STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185234	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calvert City Convalescent Center	1201 Fifth Ave Calvert City, KY 42029

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49350 Based on interview, record review, and review of facility investigation documentation and policy, the facility failed to ensure residents were free from misappropriation of property for 1 of 19 sampled residents, (Resident (R)48). On [DATE], the facility's Registered Nurse (RN) 1, the Assistant Director of Nursing (ADON) misappropriated R48's liquid oral morphine concentrate by injecting water into the multi-dose vial in order to correct the volume loss reported by a staff nurse. RN 1/ADON admitted to the facility that she injected water into R48's morphine vial. The facility failed to ensure a medication administration record of oral liquid morphine concentrate on [DATE] at 2:30 AM for R48. The facility implemented plans of correction regarding the incident and alleged past non-compliance date of [DATE]. The findings include: Review of the facility policy entitled Prohibiting Abuse, Neglect, Misappropriation, and Exploitation, undated, revealed the facility believed each individual (resident) had the right to be free from (all) abuse, as well as neglect and exploitation. Continued review revealed residents of the facility were not to be subjected to abuse by anyone including, but not limited to facility staff, other residents, or others serving the residents, including family members. Review of the facility policy entitled, Medication Administration General Guidelines, dated 2006 and last revised ,d+[DATE], revealed medications were administered as prescribed in accordance with good nursing principles and practices, and only by persons legally authorized to do so. Continued review revealed personnel authorized to administer medication were to do so only after they had been properly oriented to the facility's medication distribution system. Per policy review, personnel authorized to administer medication were also to do so when the facility had a medication distribution system to ensure safe administration of medication without unnecessary interruptions. Review of the policy revealed when administering high risk medication in liquid form, or those requiring precise measurement, such as morphine, devices provided by the manufacturer or obtained from the provider pharmacy, such as oral syringes were to be used to allow accurate measurement of doses. Further review of the policy revealed the individual who administered the medication dose was to record the administration on the resident's medication administration record (MAR) directly after the medication was given. In addition, review revealed at the end of each medication pass, the person administering medication was to review (residents') MARs to ensure necessary doses were administered and documented. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's medical record for R48 revealed the facility admitted the resident on [DATE], with diagnoses that included: chronic pain syndrome, right sided sciatica, and generalized muscle weakness. Further review revealed R48 was noted as deceased as of [DATE]. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date of [DATE] revealed the facility assessed R48 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Review of R48's care plan date initiated [DATE], revealed the resident had a problem for potential for alteration with pain or comfort related to osteoarthritis. Continued review revealed the facility's goal for R48 was for the resident not to have an interruption in normal activities due to pain through the review date. Per care plan review, the resident had an order for as needed pain medication, with intervention that included administering pain medication as ordered per the Physician. Review of the facility's MAR for R48 for [DATE], revealed a current order for morphine sulfate concentrate solution 20 milligrams/milliliter (mg/ml). Continued review of the MAR revealed R48 was to receive 0.25 milli units by mouth every four hours for pain. Further review of R48's MAR revealed doses of PRN morphine sulfate concentrate solution were also ordered for the resident. Review of the facility's Long-Term Care Facility Self-Reported Incident Form submitted to the State Survey Agency revealed an incident report noting a diluted morphine vial revealed the date of the incident noted was [DATE]. Per review, staff involved in the incident included Registered Nurse (RN) 1 and Licensed Practical Nurse (LPN) 10. Review of the facility's Five-Day Follow up Form/Five-Day Final Investigation Report Summary dated [DATE], revealed on [DATE], a morphine bottle was 2 milliliters (ml) short of the amount that should have been in it. Per review, the Administrator was informed and an investigation was started in to why the bottle was short of the amount that should have been in it. Review of the Five-Day Final Investigation Report Summary, revealed the ADON was measuring the amount in the one morphine bottle in question that was low. Continued review of the Summary revealed LPN 10 was present in the medication room and was asked to step outside the room leaving the ADON alone. Review of the Summary revealed the ADON asked LPN 10 to come back into the medication room and the nurses measured the amount in the vial of morphine together, which was noted to have measured the correct amount. Further review of the Summary revealed LPN 10 questioned the ADON as to if the bottle had been diluted with water to bring it to the proper level. Additional review revealed LPN 10 did not feel comfortable administering medication from the morphine vial and contacted management. In continued review of the facility's Five-Day Follow up Form/Five-Day Final Investigation Report Summary dated [DATE], for the incident on [DATE], involving R48's morphine revealed to ensure no resident received any medication from a bottle that had been tampered with, it was agreed the bottle (vial of morphine) would be taken out of circulation and locked away. According to review of the Summary, that vial was immediately replaced with a new bottle at the expense of the facility. Review further revealed at no time was there any medication administered from a tampered bottle and no resident missed any doses or were late on their medication times. In addition, review revealed when the ADON was questioned about the incident, she confirmed she had diluted the morphine vial to bring it up to the proper level. The Summary review further revealed based on the investigation findings, the facility verified that medication tampering had taken place. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with RN 1 (former ADON) on [DATE] at 1:40 PM, she stated she recalled the incident in question regarding the morphine vial for R48. She stated she was approached by a staff member (LPN 10) on [DATE], who was concerned that an oral morphine vial was missing medication volume. RN 1 stated she did some research and found that the narcotic (narc) logbook for signing medications out against the MAR was also not correct. She stated in an effort to correct the problem, she injected water into the vial of liquid morphine concentrate to refill it to the correct level. Per RN 1 in interview, she did that in the presence of another nurse (LPN 10) who reported her for doing that. She said and she was terminated for her actions the next day. RN 1 stated that during the time she was investigating the matter, she had been unable to specifically identify individuals who might have failed to sign the narc log or MAR. She stated the incident was reported to the State Board of Nursing, and she was investigated and reprimanded for the matter by the Board of Nursing. RN 1 further stated she did not know why the doses in the morphine vial were off. She additionally stated the diluted morphine concentrate in the vial was never administered to R48. In interview with LPN 10 on [DATE] at 4:00 PM, she stated she recalled the incident in question. LPN 10 stated R48's morphine had been short and I did not want to sign the narc log because it wasn't right. She stated she tried to get help from the ADON who told her to let the night shift nurse go home and she would take care of it. Per LPN 10, when she went back to the patient care area, no one was looking into the morphine shortage and the ADON had not told the DON about the problem. According to LPN 10 in interview, the ADON said I'm going to fix this and you are not going to like it. She stated at that point the ADON added water to the vial of morphine to replace the missing volume and told her R48 would never notice, just give her that. LPN 10 stated the ADON did not care and she left but, I was concerned that she was covering it up so I called my manager first and then the administrator of the building and the doctor. The LPN said when she came on shift and started counting the morphine with the nurse from the previous shift (LPN 11) she found a major discrepancy. She stated I was not comfortable with that. LPN 10 stated she did not question the other nurse who worked before her about it and did not ask her what happened. She further stated she had not thought the previous nurse had done anything wrong, but, that nurse was permitted to leave. In addition, the LPN said the ADON had been trying to cover it all up and that was my problem. Review of the facility's controlled substance use record or narc logbook revealed on [DATE], five individual doses oral morphine were all administered from the same vial. Per review of the narc logbook, LPN 11 noted administration of three doses on [DATE] at 12:00 AM, 2:30 AM, and 6:00 AM. Continued review revealed LPN 10 noted two doses of morphine were administered on [DATE] at 12:00 PM and 2:36 PM. Review of the MAR for R48 revealed LPN 11 recorded administration of morphine at 12:00 AM and at 6:00 AM on [DATE]; however, the LPN failed to record the morphine dose on [DATE] at 2:30 AM, that was signed as given on the narc log. Further MAR review revealed LPN 10 noted two doses of morphine administered at 12:00 PM and 4:00 PM on [DATE]. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview with the Administrator on [DATE] 8:43 AM, I got a call after I left work from an employee that ADON/RN 1 had diluted a morphine bottle. Per the Administrator in interview, I remembered thinking this cannot be right, why would the ADON have done this? He stated he talked with the Medical Director and decided for purposes of immediacy pull the vial and replace it with a new bottle so no diluted medication was given. The Administrator stated it was indisputable that ADON/RN 1 had diluted the morphine bottle after review of the facility's (video) tape. He stated he terminated the ADON the next day and the facility's report was submitted to the SSA. According to the Administrator, the practice of the dilution of the morphine bottle caused us to report and turn that information in to the State Board of Nursing. In continued interview with the Administrator on [DATE] 8:43 AM, he stated checking the morphine level was a big part of our investigation and was how the facility improved because of doing that. He said the facility switched syringe types also which had helped with solving a slight variation problem. The Administrator stated staff education and demonstration was a big part of what we needed to do so all nurses understood how to use the syringe and learned to read it the same way. He stated we did not feel like anyone here was trying to take advantage of the situation by stealing medication. According to the Administrator, we ended up installing level shelving for measurement so that we get the same reading every time. When the SSA Surveyor asked the Administrator what a potential outcome was if a resident's care plan for pain medication was not followed or the medication had been diluted, he stated, an outcome would be that the resident would still be in pain. In interview with the Director of Nursing (DON) on [DATE] at 2:00 PM, she stated she was aware of what the ADON had done and to her knowledge the morphine was not given to R48. She stated they opened a new bottle at that time because a dose was due for R48. Per the DON in interview, the ADON was dismissed after admitting to what she did. The DON stated she did not recall ever speaking with LPN 11 about why the dose from R48's MAR was missing for the date of [DATE]. She stated the ADON/RN 1 admitted to diluting the morphine vial and we went back and forth on termination versus education for her and we went with termination in the end. She stated they went with termination of the ADON/RN 1 because of the potential for R48's pain to not have been controlled due to her actions. The DON stated if R48's care plan had not been followed, increased pain could have been a negative outcome, if the diluted morphine had been administered to the resident. She stated she could not recall specifically what LPN 10 said her concerns were, but did recall that the LPN was refusing to document on the narc log after the morphine had been diluted by the ADON/RN 1. In continued interview with the DON on [DATE] at 2:00 PM, she stated We looked through documentation, syringes, etc to try to find causation and we found that a problem had arisen with the way the syringes were reading. She said so they educated nurses to that and got rid of the old syringes and put the new syringe type in place. The DON stated other measures, such as lock boxes were put into place and nursing staff had been instructed to notify us immediately if any discrepancy was detected. According to the DON, We also installed level shelving to identify morphine volume for measurement. She stated she thought the problem was stabilized today, but measurement of the product was the challenge and that's why the shelving was installed. When the SSA Surveyor asked the DON about the key improvements from the facility's internal plan of correction she stated, shelving in place for leveling the volume, new syringe type in place is much more accurate for measurement and that makes it easier for nurses. The DON stated the nursing education provided included how to draw the medication up properly and lock boxes were installed to keep bottles upright and to prevent leakage. She further stated discussions about accuracy of the narc log and MAR documentation had also been included.