STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185174	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florence Park Care Center	6975 Burlington Pike Florence, KY 41042

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)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview, record review, and review of the facility's policies, the facility failed to ensure residents received necessary pain management as ordered when it did not safeguard and account for controlled substances to prevent diversion by staff. This deficient practice resulted in ordered pain medication not being available for administration causing unmanaged pain and discomfort for 3 of 9 sampled residents reviewed for pain, Resident (R) 1, R3, and R4. On 10/25/2025, a comparison of the medications on hand with the documented controlled substance record sheets revealed the narcotic counts for the C-Hall medication carts were inaccurate. The investigation into the discrepancies showed that residents had not received their scheduled narcotic pain medications. During this time, R1, R3, and R4 were not administered their ordered pain medication.An investigation into drug diversion was initiated after Registered Nurse (RN) 1 observed Licensed Practical Nurse (LPN) 2 repeatedly removing pills from the medication cart drawer, concealing them in medication cups, and then her observation of LPN2 placing something in her mouth and pockets. Refer to F602The findings include: Review of the facility's policy titled, Pain Management, reviewed 01/2024, revealed the facility would ensure residents were provided pain management, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. According to the policy, residents would be assessed for the effectiveness of pain interventions to promote comfort and meet residents' goals. Residents who were unable to communicate pain were monitored for nonverbal signs and symptoms to ensure the prompt recognition and treatment of pain. Review of the facility's policy titled, Medication Administration General Guidelines, reviewed 04/28/2025, revealed medications must be administered in accordance with physician orders, including any required time frame. Review of the facility's policy titled, Controlled Substances, revised 11/2024, revealed licensed nurses were required to count all controlled medications at every change of shift. The policy stated reconciliation was performed jointly by the outgoing and incoming licensed nurse. Per the policy, a physical count and reconciliation of controlled substances, including identification of the individuals conducting the reconciliation, must be documented on the proof-of-use sheets for each shift-to-shift count. According to the policy, when a nurse removed a controlled substance for administration, the removal must be documented on the controlled substance record at the time of removal, including the date, time, and amount removed for that resident. 1. Review of the admission Record found in R1's electronic medical record (EMR), revealed the facility admitted the resident on 07/22/2024 with diagnoses to include chronic pain syndrome, osteomyelitis, and peripheral vascular disease. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set [MDS], found in R1's EMR with an Assessment Reference Date (ARD) of 05/16/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating the resident was cognitively intact. According to the MDS, Section J, R1 reported almost constant pain that interfered with day-to-day activities, with an intensity documented as nine on a one to 10 scale, with 10 being the most intense pain. Staff was to assess and monitor the resident for pain. Review of the Comprehensive Care Plan [CCP], dated11/03/2025, found in R1's EMR, revealed the resident was assessed on 07/23/2024 of the potential for comfort alteration related to chronic pain, diabetes mellitus II with polyneuropathy, impaired mobility, and peripheral vascular disease (PVD). Goals initiated included staff was to manage/control pain with current medications and/or nursing interventions. Further review revealed interventions, revised 07/29/2024, included pain would be managed/controlled with current medications and/or nursing interventions; administer pain medications as ordered; and monitor/record medication effectiveness and side effects. However, during an interview with the Director of Nursing (DON) on 11/12/2025 at 10:51 AM, she stated her review of narcotic records revealed R1 missed one dose of oxycodone 15 milligram (mg) on 10/25/2025. Additionally, the DON stated evening shift staff contacted the on-call provider at 9:24 PM to request pain medication for R1, and the on-call provider, Nurse Practitioner (NP) 2, denied the request. She further stated there were no nursing notes or a pain assessment in the resident's EMR related to R1's complaint. Review of a print-out of an online communication note, dated 10/25/2025 at 9:24 PM, from Licensed Practical Nurse (LPN) 4 to on-call Nurse Practitioner (NP) 2, revealed she explained R1 did not receive his scheduled oxycodone (an opioid pain medication) 15 milligrams (mg). LPN4 documented in the communication she gave R1's 8:00 PM dose, but the resident was requesting a one-time dose. She explained R1 was missing medications. NP2 replied at 9:43 PM and stated, No, I'm not comfortable with this. He will have to wait. Review of the October 2025 Order Summary Report, found in R1's EMR, revealed the resident's active orders for 10/25/2025 included oxycodone HCL 15 milligram (mg) tablet, give one every four hours related to chronic pain with a start date of 03/28/2025. Review of the October 2025 Medication Administration Record [MAR], found in R1's EMR, revealed the 10/25/2025 12:00 PM and 4:00 PM doses of oxycodone HCL 15 mg were signed out as given by LPN2. However, review of R1's medical record revealed there was no documented pain assessment for R1, and the record did not show where the nursing staff assessed his reported pain or if it was relieved. Review of the Individual Patient Controlled Substance Administration Record [IPCSAR], found in R1's EMR, revealed R1's 10/25/2025 4:00 PM dose of oxycodone HCL 15 mg was signed out as given. However, the 10/25/2025 12:00 PM dose was not signed out as given. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with R1 on 11/12/2025 at 2:40 PM, he stated he did not receive his medications at both noon and 4:00 PM on 10/25/2025 from the nurse on duty. He stated he asked another nurse for his medications and was told she could not give them. He stated it was not until later that he found out a nurse had taken resident medications. He stated he was in severe pain, and it took several days to bring the pain down to its normal level. He stated, I was sick for two days due to the pain. 2. Review of the admission Record found in R3's EMR, revealed the facility admitted the resident on 07/09/2025 with diagnoses to include malignant neoplasm of liver, unspecified fall, and atrial fibrillation. Review of the quarterly MDS, with an ARD of 10/29/2025 and found in R3's EMR, revealed the facility assessed the resident to have a BIMS score of 12 out of 15, indicating the resident was moderately impaired with cognition. According to the MDS, Section J, R3 reported almost constant pain that interfered with day-to-day activities. Staff was to assess and monitor the resident for pain. Review of the CCP, which showed a revision date that was current for 10/25/2025, found in R3's EMR, revealed the resident was assessed on 07/10/2025 for alterations in comfort related to generalized discomfort. Goals initiated included pain would be managed/controlled with current medications and/or nursing interventions. Further review revealed interventions included to administer pain medications and to monitor medication effectiveness and side effects. Additionally, R3 was receiving hospice services. Goals included staff was to ensure his needs were met with comfort and dignity throughout end-of-life services. However, during an interview with the DON on 11/12/2025 at 10:51 AM, she stated her review of narcotic records revealed R3 missed one dose of morphine sulphate 15 mg on 10/25/2025. She stated there was no documentation R3 was assessed for pain or that the on-call provider was notified of the resident's pain during the shift. Review of the October 2025 Order Summary Report, found in R3's EMR, revealed the resident's active orders for 10/25/2025 included morphine sulphate 15 mg tablet, give one tablet by mouth every eight hours related to chronic hepatitis, chronic pain, and liver cell carcinoma. Review of the October 2025 MAR, found in R3's EMR, revealed the 10/25/2025 2:00 PM dose of morphine sulphate 15 mg was signed out as given by LPN2. However, review of R3's medical record revealed there was no documented pain assessment for R3, and the record did not show where the nursing staff assessed his reported pain or if it was relieved. Review of the IPCSAR, found in R3's EMR, revealed R3's 10/25/2025 2:00 PM dose of morphine sulphate 15 mg was not signed out as given. During an interview with R3 on 11/13/2025 at 3:05 PM, he stated he requested his noon medications from the agency nurse on duty because she had not given him the 12:00 PM dose of morphine. He stated the nurse left the room and did not return. R3 stated he was in severe pain that day, rating it as an eight out of 10 on a pain scale with 10 being the worst possible pain. R3 stated he cried because the pain was so bad. He stated he was told by staff the agency nurse who did not give his medication took my morphine. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	3. Review of the admission Record found in R4's EMR, revealed the facility admitted the resident on 07/24/2024 with diagnoses to include pain, major depressive disorder, and personality disorder. Review of the quarterly MDS, with an ARD of 06/15/2025 and found in R4's EMR, revealed the facility assessed the resident to have a BIMS score of eight out of 15, indicating the resident was moderately cognitively impaired. According to the MDS, Section J, R4 reported frequent pain that interfered with day-to-day activities, with an intensity documented as nine on a one to 10 scale, with 10 being the most intense pain. Staff was to assess and monitor the resident for pain. Review of the CCP, revision date current for 10/25/2025, found in R4's EMR, revealed the resident was assessed for alterations in comfort, revised 05/12/2022, related to polyneuropathy and low back pain. Goals initiated included pain would be managed/controlled with current medications and/or nursing interventions. Further review revealed interventions included to administer pain medications and to monitor medication effectiveness and side effects. However, during an interview with the DON on 11/12/2025 at 10:51 AM, she stated her review of narcotic records revealed R4 missed an afternoon dose of oxycodone-acetaminophen 5-325 mg. She stated there was no documentation R4 was assessed for pain or that the on-call provider was notified of the resident's pain during the shift. Review of the October 2025 Order Summary Report, found in R4's EMR, revealed the resident's active orders for 10/25/2025 included oxycodone-acetaminophen 5-325 mg tablet, give one tablet two times a day for pain. Review of the October 2025 MAR, found in R4's EMR, revealed the 10/25/2025 2:00 PM dose of oxycodone-acetaminophen 5-325 mg was signed out as given by LPN2. However, review of R4's medical record revealed there was no documented pain assessment for R4, and the record did not show where the nursing staff assessed his reported pain or if it was relieved. Review of the IPCSAR, found in R4's EMR, revealed R4's 2:00 PM 10/25/2025 dose of oxycodone-acetaminophen 5-325 mg was not signed out as given. During an interview with R4 on 11/13/2025 at 9:30 AM, she stated she had requested her medication due to increased pain, but her nurse wouldn't give it to me. R4 stated the nurse told her she did not have any ordered medications left to give her. Furthermore, R4 stated she was not aware why she did not receive her medication, and she could not identify the nurse. During an interview with State Trained Nurse Aide (STNA) 3 on 11/13/2025 at 1:34 PM, she stated on 10/25/2025 she was concerned that R1, R3, and R4 told her they had not received their pain medication, particularly toward the end of her shift around 4:00 PM. She stated the residents asked her if she could check with the nurse about their medications. She stated she told LPN2 about the residents' complaints of pain, and LPN2 went to check on the residents. During an interview with STNA4 on 11/13/2025 at 9:02 AM, she stated if she observed a change in a resident's usual behavior or mood, she notified the nurse and attempted to make the resident as comfortable as possible. She stated if a resident told her they did not receive their pain medication or reported being uncomfortable, she would notify the nurse and, if needed, the supervisor. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During a continued interview with the Director of Nursing (DON) on 11/12/2025 at 10:51 AM, she stated on 10/25/2025 at approximately 5:00 PM, Registered Nurse (RN) 1 observed Licensed Practical Nurse (LPN) 2 to exhibit unusual behavior at the medication cart and requested the keys to LPN2's cart. She stated RN1, along with another licensed professional, then conducted a controlled substance count on LPN2's medication cart. She stated, during the count, multiple medication cups were found on the cart containing unidentified tablets that appeared consistent with narcotic medication. She stated comparison of the medications on hand to the documented controlled substance record sheets revealed the narcotic count on LPN2's medication cart (C-Hall) was incorrect. The DON again stated her review of narcotic records revealed R1 missed one dose of oxycodone 15 milligram (mg), R3 missed one dose of morphine sulphate 15 mg, and R4 missed an afternoon dose of oxycodone-acetaminophen 5-325 mg. During an interview with the Ombudsman on 11/12/2025 at 1:29 PM, she stated R1 had shared an incident from a few weeks ago when he did not receive his scheduled pain medication on a weekend. She stated R1 informed her when he requested his pain medication, the nurse on duty stated it was not available. She stated R1 told her, later that evening, he experienced terrible pain, prompting the evening nurse to contact the provider. However, she stated the evening nurse told her the provider stated they could not order an as-needed pain medication since his next scheduled dose was due to be given shortly. During a telephone interview with RN1 on 11/13/2025 at 12:14 PM, she stated R1 and R3 came to her throughout the day on 10/25/2025 and complained of being in pain and stated they had not received their pain medications all day. RN1 stated R3 had chronic pain due to cancer, and R3 was crying in pain. RN1 stated she notified LPN2 of the residents' pain. During an interview with NP1 on 11/13/2025 at 11:11 AM, she stated she was not the on-call provider the night of the narcotic diversion incident; however, another nurse practitioner from their group was on call. NP1 stated notes to on-call providers were not documented in the facility's EMR but were instead recorded through the group's on-call documentation system. NP1 stated according to the communication note, R1 stated he did not receive his oxycodone. She stated the on-call NP (NP2) was notified that R1 received his 8:00 PM dose of oxycodone but was requesting a PRN (as needed) medication to hold him over until his next scheduled dose at 12:00 AM. She stated it was not established that the NP on call was told the facility believed the narcotics were diverted. Furthermore, NP1 stated NP2 was not informed R3 or R4 had complaints of pain after not receiving their ordered medications. During continued interview with NP1 on 11/13/2025 at 11:11 AM, she stated the communication from facility staff to the on-call NP was not ideal, and it was horrible the resident experienced pain. She stated she was more familiar with the residents in the facility and had direct access to the EMRs, whereas the on-call nurse practitioner did not. She stated, had she been contacted, she absolutely would have attempted to provide some type of pain relief for the resident. However, she stated not knowing the true extent of the possible narcotic diversion, it would be better not to give the medication than to risk giving a double dose. She further stated it was important that medications were administered as prescribed. She stated failure to provide ordered medications could potentially result in withdrawal symptoms and pain that was difficult to get under control. She stated, while it was unlikely for withdrawal to occur with a single missed dose, residents who had been on pain medications for a long time were on them for a reason, and missing doses could leave them uncomfortable and in pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with the Medical Director on 11/13/2025 at 1:55 PM, he stated the DON informed him of the diversion incident on the Monday following its occurrence (10/27/2025) and assured him the facility was following appropriate protocols. The Medical Director stated it was his expectation that residents received all of their medications, including pain medications, as ordered, and it was important to prevent pain. During a telephone interview with NP2 on 11/13/2025 at 2:55 PM, she stated she received notification that R1 required his pain medication early. She stated she was not comfortable with giving him a dose too close to his next scheduled dose. Furthermore, NP2 stated she was not informed R3 or R4 had complaints of pain after not receiving their ordered medications. She stated she was aware of a potential diversion of narcotic medications, and residents might not have received medications as ordered. However, NP2 stated given the same circumstances, she would make the same call. During additional interview with the DON on 11/14/2025 at 10:43 AM, she stated it was important that residents received their scheduled pain medications on time because if doses were missed or given late, it was harder to bring the pain back under control. Then, she stated, the resident might require more medication to achieve relief. She stated she expected staff to document thoroughly and timely residents' reports of pain and staff observations of residents' pain so the facility could review, respond, and address concerns promptly rather than allowing residents to wait in pain. During an interview with the Administrator on 11/14/2025 at 11:15 AM, she stated she expected staff to manage residents' pain in accordance with physician orders. She stated if a resident reported pain, medication should be provided. Additionally, she stated staff should request additional pain management from the physician as needed, and when medication could not be given, they should use non-pharmacological interventions such as heat, cold, or therapy. She stated it was important to follow physician orders and manage pain for the physical well-being of the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, record review, review of the General Observation Form for Narcotics and Documentation, and review of the facility's policy, the facility failed to ensure proper control, accountability, reconciliation, and safeguarding of controlled substances in accordance with professional standards of practice when staff did not accurately complete and reconcile controlled medication record sheets for 4 of 4 sampled residents, Resident (R) 10, R11, R12, and R13. The findings include: Review of the facility's policy titled, Controlled Substances, revised 11/2024, revealed licensed nurses were required to count all controlled medications at every change of shift. The policy stated reconciliation was performed jointly by the outgoing and incoming licensed nurse. Per the policy, a physical count and reconciliation of controlled substances, including identification of the individuals conducting the reconciliation, must be documented on the proof-of-use sheets for each shift-to-shift count. According to the policy, when a nurse removed a controlled substance for administration, the removal must be documented on the controlled substance record at the time of removal, including the date, time, and amount removed for that resident.Review of the General Observation Form for Narcotics and Documentation, completed by the pharmacy's Client Service Manager (CSM), dated 11/03/2025, revealed, in the audit findings, she made an observation of a nurse seated at the C-Hall nurses' station, with the controlled medication book filling in documentation. Per the report, when the CSM asked the nurse what she was doing, the nurse stated she, was filling it in before I looked at it. The auditor stated that she educated all nurses not to sign out controlled medications until administered. During an observation of the C-Hall morning medication administration on 11/13/2025 at 9:34 AM, Licensed Practical Nurse (LPN) 4 failed to document administered controlled medication doses on the Individual Patient Controlled Substance Administration Record [IPCSAR], at the time the medication was given for R10, R11, R12, and R13. Additional review of a controlled medication count for the C-Hall medication cart, conducted with the Director of Nursing (DON) on 11/13/2025 at 9:34 AM, revealed LPN4 had not signed out six morning doses of controlled pain medication which she had administered to R10, R11, R12, and R13. 1. Review of the admission Record found in R10's electronic medical record (EMR), revealed the facility admitted the resident on 10/27/2021. R10's diagnoses included cerebral infarction, paranoid schizophrenia, and contractures of the right and left knees.Review of the annual Minimum Data Set [MDS], found in R10's EMR with an assessment reference date (ARD) of 09/27/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 13 out of 15. This score indicated the resident was cognitively intact.Review of the Order Summary, dated 11/13/2025 and found in R10's EMR, revealed the physician prescribed gabapentin capsule (a controlled medication given for nerve pain) 300 milligrams (mg), give one capsule by mouth three times a day related to polyneuropathy with a start date of 10/28/2021. Review of the Medication Administration Report [MAR], dated 11/2025, found in R10's EMR, revealed documentation on 11/13/2025 that he was given his 8:00 AM dose of gabapentin capsule 300 mg. Review of the IPSCAR for gabapentin capsule 300 mg, date received 11/03/2025 and found in R10's EMR, revealed LPN4 had not signed out the 11/13/2025, 8:00 AM dose.However, observation on 11/13/2025 at 9:57 AM revealed LPN4 signed the record in front of the State Survey Agency (SSA) Surveyor and documented 9A as the time administered. 2. Review of the admission Record found in R11's EMR, revealed the facility admitted the resident on 05/12/2018 with diagnoses to include Parkinson's disease, osteoarthritis, and anxiety disorder.Review of the annual MDS, found in R11's EMR with an ARD of 08/12/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15. This score indicated the resident was cognitively intact.Review of the Order Summary, dated 11/13/2025 and found in R11's EMR, revealed the physician prescribed pregabalin capsule (a controlled medication given for nerve pain) 100 mg, give one capsule by mouth three times a day related to fibromyalgia with a start date of 04/20/2022. Additionally, R11 was prescribed morphine sulfate extended-release tablet 30 mg, give one tablet two times a day related to left knee pain.Review of the MAR, dated 11/2025 and found in R11's EMR, revealed documentation on 11/13/2025 that she was given her 8:00 AM doses of pregabalin capsule 100 mg and morphine sulfate extended-release tablet 30 mg.Review of the IPSCAR for pregabalin capsule 100 mg, date received 10/31/2025 and found in R11's EMR, revealed LPN4 had not signed out the 11/13/2025 8:00 AM dose. Review of the IPSCAR for morphine sulfate extended-release tablet 30 mg, date received 10/31/2025 and found in R11's EMR, revealed LPN4 had not signed out the 11/13/2025 8:00 AM dose. However, observation on 11/13/2025 at 9:57 AM revealed LPN4 signed both records in front of the SSA Surveyor and documented