STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165017	A. BUILDING _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS	F 000		
OK/TAG ✓	Correction Date: 7/12/2023 (and 5/17/2023) (Overall Compliance 7/12/2023) The following deficiencies resulted from an investigation of Complaints #112420-C, #112783-C, #112823-C, #112838-C, #113068-C and a Facility Self-Reported Incident #112549-M conducted May 15, 2023 to May 31, 2023. Complaints #112420-C. #112783-C, #112823-C and #113068-C were substantiated. Findings for the Facility Self-Reported Incident #112549-M will be sent to the facility at a later date under separate cover. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.		Please see attached Plan of Correction	
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.	F 551		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jean Bode	Administrator	06/21/2023

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

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F 551	Continued From page 1 §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.	F 551		

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F 551	Continued From page 2	F 551		

(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.
This REQUIREMENT is not met as evidenced by:
Based on clinic record review, State of Iowa document review, and Medical Director and staff interviews the facility failed to notify the doctor or honor a family request to send a resident to the Emergency Room (ER) for 1 of 5 residents reviewed (Resident #2). The facility reported a census of 79 residents.

Findings Include:

Resident #2's Minimum Data Set (MDS) dated 3/16/23, documented an admission date of 3/16/23.

The Electronic Health Record (EHR) Medical Diagnosis Section documented admission medical diagnosis including esophageal varices without bleeding and secondary esophageal varices with bleeding.

The Progress Note written on 3/16/23 at 5:55 PM, documented the resident admitted from a local hospital by a transportation service. He was in the facility for strengthening. The resident oriented to his room, call light, and TV remote. Medication orders were faxed to the Pharmacy and the Doctor (MD) was aware of the admission.

The Progress Note written on 3/19/23 at 9:48 AM, documented the resident vomiting and refused (his medications). The clinical record lacked documentation of a physical assessment, vital signs or physician notification at that time.

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F 551	Continued From page 3	F 551		

The Progress Note written on 3/19/23 at 11:15 AM, documented the nurse entered the resident's room at 10:30 AM. The resident was making retching noises and had an emesis basin with spit and a tinge of blood. The resident asked the nurse if he was going to die that day and began to get worked up and breath heavy. The nurse encouraged the resident to deep breath through his nose and out through his mouth as he was "exhibiting signs of an anxiety attack." His pulse was 102 beats per minute and his oxygen saturation was 100 % on room air. The nurse called the resident's daughter to ask medical questions as the resident did not appear to be an accurate historian. The daughter requested the resident be sent to the ER immediately. The nurse documented she told the daughter this was not an emergency situation, he was just anxious. The resident was given Zofran (medication given for nausea) and water, covered with a blanket and the nurse told the resident she would be back to see if the Zofran helped. At 11:05 the nurse entered the resident's room to see the resident with a blank stare, pupils fixed, his mouth and chin were blood stained. He did not have a pulse or respirations. The nurse documented an overhead page was made for the code blue and compression were started. The nurse, another nurse and the Activity Assistant rotated compression and the ambu bag (to provide breaths to resident). At 11:06 the Assistant Director of Nursing (ADON) called 911. At 11:13 AM the ambulance crew arrived and took over care. At 1:00 PM the Medical Examiner called and reported the cause of death to be ruptured esophageal varices.

The State of Iowa Certificate of Death documents

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F 551	Continued From page 4	F 551		

the date and time of death as 3/19/23 at 11:45 AM. The immediate cause of death is listed at exsanguination (sever blood loss) secondary to esophageal varices with other significant conditions being COVID-19.

During an interview on 5/15/23 at 1:59 PM, the Director of Nursing (DON) explained if a resident or family member was requesting a resident be sent to the ER, she would expect an assessment to be completed, the doctor be notified and made aware of the request and assessment findings. She further explained the nurse would get the order to send at that time. She would expect that information to be documented. She explained that if it isn't documented that doesn't necessarily mean it wasn't done. If there was an emergency or something it could have slipped the nurse's mind.

During an interview on 5/16/23 at 8:49 AM, Staff B, Licensed Practical Nurse (LPN) explained if a family member requested a resident go to the ER she would do an assessment, vitals, then notify the Doctor.

During an interview on 5/16/23 at 8:52 AM, Staff C, LPN explained if a family member or resident was requesting the resident go to the ER she would do an assessment and notify the Doctor.

During an interview on 5/16/23 at 8:58 AM, Staff D, Registered Nurse (RN), explained if a resident was requesting to go to the ER she would do an assessment, call the Doctor and would send the resident to the ER. She explained if a family member was requesting the transfer, the resident gets transferred, the request can't be declined.

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During an interview on 5/16/23 at 9:15 AM, Staff A, RN explained the resident passed away on her last day working in this facility. She recalled the resident wasn't feeling well and had a little blood in his mouth. She explained the resident was anxious that day (March 19, 2023) and he was in the facility for COVID. The resident felt nauseated and she gave him a Zofran. He did not vomit but spit up. She called the daughter from the resident's cell phone with his permission. She remembers the cell phone recording they talked for 13 minutes. The resident was spitting up pink tinged sputum and the daughter thought he should go to the emergency room. Staff A explained to the daughter that he was anxious, this was not an emergency and she was calling to get a better picture of his previous history and background. The daughter gave that picture. Staff A explained she left the resident with an emesis basin as he was feeling nauseated and his call light and went to tend to another resident. When she was done with the other resident, she went back to check on the resident and found him with a blank stare, pupils fixed. She stated she shouted his name and felt for a pulse. She did not find one. She explained she knew he was a full code (wanted life saving measures), she called the code overhead and called for the crash cart and began compressions. She reported bright red blood clots were coming out of his mouth with compressions. She stated she was not aware the resident had esophageal varices at that time.

During an interview on 5/16/23 at 11:42 AM, Staff F, RN, Unit Manager explained she was working in another part of the building when she heard the code page. She explained 2 nurses were doing Cardiopulmonary Resuscitation (CPR) when she got to the room. She recalled she ran and

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grabbed the suction machine and took it into the room and called 911. She went back in the room to get the suction machine going and the ambulance crew was there very quickly. She recalled the resident had blood coming from somewhere on or near his face. His color was completely pale. She explained she called the resident's daughter and notified her the resident was on his way to the hospital.
Staff F explained if a family member requested the resident be sent to the ER the doctor should be notified and she would get a Doctor's Order to send the resident to the hospital. When asked about a nurse refusing to call the doctor, she stated "That would be wrong." She stated the nurse needed to put forth the effort to call the doctor and let the doctor know and decide what would happen next.

During an interview on 5/16/23 at 11:59 AM, the DON acknowledged Staff A had received a request from the resident's daughter for the resident to go to the ED but she received that information later. She explained it would not be appropriate for the nurse in the facility to tell the family no, this is not an emergency and refuse to send the resident or even call the doctor.

During an interview on 5/16/23 at 1:05 p.m. the DON reported they do not have a transfer out policy. They follow standards of care and call the physician and get an order to transfer out.

During an interview on 5/30/23 at 4:12 PM the Medical Director explained when a resident or family member requests to go to the ER we send them. That's standard, we don't refuse to send them. He further explained if it is an emergent situation they can call 911 and send the resident

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F 551	Continued From page 7 to the ER, get them taken care of and then notify us (himself and his team). If it's not emergent we like to be notified ahead of time so we can give the order and be aware. He explained he would expect a new set of vitals and an assessment from the nurse's interaction with the resident, that is standard. If they call and don't have that information I will ask them to get that information and call back.	F 551		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		

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resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, State of Iowa Certificate of Death review, Pre-Admission Hospital record review, facility document review and Medical Director and staff interviews, the facility failed to complete a thorough assessment, provide interventions necessary, and notify the resident's Physician of significant changes for the resident and respect the resident's representative from exercising the resident's right to access emergency services for 1 of 5 residents reviewed (Resident #2). The facility reported a census of 79 residents.

The Pre-Admission Hospital Record documented diagnoses including COVID, acute cough, hematemesis, esophageal varices, and Grade D

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(sever) esophagitis. The hospital record documents the resident presented to the Emergency Room (ER) on or around 2/27/23 after his daughter observed coffee ground emesis.

Resident #2's Minimum Data Set (MDS) dated 3/16/23, documented an admission date of 3/16/23.

The Electronic Health Record (EHR) medical diagnosis section documented admission medical diagnosis including esophageal varices without bleeding and secondary esophageal varices with bleeding.

The Progress Note written on 3/16/23 at 5:55 PM, documented the resident admitted from a local Hospital by a transportation service. He was in the facility for strengthening. The resident was oriented to his room, call light, and TV remote. Medication orders were faxed to the Pharmacy and the Doctor (MD) was aware of the admission.

The Progress Note written on 3/19/23 at 9:48 AM, documented the resident vomiting and refused (his medications). The clinical record lacked documentation of a physical assessment, vital signs or physician notification at that time.

The Progress Note written on 3/19/23 at 11:15 AM documented the nurse entered the resident's room at 10:30 AM. The resident was making retching noises and had an emesis basin with spit and a tinge of blood. The resident asked the nurse if he was going to die that day and began to get worked up and breath heavy. The nurse encouraged the resident to deep breath through his and out through his mouth as he was

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"exhibiting signs of an anxiety attack." His pulse was 102 beats per minute and his oxygen saturation was 100 % on room air. The nurse called the resident's daughter to ask medical questions as the resident did not appear to be an accurate historian. The daughter requested the resident be sent to the ER immediately. The nurse documented she told the daughter this was not an emergency situation, he was just anxious. The resident was given Zofran (medication given for nausea) and water, covered with a blanket and the nurse told the resident she would be back to see if the Zofran helped. At 11:05 the nurse entered the resident's room to see the resident with a blank stare, pupils fixed, his mouth and chin were blood stained. He did not have a pulse or respirations. The nurse documented an overhead page was made for the code blue and compression were started. The nurse, another nurse and the activity assistant rotated compression and the ambu bag (to provide breaths to resident). At 11:06 the Assistant Director of Nursing (ADON) called 911. At 11:13 AM the ambulance crew arrived and took over care. At 1:00 PM the Medical Examiner called and reported the cause of death to be ruptured esophageal varices.

The State of Iowa Certificate of Death documented the date and time of death as 3/19/23 at 11:45 AM. The immediate cause of death is listed at exsanguination (sever blood loss) secondary to esophageal varices with other significant conditions being COVID-19.

During an interview on 5/15/23 at 1:59 PM, the Director of Nursing (DON) explained if a resident or family member was requesting a resident be sent to the ER, she would expect an assessment

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to be completed, the doctor be notified and made aware of the request and assessment findings. She further explained the nurse would get the order to send at that time. She would expect that information to be documented. She explained that if it isn't documented that doesn't necessarily mean it wasn't done. If there was an emergency or something it could have slipped the nurses mind.

During an interview on 5/16/23 at 8:49 AM, Staff B, Licensed Practical Nurse (LPN) explained if a family member requested a resident go to the ED she would do an assessment and vitals and notify the doctor.

During an interview on 5/16/23 at 8:52 AM, Staff C, LPN explained if a family member or resident was requesting the resident go to the ER she would do an assessment and notify the doctor.

During an interview on 5/16/23 at 8:58 AM, Staff D, Registered Nurse (RN), explained if a resident was requesting to go to the ER she would do an assessment, call the doctor and would send the resident to the ER. She explained if a family member was requesting the transfer, the resident gets transferred, the request can't be declined.

During an interview on 5/16/23 at 9:15 AM, Staff A, RN explained the resident passed away on her last day working in this facility. She recalled the resident wasn't feeling well and had a little blood in his mouth. She explained the resident was anxious that day (March 19, 2023) and he was in the facility for COVID. The resident felt nauseated and she gave him a Zofran. He did not vomit but spit up. She called the daughter from the resident's cell phone with his permission. She

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remembers the cell phone recording they talked for 13 minutes. The resident was spitting up pink tinged sputum and the daughter thought he should go to the emergency room. Staff A explained to the daughter that he was anxious, this was not an emergency and she was calling to get a better picture of his previous history and background. The daughter gave that picture. Staff A explained she left the resident with an emesis basin as he was feeling nauseated and his call light and went to tend to another resident. When she was done with the other resident, she went back to check on the resident and found him with a blank stare, pupils fixed. She stated she shouted his name and felt for a pulse. She did not find one. She explained she knew he was a full code (wanted life saving measures), she called the code overhead and called for the crash cart and began compressions. She reported bright red blood clots were coming out of his mouth with compressions. She stated she was not aware the resident had esophageal varices at that time.

During an interview on 5/16/23 at 11:42 AM, Staff F, RN, Unit Manager explained she was working in another part of the building when she heard the code page. She explained 2 nurses were doing Cardiopulmonary Resuscitation (CPR) when she got to the room. She recalled she ran and grabbed the suction machine and took it into the room and called 911. She went back in the room to get the suction machine going and the ambulance crew was there very quickly. She recalled the resident had blood coming from somewhere on or near his face. His color was completely pale. She explained she called the resident's daughter and notified her the resident was on his way to the hospital.
Staff F explained if a family member requested

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the resident be sent to the ED the doctor should be notified and she would get a doctor's order to send the resident to the hospital. When asked about a nurse refusing to call the doctor, she stated "That would be wrong." She stated the nurse needed to put forth the effort to call the doctor and let the doctor know and decide what would happen next.

During an interview on 5/16/23 at 11:59 AM, the DON acknowledged Staff A had received a request from the resident's daughter for the resident to go to the ED but she received that information later. She explained it would not be appropriate for the nurse in the facility to tell the family no, this is not an emergency and refuse send the resident or even call the doctor.

During an interview on 5/30/23 at 4:12 PM the Medical Director explained when a resident or family member requests to go to the ER we send them. That's standard, we don't refuse to send them. He further explained if it is an emergent situation they can call 911 and send the resident to the ED, get them taken care of and then notify us (himself and his team). If it's not emergent we like to be notified ahead of time so we can give the order and be aware. He explained he would expect a new set of vitals and an assessment from the nurse's interaction with the resident, that is standard. If they call and don't have that information I will ask them to get that information and call back.

The facility document titled Change in Condition, dated 11/2016, directed staff to consult with the resident's Physician for any need to alter treatment or a decision to transfer the resident from the facility. The document further directed

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F 580	Continued From page 14 staff to immediately notify the Physician for any symptom, sign or apparent discomfort that is acute or sudden onset and a marked change in relation to usual symptoms and signs.	F 580		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §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 medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, document review, resident and staff interviews the facility failed to ensure residents remained free from misappropriation of narcotic pain medications including oxycodone, hydrocodone-acetaminophen, and hydromorphone for 8 of 8 residents reviewed (Resident #3, #4, #5, #6, #14, #15, #16, #17). The facility identified a census of 79 residents. Findings Include: 1. The Minimum Data Set (MDS) Assessment dated 3/22/23 for Resident #3 showed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive loss. The resident required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. The MDS documented Resident #3 utilized as needed pain medication for occasional pain of 5	F 602		

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on a 1-10 scale receiving opioids 6 out of the 7 day look-back period. The MDS listed diagnoses of left hip fracture, anemia, hypertension, end stage renal disease, chronic obstructive pulmonary disease (COPD) and a wound infection.

The Care Plan dated 3/17/23 identified Resident #3 at risk for pain related to arthritis, surgical incision and infection to a wound site. The Care Plan directed the nurses to provide analgesics as ordered and evaluate efficacy of pain management.

A Hospital After Visit Summary dated 3/17/23 documented a Physician Order for oxycodone 5 milligrams (mg) immediate release (IR) by mouth every 4 hours as needed for pain of the left hip.

A review of the Controlled Substance Administration Record (CDAR), Pharmacy Delivery Slip, March 2023 EMAR, March 2023 Daily Deployment Sheets, Facility Investigation, March 2023 Vital Signs Records and Narcotic Count by Nurses March 2023 for Resident #3's use of oxycodone hydrochloride (HCL) oral tablet 5 mg. Give 5 mg by mouth every 4 hours as needed for left hip pain revealed the following discrepancies:
a. A Statement hand written by Staff G, Registered Nurse (RN) addressed to the Director of Nursing (DON) and Staff F, Assistant Director of Nursing (ADON)/Nursing Supervisor on 3/17/23 documented the pharmacy had been unable to deliver medications for Patient #3 until the morning of 3/18/23 between 5 a.m. - 6 a.m. Staff G had been on Linn Hallway when Staff I, RN, informed her Pharmacy had delivered medications. Staff G counted 30 tablets of

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oxycodone for Resident #3. Staff G detailed in her statement she had given Resident #3 975 mg of Tylenol for complaints of pain since the oxycodone had not been available from the pharmacy. Staff G documented she gave report that morning to Staff A, RN and they both counted the narcotics before she left shift. Staff G returned 3/18/23 for the 10 p.m. - 6:30 a.m. shift to find that her signature had been forged to show administration of oxycodone at midnight and 4 a.m. Staff G documented she had never administered oxycodone on her shift on 3/17/23. She attached a copy of the March 2023 EMAR and the Pharmacy Delivery Slip for verification. The March 2023 EMAR documented Staff G administered 975 mg of Tylenol per the physician order 3/18/23 at 2:04 a.m. which had been effective for pain control.

b. On 3/18/23 at midnight and 4:00 a.m., the CDAR showed the doses of medication signed out by Staff G. The March 2023 EMAR lacked documentation by Staff G of the administration of the medication doses. A Pharmacy Packing Slip signed by Staff G contained Staff's G signature that she signed for 30 tablets of oxycodone IR 5 mg tablets on 3/18/23 at 5:30 a.m. The 3/18/23 Daily Deployment Sheet showed Staff A assigned to Resident #3's hallway (Medbridge). The Facility Investigation detailed the signature for the doses on the CDAR did not match Staff G's signatures. The Investigation further detailed during the Narcotic Count the next day (3/19/23) Staff G noticed it seemed like her signature had been forged on the narcotic count sheet and that "she" had signed out 2 pills of oxycodone for Resident #3. She reported that had not occurred. The doses were not documented on the March 2023 EMAR. The Investigation also detailed Staff G stated the Resident's oxycodone had not yet been

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delivered from the pharmacy, so she couldn't have administered the medication at midnight and 4:00 a.m. She had handed the medication cart keys off to Staff A around 6:00 a.m. Staff G recalled the narcotic count being at 30 tablets for the oxycodone card because she had just received it from pharmacy. The Narcotic and Controlled Substance Shift to Shift Count Sheet for 3/18/23 showed Staff G completed the narcotic count with Staff A at the change of from night shift to day shift, handing the keys off to Staff A for Medbridge hallway. A Time Card Report for 3/18/23 showed Staff A worked from 5:58 a.m. - 4:28 p.m.

c. On 3/18/23 at 7:45 a.m., the March 2023 EMAR showed Staff A administered a dose of oxycodone 5 mg for Resident #3 at 7:46 a.m. which had been ineffective and at 7:57 a.m. documented the administration of a second dose of the medication. The CDAR documented one tablet of oxycodone signed for 3/18/23 at 8:00 a.m. and 12:30 p.m. by Staff A. The Facility Investigation noted the discrepancy from the time documented on the March 2023 EMAR of 7:46 a.m. to the CDAR dose of the medication which had been signed out at noon. The March 2023 CDAR for oxycodone count 30 tablets documents the dose had been signed out by Staff A at 12:30 p.m.

d. On 3/19/23 at 4:00 a.m. the CDAR documented one tablet of oxycodone 5 mg had been signed out by Staff G. The dose had not been signed out on the March 2023 EMAR. The 3/18/23 - 3/19/23 Daily Deployment Sheet listed Staff G assigned to the Resident's wing (Medbridge) 2:00 a.m. - 6:30 a.m. The Facility Investigation documented Staff G reported she only administered the resident one dose of the medication at 00:18 a.m. which had been signed

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out on the CDAR and March 2023 EMAR appropriately. Staff G reported the signature on the 4:00 a.m. dose had not been her signature. The 3/19/23 Daily Deployment Sheet documented Staff A assigned to work on Resident #3's hallway (Medbridge). The Narcotic and Controlled Substance Shift to Shift Count Sheet for the Medbridge Hallway dated 3/11/23 showed Staff G as the off-going nurse handed the medication cart keys to Staff A as the on-coming nurse.

e. On 3/19/23 at 8:30 a.m. and 12:30 p.m., Staff A signed out a 5 mg oxycodone doses on the CDAR. She failed to document the doses on the March 2023 EMAR. A Time Card Report dated 3/19/23 showed Staff A worked 6:03 a.m. - 7:04 p.m.

f. The Facility Investigation documented Resident #3 had been interviewed on 3/19/23 and reported he didn't recall receiving any narcotics on 3/18/23.

g. Resident #3's Vital Signs Record documented reflected pain levels from 3-9 on a 1-10 pain scale for 3/18/23 and pain levels from 4-7 on a 1-10 pain scale on 3/19/23.

h. On 3/19/23 at 6:45 p.m., Staff A wrote a statement when she completed Narcotic Count with Staff G the Narcotic Count had been correct. At 6:58 p.m. Staff A wrote in a statement she did not sign any medications out under Staff G's name.

i. On 3/20/23 Staff E, RN, wrote a statement noting it had been 1:40 a.m. when Staff A alerted her about her signature being forged. Staff E wrote Staff G's signature had been forged twice. She wrote Staff G called Staff F and informed her of what had happened. Staff F told Staff G to write a statement and leave a copy for her and she would review it on Monday 3/20/23. When Staff E came to work (3/19/23), she knew how

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many pills she had counted with Staff G since there were not many narcotics on the Medbridge hallway. Staff E noticed some CDARs had forged signatures with different names, Staff I, RN, Staff M, RN and Staff D, RN for the same day. Staff E wrote she asked Staff A about it and wasn't satisfied with the answer because clearly pills were taken illegally or administered in suspicious ways. Staff E called the DON and reported. She had also reported to Staff F as well. The 3/19/23 Daily Deployment Sheet dated 3/19/23 showed Staff E worked 2 p.m. - 10:30 p.m. on the Medbridge Hallway. A Time Card Report showed Staff A worked 6:03 a.m. - 7:04 p.m.

An interview conducted via phone on 5/16/23 at 9:52 a.m., Resident #3 voiced he had received oxycodone and a muscle relaxant medication during his stay at the facility. The nurses would only give him his oxycodone every 4 hours. He thought there had been an incident of a nurse signing out his medications and he didn't think that he had received them. He thought he voiced that situation to Staff G but couldn't recall a date or time of the incident. Resident #3 didn't want to get anyone in trouble, but he felt he needed to get out of the nursing home before they killed him there. A nurse had brought insulin into his room and informed him it was time for his insulin. Resident #3 didn't receive insulin and immediately voiced this to the nurse. The nurse went out to double check the EMAR and he did not receive the insulin.

During an interview on 5/16/23 at 10:47 a.m., Staff G reported she worked that Friday and Saturday (3/17/23 and 3/18/23) at the facility. She remembers it involved a new admit in room 205 B (Resident #3). The facility had switched to

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a new pharmacy that delivered the medications in the early morning. She recalled Resident #3 had called with a pain level of 8 and asked for his oxycodone. She specifically remembered she told him the medication had not been delivered from the pharmacy. She explained he had Tylenol available to take for pain. She gave him 3 tablets of 325 mg (975 mg) of APAP around 2 a.m. She went in to hang his intravenous medication later and he reported being "fine" at that time. He didn't seem to have much for pain. At 5:30 a.m. the nurse from the TCU hallway came over and informed her of a pharmacy delivery. The pharmacy provided a CDAR with the delivery of each narcotic medication card. She went to record the time received on the CDAR and noticed the absence of an area to document the time of delivery down on the form. She wrote 5:30 a.m. on the CDAR for receiving 30 oxycodone pills delivered. Staff A had been the nurse that followed her coming onto dayshift. They counted the narcotics and she handed the keys off to Staff A. She reported when she returned back to work, she received report from Staff E on Saturday night (3/18/23). Staff E specifically told her that Resident #3 had not complained of any pain and she had not given him any pain medications. She recalled Resident #3 called around 12:00 a.m. for pain medication. Resident #3 said he hadn't had pain medication for a long time. She asked him about his pain level and went to the cart to get medication. When she opened the cart and checked his oxycodone card, there had been a lot of medication that had been pulled from the card. She double checked with his orders. He could take the oxycodone medication every 4 hours. She specifically remembered that Staff E had told her she had not given the resident any pain

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medication. The Resident adamantly voiced he hadn't had pain medications in a long time. She compared the oxycodone medication card with the EMAR and the CDAR. She realized oxycodone had been signed out for 12:00 a.m. and 4 a.m. for Friday night during her shift. She had not given the medication as it had not been delivered from the pharmacy and the signatures on the CDAR were not her signatures. She had only given Tylenol around 2:00 a.m. She called Staff E to come look at the signatures as a second witness. They compared the signatures from the pharmacy delivery slip on 3/18/23 to the CDAR. Her signature had been forged by someone else. Staff G stated they are trained to sign off medications in the EMAR and the CDAR. She had always been taught to sign out a narcotic with her full signature when she gave a PRN pain medication. The charge nurse is the only one that has keys to the medication cart. She keeps the medication cart keys on her.

During an interview on 5/16/23 at 2:10 p.m., the Human Resource Coordinator voiced the first day during Staff A's orientation she left for about 3 hours. She said she had a therapy appointment via phone. She thought that was odd it hadn't come up before. Looking back, she didn't know if she had taken something and had to go sleep or something. She seemed sort of "shell shocked" when she came back, visibility upset and not able to pay attention when she returned. She had 3-4 days of in-services to do and she had to redirect her. She wanted to go to the town hall meeting on the change of company. She directed Staff A to stay on task. Staff A went to the floor to work and they saw a big change in her. Her professionalism changed. She had a dental appointment the first week she worked the floor.

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They honored it, but wondered why she hadn't brought up these appointments ahead of time since she was a new hire. There had been a time when she kept asking the Certified Nurse Aides (CNA's) to get her coffee and food. She wondered if Staff A had been trying to clear staff out of the area so that no one would be around. They provide meals at 10 a.m. and 4:00 p.m. for staff and coffee in the break room. They don't allow those things at the Nurses' Station and Staff A needed constant reminders.

On 5/16/23 at 3:11 p.m., Staff M, RN explained the Director of Nursing (DON) asked him to verify signatures on shifts that he worked. He did verify several signatures were not his handwriting. It happened a long time ago and he couldn't recall exactly which residents he had been asked about. He did report with Staff A and passed the keys on to her a lot. Staff M reported he worked Medbridge hallway.

On 5/17/23 at 6:34 p.m., the Administrator voiced he had first become aware of the situation on the evening of 3/19/23 by the DON. The DON went to the facility and got a statement from Staff A and suspended her from duty. At that point they didn't think they had an allegation of abuse. The narcotic counts were not off, but something had been "fishy." He had not been able to verify Staff G's statement until the evening of 3/20/23 when the pharmacy receipt came to verify the date and time the medication had been received by the facility. That confirmed Staff G's story. He reported to the Iowa Department of Inspection and Appeals (DIA) on 3/21/23. He had verified with the ADON on 3/19/23 that the narcotic count had been accurate. They thought it may have been a simple case of someone forgetting they

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had administered a dose of medication and it turned into someone stealing medications. He had never seen anything like it. From their final investigation, it had affected up to 9 residents and showed a trend that Staff A had taken the pills. He stated they had reported Staff A to the Board of Nursing. He further reported Staff A would be terminated. He didn't feel this had been the first time that Staff A had taken medications. She seemed to know exactly what she was doing. He wondered if it had happened at other facilities and they never did anything about it. They tried to do the right thing and get it reported into the State.

An interview on 5/18/23 at 11:37 a.m. with Staff K revealed when she gives a narcotic she documents it in the EMAR and the CDAR. She voiced she does not give out a lot of narcotics as she works night shift. She just does the as needed doses of narcotic pain medications. She is assigned to two hallways at night, usually TCU and Legacy. She has the medication cart keys for those two carts. She is the only one that has the medication cart keys as a charge nurse. Unless you have to leave the building, you keep the keys on you, even at break. She recalled the DON asking her to verify her signatures on the CDAR after the incident. She documents narcotics out in both places the CDAR and the EMAR. If both places were not documented out, she did not administer that dose of narcotic. She can't remember the specific residents involved, it has been too long ago. She reviewed the Facility Investigation and reported the findings were accurate regarding her signatures.

On 5/22/23 at 10:50 p.m., Staff I, RN, voiced she identified the issue as the Narcotic Count had always been correct. The medication cards

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matched the CDAR counts. No one had been looking at the actual signatures on the sheets. At the time she had worked all the hallways. If the counts were correct, they didn't pay attention to the signatures. Two nurses perform the Narcotic Count at the shift change. One nurse holds the book and looks at the CDAR and the other nurse compares the narcotic medication cards. The medication cart keys are between two nurses on the cart usually at shift change. Once the count is done they officially hand over the keys to the oncoming nurse. The keys stay on her the whole shift including break times. If she leaves the building she will give them to another nurse. That did not affect any of the signatures she reviewed on the narcotic sheets. She is required to document the administration of as needed (PRN) pain medication in the EMAR as well as where the pain is and the level of the pain. There is a Progress Note that comes up and they record the pain level and location. If generalized pain they don't write a location. The Progress Notes flag for a follow-up pain level. The pain follow-up is flagged in the computer as yellow to indicate a pain follow-up is needed. If it shows up in red, the pain assessment is overdue. If it changes to green, the follow-up is completed. That is how they communicate the as needed pain medication follow-up through the computer system. Staff I voiced Staff A had an odd "flighty" personality. She would pop from one subject to another. It was hard to follow her. In her opinion she had been like that throughout her employment. She didn't have a clue that Staff A had been taking narcotics. If someone got a narcotic and they were in a lot of pain they would alternate the narcotic with Tylenol. They would stagger the two medications to try to keep an even keel going for the pain control. They also would use ice packs.

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On 5/23/23 at 9:12 a.m., Staff G reported she had called Staff F (ADON/Unit Supervisor) between 1-2 a.m. on 3/19/23. Twice she called with no answer. She called the DON's personal cell phone. The DON missed the call, so she left a voicemail. She called Staff F's personal cell phone and Staff F answered. Staff F directed her to write a statement and leave copies in the office. Staff F said she would deal with it on Monday. Staff A reported she specifically told Staff F someone had forged her signature for narcotics on the narcotic record that she hadn't given. Once you give report and hand off the keys, that is the only nurse that has medication keys to the narcotic lockup. Staff G suspected Staff A as she had been the only person that could have given Resident #3 his narcotic pain medication. Staff E worked the 2-10:30 p.m. shift following Staff A. When staff G returned to work the early morning of 3/19/23 Staff E had reported off to her that Resident #4 had not taken any pain medication. Staff A had been the only other nurse that had access to his narcotic medications. Resident #3's CDAR had been blank when she left duty on the morning of 3/18/23. He had no complaints after the Tylenol she administered on 3/18/23 around 2:00 a.m. She handed the keys off to Staff A around 6:00 a.m. on 3/18/23. Staff E followed Staff A on the evening shift and Staff E had specifically told her in report she had not given any pain medications to the resident. When she reviewed the CDAR and reviewed Resident #3's physician order. He could only have his oxycodone every 4 hours. She reported not being happy about the situation. Staff G had no relation to Staff A prior to working with her at the facility.

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During an interview on 5/25/23 at 11:31 a.m., the DON reported the CDAR once all doses have been administered or doses destroyed are to go to the Unit Supervisor to put the CDAR into the folder. If it is a weekend, the nurses can put the CDAR into the folder. Prior to the incident she had just looked at the CDARS to see if the narcotic doses were signed. She had not been going back and checking the EMAR or the actual medication cards. The nurses were initialing on the CDAR to sign out narcotic doses. Now she is encouraging the nurses to sign with their full last name. That is her preference but not facility policy. She didn't know of any real processes in place prior to the incident regarding missing CDAR's. They just followed standard procedures. Going forward, she has asked the pharmacy to email her a list of all narcotics that are delivered to the facility so she can check the medication cards have been signed in, counts verified and the medication card is in the double lock up. She will ensure narcotics are signed in correctly. She plans to utilize the Master Controlled Substance Log. She provided more education this morning (5/25/23) to the nurses. She is requiring two nurses to sign in narcotic medication cards with pharmacy delivery and place into lock-up. Both nurses have to sign the Master Controlled Substance Log to document the delivery of the narcotics and both nurses have to sign the Log after destruction of any narcotics. The EMAR to the CDAR to the Master Controlled Substance Log should all match. She reported she carries the accountability for the accuracy of the process. She expects the nurses to sign out narcotics on both the EMAR and the CDAR.

During an interview on 5/23/23 at 1:35 p.m., the DON reported she would expect the nurses to

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document out all as needed narcotic medication doses on the CDAR and on the EMAR so that a follow-up pain assessment could be completed. She reported they had concluded from their investigation that Staff A had been taking resident narcotic pain medications.

On 5/31/23 at 9:55 a.m., the Administrator provided a copy of an audit list dated 4/25/23 that detailed for Resident #3 use of oxycodone IR 5 mg the pharmacy delivered of 30 tablets, with the CDAR showing 9 doses signed out. The March 2023 EMAR showed only 2 doses signed out. The medication card had 21 doses remaining on the card at the time of the audit with 7 discrepancies found. The Audit contained a note that documented two doses had been given by Staff A and were questionable so the facility reimbursed out of good faith.

The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, dated July 2019, provided by the facility, included a Policy Statement: all residents have the right to be free from abuse, neglect misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking acts that result in person degradation. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It shall be the policy of this facility to implement written procedures to prohibit abuse, neglect, exploitation and misappropriation of resident property.

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The Policy included the following definition:
1. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a Resident's belongings or money without the Resident's consent. This includes misappropriation or diversion of resident medications.

2. The MDS Assessment dated 3/15/23 for Resident #4 showed a BIMS score of 11 indicating moderate cognitive loss. The Resident required limited assistance with transferring, dressing and toileting. The MDS documented Resident #4 utilized scheduled and as needed medication for frequent pain of a 4 on a 1-10 scale (1 being the least amount of pain and 10 being the worst pain). The Resident utilized opioid (narcotic) medication 3 out of 7 days of the look-back period. The MDS listed diagnoses of fracture of the pubis ramus (pelvic fracture), coronary artery disease, heart failure, hypertension, arthritis and long-term use of opioids.

Resident #4's Care Plan dated 3/05/23 had a focus the Resident is at risk for pain related to arthritis, neurogenic cause, orthopedic surgery and musculoskeletal issues. The Care Plan directed the nurses to provide analgesic as ordered and monitor for non-verbal signs of pain.

A Physician Order electronically signed by the Provider on 3/09/23 showed a current order as of 3/04/23 as follows:
a. Roxicodone (generic: oxycodone, narcotic/opioid pain medication) oral tablet 5 milligrams (mg), give one tablet by mouth every 4

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hours as needed for pain control.
b. Hydrocodone-acetaminophen (narcotic/opioid pain medication) oral tablet 5-325 mg, give 1 tablet by mouth every 24 hours as needed for pain control to be given at bedtime.

A review of the CDAR, March 2023 MAR, March 2023 Daily Deployment Sheets and Facility Investigation for Resident #4's use of hydrocodone-acetaminophen, give 1 tablet by mouth every 24 hours as needed for pain control to be given at bedtime, revealed the following discrepancies:
a. 3/04/23 at 11:10 p.m., dose of hydrocodone-acetaminophen 5-325 mg one tablet signed out on the CDAR with an unknown signature. The dose had not been signed out on the March 2023 EMAR. The Daily Deployment Sheet for 3/04/23 showed Staff G assigned 2:00 a.m. to 6:30 a.m. the Resident's hallway (Medbridge) at that time. A Facility Investigation, undated, documented stated she did not administer the medication and it is not her signature on the CDAR. Staff G further voice she could not have given the medication at 11:10 p.m. as the medication had not been delivered from the pharmacy at that time. A Pharmacy Delivery Slip showed a signed "wet signature" Staff G signed for the medication delivery 3/05/23 at 3:52 a.m. The 3/05/23 schedule documented Staff A, worked 6-2:30. Staff G handed the medication cart keys off to Staff A at the change of shift.
b. On 3/05/23 the CDAR documented Staff G signed receipt of 14 tablets of hydrocodone-acetaminophen 5-325 mg tablets from the pharmacy.
c. On 3/11/23 at 5:45 a.m., hydrocodone-acetaminophen 5-325 mg 1 tablet signed out on the CDAR by Staff L, RN. The

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dose had not been signed out on the March 2023 EMAR.
d. on 3/13/23 at 3:00 a.m. and 3/14/23 at 5:30 a.m., the CDAR documents one tablet of hydrocodone-acetaminophen 5-325 mg medication signed out by Staff I. Neither of the medication doses were documented in the March 2023 EMAR. The Facility Investigation noted Staff I reported she did not administer those doses of hydrocodone-acetaminophen to Resident #4 and the signatures on the CDAR were not her signatures. The 3/13/23 - 3/14/23 daily schedules documented Staff I worked 2:00 a.m. - 6:30 a.m. on the Medbridge hallway and handed the medication cart keys off to Staff A who worked 6-2:30 p.m. on the Medbridge hallway. A witness statement signed by Staff I as part of the facility investigation documented the 3/13/23, 3/14/23 and 3/15/23 doses that were signed out on the CDAR in Staff I's name were not her signatures. A Time Card Report showed Staff I did not work on 3/14/23 and 3/15/23.
e. On 3/14/23 at 6:05 p.m., Staff E, RN, signed out one tablet of hydrocodone-acetaminophen 35-325 mg on the CDAR, but failed to sign the medication dose out on the March 2023 MAR. The Facility Investigation documented Staff E confirmed she did administer the medication dose.
f. On 3/15/23 at 4:00 a.m., the CDAR documents one tablet of hydrocodone-acetaminophen 5-325 mg signed out by Staff D, RN. The dose had not been signed out on the March 2023 MAR. The Facility Investigation documented Staff D verbalized she did not give this medication. The 3/14/23 daily schedule documented Staff D worked 2 a.m. - 4 a.m. on Medbridge. The 3/15/23 daily schedule documented Staff A worked 6:00 a.m. - 2:30 p.m. on Medbridge. The

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March 2023 Narcotic and Controlled Substance Shift to Shift Count Sheet for Medbridge hallway showed Staff D completed narcotic count with Staff A and handed the medication cart keys to Staff A. A Time Card Report dated 3/15/23 showed Staff A worked 5:59 a.m. - 4:51 p.m. Staff D's Time Card revealed she clocked in 3/15/23 at 1:54 a.m. - 10:57 a.m.

g. On 3/15/23 at 0000, the CDAR showed Staff I signed out one tablet of hydrocodone-acetaminophen 5-325 mg. The dose had not been documented on the March 2023 MAR. The 3/15/23 daily schedule showed Staff I had not been working at the facility at that time. The Facility Investigation detailed the signature on 3/15/23 at 0000 p.m. had not been Staff I's actual signature. The 3/14/23 - 3/15 23 Daily Deployment Sheet documented Staff A worked 6-2:30 p.m. A Time Card Report dated 3/15/23 showed Staff A worked 5:59 a.m. - 4:51 p.m. A Time Card Report for Staff I supported she did not work on 3/15/23.

h. On 3/16/23 at 5:30 a.m. the CDAR detailed one tablet of hydrocodone-acetaminophen 5-325 mg had been signed out by Staff L. The 3/15/23 into 3/16/23 Daily Deployment Sheet revealed Staff L had not been working at that time. The dose had not been documented on the March 2023 EMAR.

i. A Written Statement dated 3/23/23 by Staff I documented the narcotic sign out sheet (CDAR) documented with her initials for March 13, 14, and 15, were not her signatures. A Time Card Report supported Staff I did not work on 3/14/23 and 3/15/23.

On 5/16/23 at 2:46 p.m., Staff D reported she became aware of missing narcotic medication the Monday after Staff A had been walked out of the

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facility. Staff E informed her she may want to look back at the CDAR's as her signature had been used a lot. Staff D looked back at the CDAR's and found her signature had been used when she had not even been working. It was bad enough that Staff A stole medication but she was trying to take other staff down with her. Staff D voiced she had been made when she found out. She thought she had counted at least 15 times that A had signed medications out under her initials. Staff D voiced Resident #4 had been on oxycodone for pain, but she didn't take it that much. Staff D remember the weekend prior to the time change, Resident #4 had pain and took Tylenol and her oxycodone. She voiced she didn't feel good afterward. Later that day Resident #4 had voiced it had been too much pain medication and she wouldn't do that again. However, if you look back, Staff A according to the CDAR had been giving a lot of them. Staff D didn't think Resident #4 would have been taking that many pills. She reviewed Resident #4's CDAR and reported dose #7 3/14/23 at 4:00 a.m. had not been her handwriting. She has not found any other signatures that are not hers since 3/19/23 when Kayla was walked out of the facility. She is the only one that has keys to the medication card. She keeps the keys on her until the shift change over. She doesn't feel anyone could have gotten her keys. The narcotic counts were never off when she counted. She trained Staff A when she came on staff. She noticed during Staff A's orientation, she had been really "flighty." She had a hard time staying focused. She would take medications into a resident room and then start doing other tasks for the residents. She had to really try to keep her on task. Staff A seemed to always be seeking out something to eat and drink all the time. She would wander off.

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During an interview on 5/17/23 at 4:24 p.m., Staff E reported she questioned that Sunday (3/19/23) the CDAR. There had been two residents, she knew that resident would never take 6-7 pain medications in a shift. She voiced it seemed like Staff A had two different signature styles. She would sign one way and give a resident their narcotic medication, then sign her signature another way to steal a medication. She couldn't watch someone steal resident medication. Staff E checked her cell phone and brought up a voicemail on her phone dated 3/19/23 at 4:50 p.m. that contained a recording from the ADON instructing her to keep all staff at the facility (since there had been an issue with the narcotic records). She reported she called the DON and the DON stated she would be coming to the facility.

During an interview on 5/22/23 2:52 p.m., Staff E reviewed Resident #4's CDAR from March 2023. She stated dose #9 and #10 from the sheet were signed out to look like Staff I's signature, but she can tell that is not Staff I's signature. Dose #14 didn't resemble any ofthe nurse known signatures. She pointed out that Staff I had signed out the #11 dose on 3/13/23 at 1:40 a.m. and 13 th dose on 3/09/23 at 2:30 a.m. If you compared the signatures to the writing for the #10 dose on 3/13/23 at 3:00 a.m. and the 9th dose on 3/14/23 at 5:30 a.m. Staff I's signature do not look alike. She reported Staff A also tried to sign Staff D's signature for 3/15/23 at 4:00 a.m. but that is not Staff D's hand writing. She also stated dose #5 signed out on 3/16/23 at 5:30 a.m. is not Staff O's usual signature either. Staff E reported the #8 dose hydrocodone-acetaminophen 5-325 mg dose signed out on of the CDAR on 3/14/23 at

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6:05 p.m. is her signature.

3. The March 2023 EMAR for Resident #4 revealed administration of oxycodone (Roxicodone) oral tablet 5 mg, give 1 tablet by mouth every 4 hours as needed for pain control as follows.
a. On 3/05/23 at 7:40 a.m., for a pain level of 10 on a 1-10 pain scale by Staff A; dose effective.
b. On 3/05/23 at 7:27 p.m., for a pain level of a 4 on a 1-10 pain scale by Staff E; dose effective.
c. On 3/07/23 at 4:08 a.m., for a pain level of a 5 on a 1-10 pain scale by Staff C; dose effective.
d. On 3/10/23 at 6:15 a.m., for a pain level of 9 on a 1-10 pain scale by Staff A; dose ineffective.
e. On 3/18/23 at 6:36 a.m., for a pain level of 5 on a 1-10 pain scale by Staff A; dose ineffective.
f. On 3/19/23 at 6:18 a.m., for a pain level of 10 on a 1-10 pain scale by Staff A; dose ineffective.

A review of Resident #4's Controlled Drug Administration Record (CDAR) showed a pharmacy label reading: oxycodone IR 5 mg tablets (generic for Roxicodone) take 1 tablet by mouth every four hours as needed for pain x 7 days. The CDAR documented the facility received 12 tablets on 3/18/23. Further review revealed no doses of the oxycodone medication had been signed out on the CDAR. The CDAR documented the signature of the DON and Staff E, RN destroyed 12 tablets of the narcotic medication. The CDAR did not contain a date the destruction took place.

On 5/15/23 at 12:01 p.m., Staff C explained she signs out the narcotics in the CDAR and the EMAR. She administers her own PRN pain narcotics. The medication keys always stay with

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her. She ensures the oncoming nurse does the Narcotic Count with her. They look at both the medication narcotic card and the narcotic sign out sheets. The counts are done at the beginning and end of the shift. She has never had a Narcotic Count be off, if she did, she would report it to the DON.

On 5/16/23 at 7:20 a.m., Staff D reported the Pharmacy sends out a Narcotic Count Sheet with each medication card. Some of the nurses throw all the narcotics they sign out on one sheet instead of using the narcotic sheet that comes with the card. She verifies the count when pharmacy delivers a new narcotic medication card and circles the count number on the narcotic sheet. She writes the amount received on the top of the narcotic sheet. She reported at 7:31 a.m. in regard to documenting out a narcotic medication they assess the resident's pain level, why they are requesting the medication, check the physician order, sign out in the EMAR and on the narcotic count sheet. If the count is off, she would notify the DON or ADON for an immediate investigation. She has never had the count be off.

On 5/18/23 at 7:56 a.m., Staff D reported when the Pharmacy delivers the medications to the facility, the Pharmacy requires them to sign a sheet of paper showing they received the medication. The Pharmacy person takes a copy and leaves a copy for the facility. The Pharmacy provides a CDAR for each narcotic card of medication that is delivered. She circles the number of doses on the CDAR to match the number that were delivered on the delivery slip. They are required to sign a narcotic pain medication out on the resident's CDAR and the EMAR. The Pharmacy Delivery Slip goes into the

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24 hour communication book.

On 5/22/23 at 2:22 p.m., Staff O, LPN voiced she had worked at the facility since September 2022. She received training from Staff D as her preceptor and went through medication administration and signing out of narcotics as part of her orientation. She explained she signs out a narcotic for administration in the EMAR and the CDAR. If the count is off, she would report to the DON. She would review to see if a nurse forgot to sign out a dose, but if there is a mistake in the narcotic count she would notify the DON immediately. She has never had to report any issues with the narcotic count to the DON.

During an interview on 5/23/23 at 1:35 p.m., the DON reported she expected the nurses to document all PRN narcotic medication doses on the CDAR and on the EMAR so that a follow-up pain assessment could be completed.

On 5/23/23 2:35 p.m., Staff Q, LPN, reported they are required to sign narcotic pain medications out on the CDAR and the EMAR. He has to record the amount of pain and the location of the pain. The EMAR system will flag for him to do a follow up on any pain medications that will go to a progress note in the resident's chart.

On 5/23/23 on 2:42 p.m., the DON reviewed the March 2023 EMAR for oxycodone as needed order and the March 2023 CDAR. She reported she remembered wasting Resident #4's narcotics. She did not have an explanation for why the oxycodone had been signed out as administered on the March 2023 EMAR and had not been signed out on the March 2023 CDAR.

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On 5/23/23 at 2:57 p.m., the DON reported she did not have an answer for the discrepancy on Resident #4's records. She acknowledged the 7 day limit on the oxycodone label the pharmacy had placed on the CDAR and the facility physician order for oxycodone did not have a time limit on the order. The DON returned at 3:02 p.m. and reported the Pharmacy verified they sent out 12 tablets of oxycodone. The DON also reported the Pharmacy confirmed they sent out a medication card containing 30 tablets of oxycodone that the facility did not have a CDAR on.

An interview with the Pharmacist on 5/24/23 at 9:55 a.m., revealed the Pharmacy had sent 9 tablets of oxycodone to the facility on 3/5/23; 30 tablets of oxycodone on 3/10/23 and 12 tablets of oxycodone on 3/18/23. The Pharmacist checked the records at 10:03 a.m. and voiced the facility had not returned any of the medication cards to the Pharmacy.

During an interview on 5/24/23 at 10:25 a.m., the Administrator explained he had been aware of the missing CDAR for Resident #4. He had looked all over the facility for the CDAR and had not found the records.

On 5/24/23 at 10:50 a.m., Staff P Medical Records/Scheduler reported she could not find a CDAR for Resident #4 oxycodone 9 tablets. She stated she had reported it to the Administrator and he had already talked to the Surveyor about it.

During an interview on 5/24/23 at 12:15 p.m., the DON reported she had not been aware of Resident #4 missing a CDAR for an oxycodone

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count of 9 tablets. The nurses are to document the narcotic delivery on the Master Controlled Substance Log and they circle the count number received on the CDAR however, she commented they do this, but it is not a facility policy. She reported two nurses have to destroy narcotics and document the destruction on the CDAR record. She stated the paper they filled out and attached to the CDAR following destruction had been under the old processes and management. They no longer do that. Both nurses sign the CDAR for the quantity of tablets destroyed.

On 5/31/23 at 9:55 a.m., the Administrator provided an Audit Record dated 4/25/23 that detailed for Resident #4 the pharmacy delivered 14 tablets of hydrocodone-acetaminophen 5-325 mg on 3/05/23. The CDAR showed 10 tablets signed out. The EMAR documented 4 doses signed out for administration. The medication card had 4 remaining tablets. The Audit Report documented 6 discrepancies in the records. The audit documented one dose had been signed out by an agency staff nurse. The facility could not confirm the accuracy so would reimburse out of good faith. The Audit Report documented the pharmacy delivered 9 tablets of oxycodone IR 5 mg on 3/05/23. The EMAR showed 4 doses signed out as administered. The audit detailed the facility had no CDAR and no amount remaining due to no CDAR. The Audit Report detailed the pharmacy delivered 30 tablets of oxycodone IR 5 mg on 3/11/23. The EMAR showed two doses of the medication had been signed as administered. The facility had no CDAR and the audit documented "unknown" for the remaining medication card. The facility could not produce documentation to show what happened to the oxycodone 9 tablet or 30 tablet medication

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cards or narcotic records.

4. The MDS for Resident #5 dated 3/7/23 showed a BIMS of 15 indicating intact cognition. The Resident required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. The Resident received scheduled and as needed pain medication for occasional pain of a 6 on a 1-10 scale including the use of opioid medications 7 days of the lookback period. The MDS listed diagnoses of spina bifida (a birth defect in which an area of the spinal column doesn't form properly leaving a section of the spinal cord and spinal nerves exposed through an opening in the back), diabetes mellitus, paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) anxiety, depression and a stage 3 pressure injury.

The Care Plan dated 7/24/18 included a focus Resident #5 had a history of pain to the bilateral flank related to kidney and ureter calculus (the presence or formation of stones within the ureters, which are the tubes responsible for the passage of urine from the kidneys to the bladder); left shoulder pain; chronic history of migraines, chest pain and burning hips. The Care Plan directed the nurses to administer pain medication per the physician orders with a goal the Resident would express that her pain management stayed within acceptable limits.

A Physician/Prescriber Order Sheet signed by the Provider on 3/1/23 approved the Resident's orders and plan of care. The physician orders included oxycodone hydrochloride (HCL) (narcotic/opioid pain medication) tablet 10 mg, give one tablet by mouth every 6 hours as

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needed for dressing changes and breakthrough pain.

A review of the CDAR, March 2023 EMAR, March 2023 Daily Deployment Sheets, Facility Investigation and March 2023 Vital Sign records for Resident #5's use of oxycodone immediate release 10 mg tablet, give one tablet by mouth every 6 hours as needed for dressing changes and breakthrough pain revealed the following discrepancies:
a. On 3/8/23 at 4:15 p.m., the CDAR showed one tablet signed out by Staff I. The 3/08/23 Daily Deployment Sheet showed Staff I worked from 10 p.m. - 2:00 a.m. on the Linn Hallway and 2 a.m. to 6:30 a.m. on the Medbridge hallway. Staff I had not been assigned to Resident #5's hallway (Legacy). The Facility Investigation documented Staff I reported the signature on the CDAR had not been her actual signature. The dose had not been signed out on the March 2023 EMAR. The 3/08/23 Daily Deployment Sheet showed Staff A worked on Resident #5's hallway (Legacy) from 6 a.m. - 2:30 p.m. A Time Card Report showed Staff A clocked in from 5:59 a.m. - 3:02 p.m.
b. On 3/08/23 at 10:40 a.m., one dose of the medication had been signed on the CDAR by Staff A. The dose had not been signed out on the March 2023 EMAR. The Vital Sign record dated 3/08/23 documented Resident #5 with a pain level of 0 on a 1-10 pain scale.
c. On 3/12/23 at 9:00 p.m. and 4:30 a.m., a dose oxycodone 10 mg had been signed had been signed out on the CDAR by Staff C, Licensed Practical Nurse (LPN). Neither dose had been signed out on the March 2023 MAR. The Facility Investigation detailed Staff C stated she did not administer these medication doses and the signatures on the CDAR were not her signatures.

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The 3/12/23 Daily Deployment Sheet showed Staff C had not been assigned to Resident #5's hallway (Legacy). Staff C had been assigned to the TCU hallway from 2 p.m. - 2 a.m. The Vital Sign record dated 3/12/23 documented Resident #5 with a pain level of 0 on a 1-10 pain scale.
The 3/13/23 Daily Deployment Sheet showed Staff A assigned to the Legacy hallway from 6 a.m. - 2:30 p.m.
d. On 3/13/23 at 2:45 a.m., the CDAR showed one 10 mg tablet of the narcotic medication signed out by Staff I. The dose had not been documented as administered on the March 2023 EMAR. The Facility Investigation documented Staff I verbalized she did not administer this dose of medication to Resident #5 and the signature had not been her signature. The 3/13/23 Daily Deployment Sheet detailed Staff I did not work Resident #5 hallway (Legacy). Further review of the 3/13/23 daily schedule showed Staff A assigned to the Legacy hallway working the day shift.
e. On 3/13/23 at 1:05 p.m., one dose signed out on the CDAR by Staff A. The dose had not been documented as administered on the March 2023 EMAR.
f. Per the Facility Investigation, Resident #5 reported she only remembered getting one dose of her pain medication on 3/13/23, not two doses. The Vital Signs Record dated 3/13/23 showed Resident #5 with a pain level of 5 at 8:41 a.m.; pain level of 2 at 9:43 a.m.; and a pain level of a 5 at 9:51 a.m. on a 1-10 pain scale. All the 3/13/23 pain levels were documented in the Vital Signs Record by Staff A.
g. A Written Statement signed by Staff C on 3/23/23 documented she did not administer oxycodone to Resident #5 on 3/12/23.
h. A Written Statement signed by Staff I on

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3/23/23 documented she did not administer narcotics to Resident #5 on 3/08/23 and 3/13/23. The medications had been signed out under her name, but she had not administered those doses.

During an observation on 5/15/23 at 1:41 p.m., Resident #5 sat in the reclined wheelchair in her room. She stated she didn't feel good and hadn't had a good day. She reported getting her oxycodone. She couldn't recall any time she had asked for her oxycodone and not gotten it. She stated her pain is controlled the best it can be.

On 5/15/23 at 3:35 p.m., Staff C, LPN, explained the DON came to her and specifically asked her about not signing out as needed pain medications in the EMAR for Resident #5. They looked at the narcotic book sign out. The narcotic medications were signed out as "RK agency" on the narcotic sheet. She stated she had never signed her name that way. There were pain medications signed out on Legacy and she had not been assigned to Legacy. At 3:42 p.m. Staff C reviewed the CDAR for 3/12/23 at 4:30 a.m. and 1:30 p.m. She verified the document did not contain her signature for those medications. She reviewed the schedule and had been assigned to the TCU hallway. Resident #5 resided on the Legacy hallway. Staff C voiced after 10 p.m. she had both the TCU and Legacy hallways. She reported off to Staff A at 6 a.m. that next morning. She stated when they completed the Narcotic Count in the morning the count had been on. She did not recall there being any narcotics documented as given during the night shift when the narcotic count had been completed for Resident #5.

During a review of Resident #5's CDAR on

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5/22/23 at 10:50 p.m., Staff I, stated Resident #5 gets what she calls a "cocktail." Resident #5 generally always asks for a cyclobenzaprine and hydrocodone together between 1-2 a.m. She had reviewed the signature with the DON. The signatures on Resident #5's CDAR 3/08/23 and 3/13/23 were not her signatures. The time of the administration for Resident #5 struck her as odd. Resident #5 doesn't ask for her pain medication at the time of the early morning. She doesn't work Resident #5's hallway (Legacy) often. They have another nurse, Staff G, when she is on she works Medbridge and the Linn hallway. Staff I reported then she works the Legacy and TCU hallways, but that is only 1 or 2 times a month.

On 5/31/23 at 9:55 a.m., the Administrator submitted an Audit report dated 4/25/23 that documented Resident #5 received from pharmacy on 2/11/23 30 tablets of oxycodone IR 10 mg. The CDAR showed 28 doses had been signed off on the record. The EMAR had 22 doses documented as administered. The medication card had 2 doses of the medication remaining at the time of audit. The audit noted 6 discrepancies in the medical records.

5. The MDS Assessment dated 3/17/23 for Resident #6 showed a BIMS score of 15 indicating intact cognition. The Resident required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. The MDS documented Resident #6 utilized as needed pain medication for occasional pain of a 3 on a 1-10 pain scale. The MDS showed the Resident utilized opioid medications 4 out of 7 days of the look-back period. The MDS listed a diagnosis of cellulitis, end stage renal disease and

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Non-Alzheimer's Dementia.

The Care Plan dated 3/14/23 identified Resident #6 at risk for pain related to arthritis, diabetic neuropathy, and incision to a right below knee amputation and directed the nurses to provide analgesics as physician ordered and monitor for non-verbal signs of pain.

An Order Recap Report detailed the following physician orders:
a. Hydrocodone-acetaminophen (narcotic/opioid pain medication) oral tablet 5-325 mg. Give 1 tablet by mouth every 6 hours as needed for pain. Start Date 3/14/2023. Discontinuation date 3/15/23.
b. Hydrocodone-acetaminophen oral tablet 5-325 mg. Give 1 tablet by mouth every 8 hours as needed for pain. Start Date 3/15/2023. Discontinuation date 3/25/23.
c. Hydrocodone-acetaminophen oral tablet 5-325 mg. Give 1 tablet by mouth every 6 hours as needed for pain. Start Date 3/31/2023. Discontinuation date 4/18/23.

A review of the CDAR, March 2023 EMAR, March 2023 Daily Deployment Sheets, Facility Investigation and Vital Sign records for Resident #6's use of hydrocodone 5-325 mg as needed medication orders revealed the following discrepancies for a medication card count of 9 tablets:
a. On 3/14/23 at 5 a.m., the CDAR showed Staff D signed out one tablet of 5-325 mg hydrocodone-acetaminophen from the CDAR of 9 hydrocodone-acetaminophen tablets. The dose had not been documented on the March 2023 EMAR. The 3/14/23 Daily Deployment Sheet showed Staff D did not work on 3/14/23. The

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3/14/23 Daily Deployment Sheet showed Staff A worked 6-2:30 p.m. on Resident #6's hallway (Medbridge).
b. On 3/15/23 the CDAR showed a 5-325 mg hydrocodone-acetaminophen dose signed with an illegible time by Staff I. The next hydrocodone-acetaminophen dose 5-325 mg one tablet dose had been signed out 3/15/23 at 5:00 p.m. Staff I had not been working at the time the 3/15/23 dose with the illegible time had been signed out. The Daily Deployment Sheet dated 3/15/23 showed Staff A worked the Medbridge hallway from 6 a.m. - 2:30 p.m. and would have had the medication cart key for the narcotic lock up. A Time Card Report showed Staff A worked 5:59 a.m. - 4:51 p.m. A Time Card Report for Staff I supported she had not worked on 3/15/23.
c. On 3/17/23 at 11:00 a.m. and 4:30 p.m., the CDAR showed unidentified signatures had signed out one tablet each time of the hydrocodone-acetaminophen 5-325 mg medication for Resident #6. The Facility Investigation noted Staff C worked at noon on 3/17/23 and reported she had not given the medication and it is not her signature on the record. Staff M, RN, worked at 4:30 p.m. and reported he did not administer a 4:30 p.m. dose of the medication to Resident #6 and the signature on the record had not been his. Neither of the doses had been signed as administered on the March 2023 EMAR.
d. On 3/18/23 at 4:20 a.m., the CDAR showed Staff D signed out one tablet of hydrocodone-acetaminophen 5-325 mg from the narcotic lock up. The dose had not been signed out as administered on the March 2023 EMAR. The 3/18/23 Daily Deployment Sheet documented Staff D did not work at 4:20 a.m. Staff D's shift started at 6:00 a.m. on the Legacy hallway.

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e. On 3/18/23 at 8:30 a.m. and 1:00 p.m., the CDAR showed Staff A signed a tablet out at these times from the narcotic lock up. The Facility Investigation notes only one of the doses had been documented out properly in the EMAR and it had been the once a daily dosing order, not the PRN as needed order. This finished the hydrocodone-acetaminophen 5-325 mg medication card of 9 tablets. A Time Card Report for Staff D showed she clocked in for work at 5:54 a.m. on 3/18/23.
f. A Written Statement dated 3/20/23 documented by Staff D detailed 3/14/23, she did not work on 3/14/23 and 3/17/23. She had only worked 4 hours, 6:00 a.m. - 10:00 a.m. on 3/18/23 on the Legacy Hallway. She had not given the medications on 3/14/23 or 3/18/23 at 4:20 a.m. A time Card Report supported Staff D did not work on 3/14/23 and 3/18/23.
g. A Handwritten Statement dated 3/28/23 signed by Staff E documented she did not administer a PRN hydrocodone at 5:30 p.m. to patient #6. It is not her signature. Also, on 3/18/23 she had been the nurse on Resident #5's hallway but did not administer any hydrocodone to him and it is not her signature on the record.

A review of the CDAR, March 2023 EMAR, March 2023 schedules, Facility Investigation and Vital Sign records for Resident #6's use of hydrocodone 5-325 mg. as needed medication orders revealed the following discrepancies for a medication card count of 24 tablets:
a. On 3/15/23 at 4:25 a.m. A Pharmacy Packing Slip showed Staff D signed for 9 and 24 tablets of hydrocodone-acetaminophen 5-325 mg for Resident #6.
b. The Facility Investigation documented the CDAR provided by Pharmscript for a 24 count of

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hydrocodone-acetaminophen 5-325 mg for Resident #6 had been changed out. The CDAR found by the facility in the narcotic book had been a blank Omnicare sheet. The Resident's physician order for hydrocodone-acetaminophen 5-325 mg BID and PRN every 6 hours had been hand written in on the Record. The BID order for the medication had not been given until the afternoon of 3/15/23.

c. On 3/14/23 at 3:00 a.m. the CDAR showed Staff D signed out one tablet of hydrocodone-acetaminophen 5-325 mg from the narcotic lock up. The Daily Deployment Sheet lacked documentation Staff D had worked on 3/14/23. A Time Card Report detailed Staff D did not work on 3/14/23.

d. The Facility Investigation documented on 3/15/23 at 12:15 p.m. the order changed to hydrocodone-acetaminophen 5-325 mg on tablet by mouth every 8 hours as needed. Staff A signed one 5-325 mg tablet of hydrocodone-acetaminophen out of the narcotic lock up at 1:00 p.m. Staff A failed to document the dose as administered on the March 2023 EMAR.

e. On 3/16/23 at 5:30 p.m. the CDAR showed one 5-325 mg hydrocodone-acetaminophen tablet signed out by an illegible signature. The Facility Investigation documented Staff E, reported she did not give the medication that night and the signature on the Record is not her signature. The 3/18/23 Daily Deployment Sheet showed Staff A worked on Medbridge hallway 6-2:30 p.m. She signed out the next dose of hydrocodone-acetaminophen 5-325 mg PRN dose on the CDAR on 3/18/23 at 8:30 a.m. The dose had not been documented as administered on the March 2023 EMAR. The Facility Investigation detailed the dose would not have been necessary as Staff A had administered a

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scheduled dose of the hydrocodone-acetaminophen 5-325 mg at the same time. A Time Card Report dated 3/16/23 showed Staff A worked 5:40 a.m. - 4:28 p.m.
f. On 3/18/23 at 5:30 p.m. the CDAR showed one tablet of hydrocodone-acetaminophen 5-325 mg signed out by an illegible signature. The Daily Deployment Sheet for 3/17/23 documented Staff E assigned to the hallway 2-10:30 p.m. The Facility Investigation detailed Staff E stated she did not give Resident #6 a PRN narcotic that night and the signature on the Record had not been her signature. The Daily Deployment Sheet showed Staff A assigned the Medbridge hallway on 3/19/23 6-2:30 p.m. A Time Card Report documented Staff A worked 5:58 a.m. - 5:45 p.m.

On 5/15/23 at 3:35 p.m., Staff C voiced regarding Resident #6 he resided on Medbridge wing. Staff C reviewed the March 2023 CDAR for 3/17/23 at noon and voice she did not know who the signature belonged to, but the signature didn't belong to her. She had been assigned to the Medbridge hallway per the schedule. She verified her initials were on the 3/17/23 7:00 a.m. dose that had been signed out, but she didn't identify the signature as her signature.

During an interview on 5/16/23 at 2:46 p.m., Staff D reported sometimes she worked a 4-hour early morning shift. She remembers the DON questioned her on her signing in the narcotic medication cards from the pharmacy. She always uses the CDAR that comes with the medication card and she circles the number of narcotic pills she receives on the card. For some reason Staff A got rid of the original CDAR for Resident #6. Staff D reviewed Resident #6's Controlled Medication Utilization Record (narcotic sheet)

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from 3/14/23 and reported the signature on the CDAR documented as receiving the 24 tablets of his narcotic is not her signature. She had accepted the card, but the documentation on the CDAR is not hers. Staff A made out a new sheet because the physician had scheduled the hydrocodone to BID and PRN which is why she made out a new sheet. Staff A got rid of the original CDAR from the pharmacy. They could not find the CDAR. Staff D reviewed the writing for 3/14/23 at 3:00 a.m. and reported the initials on the record were not her handwriting. Staff D reviewed the 3/17/23 Noon CDAR documentation reported the initials on the CDAR were not hers. She did not work that day. She had requested that 3/17/23 off. Staff D also identified the initials documented on the CDAR for 3/18/23 at 4:20 a.m. were not her written initials. She has not found any other signatures that are not hers since 3/19/23 when Staff A had been removed from the facility. Once all narcotic doses are administered, the sheets are put in the 24 hour folder and they go to the Unit Supervisors/Assistant Director of Nursing, then the records go to Medical records. She found one of the count records in the chart and they didn't know why that would happen. Those records do not get stored in the chart.

On 5/31/23 at 9:55 a.m., the Administrator provided an Audit dated 4/25/23 that showed the Pharmacy delivered 9 tablets of hydrocodone-acetaminophen 5-325 mg on 3/15/23. The CDAR had all 9 doses signed out. The EMAR showed 3 doses of the medication had been signed out as administered. The Audit noted 6 discrepancies in the record. The Pharmacy delivered 24 tablets of hydrocodone-acetaminophen 5-325 mg on 3/15/23. The CDAR showed 9 doses had been

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signed out. The EMAR documented 3 doses had been signed out. Fifteen tablets remained in the medication card. The Audit documented 6 discrepancies in the medical records for Resident #6.

6. The MDS dated 3/3/23 for Resident #14 showed a BIMS score of 14 indicating intact cognition. The Resident required extensive assistance with bed mobility, dressing and toileting. The MDS identified the resident received scheduled pain management for frequent pain of a 4 on a 1-10 pain scale and utilized opioid medication 1 day during the 7 day lookback period. The MDS listed diagnoses of right fibula fracture, diabetes mellitus, hyperlipidemia and chronic obstructive pulmonary disease.

The Care Plan dated 3/01/23 documented Resident #14 with pain to the right leg related to a fracture. The Care plan detailed a goal to reduce periods of breakthrough pain and directed the nurses to notify the physician if pain frequency/ intensity worsens or if the analgesia regimen becomes ineffective.

A After Visit Summary electronically signed by the Provider on 3/01/23 listed the following medication orders:
a. Oxycodone-acetaminophen 5-325 mg per tablet. Take 1-2 tablets by mouth every 4 hours as needed for pain. Along side the physician order in hand writing appeared a triangle indicating "change" with "1 tab" written in.

The March 2023 EMAR listed the following physician orders:
a. Oxycodone -acetaminophen oral tablet 5-325

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mg, give 1 tablet by mouth every 4 hours as needed for pain. Start Date 3/01/2023.

A review of the CDAR March 2023 MAR, facility investigation, March 2023 vital sign pain record and March 2023 schedules revealed the following discrepancies regarding the administration of oxycodone-acetaminophen 5-325 mg one tablet by mouth every 4 hours as needed for Resident #14:

a. On 3/04/23 at 0000 p.m., the dose of oxycodone-acetaminophen 5-325 mg one tablet had been signed on out on the CDAR with an unknown signature. The dose had not been signed out on the March 2023 EMAR. A review of the 3/03/23 into 3/04/23 Daily Deployment Sheet revealed Staff G had been the scheduled charge nurse over the Resident's hallway 2:00 a.m. - 6:30 p.m. The Facility Investigation cited Staff G claimed the unknown signature on the 3/04/23 0000 p.m. CDAR had not been her signature. The March 3/04/23 Daily Deployment Sheet listed Staff A had been the day shift charge nurse following Staff G and had access to the medication cart narcotic lockup. The March 2023 Narcotic and Controlled Substance Shift to Shift Count Sheet for 3/04/23 documented Staff G completed narcotic count with Staff A.

b. On 3/04/23 at 11:00 a.m. and 3:00 p.m., doses of the oxycodone-acetaminophen 5-325 one tablet dose had been signed out by Staff A on the CDAR, but had not been signed on the March 2023 MAR.

c. On 3/04/23 at 9:30 p.m., the oxycodone-acetaminophen one tablet is signed out on the CDAR, but is not signed out on the March 2023 MAR. A review of the March 3/04/23 Daily Deployment Sheet revealed Staff E as the nurse assigned the Resident's hallway. The

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Facility Investigation cited Staff E related the signature on the CDAR for that time had not been her signature. The Vital Sign record documented the Resident had a pain level of 9 on a 1-10 pain scale documented on 3/04/23 at 7:08 a.m. and a pain level of 5 on a 1-10 pain scale at 9:54 a.m. and by Staff A.

d. On 3/05/23 at 2:40 a.m., and at an unknown time the medication is signed out on the CDAR with an unknown signature. Neither dose had been signed out on the March 2023 MAR. The Facility Investigation documented logic would dictate the unknown time would have been prior to 6:00 a.m.

e. On 3/05/23 at 6:12 a.m., 10:30 a.m. and 2:00 p.m., a dose of the narcotic medication had been signed out by Staff A on the CDAR. None of the doses had been signed out on the March 2023 EMAR.

f. On 3/09/23 at 4:30 p.m., the CDAR showed an oxycodone-acetaminophen 5-325 mg one tablet dose signed out by an unknown signature. The medication dose had not been documented on the March 2023 EMAR. The 3/09/23 Daily Deployment Sheet listed Staff N assigned to Resident #14's hallway (Medbridge). The Facility Investigation detailed the signature on the CDAR did not belong to Staff N. The Daily Nursing Evaluation dated 3/09/23 signed 10:04 documented Resident #14 had a 0 level on a 1-10 pain scale.

g. On 3/10/23 at 00:45 a.m., the CDAR showed an oxycodone-acetaminophen 5-325 mg one tablet dose signed out by Staff I. The Facility Investigation cited Staff I had not been working Medbridge hallway. The dose had not been documented on the March 2023 EMAR.

h. On 3/10/23 at 6:30 a.m. and noon, the CDAR showed Staff A had signed out doses of the

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oxycodone-acetaminophen 5-325, one tablet. None of the doses were documented as administered on the March 2023 EMAR.
i. Dose #9 on the CDAR is documented as administered at 5:00 p.m. with no date written in on the CDAR. The March 2023 EMAR shows Staff C documented out administration of the oxycodone-APAP 5-325 mg 1 tablet PRN for 3/10/23 at 6:12 p.m.
j. On 3/13/23 at 4:00 a.m., the CDAR showed Staff I signed out one tablet of hydrocodone-acetaminophen 5-325 mg from the narcotic lock up. The March 2023 EMAR shows the dose had not been documented as administered to Resident #14. The Facility Investigation cited the signature on the Record is not Staff I's signature.
k. On 3/13/23 at 10:00 p.m., the CDAR showed one tablet of oxycodone-acetaminophen 5-325 mg signed out of the narcotic lock up by an unknown signature. The narcotic dose had not been signed out on the March 2023 EMAR as administered to the Resident. The Facility Investigation cited this dose had been signed out during shift change. The nurses at the change of shift were Staff M and Staff I, but neither of the signatures were their signatures on the CDAR.
l. On 3/14/23 at 3:30 a.m., the CDAR showed Staff I signed out the oxycodone-acetaminophen 5-325 mg one tablet dose from the narcotic lock up. The dose had not been documented on the March 2023 EMAR. The Facility Investigation cited the signature on the Record it not Staff I's signature. The next three doses of the medication were signed out 3/14/23 at 6:30 a.m., 11:00 a.m., and unknown time by Staff A. None of the narcotic medication doses were signed out on the March 2023 EMAR. This was the end of the narcotic medication card.

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m. The Facility Investigation documented Staff A signed out the next two doses of hydrocodone-acetaminophen 5-325 mg on a new CDAR of 30 tablets of oxycodone 3/13/23 at 9:30 a.m. and 1:10 p.m. None of these narcotic doses are signed out on the March 2023 EMAR. The Daily Deployment Sheet 3/13/23 showed Staff A had not been assigned the Resident #14's hallway.

n. on 3/14/23 at 4:30 a.m., the CDAR Record show one tablet of hydrocodone-acetaminophen 5-325 mg signed out by an unknown signature. The dose is not documented as administered on the March 2023 EMAR. The Facility Investigation cited Staff I as "on duty" but it is not her signature on the CDAR. 3/14/23 at 9:30 a.m. Staff A signed out one tablet of hydrocodone-acetaminophen 5-325 mg for Resident #14. The dose had not been documented as administered in the March 2023 EMAR. A Time Card Report showed Staff I did not work on 3/14/23.

o. On 3/14/23 at 2:50 p.m., the CDAR showed one table of oxycodone-acetaminophen 5-325 mg signed out of the narcotic lock up with an unknown signature. The narcotic dose had not been signed out on the March 2023 EMAR. The Facility Investigation cites the nurse on duty as Staff E but it is not her signature on the CDAR.

p. The next dose of the narcotic medication signed out on the CDAR is 3/15/23 at 7:10 a.m. by Staff A. The dose signed out on the CDAR at 11:30 p.m. is not documented on the March 2023 EMAR as administered by Staff A.

q. On 3/17/23 at noon, the CDAR showed Staff D signed out one tablet of hydrocodone-acetaminophen 5-325 mg from the narcotic lockup. The narcotic dose is not documented as administered on the March 2023 EMAR. The Facility Investigation cited Staff D did

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not work at this time and the signature on the CDAR had not been her signature. A Time Card Report supported Staff D did not work on 3/17/23.
r. On 3/18/23 at 9:00 a.m., the CDAR showed Staff D signed out one tablet of hydrocodone-acetaminophen 5-325 mg from the narcotic lock up. The narcotic dose had not been documented as administered to the Resident on the March 2023 EMAR. The 3/18/23 Daily Deployment Sheet showed Staff A assigned 6-2:30 p.m. on the Medbridge hallway. Staff A would have been in charge of the medication cart keys for Resident #14's hallway. The Facility Investigation cited Staff A had been the nurse on the Medbridge hallway. A Time Card Report documented Staff A worked 5:58 a.m. - 5:45 p.m.
s. On 3/18/23 at 5:55 p.m., the CDAR documented an unidentified signature signed out a one tablet of hydrocodone-acetaminophen 5-325 mg from Resident #14's PRN medication card. The Facility Investigation documented Staff E as the nurse on duty and the signature on the CDAR is not her signature.
t. On 3/18/23 at 10:00 p.m., showed one tablet of hydrocodone-acetaminophen 5-325 mg signed out on the CDAR by an unknown signature. The Facility Investigation notes this had been at the change of shift and the charge nurse would have been either Staff E or Staff G, but the recorded signatures on the narcotic record are neither of their signatures.
u. On 3/19/23 at 2:30 a.m., one dose of hydrocodone-acetaminophen 5-325 mg had been signed out on the CDAR by Staff I. The Facility Investigation cited Staff I had not been working on 3/19/23. The next two doses of Resident #14's hydrocodone-acetaminophen 5-325 mg PRN doses were signed out on the CDAR 3/19/23 at 6:40 a.m. and 11:35 a.m. by Staff A. Neither of

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the narcotic doses were signed as administered to Resident #14 on the March 2023 EMAR.
v. A Written Statement completed by Staff I on 3/23/23 documented the narcotics signed out in her name on 3/13/23 and 3/19/23 had not been administered by her.

On 5/22/23 at 10:50 p.m., Staff I voiced the narrative in the Facility Investigation for Resident #14 is a true statement regarding her signatures.

An interview conducted on 5/22/23 at 3:02 p.m., with Staff E revealed Resident #14 never had pain. She hadn't been the type to ask for as needed pain medication often.

On 5/31/23 at 9:55 a.m., the Administrator provided an Audit Record dated 4/25/23 that detailed Resident #14 had a pharmacy delivery on 3/02/23 of oxycodone IR 5 mg, 30 tablets. The facility had no CDAR. The EMAR showed no doses of the medication had been signed out as administered. The amount remaining on the medication card could not be accounted for. The audit detailed 30 discrepancies from the audit. The facility could not account for what happened to the CDAR or the medication card.

7. The MDS dated 3/17/23 for Resident #15 showed a long/short term memory impairment with moderately impaired decision-making capabilities. The Resident required extensive assistance of two staff for bed mobility, transfer, dressing, toileting and personal hygiene. The Resident received scheduled and as needed pain medication for a constant pain level of 7 on a 1-10 pain scale. The MDS identified the Resident received two days of opioid medication in the

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7-day lookback period. The MDS listed diagnoses of sepsis, cancer, anemia, atrial fibrillation, Benign prostatic hyperplasia, end stage renal disease and pneumonia.

The Care Plan dated 3/11/23 detailed Resident #15 at risk for pain related to arthritis and pressure ulcers and directed the nurses to administer analgesics as physician ordered, observe for non-verbal signs of pain and evaluate the efficacy of the pain management program.

A Hospital Prescription dated 2/16/23 documented a Physician Order for hydromorphone 2 mg by mouth every 4 hours as needed for pain.

A Telephone/Verbal Order Signature Detail Report documented a physician order dated 3/10/23 for hydromorphone HCL tablet 2 mg, give one tablet by mouth every 4 hours as needed for pain.

A review of the of the Controlled Medication Utilization Record for February 2023 Hydromorphone HCL 2 mg take one tablet by mouth every four hours as needed for pain for Resident #15 documented the following:
a. On 2/18/23 7:00 a.m., 2 tablets signed out by Staff A and not documented on the February 2023 MAR.
b. On 2/18/23 at 1:05 p.m., 2 tablets signed out by Staff A and not documented on the February MAR.
c. On 2/22/23 at 8:45 a.m., 1 tablet signed out by Staff A and not documented on the February EMAR.
d. On 2/22/23 at 1:45 p.m., 1 tablet signed out by Staff A and not documented on the February 2023 MAR.

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e. On 2/23/23 at 1: 30 p.m., 1 tablet signed out by Staff A and not documented on the February 2023 MAR.
f. On 2/24/23 at 12:00 p.m., 1 tablet signed out by Staff A (Logic would follow this is 2/25/23 date). The dose had not been documented on the February 2023 MAR.
h. On 2/25/23 at 1:00 p.m., 1 tablet signed out by Staff A and not documented on the February 2023 MAR.
i. On 2/24/23 at 2:00 p.m., 1 tablet signed out by Staff A (Logic would follow this is 2/25/23 date), and not documented on the February 2023 MAR.
j. On 2/28/23 at 0000 a.m., 1 tablet signed out by a signature that could not be identified and not documented on the February 2023 MAR.
k. On 2/28/23 at 12:00 p.m., documentation did not specify the amount of medication taken out of lockup by Staff A. The count went from 9 tablets to 8 tablets. The dose had not been documented on the February 2023 MAR.
l. On 2/28/23 at 1:45 p.m., the documentation did not specify the amount of hydromorphone taken out of lock up by Staff A. The Narcotic Count went from 8 tablets to 7 tablets remaining.
n. On 2/28/23 at 3:25 p.m., an unknown signature signed out 1 tablet of hydromorphone from the narcotic lock up. The medication count went from 7 to 6 tablets. The dose had not been documented on the February MAR. Neither doses were signed out on the February 2023 MAR.

Resident #15's second CDAR noted the following discrepancies:
a. On 3/14/23 at 3:30 a.m., showed Staff I documented she signed out 1 tablet of hydromorphone 2 mg on the CDAR. The Facility Investigation detailed the signature on the entry for 3/14/23 at 3:30 a.m. is not Staff I's signature.

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The dose had not been signed as administered to Resident #15 on the March 2023 EMAR.
b. On 3/14/23 at 10:30 a.m., the CDAR showed Staff A, signed out one 2 mg tablet of hydromorphone. The dose had not been signed out as administered on the March 2023 EMAR.
c. On 3/14/23 3:00 p.m. and 7:30 p.m., hydromorphone 2 mg tablets signed out on the Controlled Drug Administration were unidentified signatures per the Facility Investigation. The two doses were not documented on the March 2023 EMAR.
d. On 3/14/23 at 1:00 a.m. and 1:20 a.m., the Facility Investigation notes the hydromorphone 2 mg medication had been signed out at those times and the logic dictates an error occurred and the documentation should have been for 3/15/23 by Staff D. The doses of the narcotic medication were not signed out as administered on the March 2023 EMAR. The Daily Deployment Sheet for 3/14/23 showed Staff D scheduled for 3/15/23 2:00 a.m. - 6:30 a.m. Staff E had been scheduled from 2:00 p.m. - 2:30 p.m. Staff D had not been on shift to administer the doses as documented on the CDAR. The Facility Investigation detailed the signature on the entries had not been Staff D or Staff E's signatures.
e. On 3/15/23 at 8:30 a.m. and 12:00 p.m., the CDAR showed Staff A signed out one tablet of hydromorphone 2 mg. Neither of the doses were documented as administered to Resident #15 on the March 2023 EMAR.

Resident #15's third CDAR noted the following discrepancies:
a. A Pharmacy Delivery Slip showed Staff E signed for a delivery of hydromorphone 2 mg tablets on 3/18/23 at 6:30 p.m. The CDAR showed a received date of 3/18/22 for 30 tablets.

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b. On 3/18/23 at 2:30 p.m., the CDAR of 30 tablets listed an unknown signature for the dose. According to the Delivery Slip the CDAR Sheet and the 30 tablets of hydromorphone were not in the facility at 2:30 p.m. The Facility Investigation detailed Staff E reported she had not given the medication and the record did not contain her signature for the 2:30 p.m. entry. The dose had not been signed out on the March 2023 EMAR.
c. On 3/18/23 11:50 p.m., the CDAR documented an unknown signature that signed out the hydromorphone 2 mg tablet. The dose had not been documented as administered on the March 2023 EMAR.
d. On 3/19/23 at 2:30 a.m., the CDAR documented an unknown signature signed out one tablet of hydromorphone 2 mg. The dose had not been documented as administered on the March 2023 EMAR. The Daily Deployment sheet for 3/18/23 showed Staff G worked 2:00 a.m. - 6:30 a.m. going into the morning of 3/19/23. The Facility Investigation detailed the signature on the CDAR had not been Staff G's signature.
e. On 3/19/23 at 6:00 a.m. 10:05 a.m. and 2:00 p.m., the CDAR shows hydromorphone one 2 mg tablet signed out by Staff A for Resident #15. None of the narcotic medication doses are documented as administered on the March 2023 EMAR. The Daily Deployment Sheet dated 3/19/23 documented Staff A as the charge nurse on Medbridge working 6:00 a.m. - 2:30 p.m. The Narcotic and Controlled Substance Shift to Shift Count Sheet documented Staff G completed narcotic count with Staff A. Staff G would have handed the keys off the Staff A at shift change report.

A Time Card Report dated 3/19/23 documented Staff A worked 6:03 a.m. - 7:04 p.m.

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A photocopy of the March 2023 CDAR for a 30 count of hydromorphone 2 mg as part of the Facility Investigation file had written in "unknown signature," not Staff E's.

During an interview on 5/22/23 at 3:20 p.m., Staff E review Resident #15's Controlled Medication Utilization Record. Staff E voiced Resident #15 did not have a lot of pain. He didn't even talk so he couldn't request pain medication. They would look at his facial expressions for pain. He never seemed to express that much pain. After reviewing the CDAR she reported dose #9 for 3/14/23 at 3:30 a.m. doesn't belong to Staff I. It is not her signature. She reviewed the record and stated seven doses of the hydromorphone for him on 3/14/23 seemed excessive for him since he never exhibited much pain. She reported dose #4 for 3/14/23 at 1:20 a.m. for Staff D is not Staff D's signature. Staff E reported she worked 3/19/23 but that is not her signature on the 0230 dose. She went home at 3:00 a.m. so that is not her signature. When she left on the 3/18/23 the Resident had 30 pills. When she returned on 3/19/23, the CDAR showed he had taken 6 pills on Staff A's 6-2:30 p.m. shift and only had 24 left when she came back. Staff A knew how to play the game and change her signature. Staff G had stated to her she had not signed out dose 60 3/18/23 at 7:30 p.m. and dose #59 3/18/23 at 2:30 a.m. That is not her signature on the sheet. Staff A had a pattern of using different signatures so no one could see it right away. Staff E thought Staff A had been taking the narcotic medication and signing the narcotic sheets later because no one checked the signatures. They used to only check the count on the CDAR with the count on the medication card. No one had been checking

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the signatures. Now they check the signatures, the card and the count on the controlled drug administration sheets.

On 5/31/23 at 9:55 a.m., the Administrator provided an Audit report dated 4/25/23 that detailed the pharmacy delivered 56 tablets of hydromorphone 2 mg on 2/16/23 to the facility. The CDAR documented all 56 doses had been signed out. The EMAR documentation supported only 43 doses had been signed off as administered. The audit report documented 13 discrepancies in the records. The pharmacy delivered hydromorphone 2 mg, 10 tablets on 3/02/23. The CDAR showed all 10 doses had been signed out. The EMAR revealed only 2 doses had been signed off as administered. The Audit report identified 8 discrepancies in the records. On 3/18/23 the pharmacy delivered 30 tablets of hydromorphone 2 mg to the facility. The CDAR showed 6 doses had been signed out. The EMAR reflected no doses of the medication had been signed out as administered. The Audit report detailed 24 tablets remained in the medication card at the time of the audit and there were 6 discrepancies in the medical records.

8. The MDS dated 3/3/23 for Resident #16 showed a BIMS score of 14 indicating intact cognition. The Resident required extensive assistance with bed mobility, transfer, ambulation in room, dressing, bathing, toileting and personal hygiene. The MDS documented that the Resident received scheduled pain medication for a pain level of a 3 on a 1-10 pain scale as well as utilized opioid medication for 4 of the 7 days of the lookback period. The MDS listed diagnoses of hip fracture, anemia, peripheral vascular

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disease, stroke, seizure disorder and schizophrenia.

The Care Plan dated 2/22/23 detailed Resident #16 had pain in the left hip due to a fracture. Further the Care Plan directed the nurses to administer pain medications according to the physician orders and notify the physician if pain frequency/ intensity is worsening or if the current analgesia regimen had become ineffective.

A Prescriber Order Sheet signed by the Provider showed a physician telephone order dated 2/22/23 for hydrocodone-acetaminophen oral tablet 5-352 mg, give one tablet by mouth every 6 hours as needed for pain.

A review of the CDAR February 2023 MAR, March 2023 MAR, Vital Sign Pain Record March 2023 and the Facility Investigation documented the following:
a. On 2/24/23 at 7:30 a.m. and 1:00 p.m., hydrocodone-acetaminophen oral tablet 5-325 mg one tablet signed out on the CDAR by Staff A. Neither dose is signed out on the February 2023 MAR.
b. On 2/25/23 at 1:00 p.m., hydrocodone-acetaminophen oral tablet 5-325 mg one tablet signed out on the CDAR by Staff D. The dose had not been signed out on the February 2023 MAR. A Review of the Facility Investigation documented this as an "oversight" by this nurse as the signature on the CDAR belonged to Staff D.
c. On 2/28/23 at 1:20 p.m. and 1:00 p.m., hydrocodone-acetaminophen oral tablet 5-325 mg one tablet signed out on the CDAR Record by Staff A. The doses were not signed out on the February 2023 MAR.

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d. On 3/04/23 at 0000 a.m., one tablet of hydrocodone-acetaminophen oral tablet 5-325 is signed out on the CDAR with an unknown signature and had not been documented on the March 2023 MAR. The Daily Deployment Sheet for 3/03/23 going into 3/04/23 showed staff G worked 10 p.m. - 6:30 a.m. Staff A worked 6:00 a.m. - 2:30 p.m. on the Medbridge hallway.
e. On 3/04/23 at 10:20 a.m. and 4:00 p.m., hydrocodone-acetaminophen oral tablet 5-325 mg one tablet signed out on the CDAR by Staff A. The doses are not signed out on the March 2023 MAR. The Vital Sign Pain Record showed on 3/04/23 at 6:00 a.m. Staff A documented the Resident had a pain level of 10 on a 1-10 pain scale. At 8:58 a.m. Staff A documented a pain score of 8 and at 9:59 a.m. Staff A documented a pain score of 10. The Progress notes lacked documentation the physician had been notified of the Resident's high pain levels.
f. On 3/05/23 at 6:10 a.m. and 12:30 p.m., hydrocodone-acetaminophen oral tablet 5-325 mg one tablet signed out on the CDAR Record by Staff A. The doses were not signed out on the March 2023 MAR. The 3/05/23 Vital Sign Pain Record showed Staff A documented a pain level of 10 on a 1-10 pain scale for the Resident.
g. On 3/05/23 at 5:30 p.m., hydrocodone-acetaminophen oral tablet 5-325 mg one tablet signed out on the CDAR by Staff E. The dose had not been signed out on the March 2023 MAR. The Facility Investigation provided by the facility documented Staff E had been the nurse on shift and appears to have her signature on the CDAR. The Investigation cited this as an "oversight."
h. On 3/10/23 at 1:49 p.m. one tablet of hydrocodone-acetaminophen 5-325 mg tablet had been signed out on the CDAR by Staff A. The

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dose had not been documented on the March 2023 EMAR. The Vital Signs Pain Record showed Staff A documented on 3/10/23 at 6:01 a.m. a pain level of 10 on a 1-10 pain scale; at 9:58 a.m. a pain level of 10 and at 9:31 a.m. a pain level of 8.
i. On 3/11/23 at 10:00 a.m., hydrocodone-acetaminophen oral tablet 5-325 mg one tablet signed out on the CDAR by Staff D. The dose had not been signed out on the March 2023 MAR. The Facility Investigation provided by the facility documented Staff D had been the nurse on shift and appears to have her signature on the CDAR. The Investigation cited this as an "oversight. The Vital Signs Pain Record showed Staff D documented the Resident's pain level at 6:38 a.m. as a 0 level on a 1-10 pain scale.

On 5/31/23 at 9:55 a.m., the Administrator provided an Audit Record dated 4/25/23 that detailed Resident #16 had a pharmacy delivery on 3/12/23 of hydrocodone-acetaminophen 5-325 mg, 16 tablets. The facility had no CDAR for the count of 16 tablets. The EMAR had 6 doses of the medication signed out as administered. The amount remaining on the card could not be accounted for. The audit detailed 10 discrepancies found.

On 5/31/23 at 9:55 a.m., the Administrator provided an Audit report dated 4/25/23 that documented on 2/23/23 the pharmacy delivered 8 tablets of hydrocodone-acetaminophen 5-325 mg to the facility. The CDAR documentation showed all 8 tablets had been signed out. The EMAR supported only 5 doses had been signed off as administered. The Audit documented 3 discrepancies in the medical records. On 2/27/23 the pharmacy delivered 30 more doses of the

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medication to the facility. The CDAR showed all 30 doses had been signed out. The EMAR supported only 21 of those doses had been documented as administered. The Audit report detailed a total of 9 discrepancies in the medical record. On 3/12/23 the pharmacy delivered 16 tablets of the medication to the facility. The Audit report documented the facility did not have a CDAR record and the what happened to the medication card was unknown.

9. The MDS for Resident #17 dated 2/9/23 showed a BIMS score of 14 indicating no cognitive impairment. The Resident required limited assistance for ambulation, dressing and toileting. The MDS documented the Resident received scheduled and as needed pain medication for occasional pain of a 5 on a 1-10 pain scale as well as received opioid medication 1 day during the seven-day lookback period. The MDS listed diagnoses of retroperitoneal abscess, cancer, and adult cell lymphoma/leukemia.

The Care Plan dated 1/30/23 detailed Resident #17 had voiced abdominal pain related to disease process and recent surgery. The Care Plan documented a goal the Resident would express the pain management within acceptable limits and directed the nurses to administer pain medications according to the physician orders.

A Physician order Sheet electronically signed by the provider on 2/03/23 showed an order effective 1/30/23 for oxycodone HCL oral capsule 5 mg, give 5 mg by mouth every 6 hours and as needed for pain.

A Review of the CDAR, February 2023 MAR, Vital

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Sign Pain Record February 2023 and Facility Investigation revealed the following discrepancies for the administration of the physician ordered medication of oxycodone Immediate Release 5 mg. Give 1 tablet every 6 hours as needed (PRN) for Resident #17:

a. On 2/10/23 at 8:15 a.m., the CDAR showed one 5 mg tablet of oxycodone signed out by Staff J. The dose had not been documented as administered to Resident #17 on the February 2023 EMAR. The Vital Sign Pain Record showed Staff J documented a 0 pain level on a 1-10 pain scale at 1:42 p.m. that day.

b. On 2/11/23 at 1:30 p.m., Staff A signed out one tablet of oxycodone 5 mg on the CDAR but failed to sign administration on the February 2023 EMAR. The Vital Signs Pain Record showed Staff A documented a pain level of 5 at 8:18 a.m.; a pain level of 5 at 9:06 a.m. and a pain level of 7 at 9:45 a.m.

c. On 2/13/23 at 1:40 p.m., Staff A signed out one 5 mg tablet of oxycodone the CDAR. Staff A failed to document the administration of the dose on the February 2023 EMAR. Staff A documented on the Vital Sign Pain Record a 6 pain level at 7:28 a.m., pain level of a 3 at 10:47 a.m., then repeated the same documentation a second time in the record for 10:47 a.m. with a pain level of a 3.

d. On 2/15/23 at 1:00 p.m., the CDAR revealed Staff A had signed out a one 5 mg tablet of oxycodone but had not documented the dose as administered on the February 2023 EMAR.

e. On 2/18/23 at 6:10 a.m. and 1:00 p.m., the CDAR showed Staff A signed out one 5 mg tablet of oxycodone. She failed to document the doses as administered on the February 2023 MAR.

f. On 2/19/23 at 7:10 a.m. and 1:45 p.m., the CDAR showed Staff A signed out one 5 mg tablet

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of oxycodone at those times. None of the doses were documented on the February 2023 EMAR as administered to the Resident.
g. On 2/20/23 at 7:30 a.m., the CDAR Record shows staff A signed out one 5 mg oxycodone tablet for Resident #17. Staff A had not been working at this time. The 2/20/23 Daily Schedule shows Staff D worked 6-2:30 p.m. The Facility Investigation documented Staff D reported the writing on the narcotic record is not her writing. The dose had not been documented as administered to the Resident in the February EMAR.
h. On 2/23/23 at 8:00 a.m. and 1:30 p.m., the CDAR documented Staff A signed out one 5 mg tablet of oxycodone at these times. None of the doses were documented on the February 2023 EMAR.
i. On 2/24/23 at 7:00 a.m. and 1:01 p.m., the CDAR showed Staff A signed doses of the 5 mg oxycodone out. Neither of these doses are documented in the February 2023 EMAR as administered to the Resident.
j. On 2/28/23 at 5:30 a.m. the CDAR showed Staff I signed out one 5 mg tablet of oxycodone. The dose had not been signed out on the February 2023 EMAR. A Review of the 2/28/23 schedule showed Staff I had not worked on 2/28/23. Staff K, RN had been assigned 4:00 a.m. - 6:30 a.m. The Facility Investigation identified the signature on the 2/28/23 5:30 a.m. CDAR is not Staff K's signature. The 2/28/23 Daily Deployment Sheet documented Staff A on duty on Resident #17's hallway (Medbridge) from 6:00- 2:30 p.m. The Narcotic and Controlled Substance Shift to Shift Count record for 2/28/23 the night shift to day shift is illegible on which nurse completed narcotic count with Staff A.
k. On 2/28/23 at noon, the CDAR showed Staff A

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F 602	Continued From page 69 signed out one 5 mg dose of oxycodone. The dose had not been documented on the February 2023 EMAR to show Resident #17 had received the medication. On 5/31/23 at 9:55 a.m., the Administrator provided an Audit report dated 4/25/23 that documented the Pharmacy delivered 28 tablets of oxycodone IR 5 mg to the facility on 1/30/23. The CDAR had 21 doses documented with 7 doses remaining on the card. The EMAR only had 6 of the 21 doses documented as administered. The Audit documented 15 discrepancies in the medical records. The overall Audit report documented 179 discrepancies in the medical records.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		

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accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, document review, Iowa Department of Inspection and Appeals On-Line Facility Reported Incident Report review, Facility Investigation, Abuse Policy and staff interviews, the facility failed to ensure allegations of misappropriation of resident narcotic medications had been reported to the State agency within 24 hours of the allegation of abuse for 1 of 1 resident's sampled (Resident #3). The facility identified a census of 79 residents.

Findings include:

An Iowa Department of Inspection and Appeals (DIA) On-Line Facility Report Incident Report (FRI) documented the Administrator from Harmony Cedar Rapids filed an on-line report with the DIA on 3/21/23 at 6:33 p.m. for a criminal act regarding a nurse alleging on 3/19/23 her signatures were forged on a Narcotic Record for Resident #3. The FRI detailed a report type of a criminal act that occurred on 3/18/23 at 8:00 a.m. The Incident Summary documented during the Narcotic Count, Staff G, Registered Nurse (RN) noticed it seemed like her signature had been forged on the Narcotic Count Sheet. "She" had

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signed out two pills of oxycodone for Resident #3. Staff G stated that had not occurred. The narcotic sheet documented one pill of oxycodone had been given on 3/18/23 at midnight and 4:00 a.m. The Electronic Medication Administration Record (EMAR) lacked documentation these narcotic medication doses had been documented as administered to Resident #3. Staff G stated she had given Resident #3 Tylenol around 2:00 a.m. on 3/18/23 to address his pain. Staff G stated the Pharmacy had not delivered Resident #3's oxycodone. The Pharmacy confirmed the card of oxycodone had been delivered to the facility on 3/18/23 at 5:22 a.m. Therefore, Staff G could not have possibly given the medication at midnight and 4:00 a.m. Staff G had handed the keys off to Staff A, RN around 6:00 a.m. Staff G recalled the Narcotic Count for Resident #3 being 30 for the card of oxycodone. The next dose had been given by Staff A around 8 a.m. This led the facility to suspect Staff A took the two doses of medication and signed Staff G's name on the narcotic sheet. The FRI report further documented the incident had been reported to the Cedar Rapids Police Department. The Facility failed to notify the State Department within 24 hours of the allegation of misappropriation of resident property.

A Facility Investigation, undated and unsigned, provided by the facility documented under the initial report during narcotic count Staff G noticed it seemed like her signature had been forged on the controlled drug administration record (CDAR) and "she" had signed out two pills of oxycodone for a patient. Staff G stated that had not occurred. The narcotic sheet documented one pill of oxycodone had been given at midnight on 3/18/23 and one pill given 3/18/23 at 4:00 a.m. to

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Resident #3. The March 2023 EMAR did not reflect the two doses of narcotic medication had been administered. Staff G stated she had given Tylenol around 2:00 a.m. on 3/18/23 to address the patients pain. The medication was effective and had been documented in the EMAR. Staff G stated the patient's oxycodone had been delivered to the facility on 3/18/23 at 5:22 a.m. Therefore, she couldn't have administered the medication at midnight and 4:00 a.m. Staff G had handed the keys to the next nurse on duty, Staff A around 6:00 a.m. Staff G recalled the narcotic count being 30 for the card of oxycodone as she had just received the medication from the pharmacy. The next dose given had been around 8:00 a.m. by Staff A leading them to suspect that Staff A took the two doses and signed Staff G's name on the narcotic sheet.

A Statement hand written by Staff G addressed to the Director of Nursing (DON) and Staff F, Assistant Director of Nursing (ADON)/Nursing Supervisor on 3/17/23 documented the pharmacy had been unable to deliver medications for Patient #3 until the morning of 3/18/23 between 5 a.m. - 6 a.m. Staff G had been on Linn Hallway when Staff I, RN, informed her the pharmacy had delivered medications. Staff G counted 30 tablets of oxycodone for Resident #3. Staff G detailed in her statement she had given Resident #3 975 milligrams (mg) of Tylenol for complaints of pain since the oxycodone had not been available from the pharmacy. Staff G documented she gave report that morning to Staff A, RN and they both counted the narcotics before she left shift. Staff G returned 3/18/23 for the 10 p.m. - 6:30 a.m. shift to find that her signature had been forged to show administration of oxycodone at midnight and 4 a.m. Staff G documented she had never

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administered oxycodone on her shift on 3/17/23. She attached a copy of the March 2023 EMAR and the Pharmacy Delivery Slip for verification. The March 2023 EMAR documented Staff G administered 975 mg of Tylenol per the physician order 3/18/23 at 2:04 a.m. which had been effective for pain control.

On 3/20/23 Staff E, RN, wrote a statement noting it had been 1:40 a.m. when Staff G alerted her about her signature being forged. Staff E wrote Staff G's signature had been forged twice. Staff G called Staff F, Assistant Director of Nursing (ADON)/Unit Supervisor and informed her of what had happened. Staff F told Staff G to write a statement and leave a copy for her and she would review it on Monday 3/20/23. Staff E came to work (3/19/23), she knew how many pills she had counted with Staff G since there were not many narcotics on the Medbridge hallway. Staff E noticed some CDARs had forged signatures with different names, Staff I, RN, Staff M, RN and Staff D, RN for the same day. Staff E wrote she asked Staff A about it and she hadn't been satisfied with the answer because clearly pills were taken illegally or administered in suspicious ways. Staff E called the DON and reported the situation.

During an interview on 5/17/23 at 11:19 a.m., the DON reported she received a text message from Staff E on 3/19/23 sometime in the late afternoon notifying her of the issue with Staff A. Staff E noted something wrong with the narcotic sign out and she had tried to message Staff F. Staff E seemed pretty upset so she came to the facility. Staff E showed her the narcotic sheet that had Staff G's signature on it at a time when the narcotics were not even in the facility for Resident

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#3. The DON voiced she did not receive any messages from Staff A on 3/18/23. Staff F had been on call on 3/18/23. The DON voiced she thought they had 24 hours to report abuse, but she had to go through the Administrator for reporting. She had not been familiar with the process at that time. She had only been the DON for about one year. After she came to the facility, she called the Human Resource Coordinator to come to the facility and notified the Administrator. They called Staff A into the office. She interviewed Staff A, then walked her out of the facility. The DON reported she arrived at the facility sometime after 2:00 p.m. She asked Staff A if she had documented every time she administered a scheduled narcotic and as needed (PRN). Staff A responded she tried too, but couldn't say if she had missed one. The DON reported she point blank asked Staff A if she signed out narcotics that were not administered. Staff A told her no. Staff A gave no explanation at all for that and appeared tearful as the DON walked her out of the facility. Staff A understood being suspended until they could complete an investigation. At 11:31 a.m., the DON concluded that Staff A had been stealing narcotics. The DON reported she did not know how to file an on-line report with the State of Iowa. She had never had to do that. She did not call the State hot-line number to report. The Administrator had been made aware on the 19th that Staff A had been suspended due to missing medications and forged signatures. The DON did not know if the Administrator had reported the incident via phone to DIA prior to 3/21/23.

On 5/17/23 at 12:56 p.m., Staff F reported she had been called by Staff G in the wee hours of the morning. She doesn't recall the date she

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received the call. She reported Staff G as a very upstanding nurse. She couldn't remember exactly what Staff G told her. Staff G had either reported a narcotic medication had been missing or someone had falsely signed out a narcotic using her signature. The writing on the narcotic record had not been Staff G's hand writing. It had been one of those situations. She did remember it had been one narcotic pill and involved one resident. She doesn't recall the specific direction that she gave to Staff G but did tell her she would report the situation to the DON and it would be taken care of. She did remember that Staff G had been upset and stated she had not given the resident the narcotic medication and Staff A had been the only other nurse to handle the narcotic medication. Staff F reported she had been the nurse on call at the time. She remembered she had been dead asleep when she got the call. She could not recall the exact medication, but it had been a narcotic medication. She could not recall which resident had been involved. She thought it occurred on the Medbridge hallway. The facility policy is to alert the DON of missing medications. She did not call the DON right away, but thought she had called her later the same morning. She believes the DON investigated it but doesn't recall what she actually reported-off to the DON. If there is missing resident property she alerts the DON and the Administrator. She would not be the one to call the State office. If she saw resident abuse, she would report to the State immediately, but as far as missing items, she would just report those to the DON and the Administrator.

On 5/16/23 at 10:47 a.m., Staff G reported she tried to call Staff F who had been on call that morning (3/19/23), but Staff F couldn't take the

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call. Then she called the DON and left a message. She then tried to call Staff F on her personal cell phone. Staff F (ADON) informed her to write a statement and leave it in the office and she would address it on Monday when she came in. A Missed Punch Form for Staff F provided by the facility documented Staff F worked at the facility from 10 a.m. - 2:40 p.m. on 3/19/23.

During an interview on 5/17/23 at 1:24 p.m., the DON reported she is not the Abuse Coordinator. The Abuse Coordinator is the Administrator. She stated when they first looked at it they had thought they were looking at a forgery for signatures on the narcotic sheets. They weren't aware of everything that had been going on at that point.

On 5/17/23 at 6:34 p.m., the Administrator voiced he had first become aware of the situation on the evening of 3/19/23 by the DON. The DON went to the facility and got a statement from Staff A and suspended her from duty. At that point they didn't think they had an allegation of abuse. The narcotic counts were not off, but something had been "fishy." He had not been able to verify Staff G's statement until the evening of 3/20/23 when the pharmacy receipt came to verify the date and time the medication had been received by the facility. That confirmed Staff G's story. Looking back, he stated he got it, they probably should have been looking at it from a different perspective, but he likes to think the best of people. Getting the Pharmacy Receipt had been the verification he needed. He reported the incident to the State Department on 3/21/23. He had verified with the DON on 3/19/23 that the narcotic count had been accurate. They thought it

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may have been a simple case of someone forgetting they had administered a dose of medication and it turned into someone stealing medications. He had never seen anything like it. From their final investigation, it had affected up to 9 residents and showed a trend that Staff A had taken the pills. He stated they had reported Staff A to the Board of Nursing. He further reported Staff A would be terminated. He didn't feel this had been the first time that Staff A had taken medications. She seemed to know exactly what she was doing. He wondered if it had happened at other facilities and they never did anything about it. They tried to do the right thing and get it reported into the State.

On 5/18/23 at 9:41 a.m., the Pharmacist/Director of Quality reported the customer service representative had been contacted on 3/20/23 by the DON from Harmony. He didn't have an exact time but felt that he did respond with getting her the information within 30 minutes of the request. He provided her with a copy of the pharmacy delivery slip with the wet signature from the nurse with the date and time of delivery for Resident #3's medications and a copy of the unsigned packing slip. The Pharmacist confirmed the copies were sent to the DON via email on 3/20/23 at 8:35 p.m. Due to their internal information technology, she could not provide a copy of the information.

On 5/23/23 at 11:42 a.m. the DON reported initially when Staff G brought forward the concern, it had only affected Resident #3. They initiated an investigation, but didn't know about the other residents affected until later into the investigation.

The Nursing Facility Abuse Prevention,

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Identification, Investigation and Reporting Policy, dated July 2019, provided by the facility, included a Policy Statement: all residents have the right to be free from abuse, neglect misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking acts that result in person degradation. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It shall be the policy of this facility to implement written procedures to prohibit abuse, neglect, exploitation and misappropriation of resident property.

The Policy included the following definition:
1. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a Resident's belongings or money without the Resident's consent. This includes misappropriation or diversion of resident medications.

The Policy under Reporting directed the following:
1. All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegation of abuse to the Administrator or designated representative.
2. All allegations of Resident abuse shall be reported to the Iowa Department of Inspection and Appeals not later than two (2) hours after the

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allegation is made.
3. All allegations of Resident neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation shall be reported to the Iowa Department of Inspections and Appeals, not later than two (2) hours after the allegation is made, if the events that cause the allegation result in serious bodily injury, or not later than twenty-four (24) hours if the events that cause the allegation involve neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation, but do not result in serious bodily injury.
4. If there is reasonable suspicion that the allegation of abuse also constitutes a crime committed against the resident by any person, whether or not the alleged perpetrator is employed by the facility, the Elder Justice Act requires the matter must also be reported to law enforcement. While the federal regulations require all abuse allegations to be reported to DIA within 2 hours, the Elder Justice Act has a different time frame for reporting to the police/sheriff. If the allegations of abuse (that results from a crime) results in serious bodily injury to a resident, a report must be made to law enforcement not later than two (2) hours after the allegation is made. If the allegation of abuse does not result in serious bodily injury, a report must be made to law enforcement not later than twenty-four 24) hours.
5. A report shall be made by calling the Department of Inspection and Appeals reporting hotline at (877) 686-0027, submitted an e-mail to the Department at HFD_Complaint@dia.iowa.gov, submitting an online report or sending a fax to (515) 28107106.
6. If the person in charge is the alleged abuser, the staff member shall directly report the abuse to the Department immediately pursuant to the

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F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility investigation, document review, staff interviews and policy review, the facility failed to conduct a timely and thorough investigation after discovering a reportable incident for possible drug diversion for 3 of 8 residents sampled (Resident #4, #14 and #16). The facility identified a census of 79 residents. Findings Include: An Electronic Census showed Resident #4 admitted to the facility on 3/04/23 and discharged on 3/21/23.	F 610		

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1. The Minimum Data Set (MDS) Assessment dated 3/15/23 for Resident #4 showed a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive loss. The MDS documented Resident #4 utilized scheduled and as needed medication for frequent pain of a 4 on a 1-10 scale. The Resident received opioid medication 3 out of 7 days of the look-back period. The MDS listed diagnoses of fracture of the pubis ramus (pelvic fracture), coronary artery disease, heart failure, hypertension, arthritis and long-term use of opioids.

A Physician Order electronically signed by the Provider on 3/09/23 listed a current order as of 3/04/23 for Roxicodone (generic oxycodone, narcotic/opioid medication) oral tablet 5 milligrams (mg), give one tablet by mouth every 4 hours as needed (PRN) for pain control.

The March 2023 EMAR showed the following doses of oxycodone (Roxicodone) oral tablet 5 mg, give 1 tablet by mouth every 4 hours as needed for pain control:
a. On 3/05/23 at 7:40 a.m., for a pain level of 10 on a 1-10 pain scale by Staff A; dose effective.
b. On 3/05/23 at 7:27 p.m., for a pain level of a 4 on a 1-10 pain scale by Staff E; dose effective.
c. On 3/07/23 at 4:08 a.m., for a pain level of a 5 on a 1-10 pain scale by Staff C; dose effective.
d. On 3/10/23 at 6:15 a.m., for a pain level of 9 on a 1-10 pain scale by Staff A; dose ineffective.
e. On 3/18/23 at 6:36 a.m., for a pain level of 5 on a 1-10 pain scale by Staff A; dose ineffective.
f. On 3/19/23 at 6:18 a.m., for a pain level of 10 on a 1-10 pain scale by Staff A; dose ineffective.

A review of Resident #4's CDAR showed a

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Pharmacy Label reading: oxycodone immediate release (IR) 5 mg tablets, take 1 tablet by mouth every four hours as needed for pain x 7 days. The CDAR documented the facility received 12 tablets on 3/18/23. Further review revealed no doses of the oxycodone medication had been signed out on the CDAR. The CDAR documented the signature of the Director of Nursing (DON) and Staff E, Registered Nurse (RN) destroyed 12 tablets of the narcotic medication. The CDAR did not contain a date or time the destruction took place.

On 5/23/23 at 2:30 p.m., Staff E reviewed Resident #4's CDAR from March 2023. She confirmed the signature on the CDAR for 12 oxycodone tablets as her signature. She remembered wasting the Resident's narcotics with the DON, but stated she can't remember how many tablets they wasted or when. It had been too long ago.

On 5/23/23 on 2:42 p.m., the DON reviewed the March 2023 EMAR for oxycodone as needed order and the March 2023 CDAR. She reported she remembered wasting Resident #4's narcotics. The DON reviewed the March 2023 EMAR and Controlled Drug Administration Record. She did not have an explanation for why the oxycodone had been signed out as administered on the March 2023 EMAR and were not signed out on the March 2023 CDAR.

On 5/23/23 at 2:57 p.m., the DON reported she did not have an answer for the discrepancy on Resident #4's records. She had a call out to the pharmacist to see if she could find more information. She acknowledged the 7 day limit on the oxycodone label the pharmacy had placed on

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the CDAR and the facility physician order for oxycodone did not have a time limit on the order. The DON returned at 3:02 p.m. and reported the pharmacy verified they sent out 12 tablets of oxycodone. The DON also reported the pharmacy confirmed they sent out a medication card containing 30 tablets of oxycodone that the facility did not have a CDAR on. She reported it had been Staff E, RN or M, RN that signed for the medication card.

The DON provided a copy of the Pharmacy Delivery Slip showing Staff M signed for the delivery of 30 tablets of oxycodone for Resident #4 at 3:30 p.m. A review of the 3/11/23 Daily Deployment Sheet listed Staff M as the charge nurse assigned to Medbridge hallway where Resident #4 resided.

An interview with the Pharmacist on 5/24/23 at 9:55 a.m., revealed the Pharmacy had sent 9 tablets of oxycodone to the facility on 3/5/23; 30 tablets of oxycodone on 3/10/23 and 12 tablets of oxycodone on 3/18/23. The Pharmacist checked the records at 10:03 a.m. and voiced the facility had not returned any of the medication cards to the pharmacy. On 5/24/23 the Pharmacist supplied the follow documentation:
a. A Pharmacy Manifest dated 3/05/23 documented 9 tablets of oxycodone IR 5 mg tablets had been delivered to the facility and signed for by Staff G.
b. A Pharmacy Manifest dated 3/11/23 showed 30 tablets of oxycodone had been delivered to the facility and signed for by Staff M.
c. A Pharmacy Packing Slip dated 3/19/23 showed Staff E signed for delivery of 12 tablets of oxycodone from the pharmacy for Resident #4.

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During an interview on 5/24/23 at 10:25 a.m., the Administrator explained they initiated their investigation on Monday 3/20/23. The drug investigation took a very long time. It had also been during the transition from Promedica to Harmony and that muddied everything. They initially had issues printing Physician Orders and they had to take some time to get that figured out so that they could look into things. It ended up being much longer than 5 days to completed the investigation. He reviewed the investigation summary on 5/24/23 at 10:29 a.m. He verified he had typed the investigation up and had not signed/dated the investigation. He swore he put something in the summary about Resident #4's missing narcotic record and medication card because he had looked forever for the narcotic record. He got a report from the Pharmacy of what medications had been received for Resident #4 and he looked at the EMAR. After looking for a long time, he finally concluded that Staff A had disposed of the CDAR and taken the narcotic medication card. The facility could not produce documentation of Resident #4's oxycodone CDAR to show the doses documented out on the March 2023 EMAR or the destruction of the narcotic medication and number of oxycodone tablets left when the Resident discharged on 3/21/23. The Facility Investigation lacked documentation of Resident #4 oxycodone order, EMAR administrations, missing CDAR for 30 tablets of oxycodone or medication card.

On 5/24/23 at 10:50 a.m., Staff P, Medical Records/Scheduler reported she could not find a CDAR for Resident #4 oxycodone 9 tablets. She stated she had reported it to the Administrator and he had already talked to the Surveyor about it.

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On 5/24/23 at 11:11 a.m., Staff D, RN reported she remembered being asked about Resident #6's missing CDAR which she had later found in his chart. They CDARs were to go to the 24-hour communication book, not the resident charts. She doesn't recall the Administrator or DON asking her about any missing CDAR or medications for Resident #4. She voiced two nurses have to destroy narcotic medications. They fill out a paper and attach it to the CDAR sheet. The paper has the room number, resident's name, script number and amount of the medication destroyed. The nurse both sign at the bottom of the record. They destroy the narcotic medication by disposing into a Drug Buster system.

On 5/24/23 at 11:59 a.m., Staff A, RN responded via phone text message she didn't remember the Administrator or DON asking her about missing CDARs or missing narcotic medication cards as part of the facility investigation.

During an interview on 5/24/23 at 12:15 p.m., the DON reported she had not been aware of Resident #4 missing a CDAR for an oxycodone count of 9 tablets. The nurses are to document the narcotic delivery on the Master Controlled Substance Log and they circle the count number received on the CDAR however, she commented they do this, but it is not a facility policy. She had just started a new process of having the nurses put the pharmacy delivery slips into a pharmacy binder as part of their investigation process. She said sometimes the nurses put the pharmacy delivery slips into the 24-hour communication book or they just throw them away. The don't have a policy on what the nurses are to do with the delivery slips. She reported two nurses have

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to destroy narcotics and document the destruction on the CDAR record. She stated the paper they filled out and attached to the CDAR following destruction had been under the old processes and management. They no longer do that. Both nurses sign the CDAR for the quantity of tablets destroyed.

On 5/24/23 at 12:40 p.m., the Administrator reported he had looked in his computer and he had a file saved from 4/15/23 where he reviewed Resident #4's EMAR for the oxycodone. He had looked all over the facility for the CDARs and couldn't find them. He explained the review included the CDAR for the oxycodone of 9 tablets and the CDAR of 30 tablets. The Facility Investigation lacked documentation of any review of Resident #4's use of oxycodone, missing CDAR's or medication cards.

During an interview on 5/30/23 at 10:35 a.m., the Administrator reported he did not interview all Certified Nursing Assistants (CNA's), Housekeepers, Maintenance or other personnel as part of the investigative process. He reported he felt that the Pharmacy documentation backed up Staff G's story on what had happened and pointed to Staff A. They had audited narcotic sheets prior to Staff A being hired and they may have had a narcotic pain medication here and there that had not been signed out on the EMAR, but it had not been a trend like with Staff A. Obviously, the nurses couldn't have signed out a narcotic pain medication on the EMAR if they were not the actual nurse signing it out on the CDAR. Then with all the nurses coming forward and citing the signatures on the CDAR's were not their signatures, it pointed to Staff A. He reported the CNA interviews they did were in regard to

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Resident #6 as Staff A had documented really high pain levels for him. They did CNA interviews to try to see how much pain Resident #6 had. Resident #6 had been a hard case as when staff repositioned him, he had pain. When he laid still, he never exhibited any signs of pain and he had been a pretty happy guy. He just felt the trends from the investigation pointed to Staff A. There were no other staff that he suspected of taking narcotic medications.

On 5/31/23 at 9:55 a.m., the Administrator provided an Audit Record dated 4/25/23 that detailed the for Resident #4 use of the hydrocodone-acetaminophen 5-325 mg, pharmacy delivery of 14 tablets, the CDAR showed 10 tablets signed out. The EMAR documented 4 doses signed out for administration. The medication card had 4 remaining tablets. The Audit Report documented 6 discrepancies in the records. and detailed one dose had been signed out by agency staff. The facility could not confirm the accuracy so would reimburse out of good faith. The Audit Report 4/25/23 documented for a oxycodone IR 5 mg for a pharmacy delivery of 9 tablets, the EMAR showed 4 doses signed out as administered. The audit detailed the facility had no CDAR and no amount remaining due to no CDAR. For a delivery of 30 tablets of oxycodone IR 5 mg, the facility had no CDAR. The EMAR showed two doses signed out for administration and an unknown remaining on the card as the facility did not have a card or CDAR for the medication.

2. On 5/31/23 at 9:55 a.m. the Administrator provided an Audit Record dated 4/25/23 that detailed Resident #14 had a pharmacy delivery

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on 3/02/23 of oxycodone IR 5 mg, 30 tablets. The facility had no CDAR. The EMAR showed no doses of the medication had been signed out as administered. The amount remaining on the medication card could not be accounted for. The audit detailed 30 discrepancies from the audit.

3. On 5/31/23 at 9:55 a.m., the Administrator provided an Audit Record dated 4/25/23 that detailed Resident #16 had a Pharmacy delivery on 3/12/23 of hydrocodone-acetaminophen 5-325 mg, 16 tablets. The facility had no CDAR for the count of 16 tablets. The EMAR had 6 doses of the medication signed out as administered. The amount remaining on the card could not be accounted for. The audit detailed 10 discrepancies found.

A review of the undated, unsigned Facility Investigation provided by the facility lacked documentation of the missing CDAR for Residents #4, #14 and #16.

The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, dated July 2019, provided by the facility specified under key definitions misappropriation of resident property included the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. This included misappropriation of resident medications. The Policy further detailed should a suspected incident of resident abuse as defined above be reported or observed, the Administrator or his/her designee will designate a member of management to investigate the alleged incident. The Administrator or designee will complete

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F 610	Continued From page 89 documentation of the allegation of resident abuse and collect any supporting documents relative to the alleged incident: 1. Review documentation in the resident record, including review of assessment if resident injury. 2. Assess the resident for injury if the allegation involves physical or sexual abuse; 3. Provide proper notification to primary care provider, responsible party, etc. 4. Attempt to obtain witness statements (oral and/or written) from all known witnesses. 5. If there is physical evidence that can be preserved, attempt to do so, and maintain in a safe location to minimize risk of evidence being tampered with.	F 610		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, document review, resident and staff interviews, the facility failed to follow Physician Orders regarding the administration of narcotic pain medication for 4 of 8 resident sampled (Resident #3, #4, #6, #17) and failed to show proper documentation for clarification of a narcotic pain medication order for 1 of 8 residents sampled (Resident #14). The facility identified a census of 79 residents. Findings Include:	F 658		

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1. The MDS Assessment dated 3/22/23 for Resident #3 showed a BIMS score of 12 indicating moderate cognitive loss. The Resident required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. The MDS documented Resident #3 as utilized as needed pain medication for occasional pain of 5 on a 1-10 scale receiving opioids 6 out of the 7 day look-back period. The MDS listed diagnoses of left hip fracture, anemia, hypertension, end stage renal disease, chronic obstructive pulmonary disease (COPD) and a wound infection.

The Care Plan dated 3/17/23 identified a focus Resident #3 at risk for pain related to arthritis, surgical incision, infection to wound site. The Care Plan directed the nurses to provide analgesics as ordered and evaluate efficacy of pain management.

A Hospital After Visit Summary dated 3/17/23 documented a Physician Order for oxycodone 5 milligrams (mg) immediate release (IR) by mouth every 4 hours as needed for pain of the left hip.

The March 2023 Electronic Medication Administration Record (EMAR) showed Staff A, Registered Nurse (RN), administered an oxycodone hydrochloride (HCL) oral tablet (narcotic opioid medication), give 5 mg by mouth every 4 hours as needed for left hip pain 3/18/23 at 7:46 a.m. for a pain level of a 9 on a 1-10 pain scale (10 being the worst pain). Staff A documented the 7:46 a.m. dose as "I" for ineffective and according to the EMAR 3/18/12 at 7:57 a.m. administered a second 5 mg oxycodone HCL tablet to Resident #3. The March 2023 Controlled Drug Administration Record

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(CDAR) showed Staff A signed out doses of the medication on 3/18/23 at 8 a.m. and 12:30 p.m.

A undated Facility Investigation documented Resident #3 received a dose of as needed oxycodone on 3/18/23 at 7:45 a.m. by Staff A. The dose had not been documented on the March 2023 EMAR. The March 2023 EMAR showed a second dose of the oxycodone had been administered by Staff A at 8:00 a.m. but the March 2023 CDAR showed the dose had not been signed out until noon on 3/18/23 by Staff A.

On 5/22/23 at 10:50 p.m., Staff I, RN, voiced she is required to document the administration of as needed pain medication in the EMAR where is the pain and what level is the pain. There is a progress note that comes up and they record the pain level and location. If generalized pain they don't write a location. The progress note flags for a follow-up pain level. The pain follow-up is flagged in the computer as yellow to indicate a pain follow-up is needed. If it shows up in red, the pain assessment is overdue. If it changes to green, the follow-up is completed. That is how they communicate the as needed pain medication follow-up through the computer system.

On 5/23/23 at 1:35 p.m., the Director of Nursing (DON) reported she expected the nurses to document out narcotic medications on the CDAR and the EMAR. She expects the nurses to follow the physician orders as written. She stated she didn't think the facility had a policy on following physician orders.

On 5/23/23 at 1:35 p.m., the DON reported she expected the nurses to document out narcotic medications on the CDAR and the EMAR. She

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expects the nurses to follow the physician orders as written. She stated she didn't think the facility had a policy on following physician orders.

2. The MDS Assessment dated 3/15/23 for Resident #4 showed a BIMS score of 11 indicating moderate cognitive loss. The Resident required limited assistance with transferring, dressing and toileting. The MDS documented Resident #4 utilized scheduled and as needed medication for frequent pain of a 4 on a 1-10 scale (1 being the least amount of pain and 10 being the worst pain). The Resident utilized opioid (narcotic) medication 3 out of 7 days of the look-back period. The MDS listed diagnoses of fracture of the pubis ramus (pelvic fracture), coronary artery disease, heart failure, hypertension, arthritis and long-term use of opioids.

Resident #4's Care Plan dated 3/05/23 had a focus the Resident is at risk for pain related to arthritis, neurogenic cause, orthopedic surgery and musculoskeletal issues. The Care Plan directed the nurses to provide analgesic as ordered and monitor for non-verbal signs of pain.

A Physician Order Recertification electronically signed by the Provider on 3/09/23 showed a current order as of 3/04/23 as follows for narcotic (opioid) pain medication:
a. Roxicodone (generic oxycodone) oral tablet 5 mg, give one tablet by mouth every 4 hours as needed for pain control
b. Hydrocodone-acetaminophen oral tablet 5-325 mg, give 1 tablet by mouth every 24 hours as needed for pain control to be given at bedtime.

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The CDAR for Resident #4 dated 3/4/23 - 3/18/23 documented the following pharmacy label at the top: hydrocodone-APAP (Tylenol) 5-325 mg tab, take 1 tablet by mouth nightly as needed for pain. The Record documented the following hydrocodone doses had been signed out on the Record:
a. On 3/4/23 at 11:10 p.m. one tablet.
b. On 3/9/23 at 2:30 p.m. one tablet.
c. On 3/10/23 at 5:45 a.m. one tablet.
d. On 3/13/23 at 1:40 a.m. one tablet.
e. On 3/13/23 at 3:00 a.m. one tablet.
f. On 3/14/23 at 5:30 a.m. one tablet.
g. On 3/14/23 at 6:05 p.m. one tablet.
h. On 3/15/23 at 4:00 a.m. one tablet.
j. On 3/15/23 at midnight one tablet.
k. On 3/16/23 at 5:30 a.m. one tablet.
l. On 3/18/23 at 6:10 a.m. one tablet.

The March 2023 EMAR showed the following doses of hydrocodone-acetaminophen 5-325 mg tab, take 1 tablet by mouth every 24 hours as needed for pain control to be given at bedtime documented:
a. On 3/09/23 at 2:31 a.m., for a pain level of a 3 on a 1-10 pain scale by Staff I; dose effective.
b. On 3/13/23 at 1:42 a.m., for a pain level of a 3 on a 1-10 pain scale by Staff I; dose ineffective.
c. On 3/18/23 at 6:40 a.m., for a pain level of a 5 on a 1-10 pain scale by Staff A; dose effective.

The March 2023 EMAR lacked documentation of the hydrocodone-acetaminophen 5-325 mg doses signed out by the Nursing Staff on the March 2023 CDAR Record.

The March 2023 EMAR showed the following doses of Roxicodone oral tablet 5 mg, give 1 tablet by mouth every 4 hours as needed for pain

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control:
a. On 3/05/23 at 7:40 a.m.,. for a pain level of 10 on a 1-10 pain scale by Staff A; dose effective.
b. On 3/05/23 at 7:27 p.m., for a pain level of a 4 on a 1-10 pain scale by Staff E; dose effective.
c. On 3/07/23 at 4:08 a.m., for a pain level of a 5 on a 1-10 pain scale by Staff C; dose effective.
d. On 3/10/23 at 6:15 a.m., for a pain level of 9 on a 1-10 pain scale by Staff A; dose ineffective.
e. On 3/18/23 at 6:36 a.m., for a pain level of 5 on a 1-10 pain scale by Staff A; dose ineffective.
f. On 3/19/23 at 6:18 a.m., for a pain level of 10 on a 1-10 pain scale by Staff A; dose ineffective.

A review of Resident #4's CDAR showed a Pharmacy label reading: oxycodone immediate release 5 mg tablets take 1 tablet by mouth every four hours as needed for pain x 7 days. The CDAR documented the facility received 12 tablets on 3/18/23. Further review revealed no doses of the oxycodone medication had been signed out on the CDAR. The CDAR documented the signature of the DON and Staff E, RN destroyed 12 tablets of the narcotic medication. The CDAR did not contain a date the destruction took place.

During an interview on 5/23/23 at 1:35 p.m., the DON reviewed Resident #4's CDAR with the March 2023 EMAR. She noted the as needed doses of the hydrocodone-acetaminophen ordered to be given at bedtime as needed had been given at times other than bedtime. She reported she would expect the nurses to document out all PRN narcotic medication doses on the CDAR and on the EMAR so that a follow-up pain assessment could be completed and she expected the physician orders to be followed.

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On 5/23/23 at 2:30 p.m., Staff E reviewed Resident #4's Controlled Drug Administration for March 2023. She confirmed the signature on the Record had been hers. She remembered wasting the Resident's narcotics with the DON, but stated she can't remember how many tablets they wasted. It had been too long ago.

On 5/23/23 on 2:42 p.m., the DON reviewed the March 2023 EMAR for Roxicodone PRN order and the March 2023 Controlled Drug Administration Record. She reported she remembered wasting Resident #4's narcotics. The DON reviewed the March 2023 EMAR and CDAR. She did not have an explanation for why the Roxicodone had been signed out as administered on the March 2023 EMAR and were not signed out on the March 2023 CDAR. She wanted to look further into the matter.

5/23/23 at 2:57 p.m., the DON reported she did not have an answer for the discrepancy on Resident #4's records. She acknowledged the 7 day limit on the oxycodone (Roxicodone) label the pharmacy had placed on the CDAR and the facility physician order for oxycodone did not have a time limit on the order. The DON returned at 3:02 p.m. and reported the pharmacy verified they sent out 12 tablets of oxycodone. The DON also reported the pharmacy confirmed they sent out a medication card containing 30 tablets of oxycodone that the facility did not have a CDAR on.

The DON provided a copy of the Pharmacy Delivery Slip showing Staff M signed for the delivery of 30 tablets of oxycodone for Resident #4 at 3:30 p.m. A review of the 3/11/23 Daily

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Deployment Sheet listed Staff M as the charge nurse assigned to Medbridge hallway where Resident #4 resided.

An interview with the Pharmacist on 5/24/23 at 9:55 a.m., revealed the pharmacy had sent 9 tablets of oxycodone to the facility on 3/5/23; 30 tablets of oxycodone on 3/10/23 and 12 tablets of oxycodone on 3/18/23. The Pharmacist checked the records at 10:03 a.m. and voiced the facility had not returned any of the medication cards to the pharmacy.

During an interview on 5/24/23 at 10:25 a.m., the Administrator explained he had been aware of the missing CDAR's for Resident #4. He had looked all over the facility for the CDAR and had not found the records.

On 5/24/23 at 10:50 a.m., Staff P Medical Records/Scheduler reported she could not find a CDAR for Resident #4 oxycodone 9 tablets. She stated she had reported it to the Administrator and he had already talked to the Surveyor about it.

During an interview on 5/24/23 at 12:15 p.m., the DON reported she had not been aware of Resident #4 missing a CDAR for an oxycodone count of 30 or 9 tablets. The nurses are to document the narcotic delivery on the Master Controlled Substance Log and they circle the count number received on the CDAR however, she commented they do this, but it is not a facility policy. She reported two nurses have to destroy narcotics and document the destruction on the CDAR record. She stated the paper they filled out and attached to the CDAR following destruction had been under the old processes

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and management. They no longer do that. Both nurses sign the CDAR for the quantity of tablets destroyed.

On 5/24/23 at 12:40 p.m., the Administrator reported he had looked in his computer and he had a file saved from 4/15/23 where he reviewed Resident #4's EMAR for the oxycodone. He had looked all over the facility for the CDARs and couldn't find them. He explained the review included the CDAR for the oxycodone of 9 tablets and he CDAR of 30 tablets.

During an interview on 5/25/23 at 11:31 a.m., the DON reported the CDAR once all doses have been administered or doses destroyed are to go to the Unit Supervisor to put the CDAR into the folder. If it is a weekend, the nurses can put the CDAR into the folder. Prior to the incident she had just looked at the CDARS to see if the narcotic doses were signed. She had not been going back and checking the EMAR or the actual medication cards. The nurses were initialing on the CDAR to sign out narcotic doses. Now she is encouraging the nurses to sign with their full last name. That is her preference but not facility policy. She didn't know of any real processes in place prior to the incident regarding missing CDAR's. They just followed standard procedures. Going forward, she has asked the pharmacy to email her a list of all narcotics that are delivered to the facility so she can check the medication cards have been signed in, counts verified and the medication card is in the double lock up. She will ensure narcotics are signed in correctly. She plans to utilize the Master Controlled Substance Log. She provided more education this morning (5/25/23) to the nurses. She is requiring two nurses to sign in narcotic

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medication cards with pharmacy delivery and place into lock-up. Both nurses have to sign the Master Controlled Substance Log to document the delivery of the narcotics and both nurses have to sign the Log after destruction of any narcotics. The EMAR to the CDAR to the Master Controlled Substance Log should all match. She reported she carries the accountability for the accuracy of the process. She expects the nurses to sign out narcotics on both the EMAR and the CDAR and follow the physician orders. She expects the nurses will follow the physician orders for administering narcotic medications.

3. The MDS Assessment dated 3/17/23 for Resident #6 showed a BIMS score of 15 indicating intact cognition. The Resident required extensive assistance with bed mobility, transfer, dressing, toileting and personal hygiene. The MDS documented Resident #6 utilized as needed pain medication for occasional pain of a 3 on a 1-10 pain scale. The MDS showed the Resident utilized opioid medications 4 out of 7 days of the look-back period. The MDS listed a diagnosis of cellulitis, end stage renal disease and Non-Alzheimer's Dementia.

The Care Plan dated 3/14/23 identified Resident #6 at risk for pain related to arthritis, diabetic neuropathy, and incision to a right below knee amputation and directed the nurses to provide analgesics as physician ordered and monitor for non-verbal signs of pain.

An Order Recap Report detailed the following narcotic (opioid) physician orders:
a. Hydrocodone-acetaminophen oral tablet 5-325 mg. Give 1 tablet by mouth every 6 hours as

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needed for pain. Start Date 3/14/2023. Discontinuation date 3/15/23.
b. Hydrocodone-acetaminophen oral tablet 5-325 mg. Give 1 tablet by mouth every 8 hours as needed for pain. Start Date 3/15/2023. Discontinuation date 3/25/23.
c. Hydrocodone-acetaminophen oral tablet 5-325 mg. Give 1 tablet by mouth every 6 hours as needed for pain. Start Date 3/31/2023. Discontinuation date 4/18/23.

The March 2023 CDAR for a count of 9 tablets hydrocodone 5-325 mg, take one tablet by mouth at bedtime as directed revealed the following documentation:
a. On 3/04/23 l tablet signed out at 5:00 a.m.
b. On 3/17/23 l tablet signed out at 7:00 a.m.
c. On 3/17/23 l tablet signed out at noon.
d. On 3/17/23 l tablet signed out at 4:30 p.m.
e. On 3/18/23 l tablet signed out at 4:20 a.m.
f. On 3/18/23 l tablet signed out at 8:30 a.m.
g. On 3/18/23 l tablet signed out at 1:00 p.m.

The Facility failed to follow the physician orders regarding administration of the hydrocodone-acetaminophen as needed order.

4. The MDS dated 3/3/23 for Resident #14 showed a BIMS score of 14 indicating intact cognition. The Resident required extensive assistance with bed mobility, dressing and toileting. The MDS identified the resident received scheduled pain management for frequent pain of a 4 on a 1-10 pain scale and utilized opioid medication 1 day during the 7 day lookback period. The MDS listed diagnoses of right fibula fracture, diabetes mellitus, hyperlipidemia and chronic obstructive pulmonary disease.

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The Care Plan dated 3/01/23 documented Resident #14 with pain to the right leg related to a fracture. The Care plan detailed a goal to reduce periods of breakthrough pain and directed the nurses to notify the physician if pain frequency/ intensity worsens or if the analgesia regimen becomes ineffective.

A Hospital After Visit Summary electronically signed by the Provider on 3/01/23 listed the following medication orders:
a. Oxycodone-acetaminophen 5-325 mg per tablet. Take 1-2 tablets by mouth every 4 hours as needed for pain. Alongside the physician order in hand writing appeared a triangle indicating "change" with "1 tab" written in. The handwriting did not contain any signature or initials to indicate who wrote in the "1 tab."

A review of Resident #14's medical record lacked documentation of a clarification order if the oxycodone-acetaminophen 5-325 mg dose should have been 1 tablet or 2 tables.

A review of the March 2023 CDAR for Resident #14's use of oxycodone-acetaminophen (APAP) 5-325 mg tab, take 1 tablet by mouth every four hours as needed for pain revealed the following documentation that physician orders were not followed:
a. On 3/05/23 at 10:30 a.m., 1 tablet signed out.
b. On 3/05/23 2:00 p.m., 1 tablet signed out.
c. On Dose #9 1 tablet signed out on the CDAR with no date documented.
d. On 3/14/23 3:30 a.m., 1 tablet signed out.
e. On 3/14/23 6:30 a.m., 1 tablet signed out.
f. The last dose on the CDAR dated 3/14/23 lacked any documentation for time of

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administration.

A second March 2023 CDAR with a count of 30 oxycodone-APAP 5-325 mg, take one tablet every 4 hours as needed for pain revealed the following documentation showing physician orders were not followed for administration:
a. On 3/13/23 at 9:30 a.m., 1 tablet signed out.
b. On 3/13/23 at 1:10 p.m., 1 tablet signed out.

During an interview on 5/30/23 at 11:35 a.m., the DON explained the After-Visit Summary contained the documented initials of the in-house nurse practitioner on the page of the oxycodone-acetaminophen order. She reported they would not have written a separate physician order for the clarification of the oxycodone-acetaminophen order. They just write the "1 tab" by the original order and then the nurse practitioner signs the document. The After-Visit Summary contained no date by the nurse practitioner's signature as to when the dose for the oxycodone-acetaminophen as needed order dose had been clarified.

A Review of the facility Progress Notes on 5/30/23 revealed no documentation of verification of the admission orders by the Nurse Practitioner on 3/01/23. The Progress Notes showed documentation the Nurse Practitioner did a visit on 3/06/23 at 12:49 p.m.

The Facility failed to be able to show documentation as to the date of the clarification order for the oxycodone-acetaminophen medication order upon admission to the facility on 3/01/23.

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5. The MDS for Resident #17 dated 2/9/23 showed a BIMS score of 14 indicating no cognitive impairment. The Resident required limited assistance for ambulation, dressing and toileting. The MDS documented the Resident received scheduled and as needed pain medication for occasional pain of a 5 on a 1-10 pain scale as well as received opioid medication 1 day during the seven day lookback period. The MDS listed diagnoses of retroperitoneal abscess, cancer, and adult cell lymphoma/leukemia.

The Care Plan dated 1/30/23 detailed Resident #17 had voiced abdominal pain related to disease process and recent surgery. The Care Plan documented a goal the Resident would express the pain management within acceptable limits and directed the nurses to administer pain medications according to the physician orders.

A Physician order Sheet electronically signed by the provider on 2/03/23 showed an order effective 1/30/23 for oxycodone HCL oral capsule 5 mg, give 5 mg by mouth every 6 hours and as needed (PRN) for pain.

The February 2023 Controlled Medication Utilization Record documented the following discrepancies with following the physician orders for Resident #17's use of oxycodone immediate release 5 mg tablet, take 1 tablet by mouth every 6 hours as needed for pain:
a. On 2/23/23 at 8:00 p.m., one tablet signed out for administration.
b. On 2/23/23 at 1:30 p.m., one tablet signed out for administration.

The Facility failed to follow the 6 hour administration for the PRN medication per the

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F 658	Continued From page 103 physician order for the oxycodone as needed medication.	F 658		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on Pre-Admission Hospital Record review, facility clinical record review, State of Iowa Certificate of Death review, Medical Director and staff interviews, and facility document review, the facility failed to complete a thorough assessment, contact the resident's physician timely to request transport to the hospital for provision of treatment for 1 of 5 residents reviewed (Resident #2), when a serious change in condition noted for the resident. This failure resulted in the resident not being transported to the Emergency Room (ER) in a timely manner to receive medical interventions/treatment and subsequently the resident found in bed at the facility without a pulse or respirations, therefore causing an Immediate Jeopardy to the health and welfare of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of March 19, 2023 on May 16, 2023 at 1:45 p.m. The facility staff removed the Immediate Jeopardy on	F 684		

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May 17, 2023 by implementing the following actions:

A house wide audit completed to include baseline assessment and vital signs of current resident. Based on assessment findings, interventions were put in place and actions taken to address needs for residents when applicable.
Doctor (MD) and Family Notifications completed for any changes in condition identified.
Medical Director was made aware.
Education to Licensed Nursing Staff was initiated 5/16/23 to include education on change in condition, assessment/intervention care paths.
The Director of Nursing/Designee will complete Audits to validate documentation of assessments/interventions of any changes in condition.

The scope lowered from "J" to "D" at the time of the Survey after ensuring the facility implemented staff education and procedures.

The facility reported a census of 79 residents.

Findings Include:

The Pre-Admission Hospital Record documented diagnoses including COVID, acute cough, hematemesis, esophageal varices, and Grade D (severe) esophagitis. The hospital record documents the resident presented to the Emergency Department (ED) on or around 2/27/23 after his daughter observed coffee ground emesis.

Resident #2's Minimum Data Set (MDS) dated 3/16/23, documented an admission date of 3/16/23.

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The Electronic Health Record (EHR) Medical Diagnosis Section documented admission medical diagnosis including esophageal varices without bleeding and secondary esophageal varices with bleeding.

The Progress Note written on 3/16/23 at 5:55 PM documented the resident was admitted from a local Hospital by a transportation service. He was in the facility for strengthening. The resident was oriented to his room, call light, and TV remote. Medication orders were faxed to the Pharmacy and the Doctor (MD) was aware of the admission.

The clinical record lacks a Progress Note, vital signs, any nursing documentation or physician documentation for 3/17/23.

The Progress Note written on 3/18/23 at 5:53 AM, documented the resident had a quiet night, was COVID positive with intermittent cough. His respirations were even without distress.

The Progress Note written on 3/18/23 at 8:23 PM, documented the resident's lungs sounds were clear and diminished and his abdomen had active bowels sounds in all 4 quadrants.

The Progress Note written on 3/19/23 at 4:46 AM, documented the resident was resting peacefully with his eyes closed. His respirations were even and no distress observed. The resident had an intermittent cough.

The Progress Note written on 3/19/23 at 9:48 AM, documented the resident was vomiting and refused (his medications). The clinical record lacked documentation of a physical assessment,

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vital signs or Physician notification at that time.

The Progress Note written on 3/19/23 at 11:15 AM, documented the nurse entered the resident's room at 10:30 AM. The resident was making retching noises and had an emesis basin with spit and a tinge of blood. The resident asked the nurse if he was going to die that day and began to get worked up and breath heavy. The nurse encouraged the resident to deep breath through his nose and out through his mouth as he was "exhibiting signs of an anxiety attack." His pulse was 102 beats per minute and his oxygen saturation was 100 % on room air. The nurse called the resident's daughter to ask medical questions as the resident did not appear to be an accurate historian. The daughter requested the resident be sent to the Emergency Room (ER) immediately. The nurse documented she told the daughter this was not an emergency situation, he was just anxious. The resident was given Zofran (medication given for nausea) and water, covered with a blanket and the nurse told the resident she would be back to see if the Zofran helped. At 11:05 AM, the nurse entered the resident's room to see the resident with a blank stare, pupils fixed, his mouth and chin were blood stained. He did not have a pulse or respirations. The nurse documented an overhead page was made for the "Code Blue" and chest compressions were started. The nurse, another nurse and the Activity Assistant rotated compressions and the Ambu bag (to provide breaths to resident). At 11:06 AM, the Assistant Director of Nursing (ADON) called 911. At 11:13 AM, the ambulance crew arrived and took over care. At 1:00 PM, the Medical Examiner called and reported the cause of death to be ruptured esophageal varices.

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The State of Iowa Certificate of Death documented the date and time of death as 3/19/23 at 11:45 AM. The immediate cause of death is listed at exsanguination (sever blood loss) secondary to esophageal varices with other significant conditions being COVID-19.

During an interview on 5/15/23 at 1:59 PM, the Director of Nursing (DON) explained if a resident or family member was requesting a resident be sent to the ED, she would expect an assessment to be completed, the Doctor be notified and made aware of the request and assessment findings. She further explained the nurse would get the order to send at that time. She would expect that information to be documented. She explained that if it isn't documented that doesn't necessarily mean it wasn't done. If there was an emergency or something it could have slipped the nurses mind.

During an interview on 5/16/23 at 8:49 AM, Staff B, Licensed Practical Nurse (LPN) explained if a family member requested a resident go to the ER she would do an assessment, vitals and notify the Doctor.

During an interview on 5/16/23 at 8:52 AM, Staff C, LPN explained if a family member or resident was requesting the resident go to the ED she would do an assessment and notify the Doctor.

During an interview on 5/16/23 at 8:58 AM, Staff D, Registered Nurse (RN), explained if a resident was requesting to go to the ER she would do an assessment, call the Doctor and would send the resident to the ER. She explained if a family member was requesting the transfer, the resident gets transferred, the request can't be declined.

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During an interview on 5/16/23 at 9:15 AM, Staff A, RN explained the passed away on her last day working in this facility. She recalled the resident wasn't feeling well and had a little blood in his mouth. She explained the resident was anxious that day (March 19, 2023) and he was in the facility for COVID. The resident felt nauseated and she gave him a Zofran. He did not vomit but spit up. She called the daughter from the resident's cell phone with his permission. She remembers the cell phone recording they talked for 13 minutes. The resident was spitting up pink tinged sputum and the daughter thought he should go to the Emergency Room. Staff A explained to the daughter that he was anxious, this was not an emergency and she was calling to get a better picture of his previous history and background. The daughter gave that picture. Staff A explained she left the resident with an emesis basin as he was feeling nauseated and his call light and went to tend to another resident. When she was done with the other resident, she went back to check on the resident and found him with a blank stare, pupils fixed. She stated she shouted his name and felt for a pulse. She did not find one. She explained she knew he was a Full Code (wanted life saving measures), she called the code overhead and called for the crash cart and began compressions. She reported bright red blood clots were coming out of the resident's mouth with compressions. She stated she was not aware the resident had esophageal varices at that time.

During an interview on 5/16/23 at 11:42 AM, Staff F, RN, Unit Manager explained she was working in another part of the building when she heard the code page. She explained 2 nurses were doing

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Cardiopulmonary Resuscitation (CPR) when she got to the room. She recalled she ran and grabbed the suction machine and took it into the room and called 911. She went back in the room to get the suction machine going and the ambulance crew was there very quickly. She recalled the resident had blood coming from somewhere on or near his face. His color was completely pale. She explained she called the resident's daughter and notified her the resident was on his way to the hospital. Staff F explained if a family member requested the resident be sent to the ER the Doctor should be notified and she would get a Doctor's Order to send the resident to the hospital. When asked about a nurse refusing to call the Doctor, she stated "That would be wrong." She stated the nurse needed to put forth the effort to call the Doctor and let the Doctor know and decide what would happen next.

During an interview on 5/16/23 at 11:59 AM, the DON acknowledged Staff A had received a request from the resident's daughter for the resident to go to the ER but she received that information later. She explained it would not be appropriate for the nurse in the facility to tell the family no, this is not an emergency and refuse to send the resident or even call the Doctor.

During an interview on 5/30/23 at 4:12 PM, the Medical Director explained when a resident or family member requests to go to the ER we send them. That's standard, we don't refuse to send them. He further explained if it is an emergent situation they can call 911 and send the resident to the ER, get them taken care of and then notify us (himself and his team). If it's not emergent we like to be notified ahead of time so we can give the order and be aware. He explained he would

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F 684	Continued From page 110 expect a new set of vitals and an assessment from the nurse's interaction with the resident, that is standard. If they call and don't have that information he would ask them to get that information and call back. The facility document titled Change in Condition, dated 11/2016 directed staff to consult with the resident's Physician for any need to alter treatment or a decision to transfer the resident from the facility. The document further directed staff to immediately notify the Physician for any symptom, sign or apparent discomfort that is acute or sudden onset and a marked change in relation to usual symptoms and signs.	F 684		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	F 755		

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aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, document review and staff interview the facility failed to safeguard against potential loss, and/or diversion of controlled substances due to a lack of complete documentation when administering narcotics for 8 of 8 residents sampled (Resident #3, #4, #5, #6, #14, #15, #16, #17). The facility reported a census of 79 residents.

Findings Include:

1. A clinical record review revealed staff had signed out a narcotic on the Controlled Drug Administration Records (CDAR), but lacked documentation of administration documentation on the Electronic Administration Record (EMAR) for the following residents:
a. Resident #3: 3/18/23 one entry lacked a dose signed out on the EMAR. Another narcotic dose had been signed out at 7:46 a.m. on the March 2023 EMAR, but the CDAR showed the dose signed out at 12:30 p.m. 3/19/23 (3) doses not signed out on the EMAR.
b. Resident #4: On 3/04/23, 3/11/23, 3/13/23, 3/14/23 (2) doses, 3/15/23 (2) doses, 3/16/23.
c. Resident #5: On 3/08/23 (2) doses, 3/12/23 (2)

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doses, 3/13/23 (2) doses.
d. Resident #6: On 3/14/23, 3/15/23, 3/17/23 (2) doses, 3/18/23 (2) doses.
f. Resident #14: On 3/04/23 (4) doses, 3/05/23 (5) doses, 3/09/23, 3/10/23 (3) doses, 3/13/23 (3) doses, 3/14/23 (6) doses, 3/15/23, 3/17/23, 3/18/23 (3) doses, 3/19/23 (3) doses.
g. Resident #15: On 2/18/23 (2) doses, 2/22/23 (2) doses, 2/23/23, 2/24/23, 2/25/23 (2) doses, 2/28/23 (3) doses, 3/14/23 (4) doses, 3/14/23, 3/15/23 (2) doses, 3/18/23 (2) doses, 3/19/23 (3) doses.
h. Resident #16: On 2/24/23 (2) doses, 2/25/23, 2/28/23 (2) doses, 3/04/23 (3) doses, 3/05/23 (3) doses, 3/10/23 and 3/11/23.
i. Resident #17: On 2/10/23, 2/11/23, 2/15/23, 2/18/23, 2/19/23 (2) doses, 2/20/23, 2/23/23 (2) doses.

During an interview on 5/25/23 at 11:31 a.m., the Director of Nursing (DON) reported the Controlled Drug Administration Record (CDAR) once all doses have been administered or doses destroyed are to go to the Unit Supervisor to put the CDAR into the folder. If it is a weekend, the nurses can put the CDAR into the folder. Prior to the incident she had just looked at the CDARS to see if the narcotic doses were signed. She had not been going back and checking the EMAR or the actual medication cards. The nurses were initialing on the CDAR to sign out narcotic doses. Now she is encouraging the nurses to sign with their full last name. That is her preference but not facility policy. She didn't know of any real processes in place prior to the incident regarding missing CDAR's. They just followed standard procedures. Going forward, she has asked the pharmacy to email her a list of all narcotics that are delivered to the facility so she can check the

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medication cards have been signed in, counts verified and the medication card is in the double lock up. She will ensure narcotics are signed in correctly. She plans to utilize the Master Controlled Substance Log. She provided more education this morning to the nurses. She is requiring two nurses to sign in narcotic medication cards with pharmacy delivery and place into lock-up. Both nurses have to sign the Master Controlled Substance Log to document the delivery of the narcotics and both nurses have to sign the Log after destruction of any narcotics. The EMAR to the CDAR to the Master Controlled Substance Log should all match. She reported she carries the accountability for the accuracy of the process. She expects the nurses to sign out narcotics on both the EMAR and the CDAR. She expects nurses will follow the physician orders for the administration of narcotic medications.

On 5/31/23 at 9:55 a.m., the Administrator provided an Audit Record dated 4/25/23 that detailed for Resident #3 use of oxycodone (narcotic/opioid pain medication) immediate release (IR) 5 milligrams (mg) a pharmacy delivery of 30 tablets, with the CDAR showing 9 doses signed out. The March 2023 EMAR showed only 2 doses signed out. The medication card had 21 doses remaining on the card at the time of the audit with 7 discrepancies found. The notes documented two doses had been given by Staff A, Registered Nurse (RN) and were questionable so the facility reimbursed out of good faith.

2. The March 2023 EMAR for Resident #4 revealed administration of oxycodone (Roxicodone) oral tablet 5 mg, give 1 tablet by

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mouth every 4 hours as needed for pain control as follows.
a. On 3/05/23 at 7:40 a.m., for a pain level of 10 on a 1-10 pain scale by Staff A; dose effective.
b. On 3/05/23 at 7:27 p.m., for a pain level of a 4 on a 1-10 pain scale by Staff E (RN); dose effective.
c. On 3/07/23 at 4:08 a.m., for a pain level of a 5 on a 1-10 pain scale by Staff C, Licensed Practical Nurse (LPN); dose effective.
d. On 3/10/23 at 6:15 a.m., for a pain level of 9 on a 1-10 pain scale by Staff A; dose ineffective.
e. On 3/18/23 at 6:36 a.m., for a pain level of 5 on a 1-10 pain scale by Staff A; dose ineffective.
f. On 3/19/23 at 6:18 a.m., for a pain level of 10 on a 1-10 pain scale by Staff A; dose ineffective.

A review of Resident #4's CDAR showed a pharmacy label reading: oxycodone IR 5 mg tablets, take 1 tablet by mouth every four hours as needed for pain x 7 days. The CDAR documented the facility received 12 tablets on 3/18/23. Further review revealed no doses of the oxycodone medication had been signed out on the CDAR. The CDAR documented the signature of the DON and Staff E, RN destroyed 12 tablets of the narcotic medication. The CDAR did not contain a date the destruction took place.

On 5/15/23 at 12:01 p.m., Staff C, RN explained she signs out the narcotics in the CDAR and the EMAR. She administers her own as needed pain narcotic medications. The medication keys always stay with her. She ensures the oncoming nurse does the narcotic count with her. They look at both the medication narcotic card and the narcotic sign out sheets. The counts are done at the beginning and end of the shift. She has never had a narcotic count be off, if she did, she would

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report it to the DON.

On 5/16/23 at 7:20 a.m., Staff D reported the Pharmacy sends out a narcotic count sheet with each medication card. Some of the nurses throw all the narcotics they sign out on one sheet instead of using the narcotic sheet that comes with the card. She verifies the count when pharmacy delivers a new narcotic medication card and circles the count number on the narcotic sheet. She writes the amount received on the top of the narcotic sheet. She reported at 7:31 a.m. in regard to documenting out a narcotic medication they assess the resident's pain level, why they are requesting the medication, check the physician order, sign out in the EMAR and on the narcotic count sheet. If the count is off, she would notify the DON or ADON for an immediate investigation. She has never had the count be off.

On 5/18/23 at 7:56 a.m., Staff D reported when the Pharmacy delivers the medications to the facility, the pharmacy requires them to sign a sheet of paper showing they received the medication. The Pharmacy person takes a copy and leaves a copy for the facility. The Pharmacy provides a CDAR for each narcotic card of medication that is delivered. She circles the number of doses on the CDAR to match the number that were delivered on the delivery slip. They are required to sign a narcotic pain medication out on the resident's CDAR and the EMAR. The Pharmacy Delivery Slip goes into the 24 hour communication book.

On 5/22/23 at 2:22 p.m., Staff O, LPN voiced she had worked at the facility since September 2022. She received training from Staff D as her preceptor and went through medication

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administration and signing out of narcotics as part of her orientation. She explained she signs out a narcotic for administration in the EMAR and the CDAR. If the count is off, she would report to the DON. She would review to see if a nurse forgot to sign out a dose, but if there is a mistake in the narcotic count she would notify the DON immediately. She has never had to report any issues with the narcotic count to the DON.

During an interview on 5/23/23 at 1:35 p.m., the DON reported she expected the nurses to document out all as needed narcotic medication doses on the CDAR and on the EMAR so that a follow-up pain assessment could be completed.

On 5/23/23 2:35 p.m., Staff Q, LPN, reported they are required to sign narcotic pain medications out on the CDAR and the EMAR. He has to record the amount of pain and the location of the pain. The EMAR system will flag for him to do a follow up on any pain medications that will go to a progress note in the resident's chart.

On 5/23/23 on 2:42 p.m., the DON reviewed the March 2023 EMAR for oxycodone as needed order and the March 2023 CDAR. She reported she remembered wasting Resident #4's narcotics. She did not have an explanation for why the oxycodone had been signed out as administered on the March 2023 EMAR and had not been signed out on the March 2023 CDAR.

5/23/23 at 2:57 p.m., the DON reported she did not have an answer for the discrepancy on Resident #4's records. She acknowledged the 7 day limit on the oxycodone label the pharmacy had placed on the CDAR and the facility physician order for oxycodone did not have a time

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limit on the order. The DON returned at 3:02 p.m. and reported the pharmacy verified they sent out 12 tablets of oxycodone. The DON also reported the pharmacy confirmed they sent out a medication card containing 30 tablets of oxycodone that the facility did not have a CDAR on.

An interview with the Pharmacist on 5/24/23 at 9:55 a.m., revealed the Pharmacy had sent 9 tablets of oxycodone to the facility on 3/5/23; 30 tablets of oxycodone on 3/10/23 and 12 tablets of oxycodone on 3/18/23. The Pharmacist checked the records at 10:03 a.m. and voiced the facility had not returned any of the medication cards to the pharmacy.

During an interview on 5/24/23 at 10:25 a.m., the Administrator explained he had been aware of the missing CDAR for Resident #4. He had looked all over the facility for the CDAR and had not found the records.

On 5/24/23 at 10:50 a.m., Staff P Medical Records/Scheduler reported she could not find a CDAR for Resident #4 oxycodone 9 tablets. She stated she had reported it to the Administrator and he had already talked to the Surveyor about it.

During an interview on 5/24/23 at 12:15 p.m., the DON reported she had not been aware of Resident #4 missing a CDAR for an oxycodone count of 9 tablets. The nurses are to document the narcotic delivery on the Master Controlled Substance Log and they circle the count number received on the CDAR however, she commented they do this, but it is not a facility policy. She reported two nurses have to destroy narcotics

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and document the destruction on the CDAR record. She stated the paper they filled out and attached to the CDAR following destruction had been under the old processes and management. They no longer do that. Both nurses sign the CDAR for the quantity of tablets destroyed.

5/25/23 at 10:24 a.m., Staff P reported she receives the CDAR from the two-unit managers or the DON. They personally hand the CDARs to her or put them in her mailbox which is in the Administrator's office. The CDAR's are kept in individual resident folders. The folders are not in locked cabinets, but the medical records office is locked. Outside of her office, she didn't know who had the responsibility to ensure the CDAR records were maintained. Most times once the documents were in her office, they made copies if needed so the documents did not leave the office. They retain the records for 3 years and then the records go to medical storage provider.

On 5/25/23 at 10:36 a.m., Staff R, LPN, ADON/Nursing Supervisor explained the narcotic medications have to be destroyed by two nurses. The remaining doses of narcotic medication are popped out and put into the Drug Buster. Both nurses sign the destruction on the CDAR. The CDAR once all doses are gone or after destruction are turned into her as the Unit Supervisor. She puts the CDAR into the DON ' s folder. The DON picks up the papers from the folder every day or on Mondays following the weekend. She reported there is a Master Controlled Substance Log. Hypothetically, the nurses should also log the destruction of the narcotics on that record. She thought that may be a newer process but the DON would know more about that.

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During an interview on 5/25/23 at 11:31 a.m., the DON reported the CDAR once all doses have been administered or doses destroyed are to go to the Unit Supervisor to put the CDAR into the folder. If it is a weekend, the nurses can put the CDAR into the folder. Prior to the incident she had just looked at the CDARS to see if the narcotic doses were signed. She had not been going back and checking the EMAR or the actual medication cards. The nurses were initialing on the CDAR to sign out narcotic doses. Now she is encouraging the nurses to sign with their full last name. That is her preference but not facility policy. She didn't know of any real processes in place prior to the incident regarding missing CDAR's . They just followed standard procedures. Going forward, she has asked the pharmacy to email her a list of all narcotics that are delivered to the facility so she can check the medication cards have been signed in, counts verified and the medication card is in the double lock up. She will ensure narcotics are signed in correctly. She plans to utilize the Master Controlled Substance Log. She provided more education this morning to the nurses. She is requiring two nurses to sign in narcotic medication cards with pharmacy delivery and place into lock-up. Both nurses have to sign the Master Controlled Substance Log to document the delivery of the narcotics and both nurses have to sign the Log after destruction of any narcotics. The EMAR to the CDAR to the Master Controlled Substance Log should all match. She reported she carries the accountability for the accuracy of the process. She expects the nurses to sign out narcotics on both the EMAR and the CDAR. She expects nurses will follow the physician orders for the administration of narcotic medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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On 5/31/23 at 9:55 a.m., the Administrator provided an Audit Record dated 4/25/23 that detailed for Resident #4's hydrocodone-acetaminophen 5-325 mg, the pharmacy delivered 14 tablets, the CDAR showed 10 tablets signed out. The EMAR documented 4 doses signed out for administration. The medication card had 4 remaining tablets. The Audit Report documented 6 discrepancies in the records and detailed one dose had been signed out by agency staff. The facility could not confirm the accuracy so would reimburse out of good faith. The Audit Report 4/25/23 documented for an oxycodone IR 5 mg pharmacy delivery of 9 tablets, the EMAR showed 4 doses signed out as administered. The audit detailed the facility had no CDAR and no amount remaining due to no CDAR. For a delivery of 30 tablets of oxycodone IR 5 mg, the facility had no CDAR. The EMAR showed two doses signed out for administration and an unknown remaining on the card as the facility did not have a card or CDAR for the medication.

3. On 5/31/23 at 9:55 a.m., the Administrator provided an Audit Record dated 4/25/23 that detailed Resident #14 had a pharmacy delivery on 3/02/23 of oxycodone IR 5 mg, 30 tablets. The facility had no CDAR. The EMAR showed no doses of the medication had been signed out as administered. The amount remaining on the medication card could not be accounted for. The audit detailed 30 discrepancies from the audit.

4. On 5/31/23 at 9:55 a.m., the Administrator provided an Audit Record dated 4/25/23 that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165017	A. BUILDING _____ B. WING _____	C 05/31/2023

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HARMONY CEDAR RAPIDS	1940 FIRST AVENUE NE CEDAR RAPIDS, IA 52402

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detailed Resident #16 had a pharmacy delivery on 3/12/23 of hydrocodone-acetaminophen 5-325 mg, 16 tablets. The facility had no CDAR for the count of 16 tablets. The EMAR had 6 doses of the medication signed out as administered. The amount remaining on the card could not be accounted for. The audit detailed 10 discrepancies found.

The Medication Pass Policy, revised 7/28/22, provided by the facility included a Policy Statement the facility would adhere to all Federal and State regulations with medication pass procedures. The Procedure for oral medications specified the following:
a. Follow hand hygiene procedure before and after each resident.
b. After each medication is administered to each resident, sign the MAR that it was given.

The Policy specified under Controlled Substances all scheduled 2 controlled substances will be stored properly and double locked. All medications are to be stored in room at temperature recommended by the manufacturer. The Policy lacked any direction on signing out narcotics on the CDAR and storage of the CDAR forms once completed.

The Receiving Controlled Substances Policy, revised 8/2020, provided by the facility documented medications classified by the Drug Enforcement Administration (DEA) as controlled substances and medications classified as controlled substances by state law are subject to special ordering, receipt, and record keeping requirements by the facility in accordance with federal and state laws and regulations. The Policy Procedure specified the DON, in collaboration

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with the consulting pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. Only authorized, licensed nursing and pharmacy personnel have access to controlled substances. The Procedure outlined the following:
1. The pharmacy dispenses medication listed in Schedule II, III, IV and V in readily accountable quantities and containers designed for each counting of contents.
2. Unless otherwise directed by the facility, an individual resident's controlled substance record is prepared by the pharmacy for each controlled substance prescribed for a resident. The following information is completed upon dispensing or upon receipt of the controlled substance:
a. Name of the resident.
b. Prescription number.
c. Drug name, strength, dose, form of medication.
d. Date received.
e. Quantity received.
f. Name of person receiving the medication supply.
3. Controlled substances listed in the Schedules II, III, IV, V are stored under double lock. The access key to controlled substances is not the same key that allows access to other medications. The medication nurse on duty maintains the possession of a key to the controlled substances. The DON and the pharmacy keep back-up keys to all medication storage areas, including controlled substance storage.
4. Only licensed personnel may receive controlled substances from the pharmacy courier. The Procedures for receiving controlled substances include:

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a. A nurse signs for the medications, including the controlled substances, on the pharmacy delivery ticket and inspects the medications.
b. If a discrepancy or dispensing error is identified for a controlled substance, the nurse must notify the pharmacy at point of delivery. The nurse should document the description of the discrepancy/error on the delivery packing slip/manifest and refuse/reject the delivery of the affected medication(s).
c. The receiving nurse transfers medications and accompanying inventory sheets to an authorized nurse on the unit (if different than the nurse who received the medication) or in accordance with facility policy.
d. Two nurses, and/or in accordance with facility policy, witness placement of the controlled substances in the secured compartment of the medication cart.
e. Controlled substance inventory sheets are filed appropriately. A hard-bound log book, or in accordance with the facility policy, is utilized to track the controlled substance from delivery to disposition.

The Storage and Destruction of the Designated Record Set Policy, revised 11/19/21, specified the facility will maintain accurate and completed medical and billing records for each facility resident in a designated record set, in a secure manner, at locations approved by facility in accordance with facility policy. Protected health information (PHI) is kept in locations approved by the facility administration. The Policy Guidelines directed:
a. The resident's "Designated Record Set" is comprised of the resident's medical record and billing record.
b. The Designated Record Set may be physically

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maintained in different locations at the facility (e.g., medical records may be kept at the nurses station and billing /financial records kept in the business office).
c. Facility staff will ensure that documentation in the resident's medical record complies with the facility's medical records policies and procedures, particularly in relation to accuracy, completion, and legibility.

The Policy, under Storage of Designated Record Set documented the facility would follow storage procedures to ensure that (PHI) is accessed by authorized individuals. The Policy further specified active medical records would be stored either in the medical records office or at the Nurses' Station. Archived medical records would be stored in the medical records office or at a secured off-site location. The Policy defined under Staff Access to Designated Record Set that staff will not copy, keep or maintain parts of a resident's designated record set, except as required to perform their job duties or approved by the facility policy. Under Destruction of the Designated Record Set, the Policy directed facility records must be destroyed in a manner that ensures the confidentiality of the records and renders the information unrecognizable. For PHI paper records, proper disposal methods may include shredding, burning, pulping, or pulverizing the records so that the PHI is rendered essentially unreadable, indecipherable, and other wise cannot be reconstructed. The Facility may not dispose of resident PHI by throwing whole documents in the trash can because this is not a method of destruction which ensures the resident information will be unrecognizable.

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F551 Rights Exercised by Representative

483.10(b)(4): The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

Corrective action taken for residents found to have been affected by deficient practice

- Resident #2 no longer resides at the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice

- Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur

- Licensed nursing staff education on resident rights regarding a family member requesting the patient to be sent to the Emergency Room and notification to the physician

Quality Assurance Plan to monitor performance to make sure corrections are achieved

- DON/Designee will complete random weekly audits times four weeks to validate resident representative rights.
- Audit findings to be taken through Center's QAA.

Completion Date: 7/12/2023

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F580 Notify of Changes

483.10(g)(14): The facility must immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).

Corrective action taken for residents found to have been affected by deficient practice

- Resident #2 no longer resides in the center.

How the center will identify other residents having the potential to be affected by the same deficient practice

- Residents with changes in condition have potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur

- Licensed nursing staff education on notification of significant changes and resident representative requests to access emergency services to the physician.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

- DON/Designee will complete random weekly audits x 4 weeks regarding the notification process of changes in conditions.
- Audit findings to be taken through Center's QAA.

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F602 Free from Misappropriation/Exploitation

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 medical symptoms.

Corrective action taken for residents found to have been affected by deficient practice

- Residents (#3, #4, #6, #14, #15, #16, #17) no longer reside at this facility.
- Resident #5 was assessed with no negative findings.

How the center will identify other residents having the potential to be affected by the same deficient practice

- All residents in the facility with an active order for a narcotic pain medication have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not recur

- Licensed nursing staff education on misappropriation/abuse, specifically as its related to medication and narcotic administration.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

- DON/Designee will complete random weekly audits times 4 weeks of narcotic count sheets and eMARs to ensure medications are being documented appropriately.
- Audit findings to be taken through Center's QAA.

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F609 Reporting of Alleged Violations

483.12 (b)(5)(i)(A)(B)(c)(1)(4) In response to allegations of abuse neglect, exploitation or mistreatment the facility must: (1) Ensure that all alleged violations involving abuse neglect exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made. If the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the vents that cause the allegation do not involve the administrator of the facility to other officials (including to the state survey agency and adult protective services where state law provides for jurisdiction in long term care facility) in accordance with State law through established procedures. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with state law, including to the state survey agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Corrective action taken for residents found to have been affected by deficient practice

- Resident (#3) no longer resides in the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice

- All residents in the facility have a potential to be impacted.

What changes will be put into place to ensure that the problem will be corrected and will not recur

- Administrator and DON within the facility educated on timely reporting of abuse.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

- Administrator/DON/Designee will complete random weekly audits times 4 weeks of allegations of abuse is reported in a timely manner.
- Audit findings to be taken through Center's QAA.

Completion Date: 7/12/2023

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F610 Investigate/Prevent/Correct Alleged Violation

483.12 (C)(2)-(4) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must have evidence that all alleged violations are thoroughly investigated. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or her designated representative and to other officials in accordance with state law, including to the state survey agency, within 5 working days of the incident and if the alleged violation is verified appropriate corrective action must be taken.

Corrective action taken for residents found to have been affected by deficient practice

- Residents (#4, #14, and #16) no longer reside at the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice

- All residents in the facility have a potential to be impacted.

What changes will be put into place to ensure that the problem will be corrected and will not recur

- Administrator and DON educated on thorough abuse investigations.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

- Admin/DON/designee to complete random weekly audits times 4 weeks of allegations of abuse for thoroughness of investigation.
- Audit findings to be taken through Center's QAA.

Completion Date: 7/12/2023

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F658 Services Provided Meet Professional Standards

483.12 (b)(3)(i) The services provided or arranged by the facility, as outlined by the comprehensive care plan must meet professional standards of quality.

Corrective action taken for residents found to have been affected by deficient practice

- Residents (#3, #4, #6 and #17) no longer reside at the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice

- All residents in the facility have a potential to be impacted.

What changes will be put into place to ensure that the problem will be corrected and will not recur

- Licensed nursing staff educated on following physician orders.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

- DON/Designee will complete random weekly audits times 4 weeks of narcotic pain medication orders.
- Audit findings to be taken through Center's QAA.

Completion Date: 7/12/2023

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F684 Quality of Care

483.25 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

Corrective action taken for residents found to have been affected by deficient practice

- Resident (#2) no longer resides at the facility.

How the center will identify other residents having the potential to be affected by the same deficient practice

- All residents in the facility who have a serious change in condition have a potential to be impacted.

What changes will be put into place to ensure that the problem will be corrected and will not recur

- Licensed nursing staff educated on change in condition, assessment/intervention care paths.
- Baseline assessments and vitals completed on patients in-house.
- Based on these assessment findings, interventions were put in place and actions taken to address needs for residents when applicable.
- Doctor and family notifications completed for any changes in condition identified.
- Medical Director was made aware.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

- DON/Designee will complete random weekly audits times 4 weeks to validate documentation of assessments/ intervention of any changes in condition noted.
- Audit findings to be taken through Center's QAA.

Completion Date: 5/17/2023

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F755 Pharmacy Srvcs/Procedures/Pharmacist/Records

483.45 (a)(b)(1)-(3) The facility must provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement described in 483.70. The facility may permit unlicensed personnel to administer drugs if state law permits, but only under the general supervision of licensed nurse. 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. Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- provides consultation on all aspects of the provision of pharmacy services in the facility and establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Corrective action taken for residents found to have been affected by deficient practice

- Residents (#3, #4, #6, #14, #15, #16, #17) no longer reside at the facility.
- Resident (#5) was assessed with no negative findings.

How the center will identify other residents having the potential to be affected by the same deficient practice

- All residents in the facility have a potential to be impacted.

What changes will be put into place to ensure that the problem will be corrected and will not recur

- Licensed nursing staff educated on narcotic record keeping and documentation on both the EMAR and CDAR.

Quality Assurance Plan to monitor performance to make sure corrections are achieved

- DON/Designee will complete random weekly audits times 4 weeks of narcotic record keeping and documentation on both the EMAR and CDAR.
- Audit findings to be taken through Center's QAA.

Completion Date: 7/12/2023