

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265727	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Carmel Hills Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 810 East Walnut Independence, MO 64050	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>45403</p> <p>Based on interview and record review, the facility failed to ensure one sampled resident's (Resident #1) narcotics were secure when 47 pills of Oxycodone (a narcotic pain medication) were noted as missing on 9/11/24 out of three sampled residents. The facility census was 159 residents.</p> <p>On 10/16/24 the administrator was notified of the past noncompliance which occurred on 9/11/24. On 9/11/24 the Administrator was notified of missing Oxycodone from the licensed nursing cart. The staff was educated on narcotic count and handling, and changed the policy for removing empty cards from all narcotic lock boxes on 9/11/24. The deficiency was found to be corrected on 9/11/24.</p> <p>Review of the facility's Storage of Controlled Substances Policy dated 8/2020 showed:</p> <ul style="list-style-type: none"> -Medications classified by the Drug Enforcement Agency (DEA) as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal, state, and other applicable laws and regulations. -The Director of Nursing (DON), in collaboration with the consultant pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. -Only authorized licensed nursing and pharmacy personnel have access to controlled substances. -Schedule II through V medications and other medications subject to abuse or diversion are stored in either a permanently affixed, double locked compartment separate from all other medications or in accordance with state regulations. -If a key system is used, the medication nurse on duty maintains possession of the key to controlled substance storage areas. -Back-up keys to all medication storage areas, including those for controlled substances, are kept the DON or designee. -A controlled substance accountability record is prepared by the pharmacy/facility for all Schedule II, III, IV, and V medications, including those in the emergency supply. <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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Unless otherwise indicated in a facility policy and/or as required by state regulations, the following will be performed:</p> <p>--At each shift change, or when keys are transferred, a physical inventory of all controlled substances is conducted by two licensed personnel and is documented.</p> <p>-Any discrepancy in controlled substance counts is reported to the DON immediately and/or in accordance with the facility policy.</p> <p>-The DON or designee investigates and makes every reasonable effort to reconcile all reported discrepancies.</p> <p>-The administrator, consultant pharmacist, and/or DON determine whether other actions are needed.</p> <p>-The medication regimen of residents using medications that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met.</p> <p>-Current controlled substance accountability records are kept in the Medication Administration Record (MAR) or a designated book.</p> <p>-Completed accountability records are submitted to the DON and kept on file for five years at the facility or in accordance with facility policy and state regulations.</p> <p>Review of the facility's Discrepancies, Loss and/or Diversion of Medications Policy dated 8/2020 showed:</p> <p>-All discrepancies, suspected loss, and/or diversion of medications, irrespective of drug type or class, are immediately investigated and report filed.</p> <p>-A thorough search is conducted in all drug storage areas, the resident's room, and any other locations where medications may have been used/placed during medication administration in an attempt to locate any missing container or medication supply.</p> <p>-Any corrective action that the DON deems appropriate should be taken.</p> <p>-Appropriate agencies required by state regulation will be notified.</p> <p>1. Review of the facility Delivery Manifest dated 9/7/24 showed:</p> <p>-Oxycodone/APAP (acetaminophen) 5-325 milligram (mg) tab, 20 tablets for Resident #1.</p> <p>-Signed by facility staff as received from pharmacy on 9/7/24 at 2:45 P.M.</p> <p>-The narcotic count sheet for this delivery could not be located.</p> <p>Review of the facility Delivery Manifest dated 9/8/24 showed:</p> <p>-Oxycodone/APAP 5-325 mg tab, 30 tablets for Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Signed by facility staff as received from pharmacy on 9/8/24 at 2:11 P.M.</p> <p>-The narcotic count sheet for this delivery could not be located.</p> <p>Review of Resident 1's Admission Record showed the resident was admitted with diagnoses including breast cancer and chronic pain.</p> <p>Review of the resident's Order Summary Report dated for September 2024 showed an order for Oxycodone-Acetaminophen Oral Tablet 5-325 mg, give two tablets by mouth every six hours as needed for pain.</p> <p>Review of the resident's Treatment Administration Record (TAR) dated for September 2024 showed an order for Oxycodone/APAP 5-325 administered on 9/11/24.</p> <p>During an interview on 10/1/24 at 10:30 A.M., the DON said:</p> <p>-He/She was notified by Licensed Practical Nurse (LPN) A immediately when the Oxycodone was noted to be missing.</p> <p>-He/She began an investigation immediately.</p> <p>-He/She determined the medication as well as the count/sign-out sheets for the medication was missing.</p> <p>-During a thorough search of the facility, the Assistant Director of Nursing (ADON) located the empty medication cards in the shred box at the nurse's station.</p> <p>During an interview on 10/10/24 at 2:29 P.M., LPN B said:</p> <p>-He/She counted the cards (against the shift to shift log) with LPN A on 9/11/24 and there were no cards missing at that time.</p> <p>-The facility contacted him/her on 9/11/24 in reference to the resident's Oxycodone missing.</p> <p>-He/She denied knowing what happened to the resident's Oxycodone.</p> <p>-At no time was more than one nurse able to access the narcotics lock box.</p> <p>-The only time there was two nurses able to access narcotics was during count at shift change.</p> <p>-He/She did resign his/her position at the facility.</p> <p>During an interview on 10/10/24 at 3:22 P.M., LPN A said:</p> <p>-He/She was aware of the Oxycodone received into the facility between 9/7/24 and 9/8/24.</p> <p>-When he/she counted with LPN B the count appeared to be correct and did not realize the count sheets for 9/7/24 and 9/8/24 were missing.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The sheets for the resident's Oxycodone were not in the count book when he/she and LPN B counted at shift change.</p> <p>-When the resident requested the medication for pain, he/she noticed the Oxycodone for the resident was not in the narcotic lock box.</p> <p>-He/She recalled the medication being in the narcotic box three to four days prior when he/she worked last.</p> <p>-He/She immediately reported the medication missing to the DON.</p> <p>During an interview on 10/10/24 at 4:12 P.M. the ADON said:</p> <p>-He/she located the empty cards of Oxycodone in the shred box at the nurse's station.</p> <p>-He/She was not able to locate the count sheets sent from pharmacy for the Oxycodone.</p> <p>-He/She was unable to locate the shift to shift log.</p> <p>-There was a set of master keys to all narcotics lock boxes secured in the DON office, only accessible by the DON.</p> <p>-LPN B refused to give a statement in reference to the missing medication and resigned instead.</p> <p>During an interview on 10/16/24 at 2:09 P.M. LPN C said:</p> <p>-He/She last counted the resident's Oxycodone with LPN B during shift change on 9/10/24 at approximately 7:00 P.M.</p> <p>-The narcotic sheets for the Oxycodone delivered on 9/7/24 and 9/8/24 were there at that time.</p> <p>-There was no way the resident could have taken all the Oxycodone from 9/10/24 through 9/11/24.</p> <p>-When he/she returned to work the facility had already discovered the Oxycodone missing.</p> <p>-There were prior complaints by residents stating they had not gotten narcotic pain medications on overnight shifts when LPN B worked, but the narcotics had been signed off by LPN B.</p> <p>-He/She reported his/her concerns to the ADON.</p> <p>-He/She did not know what happened to the resident's Oxycodone.</p> <p>During an interview on 10/16/24 at 2:18 P.M., the DON said:</p> <p>-He/She was responsible for monitoring the narcotic logs and adherence to policy.</p> <p>-The ADON was responsible for daily checks of the narcotic logs.</p> <p>(continued on next page)</p>		

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