

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/30/2024
NAME OF PROVIDER OR SUPPLIER  Owenton Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  905 Hwy 127 North Owenton, KY 40359	

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49267</b></p> <p>Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 of 3 sampled residents, (Resident (R)3).</p> <p>R3 began vaginal treatment with Monistat 7 (antifungal vaginal cream) for a yeast infection on 11/29/2024. R3 had complaints of pain and discomfort. The facility transferred R3 to a hospital on 12/06/2024. At the hospital, R3 had a computed tomography (CT) scan performed which revealed the resident had a foreign object present in her vaginal canal, which was later determined to be a Monistat vaginal cream applicator. R3 stated the whole situation was unnecessary, caused her unnecessary pain and was humiliating.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Provision of Quality Care, revised 02/01/2024, revealed based on comprehensive assessments, the facility was to ensure residents received treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the resident's choices. Further review revealed each resident was to be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being.</p> <p>Review of the facility's policy titled, Medication Administration, revised 02/20/2024, revealed medications were administered by licensed nurses, or other staff who were legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice. Additional review revealed medications were to be administered as ordered in accordance with the manufacturer's specifications.</p> <p>Review of the facility's policy titled, Specific Medication Administration Procedures, dated 05/2022, revealed vaginal medications were to be administered in a safe, accurate, and effective manner.</p> <p>Review of the Monistat 7 package insert revealed the directions for use included removal of the applicator after insertion of the cream medication. Further review revealed the applicator was to be washed after each use.</p> <p>Review of the Face Sheet for R3 revealed the facility admitted the resident on 11/19/2023. R3's diagnoses included muscle weakness, polyneuropathy, and urinary tract infection (UTI).</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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 11/23/2024, revealed the facility assessed R3 with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Further MDS review revealed the facility assessed R3 for bilateral lower extremities (BLE) impairment, dependent for toileting hygiene, and urinary incontinence.</p> <p>Review of R3's progress note, dated 11/27/2024, revealed the resident complained of inner vaginal pain/itching, inner labia pain/itching, and stated she had green discharge coming from her vagina. Per review, an assessment was performed by nursing staff and revealed R3 had redness to the vaginal area with no bleeding, and her urine was documented as clear yellow. Continued review revealed the physician and Unit Manager (UM) were notified, and orders were received for Diflucan (medication used to treat fungal and yeast infections) for treatment of a yeast infection. Further review revealed the Diflucan was discontinued on that date due to interactions with R3's other medications.</p> <p>Review of R3's progress note, dated 11/28/2024, revealed the physician ordered Monistat 7 with a vaginal applicator for treatment of a yeast infection.</p> <p>Review of R3's physician's orders revealed an order dated 11/29/2024, for Monistat 7 cream 2%: one applicator vaginally at bedtime for acute candidiasis of vulva and vagina.</p> <p>Review of the progress notes dated 11/29/2024, revealed the treatment with Monistat 7 had been initiated at bedtime per the physician's orders.</p> <p>Review of R3's, Medication Administration Record (MAR), dated 11/29/2024 - 12/04/2024, revealed the Monistat 7 was administered to R3 daily at bedtime 11/29/2024 - 12/02/2024. Further review revealed R3 refused administration on 12/03/2024 and 12/04/2024.</p> <p>Review of R3's progress notes dated 12/01/2024 revealed Monistat 7 was administered with slight discomfort noted during administration. Review of R3's progress note dated 12/02/2024 at 2:58 AM, revealed no adverse effects noted from Monistat (administration) and no complaints from resident.</p> <p>Review of R3's progress note dated 12/03/2024, revealed the resident complained of vaginal pain and discomfort and was assessed by nursing with findings of no bleeding, some edema to the labia, and a whitish discharge. Continued review revealed R3 refused administration of the Monistat 7 and continued to complain of vaginal pain. Per review, the on-call physician was notified, and orders were received for a urinalysis and blood work the following morning. Further review revealed R3's routine oxycodone (narcotic pain medication) was administered for pain with documented effectiveness.</p> <p>Review of R3's urinalysis and bloodwork collected on 12/04/2024 revealed positive findings for a UTI.</p> <p>Review of R3's progress note dated 12/04/2024, revealed the resident refused administration of the Monistat 7 and continued to complain of pain and told staff she felt injured. Per review, staff assessed R3 and observed redness and white patches to her vaginal area, but no sign of injury. Continued review revealed Tylenol was administered to the resident and was documented as effective.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R3's progress note dated 12/05/2024, revealed R3 started the antibiotic for a urinary tract infection (UTI) and the Monistat 7 had been discontinued. Further review revealed no additional documented complaints of pain or discomfort on 12/05/2024.</p> <p>Review of R3's progress notes dated 12/06/2024, revealed at 10:30 AM, R3 requested to speak to the Director of Nursing (DON) and asked to be sent to the emergency room (ER) for evaluation because of her vaginal pain and discomfort. Per review, R3 reported she had vaginal pain since the evening of 12/02/2024, after the nurse administered the vaginal medication. Further review revealed R3's husband took her to the hospital.</p> <p>Review of R3's progress note dated 12/07/2024, revealed the resident returned to the facility accompanied by her brother after evaluation at a hospital. Per review, R3 told staff she felt much better after the tube was removed from her at the ER.</p> <p>Review of the ER records revealed R3 presented with complaints of pain to the vaginal area and a three-day history of UTI symptoms. Per review, a computed tomography (CT) scan was performed and showed an indeterminate 12 centimeter (cm) cylindrical foreign body about the vaginal canal. Further review revealed when the foreign body was removed it was determined to be a Monistat applicator.</p> <p>Review of the facility's investigation revealed the facility was unable to definitively determine the staff member who inserted R3's (Monistat) medication. Continued review revealed immediate education for proper administration of Monistat 7 was provided to all nursing staff on 12/07/2024. Per review, the facility also reviewed all active medications in the facility on 12/07/2024, with no other residents identified who required vaginally administered medication. Additionally, review revealed the Nurse Practitioner (NP) and Medical Director were notified on 12/07/2024.</p> <p>In interview with the contract Pharmacist 1 on 12/24/2024 at 8:58 AM, she stated Monistat 7 was administered vaginally via a plunger type applicator and the applicator was then removed. She stated the directions for Monistat 7 medication for R3 were sent with the medication to the facility. Pharmacist 1 stated, in her opinion, the vaginal applicator was a foreign body and was not intended to remain in the resident. She further stated the applicator was not sterile and posed a risk for infection as well as the potential for pain if left in the vaginal canal.</p> <p>During interview with contract Pharmacist 2 on 12/27/2024 at 12:26 PM, he stated the Monistat 7 sent to the facility for R3 had been for a seven day supply. He stated the Monistat included one reusable applicator that was a plunger type system.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In interview with R3 on 12/26/2024 at 9:52 AM, she stated initially both she and nursing staff thought she had a yeast infection, so the vaginal medication was started on 11/29/2024 and given at bedtime. R3 stated she experienced no problems until the evening of 12/02/2024, when Registered Nurse (RN) 1 inserted the medication. She stated she felt like RN 1 had been a little anxious and had heard her say she hoped she had gotten it (the Monistat 7) in the right place as she walked out of the room. R3 said afterwards she had vaginal pain and reported the pain to nursing staff. She stated the pain continued and a urine sample was taken that came back positive for an infection. R3 explained her pain had been attributed to the UTI and she was placed on an antibiotic on 12/05/2024. She stated on 12/06/2026, she asked the DON for transport to the ER because she still had pain and discomfort. R3 stated at the hospital a CT scan was performed which showed something inside her and when the doctor removed the object, it was a plastic applicator. R3 stated when she returned to the facility, staff apologized, and the Administrator informed her all nurses had been retrained on administration of medications with a vaginal applicator.</p> <p>In additional interview with R3 on 12/27/2024 at 1:37 PM, she stated the whole situation was unnecessary, caused her unnecessary pain and had been humiliating to go through.</p> <p>In interview with family member (FM) 2 on 12/26/2024 at 10:53 AM, he stated he had been at the ER with R3. He stated he had the actual item that was removed from R3 in his possession.</p> <p>In interview with Certified Nursing Assistant (CNA) 1 on 12/26/2024 at 11:46 AM, she stated she was familiar with R3 and had taken care of her the day prior to her ER visit. She stated R3 complained of pain to her vaginal area that day when she tried to help her get up out of bed, and she left the resident in bed and notified nursing immediately.</p> <p>In interview with Licensed Practical Nurse (LPN) 1 on 12/26/2024 at 12:31 PM, she stated Monistat 7 was not a common medication used at the facility. She stated if she was unfamiliar with a particular medication, she asked her Unit Manager (UM) or another nurse for help. LPN 1 stated after R3 returned from the hospital, nursing was given an in-service on administration of vaginal medications that included confirmation that the applicator or device was intact and not left in the resident.</p> <p>In interview with the Administrator on 12/26/2024 at 3:02 PM, she stated no other residents were currently ordered Monistat, and that it was not a commonly administered medication at the facility. She stated an investigation was conducted after the hospital notified them of finding the applicator in R3.</p> <p>In interview with the UM on 12/26/2024 at 3:06 PM, she stated on 12/04/2024, R3 complained of vaginal pain, and she assessed the resident for signs of injury, but none were noted. She stated R3 had not complained of constant pain; however, seemed to have more discomfort when she was moved or transferred. The UM further stated R3's urinalysis had returned positive for UTI and an antibiotic was ordered, so the resident's pain had been attributed to the UTI.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In interview with LPN 2 on 12/26/2024 at 3:22 PM, she stated she had not administered medication vaginally with an applicator since she had worked at the facility. She stated she had taken care of R3 on 11/27/2024, when the resident complained of pain and itching around her vaginal area. LPN 2 reported she notified the physician and received orders for Diflucan. She stated she only worked on an as needed (PRN) basis; however, the DON contacted her two or three weeks ago regarding getting education related to administration of Monistat and any other vaginally inserted medications. LPN 2 stated a vaginal applicator was always removed after administration of the medication.</p> <p>In interview with LPN 3 on 12/26/2024 at 3:30 PM, she stated she cared for R3 when she returned from the hospital and the resident had no complaints of pain at that time. LPN 3 stated medications with applicators were rarely used at the facility; however, if she was unsure or unfamiliar with a medication, she asked her supervisor or co-worker before administering the medication. She stated the DON provided an in-service about two weeks ago that addressed proper administration of Monistat and other vaginally inserted medications. LPN 3 stated some of the applicators were pre-filled and others were filled by nursing prior to administration. She further stated, regardless of how medication was supplied, once administered the applicator was removed from the resident.</p> <p>In interview with RN 2 on 12/26/2024 at 3:46 PM, she stated she cared for R3 on 12/03/2024 and the resident had been in pain; however, the pain seemed to be with movement and not constant. RN 2 stated after the hospital report was received, the DON provided an in-service to all the nurses on how to administer Monistat.</p> <p>In interview on 12/26/2024 at 5:23 PM with RN 4, she stated she worked the evening of 12/03/2024; however, she had not administered the Monistat to R3. RN 4 stated R3 complained of pain to her vaginal and lower abdominal areas and refused the medication. RN 4 stated she notified the on-call physician and orders were received for a urinalysis and bloodwork for the following morning. She stated R3 received scheduled pain medication, and it had been administered that evening, and the resident slept all night with no complaints of pain. RN 4 stated she had not been assigned to care for R3 anymore until after the resident returned from the hospital. She stated the DON had since provided an in-service on the proper administration of vaginal medications with an applicator.</p> <p>In interview with CNA 3 on 12/26/2024 at 5:36 PM, she stated on 12/03/2024, R3 had complained of vaginal pain while she was in the resident's room. CNA 3 stated she notified nursing right away. She stated she had not been assigned to R3's care anymore until the resident returned from the hospital.</p> <p>In interview with CNA 4 on 12/26/2024 at 5:47 PM, she stated she had been present in R3's room on 12/02/2024, when RN 1 administered the Monistat 7 to the resident. She stated R3 expressed discomfort after RN 1 administered the medication; however, she was not able to say for certain if the Monistat applicator was removed or not.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In interview with RN 1 on 12/26/2024 at 6:23 PM, she stated she had given R3 her evening medications around 9:00 PM on 12/02/2024, and she administered the Monistat 7 at that time. RN 1 stated she instructed R3 to take a deep breath when the applicator was inserted to minimize discomfort. She stated after the cream was injected, she removed the applicator. RN 1 stated R3 complained of discomfort and pain at the time of administration of the Monistat 7. She stated however, she was not surprised as the resident had complaints of pain already and the actual yeast infection with the dryness was painful. RN 1 stated she was made aware R3 had gone to the hospital and an applicator was found inside of her. She stated she tried to apologize to R3 that the incident happened. RN 1 stated shortly after that incident, nursing received an in-service by the DON on how to properly insert medication with a vaginal applicator. She stated she had never administered Monistat 7 prior to R3's, and she asked a colleague about it before she gave it to the resident.</p> <p>In interview on 12/27/2024 at 9:52 AM with the DON, she stated R3 initially complained of vaginal pain in late November which appeared to be related to a yeast infection. She stated the physician was contacted and Diflucan was ordered, but the Diflucan interacted with some of R3's other medications, so it was discontinued and replaced with Monistat 7. The DON stated the medication was given the evening of 12/02/2024 and R3 complained of pain to her vaginal and abdominal areas on 12/03/2024. She explained the UM assessed R3 and reported redness and inflammation to the resident's vaginal area; however, that was expected due to her yeast infection. The DON stated there were no reported signs of injury, so nursing continued to monitor the resident's pain. She stated R3's pain continued and the nurse on duty the night of 12/03/2024 contacted the on-call doctor and received orders for bloodwork and urinalysis for 12/04/2024. The DON reported R3's urinalysis returned positive and the resident was started on an antibiotic on 12/05/2024. She stated R3 already received scheduled oxycodone for pain and had PRN Tylenol ordered.</p> <p>In continued interview on 12/27/2024 at 9:52 AM, the DON stated R3 requested to see her on 12/06/2024 and asked to go to the hospital for evaluation of her pain. She stated she was notified on 12/07/2024, there had been a foreign object found in R3's vaginal canal after the hospital report was received. The DON stated she went to the facility immediately and developed an education plan for nursing staff. She stated all the nurses had been inserviced on the proper way to administer medication with a vaginal applicator. The DON stated Monistat was not a common medication given at the facility; however, all nurses had now received education on the topic. The DON stated it was her expectation that nursing staff referred to the package insert for any over the counter (OTC) medication that were unfamiliar to them. She stated they could also contact her anytime day or night for questions or concerns.</p> <p>In an additional interview on 12/30/2024 at 1:42 PM with the DON, she stated the facility followed their policies and procedures and referenced [NAME] for professional standards of care, which was located at the nurse's station.</p> <p>In additional interview with the Administrator on 12/27/2024 at 9:17 AM, she stated obviously they acknowledged a foreign body had been left in R3; however, after their investigation they were not able to definitively determine which staff member was responsible for doing that. The Administrator stated all the nurses reported they removed the applicator after administration of the medication to R3. She stated as soon as the hospital report was received on 12/07/2024, the DON immediately began education with the nurses on proper administration of vaginal applicator medications.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	In interview with the Administrator on 12/30/2024 at 1:45 PM, she stated it was her expectation all staff followed professional standards of care. She stated each resident was unique with different needs, and it was her expectation staff followed physician's orders and the resident's plan of care (POC) for the safety and well-being of the residents.