

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Kingsbrook Lifecare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 State Route 5 Ashland, KY 41102	

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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46710</p> <p>Based on observation, interview, record review, review of the website www.drugs.com, and review of the facility's policy, the facility failed to ensure drugs and biologicals were stored according to professional standards for 1 of 3 medication room refrigerators and 3 of 4 medication carts.</p> <p>Proper temperature control for the medication room refrigerator on the Forest Heights Unit was not maintained, and staff failed to notify the Maintenance Director of the equipment failure.</p> <p>Staff failed to write the expiration date on three insulin pens (two in the medication cart on the Forest Heights Unit and one in the medication cart on the Garden View Unit) based on the date they were removed from refrigeration.</p> <p>Staff failed to discard two tramadol pills in the medication cart on the Shoreline Unit after the packaging was damaged .</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Medication Storage in the Facility, not dated, revealed medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.</p> <p>Review of the website www.drugs.com revealed, for both the unopened insulin glargine pen and the unopened insulin aspart pen, when stored at room temperature (below 86 degrees Fahrenheit (F)), they must be used within 28 days.</p> <p>1. Observation on 06/26/2024 at 8:41 AM of the medication cart on the Shoreline Unit revealed two tramadol (an opioid pain relief medication) pills in a blister pack that had been damaged and taped over.</p> <p>In an immediate interview, Registered Nurse (RN) 4 stated she did not know how the packaging had been damaged, but whoever had placed the tape over the packaging should have instead wasted the pills with another nurse as witness.</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 06/28/2024 at 8:40 AM, the Resident Care Manager (RCM) for the Shoreline Unit stated her expectation for a nurse who accidentally damaged a blister package for a controlled substance such as tramadol was for the nurse to waste the pills in the damaged container with another nurse. She further stated this was important because the pills could be contaminated and could create the risk of narcotics diversion.</p> <p>In an interview on 06/28/2024 at 2:05 PM, the Director of Nursing (DON) stated the tramadol pills observed in a damaged blister pack should have been wasted with another nurse.</p> <p>In an interview on 06/28/2024 at 2:34 PM, the Administrator stated staff should have notified the RCM when the packaging for a narcotic was damaged. She further stated her expectation was for two nurses to waste the medications in the damaged packaging and follow up with the pharmacy for any further instructions.</p> <p>2. Observation on 06/26/2024 at 9:29 AM of the medication cart on the Garden View B Unit with Licensed Practical Nurse (LPN) 12 revealed an unopened glargine insulin pen (lowered blood sugar, given for diabetes) not dated.</p> <p>During interview with LPN 12 at the time of the observation she stated the insulin might not be effective and could cause the resident harm if out of date. She stated she would return the medication to the pharmacy and request a new medication.</p> <p>3. Observation on 06/26/2024 at 10:10 AM revealed the medication room refrigerator temperature on the Forest Heights Unit was 33 degrees F. The refrigerator contained 23 unopened insulin pens, five vials of insulin, 113 suppositories, one container of skin barrier cream, two vials of lorazepam (an anti-anxiety agent) and 3 bags of intravenous ceftriaxone (an antibiotic).</p> <p>During interview with LPN4 RCM, at the time of the observation, she stated she did not know the correct temperature of the refrigerator.</p> <p>Review of the refrigerator's current Audit Sheet, dated 06/17/2024 to 06/26/2024 with LPN4 RCM, revealed the temperature was to be 36 to 45 degrees F. The sheet stated, If the temperature too high or too low, adjust thermostat and put in work order to maintenance department. The recorded temperature on 06/23/2024 was 30 degrees F; the recorded temperatures on 06/18/2024, 06/19/2024, 06/21/2024 and 06/25/2024 were 32 degrees F; and the recorded temperatures on 06/26/2024 and 06/27/2024 were 34 degrees F. The only documentation that maintenance was notified was on 06/27/2024.</p> <p>Review of past Audit Sheet, dated 06/01/2024 to 06/16/2024, revealed the temperature on 06/06/2024 was 28 degrees F; the temperatures on 06/03/2024, 06/05/2024, 06/08/2024, 06/09/2024, 06/13/2024, and 06/16/2024 were 30 degrees F; the temperatures on 06/02/2024, 06/04/2024, 06/07/2024, 06/11/2024, 06/12/2024, 06/14/2024, and 06/15/2024 were 32 degrees F; and the temperature on 06/01/2024 was 34 degrees F.</p> <p>During interview with the Maintenance Supervisor on 06/28/2024 at 8:22 AM, he stated he did not receive notifications that the refrigerator temperatures on the Forest Heights Unit were out of range from 06/01/2024 to 06/27/2024.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview with Pharmacist 2 on 06/28/2024 at 10:43 AM, he stated the facility called him on 06/27/2024 and reviewed each medication that was in the refrigerator on the Forest Heights Unit. He stated none of the medications were harmed by the colder temperatures.</p> <p>4. Observation on 06/27/2024 at 9:52 AM of the medication cart on the Forest Heights B Hall with LPN 16 revealed two unopened insulin pens, glargine and aspart, which were not dated.</p> <p>During interview with LPN 16 at the time of the observation, she stated the insulins would be returned to the pharmacy. She stated they might not be effective if they were out of date, and they could cause harm to the residents.</p> <p>During interview with the DON on 06/28/2024 at 8:50 AM, she stated she was not made aware of the temperature of the refrigerator being out of range. She stated she also was not notified that the insulin pens were not dated. She stated staff should have notified the Maintenance Director of the temperatures being out of range. She also stated staff should date insulin pens when they were taken out of the refrigerator.</p> <p>During interview with the Administrator on 06/28/2024 at 2:34 PM, the Administrator stated her expectation for the medication refrigerator temperatures was for staff to check the thermometers in the refrigerators daily and notify maintenance if the temperature was found to be out of range. She further stated she did not know what the practice was regarding labeling an insulin pen that was removed from the refrigerator for use, but the DON would be able to speak to that process.</p> <p>44000</p>