STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185311	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare at Rockford Rehab & Wellness	4700 Quinn Drive Louisville, KY 40216

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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50153 Based on observation, interview and review of facility policy, it was determined the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three of six residents sampled for pain out of the total sample of 22, (Resident (R)20, R30, R59). 1. The facility failed to ensure R20 received prescribed scheduled doses of Hydrocodone 10 milligrams (mg)/Acetaminophen 325 mg (a narcotic pain medication used to treat moderate pain) every four hours as ordered, for 28 consecutive hours starting on 09/15/2024 at 6:00 AM through 09/16/2024 at 2:00 PM, with documentation noting the medication was not available. 2. The facility failed to ensure R30 received prescribed scheduled doses of Tramadol 25 mg (an opioid medication used to treat moderate to severe pain) three times a day on 08/14/2024 at 9:31 PM and 08/15/2024 at 4:51 PM. with the documentation noting the medication was unavailable, waiting on pharmacy. Also, the facility failed to ensure R30 received the Tramadol on 08/16/2024 at 12:09 PM and at 2:41 PM due to the medication again documented as not being available. 3. The facility failed to ensure R59 received prescribed scheduled doses of Tramadol 25 mg on 08/07/2024 at 9:53 PM and 09/27/2024 at 8:44 AM, with documentation noting the medication was not available and waiting for pharmacy. The findings include: Review of the facility policy titled, Pain Management, revised on 02/08/2024 revealed the facility must ensure pain management was provided to residents who required such services. Further review revealed the facility must ensure pain management was provided for residents: consistent with professional standards of practice; the comprehensive person-centered care plan; and the resident's goals and preferences. (continued on next page)

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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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy titled, Medication Ordering and Receiving from Pharmacy Provider - Ordering and Receiving Controlled Medications dated 01/2023, revealed medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, were subject to special ordering, receipt, and record keeping requirements in the nursing care center, in accordance with federal and state laws and regulations. Per review of the policy section 5 revealed it outlined refill requests for scheduled drugs in the classification of CIII-CV or a partial fill quantity (CII's) drugs. Continued review of the policy revealed a refill request was to be requested from the pharmacy a minimum of three days in advance of need to assure an adequate supply was on hand. Review revealed if only one refill remained or only a partial fill quantity remained, the pharmacy was to simultaneously dispense the remaining fill, and, if necessary, proactively seek out a new, complete prescription from the provider for future use. Further review of the policy revealed the facility might be asked to contact the prescriber for a new prescription upon request for a medication with no remaining fills available. Review of the facility policy titled, Medication Ordering and Receiving from Pharmacy Provider - Emergency Pharmacy Service and Emergency Kits (E-Kits) dated 01/2023, revealed emergency pharmaceutical service was available on a 24-hour basis. Per policy review, emergency needs for medication were met by using the nursing care center's approved emergency medication supply or by special order from the provider pharmacy. Continued review revealed emergency medications were provided by the pharmacy in compliance with applicable state and federal regulations. Further policy review revealed the procedure for obtaining medications from the emergency kits. Observation of the C hall medication cart on 10/04/2024 at 4:17 PM, revealed the presence of an E-kit on the medication cart locked in the narcotic drawer which included Hydrocodone 10 mg/Acetaminophen 325 mg tablets. 1. Review of the medical record for R20 revealed the facility admitted the resident on 03/08/2023, with diagnoses to include osteomyelitis of vertebra, quadriplegia, chronic pain syndrome, and pressure ulcer of the sacral region, stage IV. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R20 to have a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating the resident was cognitively intact. Continued review of the MDS, section J, revealed the facility assessed R20 to receive routine pain medication and not to require as needed (PRN) medication, with the resident denying pain at that the time of assessment. Review of the Medication Administration Record (MAR) dated 09/2024, revealed R20 had orders for Hydrocodone 10 mg/Acetaminophen 325 mg one tablet by mouth every four (4) hours routinely and no PRN medication for pain. Review of the MAR Information Key legend revealed parentheses around a person's name administering medications indicated a medication was not administered or not charted, see Reasons/Comments. Continued review of R20's 09/2024 MAR revealed starting on 09/15/2024 at 6:00 AM through 09/16/2024 at 2:00 PM, there was no documented evidence the resident's prescribed scheduled doses of Hydrocodone 10 mg/Acetaminophen 325 mg pain were administered every four hours as ordered, for a total of 28 consecutive hours. Further review of the MAR, of the section for noting reasons/comments, revealed the medication (Hydrocodone 10 mg/Acetaminophen 325 mg, was not administered and had not been available for administration. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with R20 on 10/01/2024 at 3:50 PM, the resident stated he had a splint that was worn on the left upper extremity that helped with pain. He stated he had pain in his butt that was constant and he took pain medication for it. The resident stated he had not talked to anyone about pain management and the pain was worse at night. In a follow up interview with R20 on 10/04/2024 at 9:06 AM, the resident rated his pain at an eight out of 10, on a scale of one to 10, with 10 being the worst pain. R20 further stated he talked with staff about his pain. 2. Review of the medical record for R30 revealed the facility admitted the resident on 12/16/2021, with diagnoses to include Type 2 Diabetes Mellitus with diabetic neuropathy (associated nerve pain), and pain, unspecified. Review of the Quarterly MDS assessment dated [DATE] for R30, revealed the facility assessed the resident to have a BIMS score of nine out of 15, indicating moderate cognitive impairment. Continued review of the MDS, section J, revealed the facility assessed R30 to have received routine pain medication and did not require a PRN pain medication and the resident denied pain at the time of assessment. Review of the active Physician's order printed 10/02/2024 revealed an order dated 07/15/2024, for Tramadol 25 mg revealed R30 was prescribed Tramadol 25 mg to be administered by mouth three times per day with a start date of 07/15/2024. Further review of the Physician's orders printed on 10/02/2024, revealed R30 did not have additional PRN medication ordered for pain management. Review of R30's MAR dated 08/2024, revealed the Physician's order for Tramadol 25 mg. Review of the 08/2024, MAR revealed there was no documented evidence R30's Tramadol 25 mg scheduled doses were administered as ordered on 08/14/2024 at 9:31 PM; or 08/15/2024 at 4:51 PM. Continued MAR review revealed it was noted R30's Tramadol had an asterisk, which per the MAR Information Key legend was other. Per MAR review of the reasons/comments, for the asterisk, documentation revealed it was noted on 08/14/2024 at 4:51 PM, Not Administered: Drug/Item Unavailable and on 08/14/2024 at 9:31 PM, Not Administered: Drug/Item Unavailable Comment: waiting on pharmacy. MAR review revealed no documented evidence R30's Tramadol pain medication was administered: on 08/16/2024 at 12:09 PM and 2:41 PM as there were parentheses around staff's initials indicating the medication was not administered. Per continued review of the 08/16/2024 MAR documentation, under reasons/comments it was noted, Not Administered: Drug/Item Unavailable. Review of the 09/2024 MAR for R30 revealed on 09/17/2024, 12:00 PM to 3:00 PM timeframe, parentheses were around the staff's initials, and in the reasons/comments it was noted as, Not Administered: Drug/Item Unavailable. Review of the 09/18/2024 MAR, revealed for the timeframe of 12:00 AM to 9:00 PM, R30's Tramadol dose had parentheses and an asterisk with the corresponding note documented at 12:51 PM that stated Not Administered: Drug/Item Unavailable. Comment: spoke with pharmacy medication being sent STAT. Further review of the 09/18/2024 MAR documentation revealed a corresponding administration note time stamped at 9:27 PM, that stated, Not Administered: Other Comment: waiting on pharmacy. In an interview with R30 on 10/01/2024 at 10:23 AM, the resident stated he received pain medication; however, continued to have some pain related to his diabetes. (continued on next page)

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

3. Review of the medical record for R59 revealed the facility admitted the resident on 07/09/2021, with diagnoses to include pain, unspecified; cerebral infarction; and cognitive communication deficit.

Review of the Quarterly MDS assessment dated [DATE], revealed the facility assessed R59 to have a BIMS score of three out of 15, indicating the resident had severe cognitive impairment. Continued review of the MDS, section J, revealed the facility assessed R59 to have received routine pain medication and did not require a PRN pain medication and a pain assessment conducted revealed the resident had no pain at the time of assessment.

Review of the current Physician's orders for R59 revealed an order for Tramadol 25 mg twice a day.

Review of R59's MAR, for the month of 08/2024, revealed no documented evidence R59's Tramadol pain medication was administered as ordered on 08/07/2024 at 9:53 PM. Review of R59's MAR for 09/2024, revealed on 09/27/2024 at 8:44 AM, no documented evidence the resident's Tramadol 25 mg was administered as ordered, due to not being available. Further review of the 09/2024 MAR revealed documentation noting (the facility was) waiting for pharmacy documented in the reasons/comments area for 09/27/2024.

Observation of the resident on 10/02/2024 at 9:25 AM, revealed R59 sitting up in a wheelchair with no visual signs of pain displayed, such as grimacing.

In an interview with R59's Power of Attorney (POA) on 10/02/2024 at 1:43 PM, the POA stated she had no complaints with the care or treatment of the resident at the facility.

In an interview on 10/04/2024 at 4:17 PM, with Licensed Practical Nurse (LPN) 7, she stated she was responsible for administering residents' medications for the residents she was assigned to. She stated she hits the resupply button to let the pharmacy know and Physician know if a resident's medication was needed. LPN 7 stated she knew how important it was for residents to receive their pain medication to manage their pain. She said if a medication was not available on the medication cart and was due to be administered, she notified the charge nurse to assist with getting the medication. LPN 7 stated she was aware of the Emergency Drug Kit (EDK) and that some narcotics were available. She stated she was also aware of the process for how to remove medication from the EDK. The LPN further stated if the medication was not available in the EDK, she contacted the Physician for a substitute and possibly administer another analgesic that was ordered.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/04/2024 4:01 PM, with Unit Manager (UM) 2, she stated the nurses assigned to the medication cart managed the stock of medication and should notice if the level was low and notify the UM or Advanced Practice Registered Nurse (APRN) per the binder if a prescription was needed. She stated if the medication was needed, staff could call the (medical) provider and ask for the prescription and get the medication statted over from the pharmacy. UM 2 stated the pharmacy had a four (4) hour window to deliver the requested statted medication. She said if a medication was on order and it was going to be more than four hours from the usual medication delivery time and a dose was due, staff could call the (medical) provider and get a one-time dose order. The UM stated staff could then get the medication from the EDK. Per UM 2 in interview, she expected staff to take the steps to get the medication as ordered and thought staff knew the process for obtaining medication and prescriptions. She stated the facility did not document pain levels except on PRN medication and progress note charting was done only by exception (notes charted only for deviations in a resident's norm or baseline). UM 2 further stated she expected a nurse to assess a resident for pain and address pain as indicated. In an interview with the Staff Development Coordinator (SDC) on 10/04/2024 at 11:21 AM, the SDC stated staff were educated regarding the use of the EDK to obtain medications and on pain management. In an interview with the Assistant Director of Nursing (ADON) on 10/04/2024 at 3:55 PM, she stated the nurse on the hall was responsible for monitoring medication levels and if needed, checking for refills and calling the pharmacy or Physician as indicated. The ADON stated the delivery of medications depended on when the order was placed and she said the facility had an EDK, but she would have to find out what medications were stored and available in the EDK. She further stated she expected nurses to take the steps needed to obtain residents' medications and staff had been educated regarding obtaining medications from the EDK. In an interview with the Director of Nursing (DON) on 10/04/2024 at 3:59 PM, he stated it was his expectation that routine medications were administered as ordered. He stated he expected the nurse assigned to administer medications to call the Physician if a prescription was needed and then call the pharmacy. The DON stated his expectation was for staff to use the reorder process which included faxing the pharmacy requesting a refill. He said if a medication was needed, it might be available in the EDK and he expected nurses to check the EDK for the medication. The DON stated he was not aware of any audits having been done regarding narcotic drug levels for refills. He further stated if staff had a problem or did not know how to utilize the EDK, a nurse was always on call after hours. The DON additionally stated other nurses including the UM's, ADON, and DON were in the facility to assist. In an interview with the Administrator on 10/04/2024 04:40 PM, she stated the nurse and medication technician (med tech) were responsible for monitoring medication stock levels. She stated she expected staff to take the steps needed to get any medication required, including obtaining the medication from the EDK. The Administrator also stated if the needed medication was a pain medication, she expected staff to assess the resident's pain level and notify the Physician. She said the facility had on-call nurses and staff had access to those nurses' phone numbers if there were any questions or concerns. The Administrator stated she was not aware of any problems with the pharmacy sending medications, but said, at times a prior authorization might be needed before the pharmacy would send the medication(s). She further stated the DON or a designee would complete the necessary prior authorizations.