STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00414158, IN00411541, IN00409930, IN00408204, IN00407753 and IN00406416. Complaint IN00414158 - Federal/State deficiencies related to the allegations are cited at F602. Complaint IN00411541 - No deficiencies related to the allegations are cited. Complaint IN00409930 - No deficiencies related to the allegations are cited. Complaint IN00408204 - Federal/State deficiencies related to the allegations are cited at F602. Complaint IN00407753 - No deficiencies related to the allegations are cited. Complaint IN00406416 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: August 3, 4, 7, 8 & 9, 2023 Facility number: 000034 Provider number:155086 AIM number: 100274880 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 3	F 0000	Woodland Manor Nursing and Rehab request for a paper review for compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda Lewis	Administrator	09/01/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Medicaid: 56 Other: 8 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 8/18/2023.			
F 0602 SS=D Bldg. 00	483.12 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. Based on interview and record review, the facility failed to prevent the misappropriation of narcotics for 3 of 4 residents reviewed who were being administered narcotics. (Resident G, Resident F and Resident K) Findings includes: During an interview, on 8/3/23 at 1:58 P.M., LPN 4 indicated approximately 2 weeks ago Resident G had a missing Controlled Drug Record and the resident had approximately 10-12 tables left on the drug card. LPN 4 implied LPN 3 had wasted them and there were no other witnesses. LPN 4 indicated Resident F had requested a pain pill from her on July 16th and she explained to him it was to early to have a dose, since he had one a 6:00 A.M. The resident indicated to her he had never received a pain pill at 6:00 A.M. on the morning of July 16th.	F 0602	F 602 Free from Misappropriation/Exploitation It is the practice of Woodland Manor to ensure there is no misappropriation of narcotics from facility residents. · What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident K reports no concerns with receiving pain medications and his CDR form and medication sheet have been audited for accuracy. Residents G and F no longer reside at the facility. Medication error reports were completed for residents K, G and F for narcotic medications that were identified as lacking administration	09/15/2023

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	1. On 8/4/223 at 10:15 A.M., a review of the clinical record for Resident G was conducted. The record indicated the resident was admitted to the facility on 6/12/23. The resident's diagnoses included, but were not limited to: unspecified pain and dementia with anxiety. The Physician Orders indicated the resident was to be administered Hydrocodone-Acetaminophen 5/325 milligrams (mg). Order stated to give 1 tablet, by mouth, every 4 hours as needed for pain. The start date was 6/14/23 with a stop date of 6/29/23, then updated on 6/29/23 to continue order until 7/13/23. The current order, started on 7/17/23, indicated to administer Hydrocodone/Acetaminophen 5/325 mg tablet, by mouth, four times a day. The June 2023 Medication Administration Record (MAR) indicated the resident was being administered, as needed, the Hydrocodone/Acetaminophen 5/325 mg. tablet on the following dates and times: - 6/17 at 7:15 A.M. and 2:00 P.M. - 6/18 at 7:36 A.M. and 2:00 P.M. - 6/21 at 6:57 A.M., 12:22 P.M. and 8:02 P.M. - 6/22 at 8:30 A.M. - 6/23 at 7:05 P.M. - 6/24 at 6:05 A.M. - 6/25 at 12:03 A.M. and 8:24 P.M. - 6/26 at 2:20 A.M., 6:45 P.M., 12:00 P.M. and 7:50 P.M. - 6/27 at 8:00 A.M., 12:30 P.M., 4:15 P.M. and 10:00 P.M. - 6/28 at 4:40 P.M. and 11:28 P.M. - 6/29 at 8:00 P.M. - 6/30/23 at 9:?? (form cut off minutes) This equaled 24 tablets administered.		documentation or not signed out on the CDR form and the physician and responsible parties notified. · How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with orders for narcotic medications have the potential of being affected by the deficient practice. An audit has been completed on all residents with orders for narcotic medication and medication error reports completed on those found with discrepancies in documentation. Education on narcotic documentation and destruction was provided to the licensed nurses/QMA's responsible for the errors. · What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policies on "Controlled Medication Destruction, Medication Administration General Guidelines and the Long-Term Care Abuse and Incident Reporting Policy" were reviewed by the IDT. An in-service was held with all nursing staff who pass medications on the policies. A performance improvement tool has been developed to monitor narcotic medications are documented and destroyed as per	

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	The July 2023 MAR indicated the resident was administered, as needed, a Hydrocodone/Acetaminophen 5/325 mg. tablet on the following dates and times: - 7/1 at 8:46 AM and 8:04 P.M. - 7/2 at 6:22 A.M. This equaled 3 tablets administered. A Controlled Drug Records (CDR) form for June and July of 2023, were provided by the Director of Nursing. The CDR indicated LPN 6 signed for the receipt of 28 tablets of Hydrocodone/Acetaminophen 5/325 mg from the pharmacy, on 6/14/23. Documentation of those 28 tablets, being removed for administration, started on 6/17/23, with first dose removed on 6/17/23, by LPN 3 and last dose removed on 7/2/23 by LPN 6. This CDR form indicated 28 tablets were removed for administration, however the CDR indicated LPN 6 had removed a tablet for administration on 6/30 at 2:00 AM but did not document as administered, to the resident, on the MAR. The July 2023 MAR indicated the resident was administered, as needed, Hydrocodone/Acetaminophen 5/325 mg tablet on the following dates and times: - 7/4 at 7:06 P.M. - 7/5 at 12:58 A.M., 9:30 A.M. and 3:59 P.M. - 7/6 at 2:54 A.M. and 8:00 P.M. - 7/7 at 12:58 A.M. - 7/8 at 12:23 P.M. and 9:58 P.M. - 7/9 at 7:03 A.M. - 7/10 at 1:07 P.M. and 8:25 P.M. - 7/11 at 2:11 A.M. and 7:30 P.M. - 7/12 at 2:58 A.M. and 7:22 P.M. - 7/13 at 1:39 P.M. The order indicated a stop date of 7/13/23. This equaled 17 tablets administered.		policy. · How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A performance improvement tool has been initiated that randomly audits five (5) residents to endure narcotic medications are signed off on the CDR when administered, documentation is completed accurately, and narcotic medication destruction is performed as per policy. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting	

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	There was no CDR form indicating the removal of the Hydrocodone/Acetaminophen 5/325 mg from 7/4/23 through 7/13/23. During an interview, on 8/4/23 at 2:10 P.M., the Director of Nursing (DON) indicated she had provided all the CDRs for June and July. She indicated a new Controlled Drug Record would have been started and would have had the signature, of the receiving nurse and the number of tablets received. The DON did not know the amount of of tablets the facility received due to the next CDR form, starting on 7/4/23, was missing. The DON indicated LPN 3 had destroyed all the remaining medications, on the dispensing card and had another nurse witness the destruction. The DON indicated the CDR was placed in the medical records box/folder by LPN 3, and was never found. A typed Investigation, dated 7/16-7/21/23, indicated on 6/16/23 a narcotic record (CDR) was missing for Resident G. An interview was conducted with LPN 3. LPN 3 indicated she "...disposed of the medication with a witness as the medication was completed per the EMR [electronic medication record]... she was the only nurse in the building and had a CAN (sic) [Certified Nurse Aide] witness this...." The investigation indicated LPN 4 was concerned LPN 3 took the medication and did not destroy them, however LPN 4 indicated she had seen the form in LPN 3's hands and observed her to walking to the front office and then left the building.. The DON came to the building to check the medical records box and the CDR was not in the box. The DON and the Administrator searched everywhere but could not locate the form. During an interview, on 8/7/23 at 12:08 P.M., LPN			

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	3 indicated she had destroyed Resident G's Norco (Hydrocodone/Acetaminophen) with CNA 7. LPN 3 indicated she was going to administer, Resident G, a dose of the Norco, but realized the order had been discontinued. So to ensure she nor anyone else made an error, she had CNA 7 witness the count of the remaining pills, approximately 10 tablets, with her. She then crushed them, put them in water and disposed of them, down the drain, in the shower room. She was aware she should not of had the CNA 7 sign the count for the destruction of those medications, she thinks she might have been the only nurse on the unit and/or the facility. She indicated she had taken the destruction form (CDR) to the front office and placed in the Medical Records box as she was leaving the facility. 2. On 8/4/223 at 2:00 P.M., a review of the clinical record for Resident F was conducted. The record indicated the resident was admitted to the facility on 6/7/23. The resident's diagnoses included, but were not limited to: left tibia fracture, non-displace fracture of the of clavicle, multiple fractures of the ribs, motorcycle driver injuries, alcohol abuse and stimulant abuse. A Care Plan, dated 6/11/23, indicated the resident had pain related to fractures and surgical wounds. The interventions included, but were not limited to: administer analgesic (pain reliever) as ordered and monitor/record/report to nurse complaints of pain or requests for pain medication. The Physician Orders, dated 6/7/23, indicated Oxycodone/Acetaminophen 7.5/325 mg. Give 1 tablet by mouth every 12 hours as needed for pain. A Controlled Drug Record (CDR), dated 6/27/23,			

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	indicated the LPN 6 had received 30 tablets of Ocycodone/Acetaminophen 7.5/325 mg from the pharmacy The MAR from 6/27/23-6/30/23, indicated the resident was administered Ocycodone/Acetaminophen 7.5/325 mg. tablet on the following dates and times: - 6/27 at 4:10 A.M., 10:30 A.M. and 4:18 P.M. - 6/28 at 1:30 A.M. and 3:32 P.M. - 6/29 at 12:57 A.M., 9:08 A.M. 4:22 P.M. and 11:55 P.M. - 6/30 at 7:?? (minutes cut of form) and 3:?? (minutes were cut off form) This equaled 11 tablets administered. The CDR indicated an Ocycodone/Acetaminophen 7.5/325 mg. tablet had been removed from the narcotic container/card on the following dates and times: - 6/27 at 4:10 A.M., 10:30 A.M. and 2 tablets at 4:30 P.M. (dosing order was for 1 tablet, 2 removed by LPN 3) - 6/28 at 1:30 A.M., 9:00 A.M. and 3:30 P.M. (the 9:00 A.M.,administration was not document on the MAR by QMA 8) - 6/29 at 1:00 AM, 9:00 A.M., 4:30 P.M. and 11:53 P.M. - 6/30 at 7:05 A.M. and 3 :10 P.M. Surveyor did not receive the CDR for previous days in June. This equaled 13 tablets were removed for administration. The MAR from 7/1/23 - 7/19/23, indicated the resident was administered Ocycodone/Acetaminophen 7.5/315 mg. tablet on the following dates and times: - 7/1 at 2:31 A.M., 8:30 A.M. and 2:30 P.M. - 7/2 at 7:32 A.M. and 8:38 P.M. - 7/3 at 4:07 A.M., 1:31 P.M. and 8:49 P.M.			

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	- 7/4 at 12:06 P.M. and 6:20 P.M. - 7/5 at 12:24 A.M., 8:01 A.M., 3:41 P.M. and 11:05 P.M. - 7/6 at 8:12 A.M., 3:00 P.M. and 10:00 P.M. - 7/7 at 15:27 P.M. - 7/8 at 12:50 P.M., 9:04 A.M., 3:45 P.M. and 10:14 P.M. - 7/9 at 8:17 P.M. and 4:39 P.M. - 7/10 at 12:28 A.M., 8:40 A.M., 4:15 P.M. and 11:30 P.M. - 7/11 at 8:14 A.M., and 4:20 P.M. - 7/12 at 1:08 P.M., 8:43 A.M., 4:10 P.M. and 10:42 P.M. - 7/13 at 8:32 A.M. and 4:00 P.M. - 7/14 at 11:15 P.M. - 7/15 at 7:50 P.M. and 9:00 P.M. - 7/16 at 3:02 A.M., 12:00 P.M. and 6:25 P.M. - 7/17 at 12:11 A.M. and 9:19 A.M. - 7/18 at 8:25 A.M. and 3:18 P.M. - 7/19 no doses documented as administered. This equaled 46 tablets recorded as administered. The CDRs indicated an Ocycodone/Acetaminophen 7.5/325 mg. tablet had been removed from the narcotic container/card on the following dates and times: - 7/1 at 2:30 A.M., 8:30 A.M., and 2:30 P.M. with one dose sent with resident, at 6:30 P.M.,he was attending a wedding. - 7/2 at 8:00 A.M., 2:00 P.M. and 8:38 P.M. (2 tabs removed at 2:00 P.M.-1 dropped and destroyed by LPN 3 & LPN 4 and 1 tab not recorded as administered by LPN 3) - 7/3 at 4:00 A.M., 1:30 P.M. and 8:50 P.M. - 7/4 at 4:30 A.M., 12:06 P.M. and 6:20 P.M. (4:30 A.M. tablet was not documented, as administered, on the MAR, by QMA 9) - 7/5 at 12:20 A.M., 8:00 A.M. and 4:00 P.M. - 7/6 through 7/14 CDR was not received from the DON			

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	- 7/15 at 9:00 P.M. - 7/16 at 3:00 AM, 6:00 A.M., 12:00 P.M., 6:25 P.M. (6:00 A.M. administration was administered 3 hours to early, by LPN 3) - 7/17 at 12:00 A.M., 9:00 A.M. and 3:00 P.M. (3:00 P.M. tablet was not documented, as administered, on the MAR, by LPN 10) - 7/18 at 8:20 A.M., 3:20 P.M. and 10:45 P.M. (10:45 P.M. tablet was not documented, as administered, on the MAR, by LPN 11) - 7/19 at 7:30 A.M. and 2:30 P.M. (Both tablets were not documented, as administered, on MAR, by LPN 12) This equaled 30 tablets recorded as removed. The final CDR indicated 16 tablets were sent home with the resident. A typed Investigation, dated 7/16-7/21/23, indicated on 7/16/23 Resident F could not recall if he received the medication or not. On 7/17/23, LPN 3 was interviewed as part of the investigation and she indicated she had administered medications at the resident's request. The investigation results indicated results of the investigation the facility was unable to prove any misconduct. LPN 3 was provided one on one education, given a final notice and going forward will have another nurse or QMA sign out all narcotics administered. During an interview, on 8/7/23 at 12:08 P.M., LPN 3 indicated she had done a medication error with Resident F because he came and asked for a pain pill around 6:00 A.M., however it was to early to give him another one. LPN 3 thought about it and stated "the man had several fractures and was in pain so gave it to him early". On 8/9/23 at 11:18 A.M., the DON indicated there was no medication error form or documentation			

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	regarding the medication error for Resident F, performed by LPN 3. 3. On 8/7/23 at 11:50 A.M., a review of the clinical record for Resident K was conducted. The record indicated the resident was admitted to the facility on 7/15/23. The resident's diagnoses included, but were not limited to: fusion of spine-lumbar region with neurogenic claudication and vertebrogenic low back pain. A Care Plan, dated 7/15/23, indicated the resident had acute and chronic pain. The interventions included, but were not limited to: administer analgesic (pain reliever) as ordered, monitor/record/report to nurse complaints of pain or requests for pain medication and evaluate the effectiveness of pain interventions. A Physician's Order, dated 7/15/23, indicated the resident had an order for Oxycotin 10 mg. extended release(ER),by mouth, every 12 hours for pain. And another order, dated 7/15/23, for Oxycodone 5 mg every 4 hours as needed for pain. Progress Note, dated 7/15/23 at 9:35 P.M., indicated Oxycodone 5 mg was administered to the resident for pain. Resident rated pain a 6 out of 10 on the 1-10 pain scale. Another Progress Note, dated 7/15/23 at 10:51 P.M., indicated the administration of the pain medication was effective as the resident rated his pain a 2 on the pain scale. An Emergency Drug Kit (EDK) Replacement Form, dated 7/15/23, indicated 1 dose of Oxycodone 5 mg was removed, on 7/15/23 at 10:00 P.M., for Resident K. The 2 nurses who signed the removal			

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	was LPN 3 and QMA 13. The MAR from 7/15/23 - 7/31/23, indicated the resident was administered Oxycotin 10 mg. tablet on the following dates and times: - 7/15, LPN 3 documents, on the MAR, the Oxycotin 10 mg was not available at 8:00 P.M. - 7/16 at 8:00 P.M. - 7/17 at 8:00 A.M. and 8:00 P.M. - 7/18 at 8:00 A.M. and 8:00 P.M. - 7/19 at 8:00 A.M. and 8:00 P.M. - 7/20 at 8:00 A.M. and 8:00 P.M. - 7/21 at 8:00 A.M. and 8:00 P.M. - 7/22 at 8:00 A.M. and 8:00 P.M. - 7/23 at 8:00 A.M. and 8:00 P.M. - 7/24 LPN 4 and LPN 6 documents, on the MAR, the Oxycotin was not available, at 8:00 A.M. & 8:00 P.M. - 7/25 at 8:00 A.M., LPN 6 documents, on the MAR, the Oxycotin was not available, at 8:00 P.M. - 7/26 at 8:00 A.M., LPN 6 documents, on the MAR, the Oxycotin was not available, at 8:00 P.M. - 7/27 at 8:00 A.M., LPN 11 documents, on the MAR, the Oxycotin was not available, at 8:00 P.M. - 7/28 at 8:00 P.M., LPN 14, documents, on the MAR, the Oxycotin was not available, at 8:00 A.M. - 7/29, LPN 4 & LPN 15, documents, on the MAR, the Oxycotin was not available, at 8:00 A.M. & 8:00 P.M. - 7/30 at 8:00 A.M., LPN 6 documents, on the MAR, the Oxycotin was not available, at 8:00 P.M. This equaled 20 tablets recorded as administered, to the resident. A CDR, dated 7/15/23, signed by QMA 13, indicated the facility had received 12 tablets of the Oxycotin. The CDR indicated an Ocycotin 10 mg. extended			

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	155086	A. BUILDING 00 B. WING	08/09/2023

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	release tablet had been removed from the narcotic container/card on the following dates and times: - 7/15 at 10:00 P.M. (not documented on the MAR as administered by LPN 3) - 7/16 at 8:50 A.M. and 8:00 P.M. - 7/17 at 8:00 P.M. - 7/18 at 8:00 A.M. and 8:00 P.M. - 7/19 at 8:00 A.M. and 8:00 P.M. - 7/20 at 8:30 A.M. and 9:00 P.M. - 7/21 at 8:00 A.M. and 9:00 P.M. This equaled 12 tablets recorded as removed. Surveyor did not receive the next CDR as the next one received started in August. A CDR, dated 7/15/23, signed by QMA 13, indicated the facility had received 10 tablets of the Oxycodone 5 mg. Another CDR, undated and unsigned, indicated the facility received 30 more tablets of the Oxycodone 5 mg. The CDR, indicated an Oxycodone 5mg tablet had been removed from the narcotic container/card on the following dates and times. (Some nurses started using 1 or 2 of the Oxycodone to replace the Oxycontin 10 mg extended release. Oxycodone and Oxycotin would be the same except for the extended release feature for the 10 mg dose) - 7/15 at 9:30 P.M. and was documented on MAR, as administered by LPN 3. (She had removed a dose at 8:00 P.M. from the EDK also) - 7/16 at 2:30 A.M. and 4:15 P.M. - 7/17 at 9:00 A.M. and 3:00 P.M. removed by LPN 10 and documented on MAR as administering 1 Oxycotin at 8:00 A.M. - 7/17 at 7:15 P.M - 7/18 at 8:09 A.M., removed by RN 16 and document on MAR as administering 1 Oxycotin at 8:00 A.M. - 7/20 at 3:50 P.M. - 7/22 at 9:10 P.M.			

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	- 7/23 at 8:00 A.M. and 8:00 P.M. - 7/24 at 7:30 P.M. and 8:00 P.M. - 7/25 at 8:00 A.M., and 3:00 P.M., LPN removed Oxycodone 5 mg at each time, documents on MAR as administering 1 dose of Oxycotin 10 mg as administered at 8:00 A.M. - 7/26 at 8:00 A.M., LPN 18 removed 1 Oxycodone 5 mg, documents on MAR as administering 1 Oxycotin 10 mg - 7/26 at 19:26 P.M. - 7/27 at 8:00 A.M., LPN 14 removed 1 Oxycodone 5 mg, documents on MAR as administering 1 Oxycotin 10 mg - 7/28 at 8:30 P.M. - 7/30 at 8:00 A.M., LPN 10 removed 1 Oxycodone 5 mg, documents on MAR as administering 1 Oxycotin 10 mg - 7/30 at 8:00 A.M. LPN 10 removed 1 Oxycodone 5 mg, docments on MAR as administering 1 Oxycotin 10 mg - 7/31 at 7:00 P.M. During an interview, on 8/4/23 at 2:10 P.M., the DON indicated Oxycodone 5 mg had been removed from the EDK for Resident K and it's removal should be documented in the Progress Notes. During an interview, on 8/7/23 at 12:08 P.M., LPN 3 indicated there was a medication error incident with Resident K was, she had taken an Oxycodone 5 mg tablet out of the EDK for him and then his medication came from the pharmacy and she also gave him the Oxycotin 10 mg. During an interview, on 8/8/23 at 11: 05 A.M., the DON indicated facility was having difficulty getting he Oxycotin 10 mg ER from pharmacy and staff were using the 5 mg-giving 2 at a time. She indicated they may have documented the dosage			

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	in the Progress Notes. All Progress Notes reviewed from 7/15-7/31/23 had no documentation indicating a nurse had administered 2 tablets of the Oxycodone 5 mg. instead of the Oxycotin 10 mg. ER. There was documentation indicating the medication wasn't being received from the pharmacy. An Event recorded by the Administrator, dated 6/9/23, indicated the DON and ADON (Assistant Director of Nursing) were conducting a narcotic audit due to heresay regarding narcotics were missing. The Event indicated staff were educated on the counting of narcotics, the significance of making sure the count is correct and to ensure if signed out on narcotic form (CDR) it is also signed, as administered, on the MAR. A typed form, undated, indicated, "...when pulling a narcotic from the EDK you must have another nurse present and BOTH nurses must sign. Or a nurse and QMA [Qualified Medication Assistant]...." With this undated form was an In-Service Attendance form, dated 6/7/23, 6/8/23, 6/9/23 and 6/10/23. The form indicated the following staff had attended the in-service: LPN 3, LPN 6, QMA 8, QMA 9, LPN 11, LPN 12, QMA 13, LPN 14 and LPN 15. A Corrective Action Form, dated 7/21/23, indicated LPN 3 was suspended, on 7/21/22, for discrepancy in narcotic audits while issue was being investigated and given a final warning. On 8/3/23 at 2:19 P.M., the DON provided a policy titled, "Abuse Policy", dated 11/28/16 with a revision on 9/22, and indicated the policy was the one currently used by the facility. The policy indicated "...Misappropriation of resident			

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	property: is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or without the resident consent...." On 8/8/23 at 12:33 P.M., the Administrator provided a policy titled, "Controlled Medications", dated 5/21/18 with a review on 6/23/23 and indicated the policy was the one currently used by the facility. The policy indicated "....4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication record (MAR): a. Date and time of administration B. Amount administered ac. Signature of the administering the dose, completed after the medication is actually administered...." This Federal tag relates to complaints IN00408204 and IN00414158. 3.1-28(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §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			

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	acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to establish and/or maintain a system that accounted for, periodically reconciled and ensured the disposition of all controlled drugs, related to incomplete and inaccurate documentation of narcotic medications for 3 of 4 residents reviewed who were administered narcotic medications. (Resident G, Resident F and Resident K) Findings include: 1. On 8/4/223 at 10:15 A.M., a review of the clinical record for Resident G was conducted. The record indicated the resident was admitted to the facility on 6/12/23. The resident's diagnoses included, but were not limited to: unspecified pain and dementia with anxiety.	F 0755	It is the practice of Woodland Manor to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, maintain drug records in order and that an account of all controlled drugs is maintained and periodically reconciled. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident G and resident F no longer reside in the facility. Medication error reports were completed for residents K, G and F for narcotic medications that were identified as lacking	09/15/2023

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	The Physician Orders indicated the resident was to be administered Hydrocodone-Acetaminophen 5/325 milligrams (mg). Order stated to give 1 tablet, by mouth, every 4 hours as needed for pain. The start date was 6/14/23 with a stop date of 6/29/23, then updated on 6/29/23 to continue order until 7/13/23. The July 2023 MAR indicated the resident was administered, as needed, Hydrocodone/Acetaminophen 5/325 mg tablet on the following dates and times: - 7/4 at 7:06 P.M. - 7/5 at 12:58 A.M., 9:30 A.M. and 3:59 P.M. - 7/6 at 2:54 A.M. and 8:00 P.M. - 7/7 at 12:58 A.M. - 7/8 at 12:23 P.M. and 9:58 P.M. - 7/9 at 7:03 A.M. - 7/10 at 1:07 P.M. and 8:25 P.M. - 7/11 at 2:11 A.M. and 7:30 P.M. - 7/12 at 2:58 A.M. and 7:22 P.M. - 7/13 at 1:39 P.M. The order indicated a stop date of 7/13/23 This equaled 17 tablets administered. There was no CDR form indicating the removal of the Hydrocodone/Acetaminophen 5/325 mg from 7/4/23 through 7/13/23. During an interview, on 8/4/23 at 2:10 P.M., the Director of Nursing (DON) indicated she had provided all the CDRs for June and July. She indicated a new Controlled Drug Record would have been started and would have had the signature, of the receiving nurse and the number of tablets received. The DON did not know the amount of of tablets the facility received due to the next CDR form, starting on 7/4/23, was missing. The DON indicated LPN 3 had destroyed all the remaining medications, on the dispensing		administration documentation or not signed out on the CDR form and the physician and responsible parties notified. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with orders for narcotic medications have the potential of being affected by the deficient practice. CDR forms, when completed, are to be turned in to the Director of Nursing to assign uploading into the medical record. An audit has been completed on all residents with orders for narcotic medication and medication error reports completed on those found with discrepancies in documentation. Education on narcotic documentation, process for medication errors and destruction of narcotics was provided to the licensed nurses/QMA's responsible for the errors. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The policies on "Controlled Medication Destruction, Medication Administration General Guidelines and the Long-Term Care Abuse and Incident Reporting Policy" were reviewed by the IDT. An in-service was held with all nursing staff who pass	

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	card and had another nurse witness the destruction. DON indicated the CDR was placed in the medical records box/folder by LPN 3, and was never found. A typed Investigation, dated 7/16-7/21/23, indicated on 6/16/23 a narcotic record (CDR) was missing for Resident G. An interview was conducted with LPN 3. LPN 3 indicated she "...disposed of the medication with a witness as the medication was completed per the EMR [electronic medication record]... she was the only nurse in the building and had a CAN (sic) [Certified Nurse Aide] witness this...." The investigation indicated LPN 4 was concerned LPN 3 took the medication and did not destroy them, however LPN 4 indicated she had seen the form in LPN 3's hands and observed her to walking to the front office and then left the building. The DON came to the building to check the medical records box and the CDR was not in the box. The DON and the Administrator searched everywhere but could not locate the form. During an interview, on 8/7/23 at 12:08 P.M., LPN 3 indicated she had destroyed Resident G's Norco (Hydrocodone/Acetaminophen) with CNA 7. LPN 3 indicated she was going to give Resident G a dose of the Norco, but realized the order had been discontinued. So to ensure she nor anyone else made an error, she had CNA 7 witness the count of the remaining pills, approximately 10 tablets, with her. She then crushed them, put them in water and disposed of them, down the drain, in the shower room. She was aware she should not of had the CNA 7 sign the count for the destruction of those medications, she thinks she might have been the only nurse on the unit and/or the facility. She indicated she had taken the destruction form (CDR) to the front office and		medications on the policies. A performance improvement tool has been developed to monitor narcotic medication errors are documented and destroyed as per policy, and disposition of CDR sheets to the Director of Nursing when completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A performance improvement tool has been initiated that randomly audits five (5) residents to ensure narcotic medication destruction is performed as per policy, CDR sheets are turned into the Director of Nursing when completed and medication errors are documented per policy. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting	

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placed in the Medical Records box as she was leaving the facility.

During an interview, on 8/7/23 at 3:24 P.M., the DON indicated their policy was to use a drug buster (deactivates/breaks down pharmaceuticals into a chemically inactive form), which was located in the medication room on unit 1.

2. On 8/4/223 at 2:00 P.M., a review of the clinical record for Resident F was conducted. The record indicated the resident was admitted to the facility on 6/7/23. The resident's diagnoses included, but were not limited to: left tibia fracture, non-displace fracture of the of clavicle, multiple fractures of the ribs, motorcycle driver injuries, alcohol abuse and stimulant abuse.

The Physician Orders, dated 6/7/23, indicated Oxycodone/Acetaminophen 7.5/325 mg. Give 1 tablet by mouth every 12 hours as needed for pain.

The July MAR indicated the resident was administrated Oxycodone/Acetaminophen on 7/16 at 3:02 A.M., 12:00 P.M. and 6:25 P.M.

The CDR indicated LPN 3 had removed a dose of the Oxycodone/Acetaminophen, on 7/16/23 at 3:00 A.M. and at 6:00 A.M.

During an interview, on 8/7/23 at 12:08 P.M., LPN 3 indicated she had done a medication error with Resident F because he came and asked for a pain pill around 6:00 A.M., however it was to early to give him another one. LPN 3 thought about it and stated "the man had several fractures and was in pain so gave it to him early".

On 8/9/23 at 11:18 A.M., the DON indicated there

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	was no medication error form or documentation regarding the medication error for Resident F, performed by LPN 3. 3. On 8/7/23 at 11:50 A.M., a review of the clinical record for Resident K was conducted. The record indicated the resident was admitted to the facility on 7/15/23. The resident's diagnoses included, but were not limited to: fusion of spine-lumbar region with neurogenic claudication and vertebrogenic low back pain. A Physician's Order, dated 7/15/23, indicated the resident had an order for Oxycotin 10 mg. extended release(ER),by mouth, every 12 hours for pain. And another order, dated 7/15/23, for Oxycodone 5 mg every 4 hours as needed for pain. The MAR from 7/15/23 - 7/31/23, indicated the resident was administered Oxycotin 10 mg. tablet on the following dates and times: - 7/15, LPN 3 documents, on the MAR, the Oxycotin 10 mg was not available at 8:00 P.M. - 7/16 at 8:00 P.M. - 7/17 at 8:00 A.M. and 8:00 P.M. - 7/18 at 8:00 A.M. and 8:00 P.M. - 7/19 at 8:00 A.M. and 8:00 P.M. - 7/20 at 8:00 A.M. and 8:00 P.M. - 7/21 at 8:00 A.M. and 8:00 P.M. - 7/22 at 8:00 A.M. and 8:00 P.M. - 7/23 at 8:00 A.M. and 8:00 P.M. - 7/24 LPN 4 and LPN 6 documents, on the MAR, the Oxycotin was not available, at 8:00 A.M. & 8:00 P.M. - 7/25 at 8:00 A.M., LPN 6 documents, on the MAR, the Oxycotin was not available, at 8:00 P.M. - 7/26 at 8:00 A.M., LPN 6 documents, on the MAR, the Oxycotin was not available, at 8:00 P.M. - 7/27 at 8:00 A.M., LPN 11 documents, on the			

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	MAR, the Oxycotin was not available, at 8:00 P.M. - 7/28 at 8:00 P.M., LPN 14, documents, on the MAR, the Oxycotin was not available, at 8:00 A.M. - 7/29, LPN 4 & LPN 15, documents, on the MAR, the Oxycotin was not available, at 8:00 A.M. & 8:00 P.M. - 7/30 at 8:00 A.M., LPN 6 documents, on the MAR, the Oxycotin was not available, at 8:00 P.M. This equaled 20 tablets recorded as administered, to the resident. A CDR, dated 7/15/23, signed by QMA 13, indicated the facility had received 12 tablets of the Oxycotin. The CDR indicated an Ocycotin 10 mg. extended release tablet had been removed from the narcotic container/card on the following dates and times: - 7/15 at 10:00 P.M. (not documented on the MAR as administered by LPN 3) - 7/16 at 8:50 A.M. and 8:00 P.M. - 7/17 at 8:00 P.M. - 7/18 at 8:00 A.M. and 8:00 P.M. - 7/19 at 8:00 A.M. and 8:00 P.M. - 7/20 at 8:30 A.M. and 9:00 P.M. - 7/21 at 8:00 A.M. and 9:00 P.M. This equaled 12 tablets recorded as removed. Did not receive the next CDR as the next one received started in August. A CDR, dated 7/15/23, signed by QMA 13, indicated the facility had received 10 tablets of the Oxycodone 5 mg. Another CDR, undated and unsigned, indicated the facility received 30 more tablets of the Oxycodone 5 mg. The CDR, indicated an Oxycodone 5mg tablet had been removed from the narcotic container/card on the following dates and times. (Some nurses			

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	started using 1 or 2 of the Oxycodone to replace the Oxycontin 10 mg extended release. Oxycodone and Oxycotin would be the same except for the extended release feature for the 10 mg dose) - 7/15 at 9:30 P.M. and was documented on MAR, as administered by LPN 3. (She had removed a dose at 8:00 P.M. from the EDK also) - 7/16 at 2:30 A.M. and 4:15 P.M. - 7/17 at 9:00 A.M. and 3:00 P.M. removed by LPN 10 and documented on MAR as administering 1 Oxycotin at 8:00 A.M. - 7/17 at 7:15 P.M - 7/18 at 8:09 A.M., removed by RN 16 and document on MAR as administering 1 Oxycotin at 8:00 A.M. - 7/20 at 3:50 P.M. - 7/22 at 9:10 P.M. - 7/23 at 8:00 A.M. and 8:00 P.M. - 7/24 at 7:30 P.M. and 8:00 P.M. - 7/25 at 8:00 A.M., and 3:00 P.M., LPN removed Oxycodone 5 mg at each time, documents on MAR as administering 1 dose of Oxycotin 10 mg as administered at 8:00 A.M. - 7/26 at 8:00 A.M., LPN 18 removed 1 Oxycodone 5 mg, documents on MAR as administering 1 Oxycotin 10 mg - 7/26 at 19:26 P.M. - 7/27 at 8:00 A.M., LPN 14 removed 1 Oxycodone 5 mg, documents on MAR as administering 1 Oxycotin 10 mg - 7/28 at 8:30 P.M. - 7/30 at 8:00 A.M., LPN 10 removed 1 Oxycodone 5 mg, documents on MAR as administering 1 Oxycotin 10 mg - 7/30 at 8:00 A.M. LPN 10 removed 1 Oxycodone 5 mg, docments on MAR as administering 1 Oxycotin 10 mg - 7/31 at 7:00 P.M. During an interview, on 8/4/23 at 2:10 P,.M. the			

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	155086	A. BUILDING 00 B. WING	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	DON indicated Oxycodone 5 mg had been removed from the EDK for Resident K and it's removal would be documented in the Progress Notes. During an interview, on 8/7/23 at 12:08 P.M., LPN 3 indicated the medication error incident with Resident K was, she had taken an Oxycodone 5 mg tablet out of the EDK for him and then his medication came from the pharmacy and she also gave him the Oxycotin 10 mg. During an interview, on 8/8/23 at 11: 05 A.M., the DON indicated facility was having difficulty getting he Oxycotin 10 mg ER from pharmacy and staff were using the 5 mg-giving 2 at a time. She indicated they may have documented the dosage in the Progress Notes. All Progress Notes reviewed from 7/15-7/31/23 and there was no documentation indicating a nurse had administered 2 tablets of the Oxycodone 5 mg. instead of the Oxycotin 10 mg. ER. On 8/8/23 at 9:21 A.M., the Administer provided a policy titled, "Discarding and Destroying Medications", dated October 2014, and indicated the policy was the one currently used by the facility. The policy indicated "...Medications will be disposed of in accordance with federal state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances...." On 8/8/23 at 10:05 A.M., the Administrator provided a policy titled, "Controlled Medication Destruction", dated 5/21/18 and reviewed on 6/23/23, and indicated the policy was the one			

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	currently used by the facility. The policy indicated "...1. The director of nursing and the consultant pharmacist are responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. 2. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record [Controlled Drug Record] on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason...." On 8/8/23 at 10:05 A.M., the Administrator provided a policy titled, "Medication Administration General Guidelines, dated 5/21/18 and reviewed on 6/23/23 and indicated the policy was the one currently used by the facility. The policy indicated "...d.. Follow the six rights of medication administration i. Right medication ii. Right dose iii. Right patient iv. Right route v. Right time vi. Right documentation...." 3.1-25(b)(3) 3.1-25(b)(9) 3.1-25(e)(2)(3) 3.1-25(o) 3.1-25(s)(1)(2)(3)(4)(5)(6)(7)(8)			

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