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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155833 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 03/14/2019 |
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| NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF CARMEL | STREET ADDRESS, CITY, STATE, ZIP COD 12315 PENNSYLVANIA STREET CARMEL, IN 46032 |
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| F 0000 Bldg. 00 | <p>This visit was for the Investigation of Nursing Home Complaint IN00281263.</p> <p>Complaint IN00281263-Substantiated. Federal/State deficiencies related to the allegations are cited at F602, F689, F755, and F761.</p> <p>Survey dates: March 13 and 14, 2019</p> <p>Facility number: 013444 Provider number: 155833 AIM number: 201294880</p> <p>Census Bed Type: SNF: 42 SNF/NF: 7 Residential: 19 Total: 68</p> <p>Census Payor Type: Medicare: 23 Medicaid: 7 Other: 19 Total: 47</p> <p>These deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed on March 21, 2019.</p> | F 0000 | Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during complaint visit with exit on March 14, 2019. Please accept this Plan of Correction as the provider's credible allegation of compliance as of April 8, 2019. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. | |
| F 0602 SS=D Bldg. 00 | <p>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</p> | | | |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | <p>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.</p> <p>Based on interview and record review the facility failed to ensure residents' narcotic medications were kept safe and secure during their admissions for 3 of 8 residents being reviewed for abuse (Residents B, C, and D).</p> <p>Findings include:</p> <p>An "Indiana State Department of Health Survey Report System" report dated 12/14/18, was provided on 3/14/19 at 9:50 p.m., by the Director of Health Services (DHS) and reviewed at that time. On 12/6/18, LPN 3 arrived at work at approximately 10:00 p.m., and was scheduled to take over LPN 5's medication cart. He asked her to complete a shift to shift narcotic count at that time, but she left the building prior to counting the medication cart with LPN 3. LPN 3 requested RN 6 complete the narcotic shift to shift count with him and discrepancies were discovered with Residents B, C and D's narcotics. On 12/7/18, all the narcotics and the count sheets were reviewed and there were no other concerns. LPN 5 was suspended during the investigation. On 12/13/18, the follow up section indicated LPN 5 would be terminated for failure to comply with an in department drug screen and she had been notified of her failure to cooperate with the investigation.</p> <p>During an interview on 3/13/19 at 10:46 p.m., LPN 3 with the DHS (Director of Health Services) present, indicated he came into work on 12/6/18 at 10:00 p.m., and LPN 5 was busy charting, so they did not count the narcotics in the medication cart she had been passing medications out of right</p> | F 0602 | <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during complaint visit with exit on March 14, 2019. Please accept this Plan of Correction as the provider's credible allegation of compliance as of April 8, 2019. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> <p>F602 Free from Misappropriation/Exploitation 1. Resident B, C, and D were effected. The campus was aware of said inaccuracies and a thorough investigation was completed. The occurrence and investigative information was reported to the ISDH. Staff education was conducted on narcotic safe storage and</p> | 04/08/2019 | |

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| | <p>away, so he counted the other cart on the side of the unit with the other nurse working evenings with LPN 5, then he got report from her and made his rounds on those residents. At approximately 10:30 p.m., he asked LPN 5, for the second time, if she was ready to count the narcotics in the medication cart and give him report on her residents. He indicated LPN 5 seemed to "always be behind on her work when he followed her, but this particular night "she was acting "more weird than I had seen her act in the past." He indicated five to ten minutes after the last time he asked her to count the narcotic drawer he came back up to the nurses station and she still was not ready to count, so he told her to let him have the narcotic keys and he said he specifically told her not to leave the facility without counting the narcotics with him.</p> <p>LPN 3 left the desk, then came back approximately five to ten minutes later for the third time and when he came back he did not see LPN 5, so he asked a CNA where she was and the CNA told him she left. He tried to call her on her cell phone, but she did not answer, so he called RN 10 at that time to report what had happened to him. RN 10 tried to call her and he did not get a response either. LPN 3 indicated he did not count the narcotics in the the medication cart LPN 5 worked out of that night because he got behind and did not get around to it. He did take out a 5:00 a.m. Norco 7.5/325 mg for Resident B that morning. LPN 3 indicated he was behind in his work when the dayshift nurse LPN 6 arrived for her shift, so he handed the keys to the medication cart LPN 5 had worked out of the night before, that still had not been counted, and LPN 6 started counting it. LPN 5 had passed narcotics out of this medication cart on the evening shift the night before and LPN 3 and LPN 6 counted the narcotics in this</p> | | <p>abuse prevention and reporting.</p> <p>2.All residents receiving narcotic medications have the potential to be effected.</p> <p>Nurses received education on appropriate disposal and destruction of discontinued medications and narcotic accountability. Nurses educated on abuse and misappropriation with regards to use of residents property without consent; proper reporting and responsible party notification.</p> <p>3.As a measure of ongoing compliance, the DHS or designee will audit individual count sheets against emar documentation and ensure an active order is in place for 5 residents 5x weekly x 4 weeks, then 5 residents 3x weekly x 4 weeks, then 5 residents weekly x 4 weeks and 5 residents monthly ongoing.</p> <p>4.For quality assurance, the DHS or designee will review audit results and subsequent corrective action at least quarterly in the campus Quality Assurance Committee meeting. The plan will be revised, as warranted. If increased problems noted, audit frequency may increase. If no problems noted after six months, the frequency of audits may decrease.</p> | | |

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| | <p>medication cart and found five controlled substance counts, which were off from the narcotic count sheets in the narcotic binder, so she called RN 10 at that time. He indicated several times when he counted the narcotic counts with LPN 5, she would mark through a medication on the narcotic sheet and say she did not give it, then she said she gave it and rewrote it back onto the narcotic sheet again. He indicated he and LPN 6 filled out the paperwork with the discrepancies of the narcotic cards versus the narcotic sheets.</p> <p>A handwritten statement by LPN 6 dated 12/7/18, indicated that morning approximately 6:45 a.m., she counted the narcotics drawer on Keystone West while counting narcotic pills on the individual cards with LPN 3, there were several discrepancies.</p> <p>During an interview on 3/14/19 at 1:05 p.m., LPN 6 indicated she came into work on 12/7/18 to work on Keystone West. She indicated LPN 3 indicated he had not counted the narcotics the night before with the off going nurse because she left the building before he could count them. She indicated she no longer worked for this facility and she could not remember the exact narcotic counts that were off, but she handwrote a statement and signed a count sheet after counting with LPN 3, and the information would be in those statements, so to refer to those for specifics of what narcotics were missing.</p> <p>1. Resident B's Lorazepam (a medication used to treat anxiety) 0.5 mg (milligrams) card had 4 pills and the sheet in the binder indicated the count should have 5 pills. LPN 6 indicated she noticed there was no current order for this resident's 0.5 mg Lorazepam while checking the EMAR.</p> | | | | |

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| | <p>The record review was completed for Resident B on 3/14/19 at 10:07 a.m. Diagnoses included, but were not limited to, hypertensive heart disease with heart failure, dementia in other diseases classified elsewhere with behavioral disturbance, atrial fibrillation, chronic obstruction pulmonary disease, cognitive communication deficit, age related osteoporosis without current pathological fracture and polyneuropathy.</p> <p>The resident had a Physician order to discontinue the Lorazepam 0.5 mg on 9/21/18. There was no order on the resident's November 2018 or December 2018, EMAR (Electronic Medication Administration Record) to administer this medication</p> <p>A "Controlled Drug Use Record" dated 12/14/18, indicated LPN 5 signed out a Lorazepam 0.5 mg tablet for this resident and there was no documentation on the EMAR indicating this resident received her medication on these dates and times: 11/30/18 at 6:46 p.m. 12/5/18 at 7:30 p.m.</p> <p>2. Resident C's Norco (a narcotic pain medication) 10-325 mg card had 10 pills, while the narcotic sheet indicated there were 11 pills present. LPN 6 also wrote she noticed there was a line in, which a two had been changed to a one administered, but the total count had been decreased by two, suggesting an additional missing pill.</p> <p>The record was reviewed for Resident C on 3/14/19 at 11:42 a.m. Diagnoses included, but were not limited to, dysphagia, unspecified severe protein-calorie malnutrition, acute pancreatitis with infected necrosis, malignant neoplasm of the bladder, respiratory failure, chronic atrial</p> | | | |

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| | <p>fibrillation, type 2 diabetes mellitus, polyneuropathy, other recurrent depressive disorders, generalized anxiety disorders, cognitive communication deficits and hypertension.</p> <p>A "Controlled Drug Use Record" dated 11/28/18, indicated LPN 5 signed out a Hydrocodone-APAP (Acetaminophen) (Norco) and there was no documentation on the EMAR he had received his medication on this date and time: 11/30/18 at 10:00 p.m.</p> <p>3. Resident D's Norco 5/325 mg had 16 pills, while the narcotic sheet stated the correct count should be 17. LPN 6 wrote she immediately checked the EMAR (Electronic Medication Administration Record) and none of the missing pills had been signed out.</p> <p>The record review was completed for Resident D on 3/14/19 at 11:21 a.m. Diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage without loss of consciousness, heart failure, obstructive sleep apnea, other chronic pain and moderate protein calorie malnutrition.</p> <p>A "Controlled Drug Use Record" dated 11/17/18, indicated LPN 5 signed out a Hydrocodone/APAP 5/325 mg tablet for this resident and there was no documentation on the EMAR for this date and time that he received this medication: 11/27/18 at 6:00 p.m.</p> <p>During an interview on 3/14/19 at 12:53 p.m., the Administrator indicated the reportable sent to the ISDH (Indiana State Department of Health) office said the family members were notified the medications were diverted, but it was not documented in the residents' electronic record.</p> | | | | |

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| | <p>A time log of LPN 5's time punches dated 3/14/19 at 1:35 p.m., indicated she worked on the following dates and times when the these residents narcotic medications came up missing.</p> <p>11/27/18 from 2:00 p.m. to 11:00 p.m.</p> <p>11/30/18 from 2:00 p.m. to 11:00 p.m.</p> <p>12/05/18 from 2:01 p.m. to 10:45 p.m.</p> <p>A "Personnel Action Form" for LPN 5 dated 12/17/18, reviewed on 3/14/19 at 3:53 p.m., when provided by the Administrator indicated her last day to work was 12/6/18 and she was terminated 12/17/18, for Failure to comply with Diversion Investigation.</p> <p>A current policy titled "Guidelines for Narcotic Count" dated 8/2/16 with a revision date 9/23/18, provided by the DHS on 3/13/19 at 9:50 p.m., contained the following, "Policy: Guidelines for Narcotic Count Purpose: To provide guidelines for tracking narcotic distribution. Procedures: 1. Each controlled drug shall have a corresponding count sheet to track distribution. 2. The narcotic book shall contain a sheet providing space for the off going and on coming nursing staff to record their signature indicating the narcotics has been reviewed. 3. The narcotic count sheet will indicate how many items are in the narcotic drawer and counted to ensure they are all present and accounted for. The count will be updated by two nurses to validate the changes with initials and date, as other items are added or removed. 4. At the time one nurse or other staff qualified to pass medications relinquishes the keys to the medication cart to another staff member the narcotics shall be reconciled by comparing the medications in the cart to the count sheets. 5.</p> | | | |

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| F 0689 SS=D Bldg. 00 | <p>Both staff members shall sign that the narcotic count is accurately reconciled. 6. Should the available medications no match the count sheets the Director of Health Services shall be notified...."</p> <p>A current policy titled "Abuse and Neglect procedural Guidelines" dated 10/10/18, provided by the DHS on 3/13/19 at 9:50 p.m., contained the following "Policy: Abuse, Neglect and Exploitation Procedural Guidelines. Procedure: [Name of Company] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect. Procedures: 1. [Name of Company] has implemented processes in an effort to provide a comfortable and safe environment...3. Definitions: Abuse is the willful infliction...Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm...I. Misappropriation of Property-means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent...."</p> <p>This Federal tag relates to Complaint IN00281263.</p> <p>3.1-28(a)</p> <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> | | | |

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| | <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review the facility failed to ensure potential accidents did not occur when 2 residents' medications (Residents H and J), including unsecured narcotics and an insulin syringe, were left unattended on top of unlocked and unattended medication carts for 2 of 3 medication carts being observed for accidents.</p> <p>Findings include:</p> <p>1. On 3/13/19 at 8:08 p.m., entering the facility and walking onto the Berkshire unit, there was 3 different syringes with medications laying on the top of the unlocked and unattended medication cart without a barrier. One syringe was an insulin syringe with a clear liquid and two piston syringes laying next to the insulin syringe. One piston syringe had 25 ml (milliliters) of a pink colored fluid in it and the other piston syringe had 10 ml of a white colored fluid in it. Two female visitors walked onto the unit while the unlocked medication cart was left unattended with medication on top of it.</p> <p>During an interview on 3/13/19 at 8:11 p.m., RN 1 came out of a room. After an introduction and informing RN 1 of the medication cart concerns, she indicated she had to run into a resident's room because she was climbing out of bed. She indicated she was going to administer this medication and went to Resident H's room. Resident H was not in his room and RN 1 placed the syringes in the top drawer indicating he was "running around the facility somewhere" and she would give him his medications when he came</p> | F 0689 | <p>F689 Free of Accident Hazards/Supervision/Devices</p> <p>1. Resident H and J were affected. Upon notification, the medications were destroyed or secured as appropriate and the medication cart immediately secured. RN 1 and LPN 2 were immediately educated on proper secured medication stroage and were suspended pending investigation.</p> <p>2. All residents requiring medication administration have the potential to be affected. All medication carts and rooms were checked to ensure all medications were stored securley. Nursing staff will be educated on maintaining secured medications as stored in locked medication carts and locked medication rooms per policy.</p> <p>3. As a measure of ongoing compliance, the DHS or designee will audit medication storage areas on varied shifts at varied times to ensure they are free of hazardous materials i.e. unsecured narcotics or sharps and that medications are stored securley. This audit will be completed 5x weekly x</p> | 04/08/2019 |
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| | <p>back to his room. She indicated she did not typically leave medications on her cart or leave her cart unlocked, but she had that "emergency" and she "had to go."</p> <p>During an interview on 3/13/19 at 8:50 p.m., RN 1 indicated Resident H was out with his caregiver, so she had destroyed the medications in the syringes because one of them had Carafate (a medication used to coat the stomach to prevent or heal stomach issues) in them and it was time sensitive. An unidentified CNA indicated to RN 1, at that time, Resident H was upstairs in the theater lounge with his caregiver watching a movie if she needed to give him medication. RN 1 indicated to the CNA, she would wait until he came back to his room. RN 1 was asked what medications she had in the syringes she disposed of earlier. She indicated the pink colored fluid in the piston syringe had 25 ml of Carafate, the white colored fluid in the piston syringe had 10 ml of Seroquel (a medication used to treat behaviors) 12.5 mg (milligrams), and the insulin syringe had 7 units of regularly scheduled Humulin NPH insulin in it.</p> <p>2. On 3/13/19 at 8:18 p.m., after walking onto the Keystone unit, the West medication cart was observed unlocked and unattended. Two plastic medication cups containing medications were observed sitting on top of the medication cart. One plastic medication cup had seven pills in it and the other plastic medication cup had two oblong white tablets (IP109 was stamped on the oblong tablets) in it. The cups were sitting next to each other on top of the unattended and unlocked medication cart.</p> <p>On 3/13/19 at 8:22 p.m., LPN 2 came back to the unlocked and unattended medication cart at that</p> | | <p>4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks and monthly ongoing.</p> <p>4. For quality assurance, the DHS or designee will review audit results and subsequent corrective action at least quarterly in the campus Quality Assurance Committee meeting. The plan will be revised, as warranted. If increased problems noted, audit frequency may increase. If no problems noted after six months, the frequency of audits may decrease.</p> | | |

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| | <p>time. After an introduction and informing LPN 2 of the medication cart concerns, she indicated she normally locked her cart and made sure nothing was on top of it when she was called away from the cart in an emergency. She indicated the medication on top of the cart belonged to Resident J and she was going there next to give it to her.</p> <p>On 3/13/19 at 8:29 p.m., LPN 2 was observed giving Resident J medications from the two plastic containers she had left unattended on the top of the unlocked medication cart. When she told the resident she had her pain medication, the resident asked her if she brought her Tylenol. LPN 2 indicated to Resident J, she did not bring her Tylenol because she brought her two Norco's (a narcotic pain medication) instead of her Xanax (a medication used to treat anxiety), which she had requested for sleep. The Xanax was available. She explained the other seven medications in the other cup to the resident. One of the medications in the other medication cup included, but was not limited to, Lyrica (a narcotic medication to treat nerve pain).</p> <p>On 3/13/19 at 8:45 p.m., LPN 2 was asked to identify the medications she gave Resident J in the two plastic medication cups. She indicated she gave her these medications, two Norco 5-325 milligrams to help her sleep and for her headache. The other plastic medication cup with seven pills had Pravastatin (a medication used to lower cholesterol), Keppra (a medication used to treat seizures), Lyrica (a narcotic medication used to relieve nerve pain), Melatonin (an over the counter supplement for sleep), a Probiotic (an over the counter supplement for the bowels), her Crestor (a medication used to lower cholesterol) and Lasix (a medication used to remove extra fluid</p> | | | |

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| F 0755 SS=D Bldg. 00 | <p>from the body).</p> <p>A current policy titled "Medication Storage in the Facility: Controlled Substance" revised 01/17, provided by the Administrator on 3/14/19 at 4:48 p.m., contained the following "Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. Procedures: A...Only authorized medication administration staff and pharmacy personnel have access to controlled substances. B. Medications subject to abuse or diversion are stored per state regulation...."</p> <p>A current policy titled "Disposal of Medications and Medication--Related Supplies--Controlled Substance Disposal" revised 01/17, provided by the Administrator on 3/14/19 at 4:48 p.m., contained the following, "Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling storage, disposal and record keeping in the facility in accordance with federal and state laws and regulations. Procedures:..."</p> <p>This Federal tag relates to Complaint IN00281263.</p> <p>3.1-45(a)</p> <p>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</p> | | | | |

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| | <p>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.</p> <p>§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.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Based on interview and record review, the facility failed to ensure narcotic count sheets were reconciled after each shift change for 3 of 3 medication carts reviewed for reconciliation. (Keystone West, Berkshire East and West)</p> <p>Findings include:</p> <p>On 3/13/19 at 10:10 p.m., LPN 3 and LPN 2 were observed counting the narcotics. They both</p> | F 0755 | <p>F755 Pharmacy services/Procedures/Pharmacist/Records</p> <p>1. No residents were effected. Keystone West, Berkshire East, and Berkshire West areas were effected. Upon notification, all shift to shift accountability records were immediately audited and</p> | 04/08/2019 | |

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| | <p>indicated they were to sign the narcotic page in the narcotic binder to affirm the count was correct for the off going nurse and the on coming nurse.</p> <p>On 3/14/19 at 4:00 p.m., the "Narcotic Count Sheet" were reviewed for each medication cart and these were the dates and shifts there were no signature to indicate a count had been completed.</p> <p>Keystone West: 1/13/19--6 a.m. shift 1/26/19--6 a.m. shift 2/05/19--10 p.m. shift 2/10/19--6 a.m. shift 2/13/19--6 a.m. shift 2/19/19--6 a.m. shift 3/3/19--10 p.m. shift</p> <p>Berkshire West: 11/29/18--2 p.m. shift 12/01/18--10 p.m. shift 12/03/18--6 a.m. shift 12/06/18--6 a.m. shift (no second signature) 12/6/18--2 p.m. shift (same person signed for both signatures) 12/6/18--10 p.m. shift (same person signed for both signatures) next three days were not dated 12/13/18--2 p.m. shift 12/16/18--2 p.m. shift 12/26/18--2 p.m. shift 12/20/18--2 p.m. shift 12/21/18 then the next two days were not dated 12/25/18--6 a.m. shift Multiple shifts with the same signature signing for counting on and off and other shifts with no signatures.</p> <p>Berkshire East: 12/25/18--6 a.m. shift 12/25/18--2 p.m. shift</p> | | <p>deficiencies corrected where applicable.</p> <p>2. Nursing staff will be educated on shift to shift narcotic count and narcotic reconciliation before relinquishing keys to next shift nurse.</p> <p>3. As a measure of ongoing compliance, the DHS or designee will audit shift to shift accountability records 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks and monthly ongoing.</p> <p>4. For quality assurance, the DHS or designee will review audit results and subsequent corrective action at least quarterly in the campus Quality Assurance Committee meeting. The plan will be revised, as warranted. If increased problems noted, audit frequency may increase. If no problems noted after six months, the frequency of audits may decrease</p> | |

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| | <p>12/28/18--2 p.m. shift 2/20/19--2 p.m. shift 2/23/19--10 p.m. shift (date not marked) 2/26/19--2 p.m. shift Multiple shifts with the same signature signing for counting on and off and other shifts with no signatures.</p> <p>A current policy titled "Guidelines for Narcotic Count" dated 8/2/16 with a revision date 9/23/18, provided by the DHS on 3/13/19 at 9:50 p.m., contained the following, "Policy: Guidelines for Narcotic Count Purpose: To provide guidelines for tracking narcotic distribution. Procedures: 1. Each controlled drug shall have a corresponding count sheet to track distribution. 2. The narcotic book shall contain a sheet providing space for the off going and on coming nursing staff to record their signature indicating the narcotics has been reviewed. 3. The narcotic count sheet will indicate how many items are in the narcotic drawer and counted to ensure they are all present and accounted for. The count will be updated by two nurses to validate the changes with initials and date, as other items are added or removed. 4. At the time one nurse or other staff qualified to pass medications relinquishes the keys to the medication cart to another staff member the narcotics shall be reconciled by comparing the medications in the cart to the count sheets. 5. Both staff members shall sign that the narcotic count is accurately reconciled. 6. Should the available medications no match the count sheets the Director of Health Services shall be notified...."</p> <p>This Federal tag relates to Complaint IN00281263.</p> <p>3.1-25(e)(2) 3.1-25(e)(3)</p> | | | | |

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| F 0761 SS=D Bldg. 00 | <p>483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observations, interviews and record reviews the facility failed to ensure medications were properly stored in medication carts and medication carts were locked for 2 of 3 medication carts being reviewed for proper medication storage. (Resident H and J)</p> <p>Findings include:</p> <p>1. On 3/13/19 at 8:08 p.m., entering the facility and walking onto the Berkshire unit, there was 3</p> | F 0761 | <p>F761 Labeling/Storage of Biologicals</p> <p>1. Resident H and J were affected. Upon notification, the medications were destroyed or secured as appropriate and the medication cart immediately secured. RN 1 and LPN 2 were immediately educated on proper secured medication</p> | 04/08/2019 | |

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| | <p>different syringes with medications laying on the top of the unlocked and unattended medication cart without a barrier. One syringe was an insulin syringe with a clear liquid and two piston syringes laying next to the insulin syringe. One piston syringe had 25 ml (milliliters) of a pink colored fluid in it and the other piston syringe had 10 ml of a white colored fluid in it. Two female visitors walked onto the unit while the unlocked medication cart was left unattended with medication on top of it.</p> <p>During an interview on 3/13/19 at 8:11 p.m., RN 1 came out of a room. After an introduction and informing RN 1 of the medication cart concerns, she indicated she had to run into a resident's room because she was climbing out of bed. She indicated she was going to administer this medication and went to Resident H's room.</p> <p>During an interview on 3/13/19 at 8:50 p.m., RN 1 indicated Resident H was out with his caregiver, so she had destroyed the medications in the syringes because one of them had Carafate (a medication used to coat the stomach to prevent or heal stomach issues) in them and it was only able to sit in the syringe for so long. She indicated the pink colored fluid in the piston syringe had 25 ml of Carafate, the white colored fluid in the piston syringe had 10 ml of Seroquel (a medication used to treat behaviors) 12.5 mg (milligrams), and the insulin syringe had 7 units of regularly scheduled Humulin NPH insulin in it.</p> <p>2. On 3/13/19 at 8:18 p.m., after walking onto the Keystone unit, the West medication cart was observed unlocked and unattended. Two plastic medication cups containing medications were observed sitting on top of the medication cart. One plastic medication cup had seven pills in it</p> | | <p>stroage and were suspended pending investigation.</p> <p>2. All residents requiring medication administration have the potential to be affected. All medication carts and rooms were checked to ensure all medications were stored securley. Nursing staff will be educated on maintaining secured medications as stored in locked medication carts and locked medication rooms per policy.</p> <p>3. As a measure of ongoing compliance, the DHS or designee will audit medication storage areas on varied shifts at varied times to ensure they are free of hazardous materials i.e. unsecured narcotics or sharps and that medications are stored securley. This audit will be completed 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks and monthly ongoing.</p> <p>4. For quality assurance, the DHS or designee will review audit results and subsequent corrective action at least quarterly in the campus Quality Assurance Committee meeting. The plan will be revised, as warranted. If increased problems noted, audit frequency may increase.</p> | | |

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| | <p>and the other plastic medication cup had two oblong white tablets (IP109 was stamped on the oblong tablets) in it. The cups were sitting next to each other on top of the unattended and unlocked medication cart.</p> <p>On 3/13/19 at 8:22 p.m., LPN 2 came back to the unlocked and unattended medication cart at that time. After an introduction and informing LPN 2 of the medication cart concerns. She indicated she normally locked her cart and made sure nothing was on top of it when she was called away from the cart in an emergency. She indicated the medication on top of the cart belonged to Resident J and she was going there next to give it to her.</p> <p>On 3/13/19 at 8:45 p.m., LPN 2 was asked to identify the medications for Resident J in the two plastic medication cups. She indicated she gave her these medications, two Norco 5-325 milligrams to help her sleep and for her headache. The other plastic medication cup with seven pills had Pravastatin (a medication used to lower cholesterol), Keppra (a medication used to treat seizures), Lyrica (a narcotic medication used to relieve nerve pain), Melatonin (an over the counter supplement for sleep), a Probiotic (an over the counter supplement for the bowels), her Crestor (a medication used to lower cholesterol) and Lasix (a medication used to remove extra fluid from the body).</p> <p>A current policy titled "Medication Storage in the Facility: Controlled Substance" revised 01/17, provided by the Administrator on 3/14/19 at 4:48 p.m., contained the following "Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling,</p> | | If no problems noted after six months, the frequency of audits may decrease | |

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| | <p>storage, disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations. Procedures:</p> <p>A...Only authorized medication administration staff and pharmacy personnel have access to controlled substances. B. Medications subject to abuse or diversion are stored per state regulation...The access system to controlled medications is not the same as the system giving access to other medications (the key that opens the compartment is different from the key that opens the medication cart)...D. A controlled substance accountability record is prepared by the pharmacy/facility for all Schedule II, III, IV, and V medications, including those in the emergency supply. The following information is completed on the accountability form upon dispensing or receipt of a controlled substance or use of a controlled substance from the emergency supply...E. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two staff members as acceptable to location regulations and is documented. The emergency supply may be verified by assuring that the seal on the supply has not been broken. If the seal has been broken to the emergency narcotic supply, then a physical count of the contents must be conducted by two staff members as acceptable according to local regulations and paperwork must be present to account for any medications removed from the supply (Contents of the emergency narcotic supply is limited by individual state and federal laws). F. Any discrepancy in controlled substance counts is reported to the Director of Nursing immediately. The director or designee investigates and makes every reasonable effect to reconcile all reported discrepancies. The Director of Nursing documents irreconcilable</p> | | | |

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

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FORM APPROVED

OMB NO. 0938-039

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| | <p>discrepancies in a report to the Administrator...2)The Administrator, Consultant Pharmacist and/or Director of Nursing determine whether other actions(s) are needed, e.g. notification of police or other enforcement personnel...3) The medication regimen of residents using medications that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met...4) Controlled substance inventory is regularly reconciled to the Medication Administration Record...I. Controlled substances remaining in the facility after the order has been discontinued or the resident had been discharged are retained in the facility in a securely locked area with restricted access until destroyed...Accountability records for discontinued controlled substances are maintained with the unused supply until it is destroyed or disposed of, and then stored as required by applicable law or regulation...."</p> <p>This Federal tag relates to Complaint IN00281263.</p> <p>3.1-25(e)(2) 3.1-25(e)(3)</p> | | | |