STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165524	A. BUILDING _____ B. WING _____	C 05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY LUTHERAN HOME	SEVEN ELLIOTT STREET COUNCIL BLUFFS, IA 51503

(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 Correction date 5/25/17 The following deficiencies were identified during investigation of mandatory report # 66399-M and facility-reported incident #67275-I conducted 4/17/17 - 5/4/17. See Code of Federal Regulations (42CFR, Part 483, Subpart B - C).	F 000	***"This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements."*** Correction date is May 25, 2017	
F 223 SS=G	483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(a) The facility must- (a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Related to investigation of facility-reported incident # 67275-I: Based on record review, facility policy and interviews, the facility failed to ensure one (1) of three (3) residents received adequate supervision to protect Resident #6 from resident to resident abuse by Resident #5. On March 30, 2017 Resident #6 and Resident #5 sat together in an	F 223	Each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of resident property, and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the resident's symptoms. Residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, family members or legal guardians, friends or other individuals.	5/25/17

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

COO 5/25/17

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.

POC accepted 5/26/17 KS

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F 223	Continued From page 1 unsupervised day room when Resident #5 inappropriately touched Resident #6. Record review revealed Resident #6 severely cognitively impaired. A reasonable person in these circumstances would feel assaulted and or violated if a person touched his/her body in the manner that Resident #5 did. The facility reported a census of 113 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/8/17 listed dementia, Parkinson's disease, seizure disorder/epilepsy, depression and schizophrenia as diagnoses for Resident #6. According to the Brief Interview for Mental Status (BIMS) assessment, Resident #6 scored 6 out of 15, which indicated a severe cognitive impairment. The MDS noted Resident #6 sometimes understood others and made him/herself understood. Resident #6 depended completely on staff to propel his/her wheelchair and required extensive assistance of two staff for all activities of daily living. The Care Plan noted an onset date of 3/26/17 noted Resident #6 had poor safety awareness and cognition related to diagnoses of dementia and Parkinson's disease and staff should anticipate the resident's needs as much as possible. The Care Plan also noted Resident #6 sometimes had difficulty interacting with others at times due to it making him/her uneasy. The Care Plan also instructed staff to develop a trusting relationship with Resident #6 and provide 1 to 1 as needed. Due to the inability to express pain, staff should monitor Resident #6 for nonverbal signs of discomfort and ensure the respect of	F 223	Regarding resident #5, the correction actions that were put in place were as follows: 1. Resident #5 was immediately separated from resident #6. 2. PIR (passive infrared) alarm was added to resident #5 doorway on 3/30/17 to notify staff when resident was out of his room to provide direct supervision. 3. Curtain was hung in doorway of resident #5 to provide additional privacy due to resident often masturbates in room. 4. Referral was made to Deer Oaks psychological services for resident #5 on 3/30/17. 5. Resident #5 was moved to a room on the main level on 3/31/17, (an open room was not available on 3/30/17). This room does provide more privacy and is on different level in the facility from resident #6. 6. Resident #5 was reviewed by pharmacy consultant and recommendation was made for Tagamet 400mg BID sexual disinhibition on 4/3/17.	

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F 223	Continued From page 2 his/her personal space. A progress note dated 3/30/17 at 9:55 a.m. revealed Resident #6 approached Resident #5 as he/she sat in the Green Garden Lounge. According to the progress note, Resident #5 put his/her hands down Resident #6's shirt and fondled his/her right breast. The residents were separated immediately. Resident #6 voiced concerns of being scared of Resident #5. A housekeeper had seen the incident and removed the resident from the situation. A progress note dated 3/30/17 recorded as a late entry 4/3/17 at 10:50 a.m. by the Assistant Director of Nursing (ADON) documented: this nurse spoke with Resident #6 after breakfast. When asked if Resident #6 ever felt scared or threatened by anyone while living in Bethany, the resident smiled and stated sometime he/she felt scared. The resident was unable to elaborate. When asked if anyone had ever touched him/her inappropriately, Resident #6 stated, "yes, a [man/woman] touched his/her breast today, and then he/she motioned to the top of her/his right breast. The ADON asked the resident if it hurt and when the resident said no, documented no apparent injuries noted. A progress note dated 3/30/17 at 11:55 a.m. by the SW (social worker) documented Resident #6 responded "yes" when the SW asked him/her if he/she felt scared following the incident. Staff made Resident #6 aware he/she would be moved and he/she smiled and said okay. 2. The Minimum Data Set (MDS) assessment dated 1/11/17 listed dementia and difficulty walking as diagnoses of Resident #5. According	F 223	7. A referral was made to a Geriatric Psychiatric Nurse Practitioner for resident #5 on 5/4/17. 8. Wanderguard was placed on w/c of resident #5 to ensure if resident goes to sit outside after meals that resident is supervised by staff. 9. The Geriatric Psychiatric Nurse Practitioner had an initial visit with resident #5 and ordered Zoloft 50mg daily secondary side effects benefit of sexual disinhibition and Nudexta 20mg daily x 7 days than 20mg BID-PBA with indication for sexual disinhibition goal. Regarding resident #6, the correction actions that were put in place were as follows: 1. Resident #6 was immediately separated from resident #5. 2. Resident #6 was assessed for injury on 3/30/17, and no injury was noted. 3. Resident #6 was moved to semi-private room on 3/30/17, which was across from the nurses station and away from perpetrator, resident #5.	

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F 223	Continued From page 3 to the BIMS (brief interview for mental status) aspect of the assessment, Resident #5 scored 15 out of 15, which indicated no cognitive impairment. The MDS noted that Resident #5 depended on the supervision of one staff to walk with a walker, but needed no supervision to self-propel his/her wheelchair throughout the facility. The 2/2/17 Care Plan identified that Resident #5 had socially inappropriate behavioral symptoms as evidence by pleasuring him/herself in community areas and in his/her room with the door open. The Care Plan instructed staff to assess whether the behavior endangered the resident and/or others, and intervene whenever necessary. According to the Care Plan, the resident should be redirected to his/her room if he/she had been in the common area while pleasuring him/herself and the door should be shut for privacy. The Care Plan also noted Resident #5's room had been rearranged on 2/2/17 to make it easier for him/her to close the door when in need of privacy. A Progress note dated 3/30/17 at 6:25 a.m. indicated Resident #5 had been sitting in the Green Garden Lounge with Resident #6. According to the document, Resident #5 approached Resident #6 and "went down the right side of Resident #6's shirt and fondled his/her breast. The note said that Resident #6 had been removed and Resident #5 had been taken to the dining room for breakfast. The progress note documented that a personal alarm had been placed on Resident #5's door.	F 223	4. Bereavement charting, which provides extra support was initiated on resident #6 on 3/30/17, and continues weekly. Various staff from each shift and other departments were interviewed by DON or designee to identify any residents that are exhibiting sexually inappropriate behaviors. Through these interviews, and a review of medical records, the facility has identified residents with sexually inappropriate behaviors. Residents identified will also have a sexual inhibition behavior investigation form completed in which will include a root cause analysis (RCA). Identified residents have had additional interventions care planned and interventions communicated to staff that are appropriate. This was completed by 5/25/17. The pre-admission assessment form was updated to include any history of sexually inappropriate behaviors. This form was updated on 5/23/17.	

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F 223	Continued From page 4 A fax sent to the physician by the ADON on 3/30/17 noted that Resident #5 had been exhibiting increased sexually inappropriate behaviors as evidence by masturbating in the doorway of his/her room or with the door of his/her open. The document also noted that staff continued to encourage the resident to do it in the privacy of his/her room with the door closed, but often without success. According to the document, the resident had a history of touching female staff in a sexually inappropriate manner, and touched a resident's breast on 3/30/17. The ADON requested an order for a medication for "sexual disinhibition". A Progress Note dated 2/7/17 at 6:25 p.m. noted that Resident #5 "tries to touch females in an inappropriate manner and him/herself with the door open". The progress note indicated that Resident #5 had remained out of the dayroom due to the behavior, and had been encouraged to close the door to his/her room while "pleasuring self". A Progress Note dated 2/2/17 at 1:49 p.m. documented that the DON (director of nursing) spoke to Resident #5 to ensure closure of door when he/she pleasured him/herself. The progress note indicated the room had been rearranged to ensure the door could close easily. A Progress Note dated 1/30/17 at 10:50 a.m. documented that Resident #5 had been observed in the day room at 8:45 a.m. in his/her wheelchair next to peers. The author noted that Resident #5 had been redirected to his/her room at that time without difficulty. The author also noted that at 10:35 a.m. Resident #5 had been seen sitting in his/her recliner in his/her room playing with	F 223	A form currently in use titled, "I reported the following to the nurse", was updated on 5/24/17, to include "behaviors", and this form will now be used in all departments. Education with nursing staff and other departments on "preventing and managing inappropriate behaviors" was completed by DON or designee by 5/25/17, staff that have not received education by 5/25/17, will receive it before working the floor by DON or Designee. Education with staff from all departments have been re-educated on reporting abuse, reporting behaviors and reporting any sexual behaviors and all staff were educated on the, "I reported the following to the nurse form". Charge nurses were also educated in documenting these behaviors and reporting them on the 24 hour report sheet, which the DON or designee reviews. Staff that have not received education by 5/25/17, will receive education before working the floor by DON or Designee.	

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F 223	Continued From page 5 his/her genitals. The author stated the bedroom door had to be closed to ensure privacy. A Progress Note dated 10/7/16 at 5:06 p.m. noted that Resident #5 "will touch female staff inappropriately at times and needed to be redirected" to abstain from doing that. A Progress Note dated 9/7/16 at 6:39 p.m. noted that Resident #5 had been inappropriate with peers and female staff at times. A Progress Note dated 8/7/16 at 1:02 p.m. noted that Resident #5 needed to be reminded to change clothes when they are soiled and had inappropriate sexual actions within view of others. The staff indicated the resident needed reminds to go to a private area. A Progress Note dated 7/22/16 at 8:46 p.m. noted that another nurse reported that Resident #5 "slapped the laundry lady on the butt". The author indicated she educated the resident about being appropriate. A Progress Note dated 6/4/16 noted that a CNA reported that Resident #5 had been seen shaving another resident, and that Resident kissed Resident #5 on the cheek. An interview on 4/20/17 at 9:45 a.m. Staff F, Housekeeper revealed she saw Resident #5 touching Resident #6's breast on 3/30/17 at about 7:30 a.m. Staff F said as she prepared to start cleaning a about ½ way down the hall where she noticed Resident #5 sitting in his/her wheelchair, she became suspicious when she noticed him/her looking around. According to Staff F, Resident #5 had a tendency to masturbate in	F 223	The Don or Designee will audit documentation on residents identified with behaviors from staff interviews, the "I reported the following to the nurse" forms, or the 24 hour report sheets 2x weekly x4 weeks, then weekly x4 weeks. Results of these audits will be reported to the QAPI meeting monthly, and the QAPI committee will then determine the continuation of audits.	

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his/her room with the door wide open. Staff F said he/she seemed to enjoy it when other people saw him/her masturbating. Staff F stated that Resident #5 leaned way over in his/her wheelchair and extended his/her arm outward. Because of the resident's history, Staff F said she walked up behind Resident #5 and observed his/her hand down through the neck of Resident #6's shirt rubbing the top of Resident #6's breast in a circular motion. They were both in wheelchairs. Staff F stated Resident #6 seemed "scared to death" with his/her head hung down and drool running out of his/her mouth. According to Staff F, Resident #6 did not respond well to people anyway. Staff F said she worked at the facility since 2004 and knew Resident #6 very well. Staff F explained she focused more on what Resident #5 had done. Staff F said she asked Resident #5,
"What do you think you're doing? Keep your hands to yourself." According to Staff F, Resident #5 promptly left. She said there are a lot of vulnerable residents down in that lounge that cannot defend themselves. She said those residents depend on staff to do almost everything for them. Staff F said she had seen Resident #5 touching other residents on their arms. Staff F said Resident #5 had not touched those other residents in the same way he/she touched Resident #6, but only because opportunity had not presented itself to him/her yet. Staff F said she reported the incident of Resident #5 touching Resident #6 to the nurse. According to Staff F, the ADON came to her and asked for a written statement, which she gladly submitted. Staff F said they moved Resident #5 upstairs and put an alarm on Resident #5's door to know when he/she left his/her room. Staff F said she had previously seen Resident #5 masturbating in

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F 223	Continued From page 7	F 223		

his/her room with the door open. She told the facility and they just told her that the resident had rights and to shut the door. According to Staff F, Resident objects to people closing door and will reopen it and continue to masturbate. Staff F said Resident #5 had been masturbating with the door ever since being admitted to the facility. She said the facility finally hung a privacy curtain about the time of the 3/30/17 incident so people that walked by the room could not see him/her.

An interview on 4/19/17 at 4:25 p.m. with Staff E, CNA (certified nurse's assistant) revealed that Resident #5 had been moved to the 2nd floor about a month ago because he touched Resident #6's breast. She stated Resident #5 had a history of inappropriate sexual behaviors. She said the resident had a tendency to masturbate with his/her door open, and did not seem to care if anyone saw him/her. The CNA said she worked both upstairs and downstairs. She stated she has been instructed to redirect Resident #5 to his/her room if she saw the resident masturbating in a common area, but had never been told to shut the door to his/her room.

An interview on 4/20/17 at 10:50 a.m. with Staff D, LPN revealed that she had been warned about Resident #5 when she oriented as an LPN. According to Staff D, Resident #5 asked her very forward and asked very intimate and graphic questions. Staff D said the resident had never touched her, nor had she ever seen him/her touching any other resident. She said Resident #5 had been moved upstairs about a month before. According to the LPN, she heard Resident #5 had his/her hand in Resident #6's shirt touching his/her breast. The LPN said she did not know of

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any other incidents where Resident #5 had touched other residents. Staff D said at some point they hung a curtain in his/her room that so people that walked by wouldn't see him/her when he/she lived downstairs. According to Staff D, they moved him/her back upstairs after he/she touched Resident #6. The LPN said they alarmed door after the incident.

An interview on 4/27/17 11:15 a.m. with Staff G, RA (Restorative Aide) revealed last October or November she saw Resident #5 in the Garden Lounge rubbing another resident's arm back and forth. According to the RA, they were the last 2 residents that waited unsupervised in the lounge to go back to their rooms after a meal. When the RA returned to the lounge and noticed Resident #5 rubbing another resident's arm, he/she stopped when he/she realized the RA had been watching. Staff G said the other resident slept through it without waking up, and then the RA took that resident to his/her room. Staff G said she mentioned what she saw to other aids who no longer worked at the facility (Staff J, CNA and Staff O, CNA). The RA said she could not remember to which nurse she reported what she saw. The RA said she never even knew Resident #5 touched Resident #6. According to the RA, she had only been told about an incident between them and not to leave Resident #5 and Resident #6 alone together. The RA denied ever having seen Resident #5 touching or talking inappropriately to staff or residents. Staff G said she had never been informed Resident #5 had talked or behaved inappropriately to staff or other residents. The RA said before this incident, she had never attended an in-service or been told that she needed to keep an eye on Resident #5 or to keep him/her away from vulnerable residents.

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F 223	Continued From page 9 Staff G said she had been told to close Resident #5's door if she saw the resident masturbating with the door open. An interview on 4/27/17 at 12:20 p.m. with the Activity Director revealed that she had worked for the facility for about 2 years. She could not remember exactly when, but she expressed concern to the DON sometime around last Christmas, give or take a couple months. The Director said Resident #5 frequently masturbated with the door of his/her room open. She expressed concern that children might see him/her because of how frequently they visited throughout the year. The Director said the one in back might reach up and touch the back of the other one's neck and smile. The Director said she heard that Resident #5 inappropriately touched another resident in the Garden Lounge. She stated she did not know who or where they had been touched. Since the incident she had been told Resident #5 should be accompanied to and from all activities, supervised during the activity and kept far enough away from vulnerable residents they cannot physically be touched by Resident #5. An interview on 4/24/17 at 1:10 p.m. with Staff I, LPN revealed that she knew that Resident #5 masturbated frequently while residing downstairs. The LPN said it happened for a quite a long time before they put a curtain up. An interview on 4/27/17 at 11:55 a.m. with the DON revealed the Activities Director expressed concern last February about the high probability of kids that visited the facility seeing Resident #5 masturbating. When asked, the DON explained about delays that hindered her efforts to provide a	F 223		

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F 223	Continued From page 10 more discreet environment for Resident #5 to masturbate She said a curtain had finally been hung in his/her room right before Resident #5 had been moved upstairs on 3/31/17. An interview on 4/27/17 at 1:15 p.m. with Staff J, CNA (ex-employee) revealed that she worked at the facility for 7 years, and quit 4 months ago. Staff J said Resident #5 could be inappropriate at time. She recalled he/she grabbed at "my privates. According to Staff J, Staff G told her Resident #5 grabbed her breasts before too. Staff J said her old boss, (Staff L, Restorative Supervisor) had told her to keep an eye on Resident #5 because he/she lifted another residents shirt up downstairs between Oakridge and Maplewood. According to Staff J, Staff L relayed that information for the resident's protection. Staff J could not remember exactly when she received the information, but thought about 6 months before she went on maternity leave in August 2016. Staff J believed the ADON, Staff P and another MDS Coordinator brought it up during a staff meeting. She said they explained what to watch for and how to prevent Resident #5 from doing it to other residents. She said they virtually said Resident #5 should be supervised at all times and should not be left unattended with vulnerable residents. As she recalled, Staff J said Resident #5 seemed to be focused on residents that could not fend for themselves or remove themselves from a situation. Staff J said Resident #5 tried touching other vulnerable residents too, but they intervened before anything happened. The CNA said she reported it to the nurse. An interview on 4/27/17 at 2:00 p.m. with Staff K,	F 223		

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BETHANY LUTHERAN HOME	SEVEN ELLIOTT STREET COUNCIL BLUFFS, IA 51503

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LPN revealed her explanation about a progress note she entered on 2/7/17 at 6:25 p.m. The entry documented "only behaviors noted Resident #5 tried to touch females inappropriately and him/herself while his/her door is open. Staff K stated he/she had remained out of day room due to behaviors. Encouraged to close door to room while pleasuring him/her(self)." Staff K said a lot of staff have seen Resident masturbating with his/her door open. Staff K denied ever making the same observations. She said they tried keeping the resident out of the Garden Lounge because he/she had been seen masturbating in front of peers, and it had been happening more frequently. Staff K said a curtain had been added to his/her room downstairs about a month before being moved upstairs. When this surveyor attempted to contact Staff K about other progress notes she authored on 10/7/16, 9/7/16 and 6/4/16, contact could not be made.

An interview on 5/1/17 at 4:55 p.m. with the DON the only thing that had ever been reported to her about Resident #5 being sexually inappropriate towards female staff was when he/she "slapped the laundry lady on the butt" last July. The DON said she attempted to get a curtain in Resident #5's room about 6 months before it actually got hung. She said she talked to the Maintenance Director, who said it could not be done because of the location of the sprinklers. The DON said when the Activity Director expressed concern about kids seeing Resident #5, she pushed to have the curtain hung again. She stated the last time she brought it up she involved the Administrator.

An interview on 5/2/17 at 8:00 a.m. with Staff L, Restorative Supervisor revealed what she knew

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about Resident #5's history. She stated that Staff G reported the resident had been seen masturbating in Garden Lounge. Staff L also recalled that Resident #5 had always been aggressive with Staff J. Staff L denied she had knowledge that Resident #5 had lifted another resident's shirt prior to the 3/30/17 incident between Resident #5 and Resident #6.

An interview on 5/2/17 at 8:15 a.m. with Staff M, LPN revealed her explanation regarding a progress not she authored on 1/30/17 at 8:45 a.m. that read "8:45 a.m. after breakfast Resident #5 had been observed in day room in wheelchair next to female peers. Resident had been redirected back to room without difficulties. 10:35 a.m. Resident #5 observed sitting in recliner in room playing with genitals. Bedroom door closed for privacy." Staff M said she saw Resident #5 in the day room with his/her hand down his/her pants so I redirected him/her back to his/her room. The LPN explained because of Resident #5's history, she did not want him/her to start masturbating and create an uncomfortable environment for the other residents sitting in the day room. The LPN said she heard that Resident #5 had been seen masturbating in the day room, but she had never witnessed that. When asked, the LPN said she did not have any knowledge that Resident #5 had ever inappropriately touched another resident. Staff M said she knew about the door alarm and to walk to and from meals with Resident #5, but she had never been told to always supervise him/her and never leave him/her unattended with vulnerable residents. Staff M said she just does that because she knows to be safe rather than sorry.

An interview on 5/2/17 at 1:45 p.m. with Staff O,

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F 223	Continued From page 13 CNA (ex-employee) revealed that she worked at the facility for about 4 years, but quit about 2 years ago. Staff O said she remembered Resident #5's name and remembered him/her making weird inappropriate comments to other residents that were sexual in nature. She stated she could not remember specifics. An interview on 5/2/17 at 9:00 a.m. with Staff P, RN/MDS Coordinator revealed she did not know of any other incidents where he/she had either touched or talked inappropriately to staff or other residents. Staff P said that since the incident with Resident #6, staff have been instructed to supervise Resident #5 anytime he/she left his/her room. Staff P said his/her door had since been equipped with an alarm too. Staff P said she knew Resident #5's Care Plan contained the information now too. She said certain things automatically pop up on the CNA's computers for them to read and sign off on every shift, so they do not have an excuse for not being informed. An interview on 5/2/17 at 11:10 a.m. with Staff R, RA revealed that she had never heard about Resident #5 masturbating in his/her room, nor had she ever seen him/her doing it. She said they recently said to watch him/her, and if he/she left the dining room staff should assist him/her back to his/her room. According to Staff R, they had never told her not to leave him/her unsupervised, nor did they make it clear that she should take responsibility to supervise him/her if she happened to see him/her outside of his/her room without supervision. An interview on 5/2/17 at 12:45 p.m. with the Administrator revealed what he knew about	F 223		

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F 223	Continued From page 14 Resident #5's sexual behavior. According to the Administrator, Resident #5 masturbated in his room with the door open, but otherwise kept to him/herself. He said that the resident never showed much interest in anything else. When this surveyor informed the Administrator what many other interviews revealed, he said if he had information that indicated Resident #5 might inappropriately touch another resident, he would have expected staff to implement the necessary interventions to protect the residents. An interview on 5/3/17 at 8:00 a.m. with Staff U, LPN revealed that she worked at the facility for about 2 years. Staff U said she used to work all over the building until about a month ago, but now she primarily worked the hallway that Resident #5 lives on. She said she had never been told that Resident #5 had sexual tendencies and if she saw him/her exhibiting them, she should intervene in a particular way. Staff U said she knew Resident #5 had been moved upstairs because he/she touched another resident's breast. According to Staff U, the ADON said he/she needed to be supervised outside of his/her room. An interview on 5/3/17 12:45 a.m. with the ADON revealed that nobody ever told her that Resident #5 lifted another resident's shirt about a year before the 3/30/17 incident between Resident #5 and Resident #6. The ADON also said she had not conducted an in-service or staff meeting that informed staff about the incident in question or instructed staff on how to intervene to prevent Resident #5 from assaulting other residents. The January 12, 2017 Abuse Policy documented	F 223		

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F 223	Continued From page 15 all residents had the right to be free from abuse (sexual &mental). The Policy identified that Abuse is defined differently under Federal and State laws and included the following key definitions that should be considered when determining whether an event constitutes abuse. Resident abuse under the Federal guidelines means the willful infliction of injury, and included intimidation or mental anguish. This policy revealed this presumes that instances of all Residents even those in a coma, cause physical harm, pain or mental anguish. Sexual Abuse includes but is not limited to sexual harassment or sexual assault. The policy identified resident to resident sexual harassment, or sexual assault is also considered abuse.	F 223		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and	F 431	Staff A was terminated on 2/21/17. All controlled substances (Schedule II medications) that are received must be added to the Q-MAR narcotic count by two licensed nurses. The previous process was done by having one licensed nurse add schedule II medications to the Q-MAR narcotic count. This updated procedure was initiated on 2/20/17. The delivery manifest that is faxed over directly from the pharmacy, which shows what type of schedule II medication(s) and the amount delivered, is checked by a third licensed nurse.	5/25/17

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F 431	Continued From page 16 disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Related to investigation of Mandatory report # 66399-M: Based on record review, facility policy and interviews, the facility failed to ensure adequate drug safeguards for handling deliveries of	F 431	The third licensed nurse must initial the manifest to ensure all controlled substances (schedule II medications) were added to the narcotic count in Q-MAR. The third licensed nurse cannot be one of the two nurses who added the schedule II medications into the Q-MAR. This procedure was initiated on 2/20/17. Nurses were trained on this process change from 2/20/17 through 2/28/17, as nurses were scheduled. This new process was also reviewed during the nurses meeting on 2/28/17. In addition to the changes made above: 1. The Medication Controlled Substance Documentation policy was updated 3/13/17. 2. Controlled Substance Destruction policy was updated 3/13/17. 3. Medication Controlled Substance Count policy was updated 3/13/17. The pharmacy manifests are sent to the Director of Nursing or designee for safe keeping and monitoring purposes.	

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F 431	Continued From page 17 Schedule II medication Norco had been validated by a 2nd employee or added to the running inventory count and secured for 4 of 42 residents (Residents #1, #2, #3, #4) who had Norco medications stolen throughout a year. Interviews with the DON and ADON revealed two nurses had not been required to check deliveries that contained narcotics and no one completed audits of narcotic counts or the newly received medication from the pharmacy. Findings include: According to the facilities policy Medication Administration/Controlled Substance Document dated 6/2/11, instructed staff that received narcotics from the pharmacy complete an "administration Record for Controlled Substances" sheet for the narcotic medication received. The policy indicated the narcotic medication must be counted and the form signed and receipt in the delivery person's presence before they left the facility. The policy did not require a 2nd staff person witness receipt of narcotics delivered, adding the narcotics into the inventory count and storage of the narcotic delivery. 1. According to the face sheet, Resident #1 had initially been admitted to the facility on 10/30/2009; and most recently admitted on 10/27/17. The face sheet also noted that Resident #1's diagnosis included rheumatoid arthritis. A Physician's Telephone Order dated 11/30/16 ordered one Norco 5 milligrams (mg)/325 mg	F 431	The DON or designee will monitor this process by printing a separate delivery manifest from the Q-MAR system 2x weekly for 8 weeks, then weekly for 4 weeks to ensure schedule II medications are all accounted for. Results of these audits will be submitted to the monthly QAPI meetings, and the QAPI committee will then determine continuation of audits.	

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F 431	Continued From page 18 tablet, by mouth every 4 to 6 hours as needed for pain. Norco is a compound of Hydrocodone/Acetaminophen narcotic pain medication. (According to the US National Library of Medicine, Daily Med Norco-hydrocodone bipartite and acetaminophen tables is considered a Controlled Substance and is classified as a Scheduled II controlled substance.) The Quick MAR/Inventory History form noted all Norco 5 mg/325 mg deliveries, administration, and reconciliation (counted by on-coming and off-going nurses at shift change) for Resident #1's Norco from 11/30/16 through 2/6/17. The MAR documented the initial delivery of 30 pills added to the count on 11/30/16 and adjusted the count as medication had been administered and/or delivered. The MAR indicated the other 6 deliveries of 30 Norco 5 mg/325 mg tablets received by Staff A, RN (registered nurse) from 12/14/16 through 1/30/17 had diverted instead of being added to the running inventory count. The Proof of Delivery list provided by the pharmacy noted that Staff A, signed for and received 6 deliveries of 30 Norco 5 mg/325 mg tablets intended for Resident #1's use on 12/14/16, 12/28/16, 1/3/17, 1/11/17, 1/19/17 and 1/30/17 respectively. 2. According to the face sheet, Resident #2 had initially been admitted to the facility on 7/14/2011; and most recently admitted on 1/22/17. The face sheet also noted that Resident #2's diagnosis included neuropathy.	F 431		

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F 431	Continued From page 19 The Refill Request for Continuing Therapy form indicated a quantity of 60 Norco 10 mg/325 mg tablets for Resident #2 to take one by mouth every 6 hours as needed for pain had been authorized and signed by the physician on 1/7/16. A Request For Continuing Therapy for Long Term- Care Patient form revealed a refill request for a quantity of 180 Norco 10 mg/325 mg tablets for Resident #2 to take one by mouth every 6 hours as needed for pain had been authorized and signed by the physician on 3/31/16. A Request For Continuing Therapy for Long Term- Care Patient form revealed a refill request for a quantity of 180 Norco 10 mg/325 mg tablets for Resident #2 to take one by mouth every 6 hours as needed for pain had been authorized and signed by the physician on 5/26/16. A fax request for Norco 10 mg/325 mg that had been prescribed for Resident #2 since 11/28/14 had been authorized to discontinued (DC'd) by the physician on 9/1/16 because the resident had never taken the medication. An 11/3/16 physician's telephone orders for Resident #2 to resume taking one Norco 10 mg/325 mg tablet by mouth every 6 hours as needed for pain had been authorized by the physician. The Quick MAR/Inventory History for all Norco deliveries, administration, and reconciliation for Resident #2's Norco 10 mg/325 mg from 2/25/16 through 2/18/17. The MAR documented a continuous inventory count of zero on 2/25/16 through 7/31/16, which indicated that Resident #2 had not taken any pain medication during that	F 431		

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time span. The MAR documented 30 Norco 10 mg/325 mg tablets had been delivered and added to the count on 7/31/16. The MAR reflected a continuous inventory count of 30 tablets from 7/31/16 through 9/1/16, which reflected that Resident #2 had not taken any of the pain medication during that time span. Thirty Norco 10 mg/325 mg tablets had been discarded and subtracted from the count on 9/1/16 because the physician ordered them discontinued for not being used.
The MAR documented 12 Norco 10 mg/325 mg tablets had been delivered and added to the count on 11/3/16 as a result of the 11/3/16 Doctor's order for Resident #2 to resume taking one Norco 10 mg/325 mg tablet by mouth every 6 hours for pain. The MAR documented a continuous count of 12 tablets on 11/3/16 through 2/18/17 which indicated Resident #2 had not taken any of the pain medication during that time span. The MAR indicated the other 23 deliveries of 30 Norco 10 mg/325 mg tablets received by Staff A from 3/7/16 through 2/9/17 had not been added to the running inventory count.

The Proof of Delivery list provided by the pharmacy noted that Staff A signed for and received 23 deliveries of 30 Norco 10 mg/325 mg tablets intended for Resident #2's use on 3/7/16, 3/28/16, 4/11/16, 4/25/16, 5/9/16, 5/23/16, 6/14/16, 6/23/16, 7/5/16, 7/18/16, 8/10/16, 8/23/16, 8/30/16, 11/7/16, 11/21/16, 11/30/16, 12/8/16, 12/20/16, 12/30/16, 1/5/17, 1/16/17, 1/25/17, and 2/9/17 respectively.

3. According to the face sheet, Resident #3 had initially been admitted to the facility on 3/17/2008; and most recently admitted on 1/29/17. The face sheet also noted that Resident #3's diagnoses

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F 431	Continued From page 21 included osteoarthritis of both knees and disorders of bone density and structure. A New Physician's Order dated 7/9/15 ordered 30 Norco 5 mg/325 mg tablets for Resident #3 to take one by mouth 4 times a day as needed for pain. A New Physician's Order dated 8/3/15 ordered 120 Norco 5 mg/325 mg tablets for Resident #3 to take one by mouth 4 times a day as needed for pain. A Physician's Telephone Order dated 11/22/16 ordered Norco 5 mg/325 mg be discontinued and changed to one (1) to two (2) tablets Norco 7.5 mg/325 mg to taken by mouth every 4 to 6 hours as needed for pain. A Physician's Telephone Order dated 11/23/16 ordered one or two Norco 7.5 mg/325 mg every 4 to 6 hours be discontinued and changed to one to two tablets Norco 5 mg/325 mg to be taken by mouth every 4 to 6 hours as needed for pain. A Physician's Telephone Order dated 3/6/17 ordered one Norco 5 mg/325 mg to be taken by mouth twice a day. The MAR noted all Norco deliveries, administration, and reconciliation for Resident #3's Norco 5 mg/325 mg from 4/12/16 through 2/9/17. The MAR indicated that the other 24 deliveries of 30 Norco 5 mg/325 mg tablets and 2 partial deliveries of Norco 5 mg/325 mg tablets received by Staff A from 4/25/16 through 2/9/17 had not been added to the running count. The Proof of Delivery list provided by the pharmacy noted that Staff A signed for and	F 431		

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F 431	Continued From page 22 received 24 deliveries of 30 Norco 5 mg/325 mg tablets intended for Resident #3's use on 4/25/16, 5/2/16, 5/9/16, 5/24/16, 6/9/16, 7/14/16, 7/25/16, 8/8/16, 8/18/16, 8/29/16, 9/8/16, 9/15/16, 9/22/16, 9/29/16, 10/19/16, 11/10/16, 11/21/16, 11/30/16, 12/13/16, 12/22/16, 12/27/16, 1/11/17, 1/23/17, 1/30/17, respectively and partial deliveries of 8 Norco 5 mg/325 mg tablets on 1/19/17 and 20 Norco 5 mg/325 mg tablets on 2/19/17. 4. According to the face sheet, Resident #4 had initially been admitted to the facility on 10/2/2014; and most recently admitted on 9/15/16. The face sheet also noted that Resident #4's diagnoses included dementia and a history of right leg fracture. A Physician's Telephone Order dated 7/17/16 ordered Resident #4 to take one to two Norco 5 mg/325 mg tablets by mouth every 6 hours as needed for pain. A Physician's Order dated 9/15/16 ordered 60 Norco 5 mg/325 mg tablets for Resident #4 to take one by mouth every 6 hours as needed for pain. A Physician's Telephone Order dated 9/16/16 ordered Norco 5 mg/325 mg be discontinued and for Resident #4 to take one Norco 7.5 mg/325 mg tablet by mouth every 4 hours as needed for pain. The Quick MAR/ Inventory History noted all Norco deliveries, administration, and reconciliation for Resident #4's Norco 5 mg/325 mg and 7.5 mg/325 mg tablets from 7/17/16 through 2/10/17. The MAR indicated that the other 24 deliveries of 30 Norco 5 mg/325 mg tablets and 2 partial deliveries of Norco 5 mg/325 mg tablets received	F 431		

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by Staff A from 4/25/16 through 2/9/17 had not been added to the running count.

The Proof of Delivery list provided by the pharmacy noted that Staff A signed for and received 17 deliveries of 30 Norco 5 mg/325 mg tablets and 30 Norco 7.5 mg/325 mg intended for Resident #4's use on 7/25/16, 8/5/16, 8/16/16, 8/29/16, 9/22/16, 9/26/16, 10/11/16, 10/18/16, 11/21/16, 11/30/16, 12/19/16, 12/27/16, 1/6/17, 1/16/17, 1/30/17, 2/6/17 and 2/9/17 respectively.

A urine specimen had been submitted by Staff A on 2/19/17, which tested positive for the use of Hydrocodone.

A printed copy of a text message correspondence between the Director of Nursing (DON) and Staff A on 2/21/17 at 9:29 a.m. revealed: Staff A expressed she was relieved the DON found out so she could get the help. Staff A's message said she had taken idk (I don't know) how many mg every day just to cope with her pitiful [life]. Staff A went on to say she knew she could not detox by herself. Staff A said she's an addict. [According to the prior text message, Staff A implied she had taken an unspecified dose of Norco on a daily basis.]

A letter dated 2/21/17 and signed by the Human Resource Coordinator informed Staff A that her employment had been terminated due to the circumstances of the active investigation and the confession she texted to the ADON that morning.

A Second Written Warning dated 9/15/16 documented Staff A failed to perform job responsibilities reasonably and properly as evidenced by the administration of injectable

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morphine orally to a resident on 9/15/16. According to the document, further violations would result in suspension and up to termination.

A written warning dated 7/22/15 indicated Staff A failed to perform job responsibilities reasonably and properly as evidenced by failure to complete thorough and correct narcotic counts of controlled substances. According to the document, 11 Ativan (anti-anxiety medication) gel syringes had been removed and given to and destroyed by the previous DON prior to 7/4/15. The warning noted that instead of visually verifying how many of the syringes there actually were, Staff A continued to write there were 11 syringes instead of adjusting the count.

A written warning dated 5/26/15 noted concern areas as false documentation, copying and pasting the same documentation 2 days in a row and not following clinical condition forms for skilled residents which resulted in documenting incorrect therapy disciplines for a skilled resident. The warning indicated that failure to improve would result in further disciplinary action, up to and including termination.

Written notification dated 5/23/15 documented Staff A failed to document multiple medications and treatments prior to the conclusion of her shift. The document warned that further non-compliance would result in disciplinary action up to and including termination.

A written warning dated 10/7/13 noted that Staff A had been reprimanded for administering two Norco tablets when only one had been ordered; failing to administer bed time medication for a resident, administering PRN (as needed) Norco

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F 431	Continued From page 25 instead of Tylenol #3 (Tylenol with Codeine (narcotic pain medication)) and for administering a medication to a resident that had been allergic to it. Interviews : An interview on 4/19/17 at 8:00 a.m. with the ADON (assistant director of nursing) revealed Skyline hallway is the only place Staff A worked. The ADON said Staff A had been there for about 3 years. The ADON said they have used the same narcotic reconciliation software for about 6 years, and it always required 2 people to verify narcotics at shift change. She said staff that received narcotic deliveries from the pharmacy had not been required to verify the deliveries and add them to the inventory count with a 2nd person. The ADON said Staff A had been a huge advocate for the residents and was shocked to realize what she had been doing. The ADON said she never saw any red flags along the way. The ADON said they wondered how pharmacy did not detect the diversion. An interview on 4/19/17 at 9:00 a.m. with the ADON revealed that Staff B first discovered missing Norco on 2/17/17. According to the ADON, a resident asked Staff B if he/she had enough pain medication for the next day. The ADON said Staff B checked the MAR and saw that none were added to the count. The ADON said Staff B checked the delivery manifest, which indicated 30 Norco tablets had been delivered. The ADON said Staff B checked 3 other residents that each had 30 Norco tablets delivered too, but none had been added to the MAR. According to the ADON, 120 Norco tablets were not accounted for. The ADON said the DON came in the next	F 431		

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day and started the investigation. The ADON did not know if Staff B called the DON that night. According to the ADON, the DON had someone from the pharmacy here to help with the investigation. The ADON said they interviewed residents to see if they got their pain medication and if it helped and they all said yes. The ADON said she came in on 2/19/17 with the DON. She said they had been in contact with the pharmacy, at which time the pharmacy concluded that probably only one person had caused the diversion. The ADON said before the pharmacy identified that, they spent a lot of time looking through the MARs. The ADON said Staff A had ordered about 11 or 12 cards of 30 Norco 10 mg/325 mg tablets for Resident #2, although he/she had only taken about 1 pill during that time frame. When asked how many pills could be dispensed at one time for each resident, the ADON said it depended on how many the physician ordered be dispensed and how many the payer would cover. The ADON said after about 3 months of non-use the physician should be consulted to see if he wanted to discontinue the medication. The ADON said apparently Staff A contacted the physician to have the order renewed by telling them the resident's pain continued, gotten worse or started again. The ADON said Staff A stole Norco when she received deliveries, but did not add them into the running inventory count. She said they did not require a 2nd nurse to verify each delivery at that time, but they do now. The ADON said they checked as far back as 2014. She said they discovered the 1st Norco went missing in February 2016, and a pattern developed from that point until Staff A had been terminated in February 2017. According to the ADON, Staff A had taken about 9000 pills over that year.

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F 431	Continued From page 27 An interview on 4/20/17 at 9:00 a.m. with Staff C, RN revealed she had known Staff A for several years. Staff C said she had been completely surprised and had never seen any red flags that would indicate Staff A had been stealing narcotics. According to Staff C, there had not been any evidence of resident/s using an unusual amount of Norco since they had not been added and subtracted from the count. Staff C said if medication had been ordered early enough in the day, the same nurse would almost be assured to receive them by about 1:00 p.m. or before the end of their shift. Staff C said once medications are received, they are signed for and put away if they belonged in the receiving nurse's cart. If the medication belonged in another nurse's cart, that nurse should be notified to assume responsibility for them. Staff C said Staff A's hall only had one medication cart, so if she ordered and received the delivery, she would have been solely responsible to check them in and put them away. Staff C said before the incident of missing Norco had been discovered, only one nurse had to receive the delivery and add the medication to the count. She said Staff A's hall only had one med cart, so if she ordered and received the delivery, she would have been solely responsible to check them in and put them away. She said they did not need a witness before, but they do now. An interview on 4/20/17 at 10:50 a.m. with Staff D, LPN revealed she worked at the facility as an LPN since last June, but worked as a CNA since 2009. Staff D said Staff A always seemed uptight about following the rules and regulations, and appeared to be the type that did. The LPN said about a week before Staff A got caught, she noticed she had been scratching her skin a lot	F 431		

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and even sweating a little. According to the LPN, Staff A always seemed kind of high strung, but that week she appeared even more anxious and moody. The LPN said Staff A had always been professional and respectful to residents and other staff, The LPN stated that she noticed that Staff A would get upset if someone's Norco had been discontinued. According to the LPN, it did not seem as concerning then, but now it did in hindsight. The LPN said Staff A frequently called the doctor to get Norco reordered and advocated for the necessity of having it. The LPN mentioned Staff A got very upset when one resident had his/her Norco discontinued and changed to Methadone. The LPN said she had worked with Staff A that day. She said Staff A called the physician and said she thought the resident had not been acting the same and needed his/her Norco instead of Methadone. According to the LPN, the physician said he wanted labs drawn and a urinalysis from the resident before he would re-order the Norco. Staff D said all the labs came back fine. She said the next time she came back to work the resident had the Norco back and the Methadone discontinued. Staff D said she seemed to recall another incident that a resident had Norco discontinued and a Fentanyl patch prescribed. According to the LPN, she had not worked with Staff A that day, but recalled her saying at shift report the resident really needed his/her Norco back because he/she still complained of pain. The LPN said Staff A stayed and called the physician's office and left a message. Staff D said after she left the message she said "I hope the doctor doesn't get upset with me". I think she said that because she called them frequently and did not want to appear too demanding. The LPN said she did not know what transpired after that, but she knew the resident

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got a prescription for Norco. Staff D stated that she only worked part time, but all of a sudden they were now required to have a witness when they checked in narcotic deliveries. The LPN said they had to add them into the count and put them in the locked drawer with the witness. The LPN said that once the delivery person finished processing things, they faxed the manifest to the front office about 10 minutes later. According to the LPN, the office prints the manifest and puts it in the appropriate mail box for each station that received a delivery. The LPN said they were supposed to check the in box for the manifest multiple times each shift and do second check to ensure the narcotic had been received and securely stored. The LPN said they are supposed to notify the DON immediately about any discrepancies.

An interview on 4/20/17 5:12 p.m. with Staff B, LPN revealed that she initially had been the one to discover the discrepancy of Norco. The LPN said when she began her overnight shift, she realized the pharmacy sheet looked different, so she checked it more carefully than she usually did. Staff B said Resident #1's name appeared at the top of the sheet. According to Staff B, the pharmacy had removed an order and replaced it with a new one; therefore it had been flagged for review. Staff B said because the pharmacy had not transferred the existing count from the old order; she had to do it manually. Staff B said the computer count of Resident #1's Norco seemed like a relatively low number, and she remembered the manifest (document of newly received medication) showed Resident #1 had received 30 tablets. Staff B said she became suspicious. The LPN said she checked the medication cart and it only contained the number she had seen on the

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computer, but not the additional 30 tablets documented on the manifest. The LPN said she searched the cart to see if they had been misplaced, but had not found them. Staff B said she checked the rest of the manifest against the actual inventory in the cart, and realized everything that had been delivered could be accounted for except the Norco. Staff B said she noticed on the computer Staff A had been the person that added the rest of the delivery to the count, so she became suspicious of her. The LPN said she immediately called the DON and ADON and left a message. According to Staff B, the DON called her back at 4:30 a.m. Staff B said they changed things so multiple people cannot be logged in at the same time now. The LPN mentioned the possibility of someone ordering medication under another person's login when multiple people were able to be logged into the computer at the same time. In hind sight, Staff B said she and other co-workers noticed that Staff A quickly went through the drawers of the medication cart to see what needed to be ordered, even before the off-going nurse left the building. Staff B said she does not know if it has always been the case, but they have to ask for narcotics to be discontinued after 90 days of not being used. Staff B said she did not know if she had been trained to do that before the incident of missing Norco had been discovered. Staff B said she assumed the Minimum Data Set (MDS) coordinators had been responsible to discontinued medication because of another situation when she had to contact the physician to reorder a cream they had discontinued for another resident. Staff B recalled an incident where Staff A contacted the doctor to have Resident #2's Norco reordered after it had been discontinued for not being used. Staff B also

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recalled a time another resident's Norco had been changed to Methadone. Staff B stated Staff A called the physician to have it changed back to Norco. According to Staff B, Staff A had been very vocal while advocating that residents should continue their use of Norco when it had been suggested the medication be discontinued. According to Staff B, Staff A had been the person that routinely worked days and had been in contact with physicians the most. Staff B said she had been surprised to know that Staff A had been stealing Norco from the residents, but now realized how Staff A talked about many of the stressors in her life.

An interview on 4/25/17 at 7:45 a.m. with the DON revealed that two nurses had not been required to check deliveries that contained narcotics. The DON said once the manifests had been received, they had been kept at the nurses' station after being filed away and not checked again. According to the DON, if the day nurse ordered medications they were the one to receive the delivery that same day. She said 2 nurses have to check deliveries now. The DON said once they receive the manifest, a 3rd nurse has to check the delivery against the manifest and then forwarded it to her. The DON said Staff A had the weekend of 2/17/17 off and the following Monday and Tuesday off work. According to the DON, once they started to put the pieces together, Staff A had been told to stay home pending the outcome of the investigation, and had ultimately been terminated. The DON said their Pharmacy consultant visited several times a month and more frequently now. The DON said he does medication reviews, chart reviews, looks at medication errors and helps with psychotropic medication meetings. The DON stated that the

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consultant writes recommendations to the physicians, and if medications are not being used, he'll recommend the medications are discontinued. The DON said nurses also monitor medication not being used. She said one time she told Staff A to check with the physician to have Resident #2's Norco discontinued for non-use. The DON said Staff A had the medication discontinued, but ultimately advocated for the medication reordered because the resident needed them sometimes. The DON said Staff A had another resident's Norco reordered after the physician changed it to another pain medication. The DON said Staff A had been quite vocal and everybody thought she had just been advocating for the residents. According to the DON, the residents and family members really liked Staff A, Reflecting back; the DON said Staff A probably had been very manipulative. The DON said Staff A had been called to the office a couple times for facilitating residents' change of physicians. The DON said Staff A involved the family and the residents too and always defended her decisions with what seemed like logical reasons.

An interview on 4/25/17 at 8:30 a.m. with the ADON revealed she knew of one resident admitted to the facility in May 2016. The ADON said the resident's pain medication had not been helping, so Staff A advocated for him/her to start Norco. The ADON said she found the drug diversion disheartening because they trusted Staff A. The ADON said they had to trust their nurses.

An interview on 4/26/17 at 10:15 a.m. with the DON revealed they did not have a policy regarding how much time was allowed before or

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comments made about the residents; and made recommendations based on that. He said the facility did not ask much advice about pain medication. He said he did not audit their books. The Consultant said it would be difficult for him to do because of the limited time he spent there. He said sending medication and revising orders in the computer accounts for about everything their pharmacy does for them. The Consultant said it would take someone monitoring very closely for theft to detect a diversion. The Consultant said a pharmacy might never catch the theft of PRN's unless they had somebody pretty sharp that would detect a red flag and let the facility know they noticed a nurse/s ordering an excessive amount. The Consultant said he knew their pharmacy (Community Pharmacy) serviced about 60 or 70 facilities. He said once a pharmacy started to service more than about 15 facilities, it became very difficult for them to track. The Consultant said he would have expected them to let him know about the drug diversion soon after they found out about it.

An interview on 5/2/17 at 12:45 p.m. with the Administrator revealed he thought Staff A had been very smart about the drug theft. He stated they thought they had a good nurse, and they had no reason to believe she had been stealing drugs. The Administrator said the DON had since implemented precautions to hopefully prevent this from happening again. When asked, the Administrator said he would not have expected the DON to practice the same precautionary measures she implemented after the yearlong series of thefts. When this surveyor informed the Administrator the Pharmacy Consultant said he had only been hired to oversee a limited number of their needs, and would be willing to supervise

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165524	A. BUILDING _____ B. WING _____	C 05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY LUTHERAN HOME	SEVEN ELLIOTT STREET COUNCIL BLUFFS, IA 51503

(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 431	Continued From page 35 every aspect of their pharmacy needs, the Administrator explained that the resources were just not available to oversee every facet of a nursing home. The facility updated their policy on 3/13/17 to included multiple measure not limited to: ensuring the receive counted Controlled Substance from the pharmacy, the nurse will verify the receipt of the corrected medication with delivery person, and any discrepancies or omissions will be reported to the dispensing pharmacy. The nurse who receives the controlled substance will count them and add them into the Receive Meds section of the Quick MAR under the resident's name with a second nurse.	F 431		