

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2024
NAME OF PROVIDER OR SUPPLIER Complete Care at Harrington Court		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Harrington CT Colchester, CT 06415	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879</p> <p>Based on review of the clinical record, facility documentation, facility policy and interviews for four (4) of nine (9) residents (Residents #1, 2, 3 and 4) reviewed for misappropriation, the facility failed to prevent the misappropriation of the residents' controlled narcotic medications. The findings include:</p> <p>1. Resident #1's diagnoses included chronic pain syndrome, low back pain and polyneuropathy (damage of the peripheral nerves, affecting the skin, muscles and organs).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition, frequently experienced moderate pain and was independent with eating, transfers and ambulation.</p> <p>The Resident Care Plan (RCP) dated [DATE] identified that Resident #1 has pain and receives pain medication related to gout, polyneuropathy and low back pain with interventions that included monitoring for non-verbal signs of pain, evaluating pain characteristics, utilizing the pain scale and advising the resident to request pain medication before pain becomes severe.</p> <p>A physician's order dated [DATE] directed to administer oxycodone (a narcotic pain medication) 10 milligram (mg) tablet, give one tablet by mouth every six hours as needed for pain.</p> <p>a) Review of the facility Reportable Event (RE) dated [DATE] identified that at 2:00 PM staff attempted to re-order oxycodone immediate release (IR) 5 mg (should have read 10 mg) for Resident #1 and the pharmacy reported that it was too soon, confirming that they had dispensed 120 tablets on [DATE] and it should have lasted through [DATE]. The RE identified that the white disposition form (that was kept with the medication on the medication cart and was used to subtract when a tablet was administered and to identify the remaining amount), was also missing.</p> <p>Review of the [DATE], [DATE] and [DATE] Medication Administration Record (MAR) for Resident #1 identified that oxycodone 10 mg was administered 160 times.</p> <p>Review of the Controlled Drug Receipt/Record/Disposition Forms for Resident #1's oxycodone 10 mg identified that from [DATE] to [DATE], 360 tablets were received by the facility.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Resident #1 on [DATE] at 1:49 PM identified that he/she has chronic back pain and requires oxycodone 10 mg around the clock to decrease the pain. The resident reported that LPN #7 always gave him/her their oxycodone when requested and stated he/she could identify the oxycodone 10 mg when it was given, reporting that it was a bright pink pill.</p> <p>2. Resident #2's diagnoses included pain and malignant neoplasm (cancer) of the bronchus (airway that leads from the trachea to the lung) or lung.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Mental Interview for Mental Status (BIMS) of eleven (11) indicative of moderately impaired cognition, frequently experienced moderate pain and required supervision assistance with eating, setup assistance with transfers and moderate assistance with ambulation.</p> <p>The Resident Care Plan (RCP) dated [DATE] identified that Resident #2 exhibited or was at risk for alterations in comfort related to diagnosis of small cell lung cancer that had spread to the spine and liver with interventions that included evaluating pain characteristics, utilizing the pain scale, advising the resident to request pain medication before the pain becomes severe, medicate the resident as needed for pain and monitor the effectiveness and monitor for non-verbal signs of pain.</p> <p>A physician's order dated [DATE] directed to administer oxycodone 15 milligram (mg) tablet, give one tablet by mouth every three hours as needed for moderate to severe pain.</p> <p>Review of the [DATE] and [DATE] Medication Administration Record (MAR) for Resident #2 identified that oxycodone 15 mg was administered 29 times.</p> <p>Review of the Controlled Drug Receipt/Record/Disposition Form for Resident #2's oxycodone 15 mg identified that 60 tablets were received by the facility on [DATE].</p> <p>Review of a nurse's note dated [DATE] at 11:04 AM identified that Resident #2's death was pronounced on [DATE] at 10:20 AM.</p> <p>3. Resident #3's diagnoses included fibromyalgia (widespread body pain and tenderness), chronic pain syndrome and muscle spasms.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition, frequently experienced moderate pain and required setup assistance for eating and was dependent on staff for bed mobility and transfers.</p> <p>The Resident Care Plan (RCP) dated [DATE] identified that Resident #3 is on pain medication therapy related to chronic pain, fibromyalgia, left hand contracture and right wrist fracture. Interventions included administering medications as ordered by physician, and monitoring and documenting side effects and effectiveness every shift.</p> <p>A physician's order dated [DATE] directed to administer oxycodone 5 milligram (mg) tablet, give one tablet by mouth every eight (8) hours as needed for pain.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the DNS on [DATE] at 3:28 PM identified that all the oxycodone that went missing was from the West-1 medication cart, reporting that for Resident #1, 360 tablets of oxycodone 10 mg had been received from the pharmacy and 160 tablets had been documented as administered in the MAR, leaving 200 tablets missing. For Resident #2, 60 tablets of oxycodone 15 mg tablets had been received from the pharmacy and 29 tablets had been documented as administered in the MAR, leaving 31 tablets missing. For Resident #3, 30 tablets of oxycodone 5 mg had been received from the pharmacy and 9 tablets had been documented as administered in the MAR, leaving 21 tablets missing. For Resident #4, 210 tablets of oxycodone 5 mg had been received from the pharmacy and 99 tablets had been documented as administered in the MAR, leaving 111 tablets missing. She reported that when a narcotic medication gets delivered to the facility, it arrives with a duplicate Controlled Drug Receipt/Record/Disposition Form, of which one is white, and one is green. She reported that she keeps the green copy in her office and the white copy goes in the narcotic book on the medication cart for the nurses to document on when any amount is removed from the original card. The DNS identified that although the white copies in the narcotic book on the medication cart went missing, along with the cards of medication for Residents #1, #2, #3 and #4 she reported that she was able to compare the green copies of actual oxycodone received to each residents MAR to determine how many tablets had been missing. Through staff interviews conducted on [DATE], she reported that the nurses assigned to the West-1 medication cart were unable to identify when the oxycodone had gone missing only reporting they saw two (2) full cards for Resident #1 at the beginning of August. Additionally, she reported that the facility medication destruction policy does not identify a timeframe for the removal of narcotics out of the medication cart once a resident is discharged or passes away, stating that she now requests nursing to bring her discontinued narcotics the same day and if she doesn't receive them she will personally go retrieve them from the unit so that they can be destroyed timely.</p> <p>Review of statement from RN #2 dated [DATE] identified that on [DATE] LPN #7 approached her reporting that the West-1 narcotic book was soiled. RN #2 identified that she went to the medication cart with LPN #7 where she observed the narcotic book face up in the medication cart trash with an open box of ensure beside the book. She reported that the chocolate ensure was dripping out of the book and all the narcotic disposition sheets were covered in it. She reported that they concluded that a resident put the book in the trash. She identified that all the sheets were blow dried and then recopied so that they could still be signed off, retaining all the originals in plastic sheet protectors. RN #2 reported that she did not check the count or have access to the locked narcotic drawer at any time.</p> <p>Interview with LPN #3 on [DATE] at 2:48 PM identified that she came in for her 11:00 PM to 7:00 AM shift one day in early August and went to count the narcotics with LPN #7 and noticed the narcotic book was covered in sauce. She reported that LPN #7 said it was pizza from a resident, reporting she didn't think much of it until it happened again a few weeks later when LPN #7 reported to her that a resident spilled chocolate ensure on the book and there were new pages inserted into the narcotic book. LPN #3 identified that at that point she felt as if LPN #7 was tampering with the book, and she didn't want to sign the book and take the keys but was assured that the nursing supervisor (RN #2) was involved, so she did. She identified that although she felt uncomfortable around LPN #7, none of the residents ever complained about her and they never reported that they had not received their medications.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Re-interview with the DNS on [DATE] at 9:24 AM identified that on [DATE], LPN #7 was working the 3:00 PM to 11:00 PM shift and had to leave for an emergency just prior to the end of the shift. She identified that LPN #7 counted the narcotics and handed off the keys to her co-worker, but then came back requesting the narcotic book because she reported that she forgot to sign something out. When the 11:00 PM to 7:00 AM shift arrived to count, the narcotic book could not be located, and the facility could not get a hold of LPN #7 by phone, so the DNS reported that she directed RN #1 and RN #3 to make copies of all the narcotics in the West-1 medication cart and make new disposition sheets. She reported that they then noticed that more oxycodone 10 mg was missing from Resident #1's stock. The DNS identified that ninety (90) tablets of oxycodone 10 mg had been delivered for Resident #1 on [DATE] and there were only thirteen (13) tablets remaining, but there should have been around fifty (50) tablets remaining with the resident receiving it every six (6) hours. She identified that after the narcotic book went missing and the past incidents of the narcotic book being soiled when LPN #7 was working, she believed LPN #7 was associated with the missing oxycodone. She reported that LPN #7 reported to her scheduled shift on [DATE], the day that the Drug Enforcement Agent (DEA) visited the facility and LPN #7 admitted to The DEA that she had taken the oxycodone, and was terminated.</p> <p>Review of the Connecticut Consumer Protection report, Case Number ,d+[DATE] dated [DATE] identified that two (2) Drug Control Agents met with LPN #7 at the facility on [DATE], where LPN #7 admitted to diverting oxycodone from the facility for her own personal use but reported that she never denied her residents pain medication.</p> <p>Although attempted, interviews with LPN #7 and RN #2 were not obtained.</p> <p>The facility initiated a Plan of Correction (POC) dated [DATE] and associated facility documentation identified a facility wide narcotic sheet audit and pharmacy notification of investigation was completed on [DATE], audits of the medication carts were completed on [DATE], all inactive or discharged resident medications were removed, Cubex cycle count of all facility emergency medications was completed on [DATE].</p> <p>All residents with a BIMS of ,d+[DATE] (50 residents) were interviewed regarding pain medication and effectiveness on [DATE]. Pain assessments were completed on all facility residents on [DATE], bi-monthly drug audits will be conducted of random medication carts, audits were completed on [DATE], [DATE] and [DATE].</p> <p>Random weekly audits to be completed and results to be reported to the Administrator. Results will also be shared at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. Audits completed on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE], Education and re-education on the narcotic process was completed on [DATE] with nursing leadership and all licensed staff.</p> <p>Interview with the Administrator on [DATE] at 12:38 PM identified that the facility QAPI meeting was held on [DATE], where the POC was discussed.</p> <p>Review of the Abuse, Neglect and Misappropriation policy dated ,d+[DATE] directed, in part, that each resident has the right to be free from misappropriation of resident property. It identified that misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879</p> <p>Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of four (4) residents (Resident #1) reviewed for medication administration, the facility failed to follow physician's orders when administering a medication. The findings include:</p> <p>Resident #1's diagnoses included insomnia (difficulty sleeping), chronic pain syndrome, low back pain and polyneuropathy (damage of the peripheral nerves, affecting the skin, muscles and organs).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition and was independent with eating, transfers and ambulation.</p> <p>The Resident Care Plan (RCP) dated 6/19/24 identified that Resident #1 takes a sedative/hypnotic medication related to insomnia with interventions that included to administer sedative/hypnotic medications as ordered by the physician and monitor and document side effects and effectiveness every shift.</p> <p>A physician's order dated 7/25/24 directed to administer Ambien (a narcotic sleep medication) oral tablet, give 5 milligrams (mg) every 24 hours as needed for insomnia.</p> <p>Review of the Controlled Drug Receipt/Record/ Disposition Form dated 7/26/24 for Resident #1's Ambien 5 mg tablet identified that the Ambien was administered twice daily by LPN #7 on 7/31/24 at 7:00 PM and 9:20 PM, 8/1/24 at 7:00 PM and 9:00 PM, 8/5/24 at 7:00 PM and 9:00 PM, 8/10/24 at 7:00 PM and 9:30 PM, 8/12/24 at 7:00 PM and 9:30 PM and 8/19/24 at 7:00 PM and 8:00 PM.</p> <p>Interview with the DNS on 10/25/24 at 12:17 PM identified that she expects nursing to always follow physician's orders, reporting that she was not aware of the error and subsequent to surveyor notification, she verified with APRN #1 that Resident #1 was only supposed to receive the Ambien 5 mg tablet once per day for that time period. She identified that she also spoke with Resident #1 who identified that LPN #7 would give him/her the Ambien to sleep and then if he/she came out into the hallway and reported to LPN #7 that it wasn't working, that she would give it to him/her again, stating that it was available to Resident #1. The DNS identified that nurses are prohibited from borrowing narcotics from other residents' personal stock and that they are directed to use the Cubex (emergency medication dispensing machine) if they run out of medication, reporting that she did not believe that it was borrowed for another resident and that the duplicate administrations appeared to be a medication error and that she would document it.</p> <p>Interview with Resident #1 on 10/25/24 at 1:49 PM identified that LPN #7 gave him/her Ambien every time that she worked. The resident reported that the Ambien was a little white pill and if he/she came out of his/her room and said it didn't work that LPN #7 would give him /her another Ambien.</p> <p>Although attempted, an interview with LPN #7 was not obtained.</p> <p>Although requested, a policy on nursing documentation was not obtained.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medication Administration Errors policy dated 7/2022 directed, in part, that a dispensing based medication error includes a dose dispensed to a resident that is greater or lesser than the amount ordered by the physician, or a drug product dispensed with no authorization by a prescriber for a resident.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879</p> <p>Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of four (4) residents (Resident #1) reviewed for medication misappropriation, the facility failed to ensure that as needed narcotics were documented as administered and evaluated for effectiveness in the clinical record. The findings include:</p> <p>Resident #1's diagnoses included chronic pain syndrome, low back pain and polyneuropathy (damage of the peripheral nerves, affecting the skin, muscles and organs).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition, frequently experienced moderate pain and was independent with eating, transfers and ambulation.</p> <p>The Resident Care Plan (RCP) dated 7/19/24 identified that Resident #1 has pain and receives pain medication related to gout, polyneuropathy and low back pain. Interventions included monitoring for non-verbal signs of pain, evaluating pain characteristics, utilizing the pain scale and advising the resident to request pain medication before pain becomes severe.</p> <p>A physician's order dated 7/25/24 directed to administer Ambien oral tablet, give 5 milligrams (mg) every 24 hours as needed for insomnia.</p> <p>Review of the Controlled Drug Receipt/Record/ Disposition Form dated 7/26/24 for Resident #1's Ambien 5 mg tablet identified that the Ambien was administered 28 times on 7/31/24 at 7:00 PM and 9:20 PM, 8/1/24 at 7:00 PM and 9:00 PM, 8/2/24 at 7:00 PM, 8/3/24 at 8:00 PM, 8/4/24 at 8:00 PM, 8/5/24 at 7:00 PM and 9:00 PM, 8/6/24 at 7:00 PM, 8/7/24 at 8:00 PM, 8/8/24 at 7:00 PM, 8/9/24 at 8:00 PM, 8/10/24 at 7:00 PM and 9:30 PM, 8/11/24 at 7:00 PM, 8/12/24 at 7:00 PM and 9:30 PM, 8/13/24 at 7:00 PM, 8/14/24 at 7:00 PM, 8/15/24 at 7:00 PM, 8/16/24 at 8:00 PM, 8/17/24 at 7:00 PM, 8/18/24 at 7:00 PM, 8/19/24 at 7:00 PM, 8/19/24 at 7:00 PM and 8:00 PM, 8/20/24 at 7:00 PM and 8/21/24 at 7:00 PM.</p> <p>Review of the July 2024 and August 2024 Medication Administration Record (MAR) for Resident #1 identified that the Ambien 5 mg tablet was documented as administered five (5) out of the 28 times that it was removed from stock (17.8%) on 7/31/24 9:00 PM, 8/1/24 at 9:00 PM, 8/5/24 at 9:00 PM, 8/8/24 at 6:02 PM and on 8/12/24 at 9:30 PM.</p> <p>Interview with the DNS on 10/25/24 at 12:17 PM identified that the nurses are expected to document in the MAR on all as needed (PRN) medications and are expected to follow-up with the resident for effectiveness of the medication. She reported that she was unsure why Resident #1's Controlled Drug Receipt/Record/ Disposition Form dated 7/26/24 for Resident #1's Ambien 5 mg tablet identified that the resident had received Ambien 5mg 28 times, yet his/her MAR only reflected documentation for 5 out of the 28 times. The DNS identified that nurses are prohibited from borrowing narcotics from other residents' personal stock and that they are directed to use the Cubex (emergency medication dispensing machine) if they run out of medication, reporting that she did not believe that it was borrowed for another resident and that the duplicate administrations appeared to be a medication error and that she would document it.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident #1 on 10/25/24 at 1:49 PM identified that LPN #7 gave him/her Ambien every time that she worked. The resident reported that the Ambien was a little white pill and if he/she came out of his/her room and said it didn't work that LPN #7 would give him /her another Ambien.</p> <p>Interview with the Administrator on 10/28/24 at 12:38 PM identified that the facility Plan of Correction (POC) dated 8/29/24 for medication misappropriation included education on documentation of all as needed medications in the MAR. She reported that the facility is alleging that this is past noncompliance which was in compliance as of 9/3/24.</p> <p>Review of the Narcotic Procedure Reminders in-service dated 8/29/24 identified that any as needed medications administered require documentation on the MAR, no exceptions.</p> <p>Although attempted, an interview with LPN #7 was not obtained.</p> <p>Although requested, a policy on nursing documentation was not obtained.</p>		