

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2023	
NAME OF PROVIDER OR SUPPLIER TRADITIONS OF COLUMBUS		STREET ADDRESS, CITY, STATE, ZIP CODE 4300 WEST GOELLER BLVD, COLUMBUS, , 47201					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00411523. Complaint IN00411523 - Substantiated. State deficiencies related to the allegation is cited at R0064. Survey date: August 15, 2023. Facility number: 015179 Residential Census: 76 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/22/23.	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review. In response to R 052 410 IAC 16.2-5-1.2 (hh) Residents' Rights Noncompliance Deficiency: (hh) The facility shall exercise reasonable care for the protection of residents'				

property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the result of the investigation are reported to the resident.

This RULE is not met as evidenced by: Based on observation, interview and record review, the facility failed to protect the resident rights related to misappropriation of resident medications.

What corrective actions will be accomplished for those residents found to have been affected by the finding:

The missing medication was reordered from pharmacy and billed to the facility.

-Completed 6/26/23

[How will you identify other residents](#)

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having the potential to be affected by the same deficient practice and what corrective action will take place:

No resident was adversely affected though the potential for adverse outcome did exist.

The Regional Director of Wellness immediately audited all med carts to verify all narcotic counts were correct.

The Director of Wellness will audit med carts weekly x 4 weeks, monthly x 3 months and the PRN. Records will be kept with the Administrator.

-Completed 6/23/23 and ongoing

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.

How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program

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will be put into place:

The Director of Wellness will audit med carts weekly x 4 weeks, monthly x 3 months and the PRN. Records will be kept with the Administrator.

-Completed 6/23/23 and ongoing

An employee Inservice was conducted to educate staff on our policy for narcotic destruction as well as misappropriation.

-Completed 6/29/23

All new employees moving forward will be inserviced at time of hire for misappropriation.

-Completed 6/29/23 and ongoing.

All new staff will continue to be screened for preemployment via background check and drug screen.

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			-Completed 6/23/23 and ongoing What date the systemic changes will be completed: 6/29/23 and ongoing	
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on observation, interview, and record review, the facility failed to protect resident rights related to misappropriation of resident medications for 1 of 3 residents reviewed for Residents' Rights. (Resident B)	R 0064	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review.	09/05/2023

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Findings include:

The clinical record for Resident B was reviewed on 08/15/23 at 10:09 A.M. The diagnoses included, but were not limited to, hypertension, osteoarthritis, and neuropathy.

A physician's order, with a start date of 06/08/23 and discontinued date of 06/23/23, indicated the resident was to receive oxycodone 5 mg (milligrams), three times a day. A new, open-ended physician's order, with a start date of 06/23/23, indicated the resident was to receive the oxycodone 5 mg medication once daily at noon.

A photograph copy of the pharmacy "Controlled Drug Record" for Resident B's oxycodone, indicated 90 doses of the medication were received on 06/09/23. The medication was first signed out on 06/11/23 at 8:00 A.M. The record indicated 33 doses of the medication had been administered to the resident and one additional dose was documented as having been dropped, to equal 34 doses removed. The form was last dated on 06/21/23 and indicated the resident had 56 doses of the medication available.

A facility "Controlled Substance Count Form" dated 06/22/23,

**In response to R 052 410
IAC 16.2-5-1.2 (hh) Residents'
Rights Noncompliance**

Deficiency:

(hh) The facility shall exercise reasonable care for the protection of residents' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the result of the investigation are reported to the resident.

This RULE is not met as evidenced by: Based on observation, interview and record review, the facility failed to protect the resident rights related to misappropriation of resident medications.

What corrective actions will be accomplished for those residents found to have been affected by the finding:

indicated the resident had 30 oxycodone 5 mg available. The form was signed by RN 2 and LPN (Licensed Practical Nurse) 3.

The EMAR (Electronic Medication Administration Record) for Resident B indicated she had received the medication three times a day from 06/11/23 through 06/22/23 to equal 36 doses administered.

There were 24 oxycodone pills that were unaccounted for after the medication administration orders were changed.

During an interview on 08/15/23 at 11:29 A.M., LPN 3 indicated a few things happened within a few days. On 06/21/23, she had come in for her shift and RN 2 was working the cart. RN 2 wanted her to sign out a dropped narcotic medication that belonged to Resident B. RN 2 said that she dropped the medication in the medication cart and couldn't find it and would look for it the next day. She signed out another one and gave it to the resident. LPN 2 called the Administrator because she didn't feel comfortable signing out the dropped medication that she didn't actually see get destroyed. The next day when she came onto her shift, LPN 4 told her that Resident B's oxycodone order had changed,

The missing medication was reordered from pharmacy and billed to the facility.

-Completed 6/26/23

[How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will take place:](#)

No resident was adversely affected though the potential for adverse outcome did exist.

The Regional Director of Wellness immediately audited all med carts to verify all narcotic counts were correct.

The Director of Wellness will audit med carts weekly x 4 weeks, monthly x 3 months and the PRN. Records will be kept with the Administrator.

-Completed 6/23/23 and ongoing

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so the medications were taken out of the cart by RN 2. That evening the medication was due and the medication wasn't in the medication cart. She contacted another nurse who then contacted RN 2. RN 2 came into the facility and brought her one blister pack of 30 oxycodone pills and a facility narcotic count sheet, not the one that was provided by the pharmacy. She knew the day before there were 2 blister pill packs. She then contacted the Administrator because RN 2 only gave her 30 pills when she knew the resident had two blister pill packs the day before.

During an interview on 08/15/23 at 11:45 A.M., the Administrator indicated LPN 3 contacted her on 06/21/23 about RN 2 dropping a narcotic pill in the medication cart and wanting her to sign off on it as destroyed when she didn't see it being destroyed. She educated the LPN about destruction of medications and signing off when destroying them. The next evening the PA (Physician Assistant) 5 sent her a message about being contacted that Resident B didn't have any oxycodone available in the medication cart due to the order being changed. PA 5 messaged RN 2 about the medications, and she said she removed the medications because the order changed, and she was going to

What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.

How will the corrective actions be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place:

The Director of Wellness will audit med carts weekly x 4 weeks, monthly x 3 months and the PRN. Records will be kept with the Administrator.

-Completed 6/23/23 and ongoing

An employee Inservice was conducted to educate staff on our policy for narcotic destruction as well as misappropriation.

-Completed 6/29/23

All new employees moving forward will be inserviced at time

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destroy them. PA 5 told her she couldn't just remove medications from the medication cart, the medication dosage never changed just the time of administration and the medication should have never been removed. She told her she needed to return the medication to the medication cart. RN 2 told PA 5 that she would be resigning. After the medication was returned, LPN 3 contacted her because RN 2 only gave her one blister pill pack with 30 pills in it and a facility narcotic count sheet, but not the pharmacy narcotic count sheet. She knew there were two blister packs the day before. She herself had contacted RN 2 and she told her she only took one blister pack of 30 pills and one narcotic count sheet. The next day (06/23/23), she reviewed the video footage that showed she had taken two blister pills packs from the Care Base (nurses' station). She searched RN 2's office and didn't find any more blister pill packs. She called RN 2 again, and she still indicated she had only taken one blister pill pack with 30 pills. The Regional Nurse also found a bottle of liquid Ativan and liquid morphine in a first aid kit, in a treatment cart, in RN 2's office, that belonged to Resident C. That medication was all accounted for. RN 2 had been in her role for about 6 weeks. They had a conversation about 3 weeks

of hire for misappropriation.

-Completed 6/29/23 and ongoing.

All new staff will continue to be screened for preemployment via background check and drug screen.

-Completed 6/23/23 and ongoing

What date the systemic changes will be completed:

6/29/23 and ongoing

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prior about never putting medications in her office. She had a treatment cart in her office that she would put medications in to be destroyed with the Dementia Director. She educated her that the facility policy was to leave the medications in the medication cart until they were ready to be destroyed. All the staff had a key to her office and could go in there at any time. The Administrator started and completed an investigation. RN 2 was suspended pending the investigation, but she resigned. The resident's family, physician, and the police were notified. The resident never went without pain medication and the facility paid for the unaccounted for medication.

During an observation on 08/15/23 at 1:47 P.M., the Administrator showed video footage she indicated was from the day of the incident. RN 2 had walked out of Care Base with two blister pill packs. She turned right and was out of the video for a few seconds and then went to the elevator. The video lasted 44 seconds.

During an interview on 08/15/23 at 2:26 P.M., PA 5 indicated she was in the facility to see Resident B on 06/22/23. She had been contacted by the nurses that the resident's pain was not being controlled. The

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resident had been taking 5 mg of oxycodone, three times a day. The resident had been apprehensive about taking opioids. The resident had been irritable with staff, so they were working on pain control. It had been better for the resident but was not where she wanted it to be. She came up with a plan to switch the resident to oxycontin every 12 hours, and then during the day she could have the oxycodone 5 mg, PRN (as needed), for break through pain. The resident didn't want to have to ask for the PRN medication, so PA 5 scheduled the oxycodone to be routinely administered daily at noon. She sent the prescription to the pharmacy. She had been in the building a little longer and was on the dementia unit around 11:00 A.M., when RN 2 came up and was talking to some other staff. The DOW RN 2 then looked at her and said she loved what she had done with Resident B's medications and thought it was a great plan. The conversation seemed unusual to her. PA 5 then asked for a meeting with the Administrator. She wanted to discuss some concerns she had about RN 2. That evening, she got a message that the resident was in pain and her medication was delayed from the pharmacy. She told them to continue the oxycodone that night and start the oxycontin the next morning.

She was alerted the medication was not in the medication cart and that RN 2 had removed it. She then sent a message to RN 2 asking where the medications were, and the RN 2 said she was on her way back to the facility to put them back in the medication cart. PA 5 told her it was inappropriate to remove medications from the cart and she should never leave them locked in her office. She explained to her that the medication was never discontinued, just modified. RN 2 said she must have missed the once-a-day order. She told her regardless the medication was a controlled substance, and she should have never taken them from the cart they should have been counted for every shift. DOW RN 2 then indicated she was going to resign. She had reached out to the Administrator and sent her all the messages to show her what had transpired.

The facility's investigation was provided by the Administrator on 08/15/23 at 10:09 A.M. The investigation included a statement from LPN 4. The statement indicated, on 06/22/23, Resident B had received a new order for oxycontin 10 mg every 12 hours and oxycodone 5 mg at noon. RN 2 came to the Care Base around 12:30 P.M. to 1:00 P.M. and asked for the resident's

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oxycodone 5 mg medication cards. She reminded her that the resident had a dose due at 2:00 P.M. RN 2 told her when she was done, she could put the medication cards under her desk and chair. LPN 4 looked at her, confused. RN 2 then told her "No, don't do that. Too many people have keys to my office." RN 2 then came back to the Care Base after the medication was given. The count of the narcotic at that time was 53. She took the medication and the medication count sheet with her. She asked her if she was going to be there the next day and she stated yes. She said they would dispose of the medications after she completed her morning medication pass.

During an interview on 08/15/23 at 3:48 P.M., the Administrator indicated RN 2 should have never removed the medications from the medication cart. If she wanted to destroy them, she should have done it right there with the nurse at the nurse's station where she removed the medications from.

The current facility policy titled, "Resident Neglect, Abuse and Misappropriation of Property" dated 6/14, was provided by the Administrator of 08/15/23 at 1:57 P.M. The policy indicated, "Residents will be free from misappropriation of resident property..."

The current facility policy titled, "Controlled Substances" and dated 6/14, was provided by the Administrator on 08/15/23 at 1:57 P.M. The policy indicated, "...The storage of controlled substances must be strictly monitored...In addition to the Medication Sheet and the Schedule II Narcotic sheet, the number of controlled substances on hand must be counted and verified at the end of each shift...When a controlled substance is discontinued by the resident's physician, all unused medication will be destroyed with two Licensed Nurses or with the Pharmacist..."

This State tag related to Complaint IN00411523.

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A facility "Controlled Substance Count Form" dated 06/22/23,

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FORM APPROVED

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OMB NO. 0938-0391

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This State tag related to Complaint IN00411523.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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

TITLE

(X6) DATE