STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235519	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King Nursing & Rehabilitation Community	2280 Tower Hill Rd Houghton Lake, MI 48629

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** 49302 This deficiency pertains to MI00148756. Based on interview and record review, the facility failed to prevent misappropriation of narcotic medication for one Resident (#1) of five residents reviewed for misappropriation. Findings include: Resident #1 (R1) Review of R1's electronic medical record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including malignant cancer of the colon and rectum. Review of R1's most recent Minimum Data Set (MDS) assessment, dated 12/12/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition. R1 signed with hospice services on 8/6/24. Review of R1's EMR physician orders revealed the following pharmacy order, initiated 9/11/24: Hydrocodone acetaminophen (opiate [narcotic] medication mixed with Tylenol) - Schedule II tablet; 10-325 mg [milligram]; 1 tab; oral, Four Times A Day. Review of R1's Medication Administration Record [MAR] revealed they were scheduled to receive a dose of hydrocodone at 2:00 AM, 8:00 AM, 2:00 PM, and 8:00 PM. Review of the FRI read, in part: On 11/27/2024 at approximately 5:58 a.m., DON [Director of Nursing] received a phone call from [Registered Nurse (RN) A] .reporting that the mandatory med [medication] count .was off by one . When this was discovered, the night nurse [Licensed Practical Nurse (LPN) D] wrote on the med sheet, in front of [RN A] and stated she gave [R1] his Norco [Hydrocodone-acetaminophen brand name] at 5:00 am .she stated she forgot to write it down. DON told [RN A] to make sure [LPN D] stayed until she got to facility to do med count with them. [RN A] reported that [LPN D] would not stay and that she had left . we confirmed with the resident . that he did not receive a 5:00 am Norco, but did get his 2:00 am [dose]. This is a scheduled medication to be given every 6 hours, so was not due to receive again until 8:00 am . (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 10:59 AM, an interview was conducted with RN A who verified she was the oncoming day shift nurse on 11/27/24. RN A stated she and LPN D were reconciling the Controlled Substance Proof of Use form and medication cart around 6:00 AM on 11/27/24 when she noticed R1 had only two remaining hydrocodone pills in the medication cart, yet the Controlled Substance Proof of Use form indicated R1 should have had three remaining pills. RN A stated after the discrepancy was noticed, LPN D stated she forgot to record an administration on the Controlled Substance Proof of Use form. RN A stated she witnessed LPN D retroactively timestamp the form to 5:02 AM. RN A stated she immediately notified the DON of the discrepancy and expressed concerns R1 could have been overmedicated as the medication was not scheduled to be given again until 8:00 AM. On 12/18/24 at 11:13 AM, an interview was conducted with the DON regarding the medication discrepancy on the morning of 11/27/24. The DON stated she received a call from RN A who reported LPN D altered the Controlled Substance Proof of Use form to match the medication cart. The DON stated she immediately called LPN D who had already left the facility and asked her to return so an official investigation could be conducted. The DON stated LPN D declined to come back to the facility claiming she was, too tired. The DON stated she interviewed R1 who was adamant he never received any medication at 5:00 AM, refuting LPN D's claims of administering this medication to R1 at that time. The DON explained the typical administration process of a narcotic is to record the use on the Controlled Substance Proof of Use form as soon as the medication is pulled from the cart. The DON continued after administration, it is then documented in the respective resident's electronic MAR. On 12/18/24 at 10:51 AM, an interview was conducted with R1 regarding medication administration between 11/26/24 - 11/27/24. R1 verified he received a dose of hydrocodone on 11/26/24 at 8:00 PM and on 11/27/24 at 2:00 AM. R1 declined receiving a dose of a hydrocodone on 11/27/24 at 5:00 AM and stated, I'm only scheduled to receive it every 6 hours. Review of an Incident Report from local law enforcement, dated 12/18/24, read, in part: .officer advised [LPN D] that it appeared she stole the pill from [R1] and hoped that no one noticed and tried to cover up what she did after she was confronted . While speaking to [LPN D], Officer did not believe that [LPN D] was telling the truth . On 12/18/24 at 1:46 PM, an interview was conducted with the Nursing Home Administrator (NHA) who verified the facility substantiated the misappropriation of R1's prescription medication and subsequently terminated LPN D. Review of the facility policy titled, Abuse Prevention Program Policy & Procedure, reviewed 1/2024, read, in part: .[Facility Name] has prevention programs in which policies and procedures safeguard our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation . Review of the facility policy titled, Controlled Substances Standards of Practice, reviewed 1/2024, read, in part: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Nurses removing controlled substance from the narcotic storage require documentation on the Proof-of-Use Sheet the amount removed using a full last name signature. Nurse documentation of inventory balance on Proof-of Use sheet MUST be made as soon as the controlled substance is removed from the package/cart. Avoid waiting until the end of med pass or end of shift. Once the nurse completes the administration, then the nurse is to document on the MAR paper record or E-MAR electronic record .Note: If documentation is not provided on MAR or E-Mar, medication will be considered not given. MAR or E-Mar is record of administration NOT the proof-of-use sheet