP to include dycem, after the fall on 03/04/2021.

3. Review of Resident #80's medical record revealed the facility admitted the resident, on 11/28/2019, with diagnoses including Type II Diabetes Mellitus, Osteoarthritis, General Anxiety Disorder, Morbid Obesity, Major Depressive Disorder, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Chondrocalcinosis of the Right Knee and Hip.

Review of Resident #80's Quarterly MDS Assessment, dated 04/21/2021, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of ten (10) of fifteen (15), indicating moderately impaired cognition. Continued review of the assessment revealed the resident required extensive assistance of two (2) staff with bed mobility, transfers, and dressing; extensive assistance of one (1) staff with personal hygiene; and total assistance of two (2) staff for toilet use. Per the Assessment, the resident did not ambulate, had impaired balance during transitions between surfaces, and could only stabilize with staff assistance. Further review revealed the resident had not fallen since the prior Assessment.

Review of Resident #80's CCP, revised on 06/24/2021, revealed the resident had a history of falls, and had multiple risk factors such as depression, medication (antidepressant, cardiovascular, and a diuretic), and an actual fall. The goal was the resident would be free of serious injury from falls. Further review revealed

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Interview with the DON (worked as the DON for one (1) year), on 08/31/2021 at 2:31 PM, revealed Resident #13's, Resident #22's and Resident #80's CCP's should have been revised to include interventions status post fall events more timely. In addition, the DON stated the CCP's should be revised as necessary to ensure residents received appropriate services and individualized care.

4. Review of Resident #245's medical record revealed the facility admitted the resident, on 01/18/2021, with diagnoses including Parkinson's Disease, Major Depression, Dementia, and Diabetes Mellitus Type II.

Review of Resident #245's Quarterly MDS Assessment, dated 02/26/2021, revealed the facility assessed the resident as having a BIMS of four (4) of fifteen (15), indicating severe cognitive impairment. Continued review revealed the resident was a one (1)-person assist for bed mobility and self-transfers; used mobility devices, a walker and wheelchair. Further review revealed the resident was not steady for moving from seated to standing position, walking, turning around, and surface-to-surface transfers between bed and wheelchair; however was able to stabilize without staff.

Review of Resident #245's CCP, dated 01/18/2021, revealed the Focus area of falls did not address the falls on 02/19/2021, 02/23/2021, and 03/13/2021. Continued review of the Interventions dated 01/18/2021 revealed no timely revision of the CCP with interventions for falls which occurred on 02/19/2021, 02/23/2021, and 03/13/2021.

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F 657	Continued From page 212 was responsible to update the CCP as needed. Additional interview with the DON, on 08/31/2021 at 2:31 PM, revealed she expected the CCP's to be revised accurately, per the RAI manual. Per the interview, nurses were responsible for revision of the CCP, including any changes related to fall events to prevent future falls. Additionally, she stated the current process in place was, during the facility's Morning Clinical Meeting, held on Monday through Friday, to review the CCP's after fall events to ensure revisions were made as necessary and for the IDT to ensure the CCP was revised with the most appropriate intervention. Interview with the Administrator, on 08/16/2021 at 3:30 PM, revealed the facility was to utilize the RAI Manual and facility policies as resources to ensure the CCP was revised as necessary. He stated it was important for the CCP to be revised accurately to reflect a resident's current status and ensure the CCP addressed each resident's individual needs.	F 657		
F 658 SS=J	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658	F 658 1. Resident #242 no longer resides in the facility. 2. On 8/19/21 and 8/20/21, the DON and QI nurse completed a review of all current residents and discharged resident charts for the past 30 days to identify any resident who had coded in the center and required Cardio-pulmonary resuscitation	

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F 658	Continued From page 214 Services Provided Meet Professional Standards. The facility was notified of the IJ on 08/20/2021. The facility provided an acceptable Immediate Jeopardy Removal Plan on 09/01/2021, with the facility alleging removal of the Immediate Jeopardy, on 08/31/2021. The State Survey Agency validated removal of the Immediate Jeopardy, as alleged on 08/31/2021, prior to exit on 09/02/2021. The facility's remaining non-compliance was at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The findings include: Review of the facility's policy titled, "Cardiopulmonary Resuscitation, Nursing Procedure Manual," Version Date: April 2013, revealed the objective was to ventilate the resident until adequate circulation to the brain was re-established. The policy stated if the resident was not breathing to call 911 and begin CPR. The policy also instructed staff on how to do chest compressions and administer rescue breathing at a rate of thirty to two (30/2) compressions/breaths. Further review revealed CPR would continue for two (2) minutes, then stop, check for breathing; if the resident was not breathing, repeat the process, checking for breath every (2) minutes. The policy stated the CPR process was to continue until there were signs of life, another rescuer took over, EMS arrived and took over, or a physician gave an order to discontinue CPR. Review of the American Heart Association 2020	F 658	responsibility during a Code Blue situation. The purpose of the drills and education is to ensure licensed nurses understand their responsibilities during a Code Blue. Results of the CPR drills and concerns with education will be forwarded to the Quality Assurance Performance Improvement (QAPI) committee for one month to determine further and/or frequency of monitoring. Compliance Date: 11/24/2021	

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(determined how much oxygen was circulating through the body). Oxygen was applied via mask for labored breathing. Further review of the progress note revealed staff were unable to obtain a pulse for Resident #242, and CPR was initiated. Per the note, EMS and the physician were notified, and Resident #242 was transported to a local hospital by EMS.

Review of the EMS run sheet, dated 01/26/2021, revealed they were dispatched at 6:06 PM and arrived on scene at 6:11 PM. Resident #242 was alert and moaning. The run sheet stated the facility reported the resident had been pulseless and apneic (without breath), was given CPR, and pulse/breath was regained. Documentation showed that a 12-lead electrocardiogram (EKG) indicated Resident #242 was throwing premature ventricular contractions (extra heart beats which could be dangerous with underlying heart conditions, with which Resident #242 had been diagnosed).

Review of the Hospital Emergency Department (ED) History and Physical (H&P) revealed Resident #242 arrived in the ED on 01/26/2021, status post respiratory arrest and CPR at the facility. Resident #242 met Sepsis criteria and was admitted for treatment. Additional review of the ED records indicated EMS staff had performed a 12-lead EKG during transport, which showed Resident #242 had sustained a ST-Segment Elevation Myocardial Infarction (STEMI), the most severe type of heart attack.

Review of the Hospital Death Discharge Summary revealed Resident #242 received broad-spectrum intravenous (IV) antibiotics, fluid boluses and appropriate sepsis protocols were

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Administrator instructed her to document the code in the Progress Notes and not to do an Incident report. She stated staff got annual training, from the SDC/QI nurse on what to do in case of a code. However, she stated the SDC/QI nurse did not tell the former Administrator to stop, she just smirked. LPN #15 stated she reported what had occurred in the code to the DON because she could not believe the Administrator did not know how to do CPR. She stated Physician #1 and the APRN both called her later that evening, and she told them what had happened. She stated nobody investigated the event or asked staff to write a statement. Additionally, LPN #15 stated it was the worst experience she had ever been in and was so traumatized by the events of 01/26/2021 that she did not work for a month.

Interview with the SDC/QI nurse, on 08/19/2021 at 1:50 PM, revealed she assessed Resident #242 before beginning CPR. She stated that when he/she regained a pulse, she also told the previous Administrator to stop CPR. Then, she demonstrated to the State Survey Agency (SSA) Surveyor how the previous Administrator put her hands over the SDC/QI nurse's hands and forced CPR for approximately another minute, until EMS arrived on the scene. She stated she was unable to remember if she reported the incident to the Corporate Clinical Nurse Consultant. Additionally, the SDC/QI nurse stated the American Heart Association (AHA) guidelines were the facility education resource.

Review of nursing staff CPR cards validated that the SDC/QI nurse and the former Administrator were certified to perform CPR on 01/26/2021.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	2323 CONCRETE ROAD CARLISLE, KY 40311

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F 658	Continued From page 220	F 658		

done immediately. He stated he was not too shocked when the resident passed away two (2) days later. He stated the previous Administrator had overstepped her bounds in ordering continued chest compressions, and resuscitation was not handled in an appropriate way. Physician #1 reported continuing CPR, on someone with a pulse, could harm them drastically.

Interview with the DON, on 08/19/2021, at 2:00 PM, revealed she had not been present for the code. She stated she met with the former Administrator the next day and told her it was wrong to continue CPR if there was a pulse. She stated the former Administrator again stated a resident needed a pulse of at least sixty (60) bpm to stop CPR. Additionally, the DON stated she sought guidance from the APRN who stated to stop CPR if there was a pulse. She stated an email was received from the APRN, about a week after the incident that included a current AHA algorithm for CPR and revealed if a resident had a pulse, chest compressions were no longer indicated.

Interview with the Regional Vice President (RVP), on 08/20/2021 at 3:03 PM, revealed he had no knowledge of the incident regarding Resident #242 and the fact that CPR continued after a pulse was obtained. He stated he was aware that CPR should be discontinued if there was a pulse. He stated he was not aware Physician #1 had concerns when he was notified of this situation. He stated his expectation was the Administrator would have reported the incident to him; others could have reported it to him as well. They could have reported through the compliance line or called him specifically. He had no thoughts on

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Support Algorithm for Healthcare providers, the CPR policy, and Code Blue. The in-service instructed nurses that: 1) if a resident was found without a pulse, blood pressure (BP), respirations or with insufficient respirations, a Code Blue must be called immediately, 2) the chart must always be checked for the resident's code status, 3) always make sure you had the correct resident's chart, 4) if a resident was a full code, then CPR must be started immediately, 5) if a resident was a Do Not Resuscitate (DNR), then CPR must not be initiated, 6) if a resident was a full-code to call 911, 7) the medical doctor (MD) must be notified as soon as possible of the resident's condition, and 8) the nursing staff must follow the Adult Basic Life Support Algorithm for Healthcare Providers.

4. On 8/19/2021, the DON, SDC/QI nurse, and Nurse Supervisor initiated a Questionnaire with all licensed nurses for validation of understanding their role in CPR. The passing score was one-hundred percent (100%). The questions included: 1) how do you know if a resident was a full code or DNR? 2) If a resident was a full code when do you initiate CPR? 3) what was the code to overhead page if a resident was found not breathing and/or no pulse? 4) when should the MD be notified if a resident was found not breathing and/or no pulse? 5) when a resident was found not breathing and/or no pulse, what were the nurse's responsibilities? and 6) do you continue CPR when heart rate and breathing had returned?
As of 8/30/2021, any nurse who was unable to answer the questions on the questionnaire after two attempts would be removed from working with residents until they were able to validate knowledge. Nurses unable to validate knowledge

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F 658	Continued From page 224	F 658		

offered feedback and suggestions to the staff. The staff were able to demonstrate and answer questions correctly, establishing staff were familiar with facility policies related to CPR, in accordance with standards of practice.

7. On 8/24/2021, the DON, SDC/QI nurse, and the Unit Manager facilitated a CPR Drill for second shift staff. During and after the drill, the DON offered feedback and suggestions to the staff. The staff was able to demonstrate and answer questions correctly, establishing staff was familiar with facility policies related to CPR, in accordance with standards of practice.

8. On 8/25/2021, the DON facilitated the morning interdisciplinary team (IDT) meeting. Members of the IDT included the Administrator, DON, Quality Improvement Nurse/Staff Development Coordinator (SDC/QI), Minimum Data Set (MDS) Nurse, Unit Manager, Activity Director, Social Services Director, and Dietary Manager. At the meeting, the RN Corporate nurse reviewed residents' medical charts, during which resident code status was reviewed. Approximately twenty-five (25%) percent of resident records were reviewed and code status was noted to be up-to-date.

9. On 8/26/2021, the DON reviewed and updated the CPR plan of correction with the Medical Director via telephone.

10. On 8/29/2021, the DON facilitated a CPR Drill for the weekend staff. The DON was assisted by three (3) RN's from a sister facility. During and after the drill, the DON and RN's offered feedback and suggestions to the staff. The staff were able to demonstrate and answer

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percent of discharged charts to identify if any residents had coded in the last thirty days. There were no residents identified.

2. Review of CPR cards revealed the SDC/QI nurse audited one-hundred (100%) percent of licensed nurses for current CPR education.

Interviews with LPN #11, RN #3, LPN #10, and LPN #6, on 09/02/2021 at 3:03 PM, 3:14 PM, 4:16 PM, and 4:26 PM respectively, revealed they were all currently CPR certified.

3. Review of signed in-service documentation sheet, dated 08/19/2021, revealed the DON in-serviced the SDC/QI nurse regarding that CPR should not be continued if there was a pulse. Continued review revealed the DON and SDC/QI nurse educated all licensed nursing staff on Adult Basic Life Support Algorithm for Healthcare Providers, CPR Policy, and Code Blue.

Interviews with LPN #11, RN #3, LPN #10, and LPN #6, on 09/02/2021 at 3:03 PM, 3:14 PM, 4:16 PM, and 4:26 PM respectively, revealed they did receive CPR education and had Code Blue drills and quizzes across every shift and on weekends.

4. Review of CPR quizzes revealed one-hundred (100%) percent of licensed nursing staff took the quizzes and passed. An employee roster was used to ensure no one was missed in receiving the education.

5. Review of CPR drill documentation revealed the facility held drills on 08/20/2021, 08/24/2021, 08/29/2021, and on 08/31/2021. Continued review revealed they were held across all shifts

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F 658	Continued From page 228 09/02/2021 at 1:18 PM, revealed she was assigned to be at the facility until the end of September 2021. She stated she would assist facility management in ensuring staff were familiar with facility policies related to CPR, in accordance with standards of practice. 13. Interview with the DON, on 09/02/2021 at 1:18 PM, revealed she had sent the CPR Drills analysis from 08/20/2021, 08/24/2021, 08/29/2021, and on 08/31/2021 to the QAPI Committee to be discussed at the next meeting.	F 658		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the American Heart Association's Cardiopulmonary Resuscitation (CPR) guidelines, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure staff were familiar with facility policies related to CPR for one (1) of thirty-two (32) residents with Full Code Status, Resident #242. On 01/26/2021 at 6:30 PM, Resident #242 suffered a cardiopulmonary arrest and Licensed Practical Nurse (LPN) #15 called a Code Blue for full CPR to be given. The Staff Development	F 678	F 678 1. Resident #242 no longer resides in the facility. 2. On 8/19/21 and 8/20/21, the DON and QI nurse completed a review of all current residents and discharged resident charts for the past 30 days to identify any resident who had coded in the center and required Cardio-pulmonary resuscitation (CPR). No other residents were identified. On 8/18/21, the QI nurse completed a 100% audit of all licensed nurses to validate CPR certifications were current and to ensure a copy of the CPR certification was on file at the facility. 3. On 8/19/21, the DON and QI nurse initiated education for all licensed nurses. The education included the	

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F 678	Continued From page 230 with systemic changes.	F 678	one month to determine further and/or frequency of monitoring.	

The findings include:

Review of the American Heart Association (AHA) 2020 CPR guidelines revealed if the victim was breathing and had a pulse, to monitor until emergency responders were on the scene. A resident would not need a heartrate of sixty (60) beats per minutes (bpm) to discontinue CPR.

Review of the facility's CPR policy, titled "Cardiopulmonary Resuscitation, Nursing Procedure Manual," Version Date: April 2013, revealed the objective was to ventilate the resident until adequate circulation to the brain was re-established. Procedure steps included to call 911 if the resident was not breathing and to begin CPR. The policy instructed that CPR would continue for two (2) minutes, then stop, check for breathing; if the resident was not breathing, repeat the process, checking for breath every (2) minutes. The policy stated the CPR process was to continue until there were signs of life, another rescuer took over, EMS arrived and took over, or a Physician gave an order to discontinue CPR.

Review of Resident #242's medical record revealed the facility admitted the resident, on 07/26/2017, with diagnoses that included Presence of Cardiac Pacemaker, Benign Prostatic Hyperplasia, Chronic Obstructive Pulmonary Disease, Atherosclerotic Heart Disease, Ischemic Cardiomyopathy, and Presence of Coronary Angioplasty Implant and Graft.

Review of the facility's resuscitative level communication sheet revealed Resident #242

Compliance Date: 11/24/2021

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she was current on CPR training through the American Heart Association.

Interview with the SDC/QI, on 08/19/2021 at 1:50 PM, revealed the American Heart Association (AHA) guideline was the facility education resource. Additionally, she stated nursing staff had Code training on hire and annually. She stated CPR certification occurred every two (2) years by a certified AHA Instructor.

However, the facility's CPR policy stated education was not from the AHA guidelines, as stated by the SDC/QI nurse, but the education was from a Nursing Procedure Manual (Version Date: April 2013).

Review of nursing staff CPR cards validated that the SDC/QI nurse and the former Administrator were certified to perform CPR on 01/26/2021.

Telephone interview with LPN #15, on 08/19/2021 at 1:28 PM, revealed she remembered the night Resident #242 coded, around 6:30 PM, right after supper. She stated a SRNA notified her Resident #242 was having trouble breathing. She stated she sat Resident #242 up, and he/she was gasping and vomiting. She stated she called a Code Blue because the resident did not have a pulse, and the SDC/QI nurse came in the room started compressions while staff were looking for mask. LPN #15 stated, when the former Administrator came in the room and discovered the resident had coded, she administered breaths through paper towels. Then, LPN #15 stated Resident #242 grunted, and the resident had a pulse, so she told staff to stop compressions. However, she stated the former Administrator told staff to not stop with compressions because they

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Interview with the DON, on 08/19/2021, at 2:00 PM, revealed she had not been present for the code. She stated she met with the former Administrator the next day and told her it was wrong to continue CPR if there was a pulse. She stated the former Administrator again stated a resident needed a pulse of at least sixty (60) bpm to stop CPR. Additionally, the DON stated she sought guidance from the APRN who stated to stop CPR if there was a pulse. The DON stated staff received Code training annually and were CPR certified every two (2) years.

Observation, on 08/20/2021 at 9:27 AM, of the North dining room revealed the Automated External Defibrillator (AED) and pads on their crash cart. However, there was no log of checking the AED.

Interviews with LPN #6, LPN #7, and Registered Nurse (RN) #3, on 08/20/2021 at 9:35 AM, revealed they were not aware where the AED was in the facility but knew where crash carts were located in facility. The Interim Administrator stated there was not an AED in the facility.

Interview with the DON, on 08/20/2021 at 9:40 AM, revealed the logs should be audited to ensure the AED was working; however, she did not audit the AED log. The DON stated the facility received the AED in April 2021. However, review of provided AED education and sign-in sheets revealed the facility received AED training on 02/22/2021 by the SDC/QI nurse. The DON stated the facility's policy should have been updated to include the AED.

Interview with the DON and SDC/QI nurse, on 08/20/2021 at 11:20 AM, revealed the facility did

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identify any resident who had coded in the center. No other residents had coded in the center within the past thirty (30) days, and no issues where identified.

2. On 8/18/2021, the SDC/QI nurse completed an audit of one-hundred (100%) percent of nurses' CPR certifications to ensure all current licensed nurses on all shifts were certified in CPR and possessed a copy of a CPR certification card. There were no concerns identified during the audit. The facility did not require nursing assistants, Kentucky Medication Aides (KMA), or therapy staff to be CPR certified because they did not perform CPR. Non-certified staff acted as runners to gather equipment and greet EMS.

3. On 8/19/2021, the DON in-serviced the SDC/QI nurse, which included that CPR should not continue after a pulse was detected. The previous Administrator was no longer at the facility. The DON, SDC/QI nurse, and Nurse Supervisor initiated an in-service with all nurses. The in-service was about the Adult Basic Life Support Algorithm for Healthcare providers, the CPR policy, and Code Blue. The in-service instructed nurses that: 1) if a resident was found without a pulse, blood pressure (BP), respirations or with insufficient respirations, a Code Blue must be called immediately, 2) the chart must always be checked for the resident's code status, 3) always make sure you had the correct resident's chart, 4) if a resident was a full code, then CPR must be started immediately, 5) if a resident was a Do Not Resuscitate (DNR), then CPR must not be initiated, 6) if a resident was a full-code to call 911, 7) the medical doctor (MD) must be notified as soon as possible of the resident's condition, and 8) the nursing staff must follow the Adult

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and 4) 8/31/2021 with first shift staff. The purpose of the drills were to ensure licensed and unlicensed staff understood their responsibilities during a Code Blue. Responsibilities included checking the resident for responsiveness, checking for pulse and respirations, summoning for assistance, checking code status, paging Code Blue, initiating CPR, ensuring adequate staff responded, nurse(s) designated staff to call 911, nurse(s) designated staff to obtain crash cart, crash cart brought to scene, CPR continued until EMS arrived, physician discontinued code, or until the resident's pulse and respirations had returned. Additional responsibilities included checking if crash carts were stocked appropriately and ensuring the correct chart was pulled/reviewed. Retraining would be conducted during the drill by the DON, SDC/QI nurse, and/or Nurse Supervisor for any identified areas of concern. There had been no issues identified.

6. On 8/20/2021, the DON, SDC/QI nurse, and the Unit Manager facilitated a CPR Drill for first shift staff. During and after the drill, the DON offered feedback and suggestions to the staff. The staff were able to demonstrate and answer questions correctly, establishing staff were familiar with facility policies related to CPR, in accordance with standards of practice.

7. On 8/24/2021, the DON, SDC/QI nurse, and the Unit Manager facilitated a CPR Drill for second shift staff. During and after the drill, the DON offered feedback and suggestions to the staff. The staff was able to demonstrate and answer questions correctly, establishing staff was familiar with facility policies related to CPR, in accordance with standards of practice.

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in accordance with standards of practice.

13. The DON would continue forwarding the results of the CPR Drills to the Quality Assurance Performance Improvement (QAPI) Committee monthly for one (1) month. The QAPI Committee would meet monthly for one (1) month and review the CPR Drill results to determine trends and/or issues that might need further interventions put into place and to determine the need for further and/or frequency of monitoring. The QAPI Committee consisted of the Administrator, DON, Infection Preventionist, Medical Director, Social Worker, Medical Records Director, Dietary Manager, and Housekeeping Supervisor, plus additional staff members as deemed necessary.

The State Survey Agency validated the implementation of the facility's Immediate Jeopardy Removal Plan as follows:

1. Review of documentation dated 08/19/2021 through 08/20/2021 revealed the DON and SDC/QI nurse audited one-hundred (100%) percent of discharged charts to identify if any residents had coded in the last thirty days. There were no residents identified.

2. Review of CPR cards revealed the SDC/QI nurse audited one-hundred (100%) percent of licensed nurses for current CPR education.

Interviews with LPN #11, RN #3, LPN #10, and LPN #6, on 09/02/2021 at 3:03 PM, 3:14 PM, 4:16 PM, and 4:26 PM respectively, revealed they were all currently CPR certified.

3. Review of signed in-service documentation sheet, dated 08/19/2021, revealed the DON

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F 678	Continued From page 242 CPR drill for second shift staff. 8. Review of the IDT meeting agenda, dated 08/25/2021, revealed the Corporate RN reviewed approximately twenty-five (25%) percent of residents' charts to ensure code status was documented and up-to-date. 9. Review of facility documentation, dated 08/26/2021, revealed the DON updated the Medical Director via telephone call. 10. Review of CPR Drill documentation, dated 08/29/2021, revealed the DON held the drill for weekend staff. 11. Review of documentation, dated 08/29/2021, revealed the Corporate RN audited twenty-five (25%) percent of residents' charts to ensure the electronic face sheets, physical charts, and residents' plans of care contained updated code status. 12. Interview with the Corporate RN, on 09/02/2021 at 1:18 PM, revealed she was assigned to be at the facility until the end of September 2021. She stated she would assist facility management in ensuring staff were familiar with facility policies related to CPR, in accordance with standards of practice. 13. Interview with the DON, on 09/02/2021 at 1:18 PM, revealed she had sent the CPR Drills analysis from 08/20/2021, 08/24/2021, 08/29/2021, and on 08/31/2021 to the QAPI Committee to be discussed at the next meeting.	F 678		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		

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F 688	Continued From page 244	F 688		

Significant Change MDS Assessment, dated 12/14/2020; and Quarterly MDS Assessment, dated 08/10/2021, in Section G: Functional Status, revealed the resident had no functional limitations in ROM for upper or lower bilateral extremities.

However, observation of Resident #13, on 08/09/2021, revealed he/she had contractures to his/her bilateral lower extremities. Further, review of the medical record revealed no documented evidence the facility developed or implemented a Restorative Care regimen with interventions, services, or treatment to maintain current functional status or to prevent a decrease in function.

2. Resident #77's most recent Annual MDS Assessment, dated 07/14/2021, Section G: Functional Status, revealed the resident had functional limitations in ROM on one (1) side upper and lower extremity. Additional review Section I: Diagnosis, revealed the resident had a diagnosis of Contracture; unspecified hand. Continued review of Section O: Special Treatment, Procedures and Programs, revealed the resident received seven (7) days of Restorative Nursing Programs, for brace or splint assistance.

However, observations of Resident #77, on 08/09/2021; 08/10/2021; 08/11/2021; and 08/12/2021 revealed his/her right hand was contracted with no brace or splint. Further review of the medical record revealed documented evidence the facility inconsistently implemented a Restorative Care regimen with interventions, services, or treatment to maintain current functional status or to prevent a decrease in

reviewed by the Interdisciplinary team (IDT) to determine if the resident required screening for additional therapy services. Referrals for screening were made as needed. On 09/16/21 through 09/27/21, the Director of Nursing and/or MDS nurses proactively in-serviced department heads (nursing activities, social work, dietary, AR, AP, maintenance, housekeeping, medical records) and nurses regarding "Mobility – transfer and ambulation, including walking."

4. Beginning 11/15/21, MDS nurse will run the Resident Response Analysis and ADL significant Change Analysis with each MDS submission weekly for four weeks, then monthly for two months. Any resident with a decline in ADLs will be reviewed by the IDT to determine if a referral to therapy is needed. This process will be on-going. Data collect will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) committee meeting for further recommendation.

Compliance Date: 11/24/2021

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the residents daily care and services. Continued review revealed the resident's Care Plan would outline restorative goals with expected outcomes, and objectives, which were individualized and resident-centered. Further, a decline in functional ability required an assessment by the licensed RNP nurse and/or a therapy referral for evaluation and treatment. The RNP SRNA should notify the RNP nurse immediately when a decline occurred in functional abilities (i.e.) mobility to ensure appropriate action in a timely manner.

1. Review of Resident #13's medical record revealed the facility admitted the resident, on 07/28/2017, with diagnoses including Dementia, Major Depressive Disorder, Arthritis, and Schizoaffective Disorder.

Review of Resident #13's Admission MDS Assessment, dated 08/04/2017, Section C: Cognitive Patterns, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of three (3) of fifteen (15), indicating severe cognitive impairment. Additional review of Section G: Functional Status, revealed the resident had no functional limitations in ROM for upper or lower bilateral extremities. Per the Assessment, the resident was ambulatory and did not use a mobility device. Further, the resident required extensive assistance of one (1) staff with Activities of Daily Living (ADL) such as bed mobility, transfer, dressing, toileting, personal hygiene, and eating. The resident did receive physical and occupational therapy minutes, starting on 07/28/2017.

Review of Resident #13' Physical Therapy Progress and Discharge Summary, dated

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F 688	Continued From page 248 unable to transfer or ambulate without assistance. Continued review revealed no documented evidence of an assessment of the resident's ROM of the bilateral lower extremities; hips and knees. Further, the goal for the resident was to demonstrate optimal positioning in the most appropriate seating system while maintaining proper positioning up to two (2) hours a day to promote optimal positioning for ADL's and increase out of bed time to improve functional status. Review of Resident #13's OT Progress and Discharge Summary, dated 01/17/2021, revealed the resident progressed to using an Evolution chair (addressed mobility and positioning issues)up to one (1) to two (2) hours a day out of bed with supervision and assistance. Further, the resident was discharged to LTC with the Evolution chair as a device to promote comfort and proper positioning. However, there was no documented evidence of an assessment of the resident's ROM of the bilateral lower extremities; hips and knees. Observation of Resident #13, on 08/09/2021 at 4:11 PM, revealed the resident lying in bed with a thin throw over his/her abdomen and lower extremities; bilateral lower extremities were bent at the knees and the residents left leg rested on the right leg. Additional observation, on 08/10/2021 at 11:58 AM, revealed the resident was lying in bed uncovered from the waist down. The resident's bilateral lower extremities were bent at the knees. Further, at rest, the resident's left leg was bent greater than the right leg was bent at rest. His/her left calf touched the left thigh. The	F 688		

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resident's legs touched each other, and the left leg crossed the right leg. The nurse stated the bilateral quadriceps were tight, and there was resistance when trying to move the resident's knees and when trying to move the resident's legs apart. Further, when RN #6 attempted to move the resident's left leg off the right leg, the resident moaned and attempted to grab the nurse's hands. When the resident was at rest, the resident's left leg rolled to the right over the right leg, and the resident was not able to control normal alignment of his/her legs.

Interview with RN #6, on 08/12/2021 at 3:06 PM, revealed Resident #13's legs were severely contracted. Per the interview, the resident had a decline in December of 2020 and had not been ambulatory since then. Additionally, RN #6 stated the SRNA's provided ROM to residents with limitations in ROM. Further, RN #6 stated it was important to provide care to residents to meet their needs and ensure quality care.

Continued observation of Resident #13, on 08/12/2021 at 3:41 PM, revealed the resident sitting up in his/her Evolution chair at the bedside. The resident's right foot was resting on the floor; however, the resident's left leg was bent at the knee and the resident's foot was suspended in the air, at rest. The resident's left leg bent at the knee was resting above the resident's right knee.

Interview with State Registered Nurse Aide (SRNA) #19 (worked at the facility for twelve (12) years), on 08/12/2021 at 11:00 AM, revealed she was often assigned to provide care to Resident #13. Per the interview, the resident did have contractures to his/her lower extremities, but the resident was not able to put his/her legs down

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F 688	Continued From page 252 on 08/13/2021 at 2:10 PM, revealed Resident #13 was not on the therapy caseload currently and had not been seen in therapy for a very long time. Per the interview, she was not aware if Resident #13 had limitations in ROM to his/her bilateral lower extremities; the resident was ambulatory on admission. She stated all residents' ROM was assessed on admission, but unless nursing staff noted a decline in a resident's functional status, therapy would not reassess routinely. The therapy department relied on nursing staff to identify and communicate declines/changes in the functional status of residents to therapy via a referral on the Electronic Health Record (EHR); then a reassessment of functional status, including ROM, would be completed. Further, she stated it was important to provide appropriate services, equipment, and assistance to maintain or improve contractures to prevent skin integrity issues, maintain joint alignment, manage pain, and to prevent/maintain further developing of contractures. Interview with Licensed Practical Nurse (LPN) #13/Minimum Data Set (MDS) Coordinator (at the facility for seven (7) years), on 08/13/2021 at 2:51 PM, revealed during the Assessment Reference Date (ARD), she would make observations of resident care and complete assessments of residents, which should be documented in a general Progress Note. Additionally, she stated, if a decline was noted in a resident's functional status, a referral should be made to the therapy department to ensure appropriate and timely action was taken to ensure the needs of the resident were met. Further, she stated Resident #13 had a significant change in December of 2020; was palliative care and had a decline in functional status. She stated the resident was no	F 688		

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the left palm; decreased pain to the left hand during stretching; and improvement of ten (10) degrees in ROM in the left hand joints. Additionally, the resident was discharged to the RNP for orthotic management. Further, OT provided caregiver training focused on decreasing increased contracture to the left hand and ensuring completion of the RNP plan, to decrease the resident's risk for potential skin breakdown and further development of the left hand contracture.

Review of Resident #77's CCP, initiated on 03/18/2020, revealed the resident required assistance and had potential to restore or maintain function of mobility by opening and closing of the left hand. The goal was the resident would not have worsening ROM in the upper extremity (left hand). Interventions included encourage the resident to participate in passive ROM, dated 05/20/2020. Additional interventions included hand hygiene prior to donning the left palmar orthotic; donning of the splint three (3) to four (4) hours; check skin prior to and after removing the splint six (6) days a week for twelve (12) weeks, dated 03/18/2020. Further interventions included, if the resident did not participate in the splint/brace program, document the reason, dated 03/18/2020.

However, there was no documented evidence the facility consistently implemented the Restorative Care regimen with interventions, services, or treatment to maintain current functional status or to prevent a decrease in function.

Review of Resident #77's RNP Restorative Aide task, dated 05/23/2021 through 08/18/2021, revealed no documented evidence the resident

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provided.

Review of Resident #77's Annual MDS Assessment, dated 07/14/2021, Section C: Cognitive Patterns, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of seven (7) of fifteen (15), indicating severe cognitive impairment. Additional review of Section G: Functional Status, revealed the resident had functional limitations in ROM on one (1) side, for upper and lower bilateral extremities. Further, the resident required extensive assistance of two (2) staff with Activities of Daily Living (ADL) such as bed mobility, transfer, and toileting; extensive assistance of one (1) staff for dressing and personal hygiene; and total assistance of one (1) staff for eating. The resident did receive occupational therapy, ending on 03/09/2020 and splint and brace assistance seven (7) days for at least fifteen (15) minutes in the last seven (7) calendar days.

However, observation of Resident #77, on 08/09/2021 at 4:28 PM, revealed the resident's left hand was edematous and his/her fingers were folded down onto the palm at rest. The resident was not wearing any device on his/her left hand.

Additional observation of Resident #77, on 08/10/2021 at 12:20 PM, revealed the resident's left hand was closed in a fist. The resident was not wearing any device on his/her left hand.

Continued observation of Resident #77, on 08/11/2021 at 9:50 AM, revealed the resident's left hand was closed in a fist at rest with his/her fingers folded onto the palm. The resident was not wearing any device on his/her left hand.

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resident wore the left hand brace for four (4) to five (5) hours a day. Further interview revealed when she was out of the facility or had other duties, such as working on the floor due to short staffing, the RNP services should be completed by other aides on the hallway. Continued interview revealed SRNA #5 had been out of the facility on 08/10/2021 and 08/11/2021.

Observations of Resident #77, on 08/12/2021 at 3:36 PM, with RN #4, revealed the resident was wearing a palmar brace to his/her left hand. Additionally, the nurse attempted to remove the palmar brace, the resident's fingers snuggly laid on the brace, and when the nurse lifted the resident's fingers, the resident pulled his/her hand away, mumbled and grimaced.

Interview with RN #4, on 08/12/2021 at 3:45 PM, revealed nursing staff was responsible to ensure Resident #77's left hand brace was applied per his/her RNP Plan. Per the interview, it was important to apply the brace per the RNP Plan to decrease risk for worsening contracture, pain, and skin impairment. Additionally, nurses should spot check the resident and ensure aides had applied the brace. Further, she stated she had not identified any issues with the resident not receiving his/her brace as care planned.

Interview with the Director of Nursing (DON), on 08/13/2021 at 2:31 PM, revealed she had worked at the facility as the DON for one (1) year. Per the interview, the facility had a RNP, she was the RNP nurse, and there were two (2) RNP aides; however, one (1) was off on medical leave. Per the interview, services, treatment, equipment, and assistance to maintain or improve a resident's mobility was also the responsibility of all aides in

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F 688	Continued From page 260 stated it was important to provide services and treatments to residents to keep their highest functioning level and to ensure those residents, without functional limitations, remained at baseline, and those with limitations did not decline.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to ensure each resident's environment was free from accident hazards over which the facility had control; and failed to provide supervision and assistive devices to each resident to prevent avoidable accidents for five (5) of forty-four (44)	F 689	F 689 1. During the week of 9/13/21 through 9/17/21, Residents #13, #22, #80, #240 and #245 were assessed by the quality improvement (QI) nurse to determine if the appropriate level of supervision was in place and/or any assistance devices were present. 2. All residents have the potential to be affected. During the week of 9/13/21 through 9/17/21, the DON, UM, nurse supervisor and MDS nurses completed an assessment of all facility residents to ensure the appropriate level of supervision and/or needed assistive devices were present. Any resident found to have the incorrect level of supervision had their care plan updated. Any resident missing an assistive device had the item provided and care plan updated.	

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5. Review of the Initial Fall Incident Reports revealed Resident #245 had falls on 02/19/2021, 02/23/2021, 03/13/2021, and 03/19/202. Review of the fall investigations revealed fall interventions were not updated on the CCP in a timely manner with interventions to help prevent future falls.

The findings include:

Review of the facility's policy titled, "Falls Protocol," dated 02/04/2021, revealed residents would be assessed for fall risk on admission, re-admission, quarterly and with a significant change. Continued review revealed residents with falls who were not identified as a fall risk would be assessed for fall risk. Additionally, residents at risk for falls would have a care plan initiated related to falls with multiple interventions. Per the policy, falls would be investigated to determine the root cause and validate that an investigation was completed. Further, trends with falls should be reviewed through the Interdisciplinary Team (IDT); and findings should be brought to the Quality Assurance Performance Improvement (QAPI) meeting.

1. Review of a Personal Care Assistant (PCA) Job Description and Training Form for PCA #2, updated on 11/23/2020, revealed "for anything beyond a one-person transfer, the PCA may only assist and must be directed by a certified/licensed staff member." The form was signed by PCA #2 and the DON on 12/31/2020.

Review of Resident #240's medical record revealed the resident was re-admitted to the facility, on 03/26/2020, with diagnoses to include Paraplegia Unspecified, Unspecified Atrial Fibrillation, and Morbid (Severe) Obesity due to

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the rail, resulting in a fall. PCA #2 revealed she notified the nurse to come help as soon as possible.

Review of a Witness Statement from LPN #17 revealed she was called into Resident #240's room on 01/27/2021, and noted resident on the floor on his/her back between the beds. LPN #17 statement revealed Resident #240 said "I couldn't hold on." LPN #17 statement revealed she completed a head to toe assessment of resident, and noted skin tear to right lower arm, skin tear to right inner knee, abrasion to left elbow, and skin tear to 2nd toe on left foot.

Review of a Witness Statement from SRNA #11 revealed she was doing rounds on 01/27/2021 with SRNA #12 and SRNA #12 yelled for her and LPN #2 to help because Resident #240 was in the floor. SRNA #11 stated PCA #2 was changing Resident #240 when Resident #240 slipped out of bed.

Review of a Witness Statement from SRNA #12 revealed she was in the hallway when someone yelled help and upon arrival at room Resident #240 was in the floor.

Interview with the Social Services Director (SSD) on 07/27/2021 at 10:29 AM revealed PCA's were not allowed to change residents. She revealed PCA's take a class and had a sheet that covered everything they were allowed to do.

Interview with Facility Consultant #1 on 07/27/2021 at 1:15 PM revealed the facility had begun utilizing PCA during the pandemic. She went on to reveal PCA's were allowed to assist SRNA's in changing residents, but were not

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01/27/2021, she and SRNA #12 had informed PCA #2 not to do anything on her own, not to provide any resident care without one of them present, but that she and SRNA #12 were down the hall, and the next thing they knew PCA #2 was yelling that Resident #240 was in the floor.

Interview with PCA #3, on 08/03/2021 at 3:02 PM, revealed as a PCA she assisted the SRNA's, and when she was done assisting the SRNA's, she assisted the Courtesy Aides. She revealed she sat with residents one-on-one (1:1) when asked to do so by nursing staff. She revealed she never did any changing or transferring of residents on her own.

Attempts to reach LPN #17 during the course of the survey were unsuccessful.

Interview with the DON, on 08/04/2021 at 8:28 AM, revealed PCA's could not provide resident care on their own. She revealed PCA's could assist aides. She revealed after Resident #240 fell out of bed, while a PCA was changing him/her, all staff were reeducated on what PCA's could and could not do.

Interview with the SDC, on 08/04/2021 at 2:58 PM, revealed PCA #2 should not have been trying to change Resident #240, as PCA's were not allowed to provide resident care without a licensed staff member present, and PCA #2 had received training and knew that. She revealed Resident #240 was a one (1) person assist, as he/she could help turn and reposition.

Interview with RN #7, the MDS Coordinator, on 08/04/2021 at 3:29 PM, revealed prior to 01/27/2021, Resident #240's care plan might not

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one (1) staff with personal hygiene; and total assistance of two (2) staff for toilet use. Per the Assessment, the resident did not ambulate, had impaired balance during transitions between surfaces, and could only stabilize with staff assistance. Further review revealed the resident had not fallen since the prior Assessment.

Review of Resident #13's CCP, revised on 10/02/2020, revealed the resident had a history of falls with injury and had multiple risk factors, such as impaired cognition and an actual fall on 10/02/2020. The goal was the resident would be free of serious injury from falls. Further review revealed interventions which included encourage the resident to wear glasses (07/14/2020); attempt to distract the resident with candy and/or snack (10/02/2020); have commonly used articles within easy reach (07/14/2020); keep call light within reach and answer timely (07/14/2020); winged mattress (07/29/2021); and high low bed (08/11/2021).

Review of Resident #13's Fall Risk Evaluation, dated 05/10/2021, revealed the facility assessed the resident to have a score of ten (10). Per the Evaluation, a total score of ten (10) or higher indicated the resident was at risk for falls and follow up was required.

A) Review of Resident #13's Fall Incident Report Form, dated 07/22/2021, signed by Licensed Practical Nurse (LPN) #9, revealed on 07/22/2021 at 5:22 PM, the resident had a fall occurrence in his/her room, falling from the bed to the floor. The resident was sitting on the floor between the two (2) beds. Per the report, the resident had no injuries or pain. Continued review revealed the resident was unable to give a

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Form, dated 07/23/2021, signed by LPN #16, revealed, on 07/23/2021 at 5:15 AM, the resident had a fall occurrence in his/her room, falling from the bed to the floor. The resident was sitting on the floor between the two (2) beds with the bed blanket and sheet. Per the report, the resident was soiled with a bowel movement and his/her buttocks were red; however, incontinence care had been provided at 3:00 AM. Continued review revealed the resident was unable to give a description of the event, and the resident had no injury. Continued review revealed there was no further immediate action taken.

Review of Resident #13's Fall Risk Evaluation, dated 07/23/2021, revealed the facility assessed the resident to have a score of fifteen (15), indicating the resident was at risk for falls and follow up was required.

The State Survey Agency (SSA) Surveyor, on 08/15/2021 at 3:25 PM, attempted to contact LPN #16 related to the Fall Incident on 07/23/2021. LPN #16 was not available, and a message was left to return the call.

Review of Resident #13's Fall Investigation Summary, dated 07/27/2021 (four (4) days after the fall event), signed by the Quality Indicator Nurse, revealed on 07/23/2021, the resident was noted sitting his/her buttocks wrapped in the bed blanket and sheet on the floor. Additionally, the actions taken during the investigation included a head to toe assessment for injuries, which revealed no injury. Per the Summary, staff provided the resident perineal care and he/she was assisted by two (2) staff back to bed; a winged mattress was placed on the bed to prevent further falls from the bed. Further, the

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the fall event), signed by the Quality Indicator Nurse, revealed, on 07/24/2021, the resident was noted sitting on the floor on his/her buttocks with his/her back resting against the dresser. Additionally, the actions taken during the investigation included a head to toe assessment for injuries, which revealed no injury. Per the Summary, dycem was placed in the chair, and the resident was assisted by two (2) staff back to the Evolution chair. Further, the root cause was related to safety awareness secondary to Dementia. Continued review revealed the resident believed he/she could still ambulate independently but was unsteady, weak, and unable to do so. The resident attempted to get out of the Evolution chair and go to the bathroom alone, which consequently caused the fall out of the chair.

However, there was no documented evidence the CCP was revised to include dycem to the chair after the fall occurrence, on 07/24/2021 at 5:40 PM.

Interview with LPN #3, on 08/15/2021 at 3:15 PM, revealed, after a fall event, it was the nurse's responsibility to implement an intervention immediately to decrease the risk of another fall of the same nature. Additionally, the CCP should be revised to include the immediate intervention to ensure continuity of care. Further, Resident #13 should have had dycem consistently placed on his/her Evolution chair seat after the 07/24/2021 fall event. Per the interview, she forgot to revise the CCP to include dycem after the fall.

Observations of Resident #13, on 08/09/2021 at 4:11 PM; 08/10/2021 at 9:35 AM; and 08/12/2021 at 3:06 PM, revealed there was no dycem in the

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provided a safe environment to keep the resident safe and to meet their needs. Further, she stated she was not aware the resident required dycem to the chair seat to prevent him/her from sliding out of the chair.

3. Review of Resident #22's medical record revealed the facility admitted the resident, on 04/17/2019, with diagnoses that included Dementia, Anxiety Disorder, Atrial Fibrillation, Sick Sinus Syndrome, Pseudobulbar Affect, Overactive Bladder, and Hypertension.

Review of Resident #22's Monthly March 2021 Physician's Orders, revealed no documented evidence of fall intervention devices.

Review of the Significant Change MDS Assessment, dated 02/22/2021, revealed the facility assessed Resident #22 as having short and long term memory problems and severely impaired cognitive skills for daily decision making. Continued review of the Assessment revealed the resident required extensive assistance of two (2) staff with bed mobility and transfers; extensive assistance of one (1) staff with eating; and total assistance of two (2) staff for personal hygiene, dressing and toilet use. Per the Assessment, the resident did not ambulate. Further review revealed the resident had two (2) non-injury falls and one (1) fall with injury since the prior Assessment.

Review of Resident #22's CCP, revised on 03/17/2021, revealed the resident had a history of falls and actual falls (03/04/2021) and had multiple risk factors such as Dementia, altered perception of awareness/surroundings, and cardiovascular medications. The resident had a

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Risk Evaluation on 03/04/2021. However, review of the facility's policy, "Fall Protocol" revealed residents with falls, who were not identified as a fall risk would be assessed for fall risk.

Additional review of Resident #22's Fall Risk Evaluation, dated 05/24/2021, eighty-two (82) days after the fall on 03/04/2021, revealed the facility assessed the resident to have a score of eleven (11), indicating the resident was at risk for falls and follow up was required.

Continued interview with LPN #3, on 08/15/2021 at 3:15 PM, revealed after a fall event, it was the nurse's responsibility to evaluate the fall risk of residents who were not previously at risk for falls. Further, Resident #22 should have had a Fall Risk Evaluation completed after his/her fall, on 03/04/2021. LPN #3 stated Resident #2's CCP should have been revised to include the use of dycem on the wheelchair seat. Per the interview, she did not recall why she failed to complete the evaluation or revise the CCP to include dycem after the fall.

Review of Resident #22's Fall Investigation Summary, dated 03/16/2021 (twelve (12) days after the fall event), signed by the QI Nurse, revealed, on 03/04/2021, the resident was noted sitting on the floor on his/her buttocks at the end of the bed; the resident's wheelchair was behind him/her. Additionally, the actions taken during the investigation included a head to toe assessment for injuries. Per the Summary, the resident was assisted back into the wheelchair by two (2) staff, and dycem was added to the wheelchair. Further, the root cause was related to safety awareness secondary to Dementia. Continued review revealed the resident had generalized

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Review of Resident #80's CCP, revised on 06/24/2021 revealed the resident had a history of falls and had multiple risk factors such as Depression, medication (antidepressant, cardiovascular, and a diuretic), and an actual fall. The goal was the resident would be free of serious injury from falls. Further review revealed interventions which included anti roll back on the wheelchair, wheelchair properly fit for resident (02/02/2021); encourage resident to wear non-skid footwear (06/08/2021); commonly used articles within easy reach (08/26/2020); and give the resident a glass of ice chips between meals and at bed time (07/15/2021).

Review of Resident #80's Fall Risk Evaluation, dated 06/08/2021, revealed the facility assessed the resident to have a score of fourteen (14). Per the Evaluation, a total score of ten (10) or higher indicated the resident was at risk for falls and follow up was required.

Review of Resident #80's Fall Incident Report Form, dated 06/29/2021, signed by the QI Nurse, revealed, on 06/29/2021 at 2:00 PM, the resident had a fall occurrence in his/her room. The resident was lying on his/her right side in the floor with regular socks on. Per the report, the resident suffered skin tears to bilateral elbows and his/her right knee. Continued review revealed the resident stated he/she was trying to get some water, lost his/her balance, spilled the water, took a step and fell. Further, the immediate action taken was the resident was provided first aid and assisted by two (2) staff into a wheelchair.

Review of Resident #80's Fall Risk Evaluation, dated 07/01/2021, two (2) days after the fall on

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important to ensure the Fall Protocol policy and facility practices were maintained to ensure residents were provided safe care and to reduce their risk for injury.

Interview with the DON, on 08/31/2021 at 2:31 PM, revealed Resident #13's CCP should have been revised more timely with interventions for the 07/22/2021, 07/23/2021, and 07/24/2021 fall events, and the Fall Investigation Summary(ies) for those falls should have been more timely. The DON stated Resident #22's Fall Risk Evaluation and CCP revisions should have been more timely for the 03/04/2021 fall event. The DON stated Resident #80's Fall Investigation Summary and CCP revision should have been more timely for the 06/29/2021 fall event.

5. Review of Resident #245's medical record revealed the facility admitted the resident, on 01/18/2021, with diagnoses including Parkinson's Disease, Major Depression, Dementia, and Diabetes Mellitus Type 2. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 02/26/2021, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of four (4) out of fifteen (15),indicating severe cognitive impairment. Continued review revealed in Section G the resident was a one (1) person assist for bed mobility and self-transfers. The resident used mobility devices, a walker and wheelchair. Further review of section G revealed the resident was not steady for moving from seated to standing position, walking, turning around and surface-to-surface transfers between bed and wheelchair; however, the resident was able to stabilize without staff. Review of section J revealed the resident had not expressed pain

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Review of Resident #245's Fall investigation, on 02/23/2021, revealed the intervention to place a sign to remind the residents it was a shared bathroom. The intervention was not updated on the care plan, until 03/11/2021, after the report was completed.

Review of Resident #245's Fall investigation, on 03/13/2021, revealed the intervention to make sure no pillows were in the wheelchair seat and that dycem was in place was not updated on the care plan, until 03/25/2021, after the report was completed.

Review of Resident #245's Fall investigation, on 03/19/2021, revealed an intervention to obtain orders from the physician for blood work to determine if there was an underlying cause of the falls, after the report was completed on 03/24/2021. However, review of the Physician's orders revealed there was no blood work ordered.

Review of the Resident #245's Fall investigation, dated 03/24/2021, revealed the resident had fallen and notified staff that he/she had gotten himself/herself back up. Continued review of the fall investigation showed the resident was assessed, but it was not until he/she complained of leg pain that an x-ray was obtained, and he/she was sent to the Emergency Department (ED) for evaluation.

Review of Resident #245's ED medical record, dated 03/26/2021, revealed Resident #245 was not a good historian and could not state if he/she had a fall. The facility reported there might have been a fall the day before. Continued review of the ED note revealed Resident #245 was

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Meeting, participants (DON, Unit Managers, QI Nurse, Activities, Therapy, Minimum Data Set (MDS) Nurse) reviewed Fall incident reports and ensured the documentation was thorough and that the CCP was revised to include the most appropriate intervention. Further, after each fall event, she stated the CCP should be revised to include an intervention to assist the resident with reducing the risk of further falls and injury. The QI Nurse stated she then was responsible to type up the Fall Investigation Summary with the Interdisciplinary Team (IDT) discussion. She stated the facility's practice was for the Fall Investigation Summary to be completed within three (3) days of the fall event, to ensure a timely investigation and actions. The QI Nurse stated when she was out of the facility she did not have a backup staff member who was responsible for her job duties and that was the reason the fall follow-up was not completed timely.

Interview with the LPN #13/MDS Coordinator and RN #7/MDS Coordinator, on 08/13/2021 at 2:51 PM, revealed Monday through Friday they met with the daily Clinical Morning Meeting and reviewed fall events. Additionally, she stated, during the meeting, the IDT would ensure the CCP was accurate to meet the resident's needs based on the fall documentation and meeting discussions. Further interview revealed there should be new interventions developed with each fall event. However, she stated she had not identified there was a failure to ensure falls were care planned with appropriate interventions timely. However, she stated all nurses were responsible to revise the CCP as necessary.

Interview with the DON, on 08/31/2021 at 2:31 PM, revealed after a resident fall event, the

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F 689	Continued From page 286 documentation and ensure there were appropriate interventions implemented timely to reduce the risk for falls, that Fall Risk Evaluations were completely timely, and that the CCP was updated timely. Further interview revealed the audit process of review in Morning Clinical Meetings should have identified the noncompliance.	F 689		
F 755 SS=K	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755	F 755 1. On 07/19/21, staff nurses performed pain assessments on all facility residents including Residents #1, #8, #9, #17, #32, #34, #47, #48, #56, #60, #65, #69, #71, #79, #82 and #84. No concerns were identified. 2. Any resident receiving a controlled substance medication had the potential to be affected. On 07/19/21, staff nurses performed pain assessments on all facility residents. No concerns were identified. 3. On 07/19/21, the staff development coordinator (SDC) initiated education for all licensed nurses and Kentucky Medication Aides (KMA) on narcotic counts, narcotic count sheets, packing slips and logging narcotics into the narcotic books. On 07/12/21, the Director of Nursing (DON) expanded the education to include documentation of as needed (PRN) medications, labeling	

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2. On 07/09/2021, a pharmacy audit determined a skid of thirty (30) tablets of Percocet (Scheduled II narcotic pain reliever) was missing for Resident #17. Licensed Practical Nurse (LPN) #2 signed the pharmacy packing slip without another licensed staff to witness, for the three (3) skids of thirty (30) tablets of Percocet each, on 06/28/2021. However, LPN #1 stated she only received two (2) skids of thirty (30) tablets of Percocet each.

3. On 07/18/2021, LPN #1 was found by Police to have in her possession controlled medications that included Oxycodone (Scheduled II narcotic), Tramadol (opiate narcotic analgesic), Hydrocodone (Scheduled II narcotic), and Gabapentin (Scheduled III anticonvulsant). Additionally, LPN #1 was found to have Primidone (non-controlled anticonvulsive) on her person, which she admitted she used to replace Resident #32's and Resident #84's controlled narcotic medications, which she had misappropriated.

Ten (10) additional residents had a total of fourteen (14) controlled medications missing and not signed out properly, on 07/18/2021, some of which were the same type of medications found on LPN #1 by the Police: Resident #71, #8, #56, #1, #79, #47, #34, #60, #48, and #65.

Additionally, staff did not adhere to proper disposal of controlled medications. Only one (1) licensed staff was documented to witness disposal, which also led to opportunities for misappropriation of controlled medications.

4. On 07/20/2021, the Director of Nursing (DON) signatures were present on the packing slip when controlled substances were received. These audits will be completed 3 times per week for 4 weeks.

On 07/20/21, the DON, SDC, MDS nurses, Social Services Director (SSD) and Activities Director (AD) or support RN nurse began interviewing three (3) random residents with a BIMs of nine (9) or higher, weekly, to ensure they have no concerns with when or how their controlled substances are administered. On 07/21/21, the DON, UM, SDC, QI nurse, Weekend Supervisor, MDS nurses, Corporate RN or support RN, will audit storage and documentation of narcotics to ensure narcotics are stored appropriately and documentation is correct. These audits will occur five (5) times per week. Any concerns identified with any of these audits will be brought to the Administrator and/or DON for review at the morning Interdisciplinary Team (IDT) meeting. The IDT will review all audits on Friday and forward information obtained to the Quality Improvement Performance Improvement (QAPI) committee for review at their monthly meeting. All

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signature of the administering nurse, and an entry if the medication was destroyed, with the completed record forwarded to the DON. The policy stated records should be reconciled each shift by two (2) staff members authorized to administer medications, with staff signing their names on the Shift Change Controlled Substance Count Check Form, with any discrepancies reported to the responsible supervisor and any non-justified discrepancies reported to the DON. The policy stated any discrepancies reported to the responsible supervisor should be investigated to determine the cause, with any explanation reported to the DON, by filing a Medication Error Report. If a reason for the discrepancy could not be found, this must also be reported on the Medication Error Report. Per the policy, should the discrepancy involve more than one (1) dose of a controlled substance, the DON shall notify the Consultant Pharmacist immediately, who in turn shall notify the Kentucky Drug Control Unit and other State or Federal agencies if deemed necessary. Furthermore, the policy stated disposal of controlled substances should always be performed by a licensed nurse, witnessed by a second licensed nurse, and should be disposed of in a pharmaceutical waste device, such as a Drug Buster. The declining inventory sheet must indicate the date, time, and quantity of medication destroyed, and the method of destruction, signed by the nurse destroying and the nurse witnessing.

1. A) Review of Resident #9's medical record revealed the resident was readmitted by the facility, on 05/03/2021, with diagnoses to include Paraplegia Unspecified, Nicotine Dependence Unspecified Uncomplicated, Other Specified Anxiety Disorders, and Other Chronic Pain. The facility assessed Resident #9, in an Admission

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sign for a second dose, and there was no indication on the back of the MAR these doses were given, for what purpose, or whether or not the doses were effective. Continued review revealed Resident #9 would normally receive a dose of Percocet 7.5/325 mg between 8:00 AM and 9:00 AM each morning.

Interview with LPN #12, on 08/13/2021 at 8:21 AM, revealed Resident #9 took his/her medication, would ask for it, knew what it looked like, and knew what pills he/she took. She revealed several staff members , including RN #1 and LPN #2, told her they had reported Resident #9 not receiving his/her medications in June 2021 to the Administrator, although she was not aware of the Administrator doing anything with that information.

Interview with LPN #5, on 08/03/2021 at 4:20 PM, revealed, on 07/06/2021, Resident #9 had indicated to her that he/she was not receiving his/her medications. She stated Resident #9 wanted his/her pain pill and Klonopin, but she was unable to give it because they had been given on the previous shift. She revealed she alerted the DON, at that time, via text message of Resident #9's allegation. LPN #9 stated Resident #9 was not in any pain that morning, but his/her routine was to receive his/her PRN pain medication in the morning.

Review of the Facility Concern/Grievance Form, dated 07/08/2021, initiated by Resident #9, revealed the resident complained about not getting pain pills on the night shift from one (1) or two (2) weeks ago, not sure of the date, and did not want LPN #1 taking care of him/her. The previous Administrator was listed as the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185028	A. BUILDING _____ B. WING _____	C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MATHERS NURSING HOME	2323 CONCRETE ROAD CARLISLE, KY 40311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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he/she was not given his/her prescribed medications by LPN #1. Resident #69 stated he/she knew what medications he/she took, and one (1) time he/she was given a cup of pills which did not include his/her PRN pain medication or his/her Xanax. Resident #69 stated he/she informed LPN #1, who acted like she had forgotten them on the cart, and retrieved them for him/her.

Review of Resident #69's MAR for 06/2021, revealed the resident was administered Tramadol 50 mg a total of four (4) times during that month, twice by LPN #1. This was not documented on the back of the MAR, but was documented on the Controlled Substance Count Record, initiated on 06/08/2021. Review of Resident #69's Controlled Substance Count Record, initiated 05/08/2021 for Tramadol 50 mg twice a day PRN, revealed the resident was frequently administered Tramadol at 8:00 PM, as signed by LPN #1 and LPN #2.

Interview with RN #2, on 08/03/2021 at 3:33 PM, revealed she remembered filling out a grievance form regarding Resident #69 where the resident had reported not getting his/her medications when LPN #1 was working and stated it had happened more than once. She stated as she was turning in the grievance form, other staff was telling her, if Resident #69 had received the documented medications, he/she would have been "snowed in" which she defined as very tired in the morning and kind of loopy, which Resident #69 had not been. RN #2 stated when Resident #69 had not had his/her pain medications, he/she was clear minded and very alert. She stated Resident #69 knew if he/she had received his/her medications.