

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185353</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>12/28/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRANDENBURG NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 OLD EKRON RD</b> <b>BRANDENBURG, KY 40108</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/28/14 as alleged.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

From:

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12/12/2014 14:00

#255 P.003/030

DEC 12 2014

OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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NAME OF PROVIDER OR SUPPLIER  BRANDENBURG NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108	
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F 000 INITIAL COMMENTS

F 000

An Abbreviated Survey was initiated on 11/12/14 and concluded on 11/14/14 to investigate KY22462. The Division of Health Care substantiated the allegation with deficiencies cited.

F 224 483.13(c) PROHIBIT  
SS=E MISTREATMENT/NEGLECT/MISAPPROPRIATN

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and policy review, it was determined the facility failed to ensure residents were free from misappropriation of property through missing narcotics for five (5) of six (6) sampled residents (Residents #1, #2, #3, #4 and #5), of the twenty-six (26) residents the Director of Nurses identified as receiving narcotic medications. The facility failed to ensure Narcotic Count Sheets and Narcotic Cards accounted for.

The findings include:

Review of the Abuse and Neglect Policy, not dated, revealed Misappropriation of Resident Property was the deliberate misplacement, exploitation, or wrongful temporary or permanent use of resident's belongings without the resident's

Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.

F 224

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

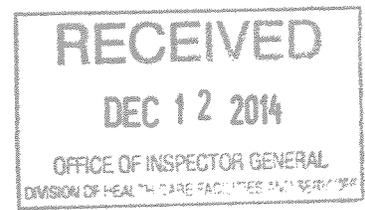
*[Signature]* Victoria Trump *[Signature]* X Administrator 12/12/14

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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	<p>F 224 Continued From page 1 consent.</p> <p>Review of the Disposal/Destruction of Expired or Discontinued Medications, revised 01/01/13, revealed the facility would dispose of discontinued medications after a resident had been discharged in a timely fashion, or no more than ninety (90) days of the date the medication was discontinued. Controlled substances could not be returned to the Pharmacy. The facility would destroy controlled substances in the presence of a Registered Nurse and a licensed professional in accordance with facility's policy. Destruction of controlled medications would be documented on the controlled medication count sheet and signed by the Registered Nurse and the witnessing licensed professional who would record the quantity destroyed, the date of destruction, and, the signature of the Registered Nurse and Pharmacist.</p> <p>1. Review of Resident #4's closed record, revealed the facility admitted the resident on 09/26/14 and discharged on 10/02/14, with diagnoses of Joint Pain, Chronic Pain and Severe Erosive and Necrotic Esophagitis and discharged to another nursing facility on 10/02/14.</p> <p>Review of Resident #4's Physician Orders, dated 09/26/14, revealed, Resident #4 was ordered Hydrocodone-Acetaminophen (APAP) 5/325 mg one (1) tablet by mouth every eight (8) hours as needed for pain. On 09/27/14, the Hydrocodone-APAP was changed to 10/325 mg one (1) tablet every four (4) hours as needed for pain.</p> <p>Review of the Controls Shipped Log, dated 08/29/14 through 10/28/14, revealed the</p>	<p>F 224 F224</p> <p>1-An audit of all narcotics dispensed for resident # 1 between 08-29-14 through 10-28-14 was completed by the Regional Nurse Consultant on 10/31/2014 and any identified narcotics that could not be accounted for were billed to the facility. On 10-28-2014 the Director of Nursing completed an audit of all narcotics delivered for resident # 1 between 10/20/2014 and 10/26/2014 and all delivered narcotics were accounted for.</p> <p>An audit of all narcotics dispensed for resident # 2 between 08-29-14 through 10-28-14 was completed by the Regional Nurse Consultant on 10/31/2014 and any identified narcotics that could not be accounted for were billed to the facility. On 10/28/2014 the Director of Nursing completed an audit of all narcotics delivered for resident # 2 between 10/20/2014 and 10/26/2014 and all narcotics were accounted for.</p> <p>An audit of all narcotics dispensed for resident # 3 between 08-29-14 through 10-28-14 was completed by the Regional Nurse Consultant on 10/31/2014 and any identified narcotics that could not be accounted for were billed to the facility. On 10/28/2014 the Director of Nursing completed an audit of all narcotics delivered for resident # 3 between 10/20/2014 and 10/26/2014 and all narcotics were accounted for.</p>	<p>(X5) COMPLETION DATE</p>



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F 224	Continued From page 2 pharmacy shipped one (1) Hydrocodone-APAP 5/325 mg narcotic card with ten (10) tablets and one (1) Hydrocodone-APAP 10/325 mg narcotic card with thirty (30) tablets on 09/27/14. The pharmacy also shipped an order of Hydrocodone 10/325 mg thirty (30) tablets on 09/30/14.  Review of Resident #4's Narcotic Count Sheets, dated 09/27/14 through 09/28/14, revealed the facility received Hydrocodone 5/325 then changed the order to two (2) tablets for a total of 10/325 mg. Review of the Medication Administration Record (MAR), dated 10/01/14, revealed the facility administered the Hydrocodone 10/325 mg for pain.  Review of Resident #4's narcotic count sheets, revealed the two (2) Hydrocodone-APAP 10/325 mg cards containing thirty (30) tablets each and delivered on 09/27/14 and 09/30/14, could not be accounted for.  2. Review of Resident #5's closed record, revealed the facility admitted the resident on 10/07/14 and discharged on 10/13/14 with diagnoses of Acute Pain and Transvaginal Tape Removal and discharged home on 10/13/14 with Rehab Services.  Review of Resident #5's Physician Orders, dated 10/07/14, revealed an order for Oxycodone-APAP 5/325 mg one (1) tablet by mouth every four (4) hours as needed for pain.  Review of the Controls Shipped Log, dated 08/29/14 through 10/28/14, revealed the pharmacy shipped one (1) Oxycodone-APAP 5/325 mg narcotic card containing thirty (30) tablets on 10/07/14, 10/09/14 and 10/11/14, which	F 224	Resident # 4 discharged to another facility on 10/028/2014. An audit of all narcotics dispensed for resident # 4 between 08-29-14 through 10-28-14 was completed by the Regional Nurse Consultant on 10/31/2014 and any identified narcotics that could not be accounted for were billed to the facility.  An audit of all narcotics dispensed for resident # 5 between 08-29-14 through 10-28-14 was completed by the Regional Nurse Consultant on 10/31/2014 and any identified narcotics that could not be accounted for were billed to the facility. Resident # 5 discharged home on 10/13/2014.  2- On 10/31/2014 the Regional Nurse Consultant and Pharmacist Consultant conducted an audit of all narcotics dispensed to the facility for any resident between 08-29-2014 and 10-28-2014. Any Identified narcotics that could not be accounted for were billed to the facility. On 10/28/2014 the Director of Nursing conducted an audit of all dispensed narcotics for any resident between 10/20/2014 and 10/26/2014 and identified no concerns.  3- On 10-24-2014 the facility implemented a system to account for and track narcotics within the facility. This system is as follows. An ongoing system to count the number of packages to the number of count sheets each shift to identify any packages removed from the cart regardless of the identification number for number of sheets dispensed on the narcotic count sheet. The system also allows for an ongoing inventory of packages of narcotics removed or added on a shift by		

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F 224 Continued From page 3

equaled three (3) narcotic cards with a total of ninety (90) tablets.

Review of Resident #5's MAR, dated 10/08/14 through 10/13/14, revealed Resident #5 received Oxycodone-APAP 5/325 mg as needed for pain. Resident #5 received his/her pain medications while living in the facility.

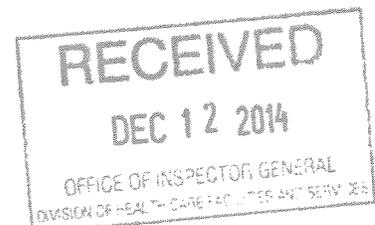
Review of Resident #5's narcotic count sheets, revealed the Oxycodone-APAP 5/325 mg thirty (30) tablets delivered on 10/07/14, 10/09/14 and 10/11/14, could not be accounted for.

Interview with Licensed Practical Nurse (LPN) #3 (who worked third shift), on 11/13/14 at 12:14 PM, revealed on the morning of 10/26/14 while conducting narcotic counts with LPN #1, she recognized there were three (3) 8 x 8 narcotic cards of medications for Resident #4 and Resident #5 located in the double locked narcotic box of the front B-Hall medication cart. LPN #3 stated when she came in for her shift the night of 10/26/14, LPN #4 passed her the medication cart keys and informed her to count the narcotics by herself because LPN #4 was too busy to complete the shift to shift narcotic count. LPN #3 stated she did not catch the discrepancy when she counted the narcotic cards by herself. LPN #3 stated during medication pass, the evening of 10/26/14 at 11:00 PM, she discovered Resident #4 and #5 narcotic cards were missing while giving another resident a pain medication. Both Residents #4 and #5 had been discharged home by this time. LPN #3 stated she then called the Director of Nursing (DON) to initiate an investigation. LPN #3 stated misappropriation of resident property was abuse.

F 224

shift basis. In addition the Director of Nursing conducts an audit of all narcotics delivered for the prior week to assure all were logged and accounted for. The Director of Nursing was educated on this process on 10-28-2014 by the Regional Director of Nursing. All current Licensed Nurses were educated on this package to count sheet process as well as conducting a narcotic count when changing cart or accepting a cart. This education was provided by the Regional Nurse Consultant or Director of Nursing or Assistant Director of Nursing and completed by 11-10-2014 with no licensed nurse working after 11-10-2014 without having received this education. Competency was validated through direct observation of staff counting and using the system. All facility staff will be re-educated on abuse and neglect including misappropriation with competency testing. This education will be via the facility electronic training program and will be completed by 12-27-2014 with no staff working after 12-27-2014 without having received this education.

4- The facility will audit narcotic packages to narcotic count sheet log daily for four (4) weeks followed by five (5) times per week for eight (8) weeks and then weekly thereafter. This audit will be completed by the Director of Nursing, Regional Nurse Consultant, and Assistant Director of Nursing or Weekend Nursing Supervisor. Results of these audits will be reviewed with the Quality Assurance and Performance Improvement Committee (QAPI) monthly. If at any time concerns are identified the QAPI committee will convene to review and make further



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F 224 Continued From page 4  
Interview with LPN #1, on 11/13/14 at 1:39 PM, revealed she could remember working the weekend of 10/26/14. LPN #1-stated LPN #3 normally worked night shift and would give her report when she came in to work during the morning shift. LPN #1 stated she never completed the narcotic count by herself. LPN #1 stated she had never taken any narcotics. LPN #1 stated she did not remember seeing three (3) 8 x 8 narcotic cards in the narcotic box. LPN #1 stated misappropriation of resident property was abuse and she would report that information right away to the DON.

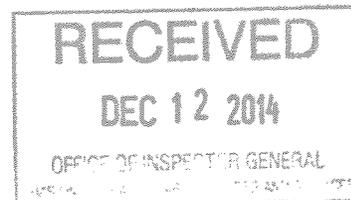
Interview with LPN #4, on 11/13/14 at 2:30 PM, revealed she worked the weekend of 10/26/14 and remembered she did not complete the narcotic count with LPN #3. LPN #4 stated she trusted LPN #3 and would pass her the narcotic keys to count by herself. LPN #4 stated she knew she was not suppose to count narcotics by herself because she could be held responsible when medications were missing. LPN #4 stated she had never taken narcotic medications from the narcotic box.

Interview with the DON, on 11/14/14 at 10:11 AM, revealed LPN #3 had called him the morning of 10/27/14 around midnight. The DON stated, on 10/27/14 at 5:00 AM, he called LPN #3 back to ensure she had completed a statement regarding the allegation. The DON stated he had reported the allegation of abuse to his Administrator on the morning of 10/27/14. The DON stated he and the Regional Nurse Consultant began interviewing the three (3) nurses (LPN #1, #3 and #4) who worked the weekend of 10/26/14 and completed a drug test on LPN #1 because she was already in the facility and called the other two nurses into

F 224 recommendations. The QAPI committee will consist of at a minimum the Director of Nursing, Assistant Director of Nursing, Administrator, Social Services Director, and Dietary Services Manager with the Medical Director attending at least quarterly.

5. Completion date of December 28, 2014

12-28-2014



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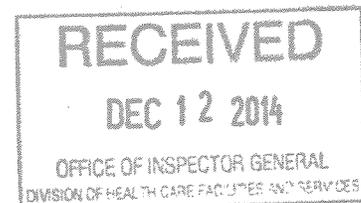
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F 224 Continued From page 5 F 224

the building to complete their drug tests. The DON stated the Regional Nurse Consultant then began completing audits of the narcotic cards and narcotic count sheets. The DON stated on Tuesday 10/28/14 they had identified diversion of medications had occurred and reported to all the required agencies.

Interview with the Regional Nurse Consultant, on 11/14/14 at 12:51 PM, revealed she became aware of the allegation of abuse on Monday morning of 10/27/14. The Regional Nurse Consultant stated she and the DON had begun to look at narcotic medications that had come up missing as to whether they had been destroyed already or if there was a narcotic control sheet laying around waiting to be filed in Medical Records. The Drug tests that were completed on LPN #1 and #4 had come back negative, but LPN #3's drug test was positive in which she was able to give the facility a list of her medications that she had been prescribed. Both LPN #3 and #4 had obtained disciplinary actions for not completing narcotic counts as directed. The Regional Nurse Consultant stated LPN #4 confessed to not completing the narcotic count with LPN #3. The Regional Nurse Consultant stated she called the Pharmacy and requested a print out of the narcotic medications that had been delivered in the last sixty (60) days.

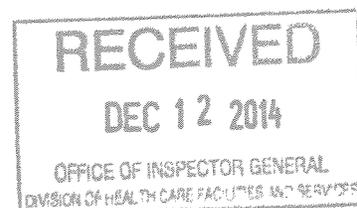
Interview with the Consulting Pharmacist, on 11/14/14 at 12:23 PM, revealed he came to the facility on 10/31/14 and conducted an audit. The Consulting Pharmacist stated he first verified the narcotic count sheets and then went through the MARS to identify if there was an order and or subsequent package in the narcotic box. The Consultant Pharmacist did not detect any



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F 224	Continued From page 6  discrepancies in the documentation of the narcotic count sheets or the number of dosages. The audit revealed the narcotic count sheets that were not located were for a resident who was already discharged or were for residents who had a change in the dosage of the narcotic medications.  3. Review of the active record for Resident #1, revealed the facility admitted the resident on 09/10/13 with diagnoses of Chronic Obstructive Pulmonary Disease, Peripheral Arterial Disease, Left and Right Above the Knee Amputations and Osteoarthritis.  Review of Resident #1's Physician Orders, dated 08/29/14, revealed an order for Norco 10/325 mg one (1) tablet by mouth every four (4) hours as needed for pain. On 10/03/14, the Physician discontinued the Norco 10/325 mg and ordered Oxycodone-APAP 5/325 mg one (1) by mouth every four (4) hours as needed for pain. On 10/20/14, the Physician discontinued the Oxycodone/APAP 5/325 mg and ordered Oxycodone-APAP 10/325 mg one (1) tablet by mouth every four (4) hours as needed for pain.  Review of the Controls Shipped Log, dated 08/29/14 through 10/28/14, revealed the pharmacy shipped one (1) Norco 10/325 mg narcotic card with thirty (30) tablets on 08/30/14, 09/06/14, 09/10/14, 09/16/14, 09/22/14, 09/27/14 and 10/01/14. The pharmacy also shipped Oxycodone-APAP 5/325 mg narcotic card with thirty (30) tablets on 10/06/14, 10/10/14, 10/14/14 and 10/18/14.  Review of Resident #1's MAR, dated 09/01/14	F 224			



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F 224 Continued From page 7  
through 09/31/14, revealed administered Norco 10/325 mg for twenty-seven (27) of the thirty-one (31) days of his/her admission. Review of Resident #1's MAR, dated 10/01/14 through 10/31/14, revealed the facility administered Oxycodone 5/325 mg fourteen (14) of the thirty-one (31) days of his/her admission and received Oxycodone 10/325 mg six (6) of the thirty-one (31) days of his/her admission.

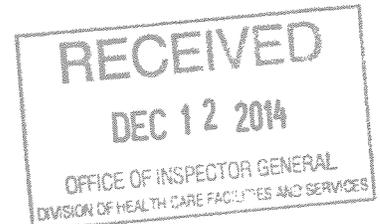
F 224

Review of the Narcotic Count Sheets revealed Norco 10/325 mg, containing thirty (30) tablets was delivered 10/01/14 and Oxycodone-APAP 5/325 mg, containing thirty (30) tablets was delivered 10/14/14, the facility could not account for either of the three narcotic cards.

Interview with Resident #1, on 11/12/14 at 11:00 AM, revealed he had no concerns with his/her pain medications. Resident #1 stated he/she always read the labels on the pills to identify that he/she received the right medications. Resident #1 stated no one had ever taken anything or physically harmed him/her in any way.

4. Review of the active record for Resident #2 revealed the facility admitted the resident on 06/08/12, with diagnoses of Below the Knee Amputation, Neuropathy and Muscle Weakness.

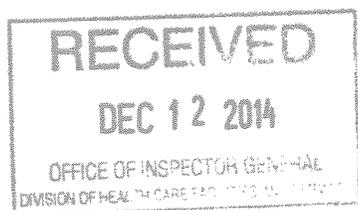
Review of Resident #2's Physician Orders, dated 09/04/14, revealed an order for Percocet 7.5/325 mg two (2) tablets by mouth at night and Percocet 7.5/325 mg two (2) tablets every six (6) hours as needed for pain. On 10/15/14, the physician ordered Oxycodone IR 15 mg one (1) tablet by mouth every four (4) hours as needed for pain. Review of Resident #2's Physician orders revealed Resident #2 was sent to the Emergency



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NAME OF PROVIDER OR SUPPLIER  BRANDENBURG NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 224	<p>Continued From page 8</p> <p>Room for evaluation and treatment on 10/25/14.</p> <p>Review of the Controls Shipped Log, dated 08/29/14 through 10/28/14, revealed the pharmacy shipped Oxycodone 15 mg IR containing thirty (30) tablets on 10/15/14, 10/20/14 and 10/23/14.</p> <p>Review of Resident #2's MARs, dated 09/01/14 through 09/31/14, revealed the facility administered Percocet 7.5/325 mg at night for thirty (30) of the thirty (30) days for the month of September. Review also revealed the facility administered Percocet 7.5/325 mg as needed eleven (11) of the thirty (30) days for the month of September.</p> <p>Review of Resident #2's MAR's, dated 10/01/14 through 10/31/14, revealed the facility administered Percocet 7.5/325 mg at night for thirteen (13) of the thirty (30) days for the October due to the fact the Percocet 7.5/325 mg had been discontinued on 10/13/14. Review of Resident #2's Oxycodone IR (immediate release) 7.5 mg revealed the facility administered the Oxycodone IR seven (7) of the fifteen (15) days it was ordered during the month of October.</p> <p>Review of the Narcotic Count Sheets for Resident #2, revealed the facility could not account for the Oxycodone 15 mg IR thirty (30) tablets delivered 10/01/14.</p> <p>Interview with Resident #2, on 11/12/14 at 12:58 PM, revealed Resident #2 had no concerns with receiving his/her pain medications. Resident #2 stated no one had every physically or verbally harmed him/her in any way.</p>	F 224	



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5. Review of the active record for Resident #3, revealed the facility admitted the resident on 09/16/13, with diagnoses of Multiple Sclerosis, Chronic Pain, Spasm of the Muscle and Muscle Weakness.

Review of Resident #3's Physician Orders, dated 09/18/14, revealed the facility administered Norco 7.5/325 mg one (1) tablet by mouth every six (6) hours as needed for pain.

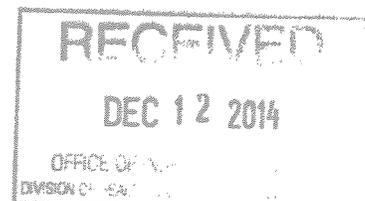
Review of the Controls Shipped Log, dated 08/29/14 through 10/28/14, revealed the pharmacy shipped Norco 7.5/325 mg card containing thirty (30) tablets on 09/02/14, 09/08/14 and 09/22/14.

Review of Resident #3's MAR's, dated 09/01/14 through 09/31/14, revealed the facility administered Norco 7.5/325 mg for eight (8) of the thirteen (13) days it was ordered in the month of September.

Review of the Narcotic Count Sheets for Resident #3, revealed Norco 7.5/325 mg thirty (30) tablets were delivered 09/08/14 and the facility could not account for the medications.

Interview with Resident #3, on 11/13/14 at 1:23 PM, revealed he/she had received his/her pain medications. He/she stated no there were no concerns with pain medications.

Interview with LPN #2, on 11/13/14 at 11:19 AM, revealed the narcotic cards and narcotic sheets stayed double locked in the narcotic box of the medication cart. The DON and Assistant Director of Nursing (ADON) would retrieve the narcotic cards and narcotic count sheets. The nurses



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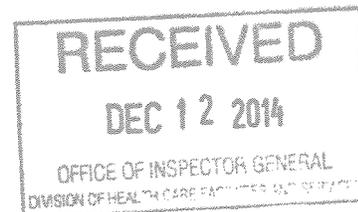
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were responsible to notify the DON or ADON when it was time to remove a narcotic card and count sheet from the narcotic box. The nurses did not have to sign off when the narcotic was removed from the narcotic box. LPN #2 stated if there was a change with a residents medications she would just have to assume the DON or ADON had removed the narcotic card from the narcotic box if she did not see the narcotic card the next day.

Interview with LPN #4, on 11/13/14 at 2:30 PM, revealed if a resident was discharged, the narcotics were given to the DON and the DON would destroy the narcotic medications. The nurses did not destroy the medications.

Interview with the ADON, on 11/13/14 at 3:08 PM, revealed she destroyed medications with the DON. The ADON stated when she and the DON would destroy narcotic medications they would only document on the narcotic count sheets. The narcotic count sheet would then be turned into medical records for filing. The ADON stated the nurses would inform her when it was time to destroy medications. However, the ADON stated she destroyed medications weekly.

Interview with the DON, 11/13/14 at 11:50 AM, revealed when a resident was discharged, the nurses would alert him and the ADON when a medications needed to be destroyed. He would then document the doses transferred for disposal, record the quantity, dated and sign with two signatures. The DON stated he would then turn the narcotic count sheets into medical records for filing. The DON stated it had only been him and ADON who destroyed medications.



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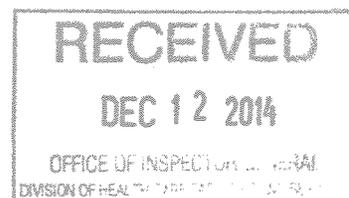
Interview with the Consulting Pharmacist, on 11/14/14 at 12:23 PM, revealed the DON should be able to see how many narcotic count sheets were printed and present, because there was a number at the top of the narcotic count sheet which indicated the number of sheets dispensed to the facility. The Consulting Pharmacist stated he had found if the narcotic medications stayed in one secured located it reduced the opportunity for someone to tamper with the narcotic medications, this process was at the facility's discretion.

Interview with the Regional Nurse Consultant, on 11/14/14 at 5:07 PM, revealed misappropriation was abuse. The Regional Nurse Consultant stated the facility would be charged for all medications that could not be accounted for.

Interview with the Regional Nurse Consultant, on 11/12/14 at 12:20 PM, revealed she and the Consultant Pharmacist completed narcotic count sheet audits 10/31/14. The Consultant Pharmacist completed the discharged residents audits and she completed the current resident audits.

Review of the audit, dated 10/31/14, revealed nine (9) active resident narcotic count sheets could not be accounted for and nine (9) discharged residents narcotic count sheets could not be accounted for. Through all of the audits of the MAR's all eighteen (18) residents received their medications.

Review of the Facility's charge list, in which the facility had to pay out of pocket for medications because they were either ordered too soon or were not present, revealed the facility was not



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charged for any narcotic medications since 09/01/14 to 11/14/14.

Observation of the Medication Pass, on 11/12/14 at 9:00 AM, revealed no medication errors were identified, narcotic count sheets were documented appropriately and no evidence of tampering with medications of four (4) of four (4) medication carts.

Further interview with the DON, on 11/14/14 at 4:44 PM, revealed when the pharmacy delivered narcotic medications, the nurse must first sign for the narcotic medications, place the narcotic sheet into the narcotic book and place the narcotic medication into the narcotic box of the medication cart. The DON stated there was no system in place which helped him to identify how many narcotic count sheets were delivered to ensure all narcotic sheets were accounted for before the destruction of narcotics. The DON stated the narcotic sheets for Residents #1, #2, #3, #4 and #5 were unaccounted for. The DON stated the narcotic sheets could have been misplaced or misfiled. The DON stated the narcotic count sheets were placed into the residents record once completed. Further interview with the DON, on 11/4/14 at 10:11 AM, revealed he was not aware there was a way for him to see how many narcotic cards were delivered and as far as he was aware there was no page number on the narcotic count sheet such as one (1) of two (2). The DON stated misappropriation of medications was abuse and needed to be reported immediately.

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