STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265861	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carnegie Village Rehabilitation & Health Care Cent	105 Bernard Drive Belton, MO 64012

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** 42984 Based on observation, interview and record review, the facility failed to prevent the misappropriation of 30 tablets of 2 milligrams (mg) Hydrocodone (an opioid pain medication used to treat moderate to severe pain) belonging to one sampled resident (Resident #2) out of four sampled residents. The facility census was 66 residents. The Administrator was notified on 9/18/24 of Past Non-Compliance which occurred on 9/3/24. An all nursing staff in-service was completed on drug diversion and working under the influence of drugs/alcohol by 9/3/24. The resident's missing medications were replaced and paid for by the facility. The deficiency was corrected 9/3/24. Review of the facility's Controlled Substance Policy revised 5/23 showed: -Controlled substances were subject to special handling, storage, disposal and record-keeping requirements. -The facility would maintain compliance with these special provisions. -Such drugs were to be accessible only to authorized nursing and pharmacy personnel. -The Director of Nurses (DON) was responsible for the control of such drugs. -Drugs listed in Schedules II, III, and IV (drugs that are regulated by the Drug Enforcement Administration, categorized based on their medical use, potential for abuse and risk of dependence) were to be stored under double-lock conditions. -The key to the separately locked storage area was not the same key used to gain access to other drugs. -The medication nurse or Certified Medication Technician (CMT) where applicable on duty at the time would maintain possession of the key. The key must remain in possession of the licensed nurse or CMT where applicable that completed the count at all times during their shift. Should it be necessary to give the keys to another licensed nurse or CMT, a count would be done to verify the inventory. A count would be done again when the keys were returned to the original licensed nurse or CMT. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A physical inventory of the controlled substance medications would be made at the change of each nursing shift. Shift verification count sheets/packages should be made at the change of each shift. -The person performing the inventory would sign to verify that the inventory was done. All controlled substances were to be counted every shift. The count was to be performed by the on-coming licensed nurse or CMT and the off-going licensed nurse or CMT. The on-coming nurse or CMT would be responsible for looking at the medication to verify the amount of medication present at the time of the count. The off-going nurse or CMT would be responsible for viewing the Controlled Substance Proof of Use Record to verify the amount on the record at the time of the count. Both nurses or CMT would sign on the Narcotic Sign In & Out Sheet that the count was completed. -Any discrepancy in the inventory of a controlled substance was to be reported to the DON immediately. The DON was responsible for investigating and making a reasonable effort to reconcile all reported discrepancies. The discrepancy of a controlled substance was to be reported to the Administrator and the Regional Nurse immediately. If a discrepancy was not reconciled, the DON was to document the details on the audit record, including the possible shift or persons responsible for the discrepancy and the efforts made to reconcile it, 1. Review of Resident #2's Admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Sickle cell disease with crisis (a condition in which red blood cells become abnormally shaped like crescents or [NAME], rather than the usual round shape). -Critical illness myopathy (a condition that affects patients who have been critically ill and have had prolonged immobility, characterized by muscle weakness). Review of the resident's Order Summary Report dated 9/18/24 showed: -He/She had an order for Hydromorphone HCl 2 mg tablet. Give 1 tablet by mouth every 3 hours as needed for pain. -He/She had an order for Hydromorphone HCl 2 mg tablet. Give 2 tablets by mouth every 3 hours as needed for pain. Review of the resident's Medication Administration Record (MAR) for the dates of of 9/2/24 and 9/3/24 showed: -The resident received Hydrocodone HCL 2 mg 2 tablets on 9/2/24 at 9:00 A.M. for pain, which was given by Licensed Practical Nurse (LPN) B. -The resident received Hydrocodone HCL 2 mg 1 tablet on 9/2/24 at 1:01 P.M. for pain, which was given by LPN B. -The resident received Hydrocodone HCL 2 mg 2 tablets on 9/2/24 at 5:00 P.M. for pain, which was given by LPN B. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident received Hydrocodone HCL 2 mg 2 tablets on 9/2/24 at 8:32 P.M. for pain, which was given by LPN A. -The resident received Hydrocodone HCL 2 mg 1 tablet on 9/3/24 at 2:15 A.M. for pain, which was given by LPN A. -The resident received Hydrocodone HCL 2 mg 2 tablets on 9/3/24 at 5:45 A.M. for pain, which was given by LPN A -The resident received Hydrocodone HCL 2 mg 2 tablets on 9/3/24 at 9:05 A.M. for pain, which was given by LPN B. Review of the resident's Care Plan dated 9/3/24 showed he/she was prescribed opioid medication. Interventions were to give the medication as ordered and monitor for side effects. Review of the facility Narcotic Diversion timeline investigation dated 9/3/24 showed: -The DON was notified by LPN B the narcotic card count was one card short. He/She believed that a card of Dilaudid (Hydromorphone HCL) 2 mg was missing. He/She stated he/she had counted the cart with the other nurse in the building and all the other medications were accounted for. -The DON received a text from LPN A stating he/she needed to talk to him/her. -The DON called LPN A, who stated he/she had left the facility as he/she had to take his/her child to school. He/She stated LPN B accused him/her of taking a card of narcotics because the count was off and he/she was offended. He/She was told he/she would need to take a urine drug screen and he/she stated he/she would come take the test. -LPN B was interviewed and statement obtained. -Registered Nurse (RN) A was interviewed and statement obtained. -All medication carts, narcotic drawers and medication rooms were cleaned and organized. Narcotic counts verified for all 3 medication carts. -Audit was completed of narcotic book against the MAR. -The DON spoke with pharmacist at the facility's pharmacy and requested to be sent a list of the narcotics sent to the facility after 6:00 P.M. on 9/2/24. He/She stated he/she was unable to run that report and would have his/her supervisor contact him/her. He/She requested the pharmacy send out a new card of Dilaudid 2 mg tabs that the facility would be paying for and the resident was not to be billed. -The Medical Director was notified of the missing narcotics. Resident #2 was his/her own person and notified of the missing narcotic and that they would be replacing it for him/her. -The Administrator called and sent multiple messages to LPN A explaining why he/she needed to come to the community to give his/her statement and complete a drug test. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A returned to the facility around lunch time and was interviewed by the Administrator and DON. He/She stated he/she didn't know what happened to the card that LPN B said was missing when they counted the cards. -There were 22 cards when LPN A took the cart from LPN B at the start of his/her shift. LPN B verified there were 22 cards when he/she took the cart and he/she only removed one empty card for the resident. -LPN A stated he/she couldn't remember for sure, but that he/she was pretty sure he/she did not give his/her keys to anyone else during his/her shift. -LPN A was notified that he/she was being suspended pending investigation. -After interviews and investigation, the only person who had access to the medication that was missing was LPN A. Based on this and the behavior during the investigation, it was believed that he/she was the nurse that took the medications. Review of LPN A's written statement dated 9/3/24 showed: -When LPN B came into work that morning, he/she gave him/her report and counted with him/her. All of his/her counts were correct, but then he/she started asking about a card of 30 hydromorphone that he/she said was missing. He/she told him/her he/she didn't know anything about that, the only card he/she took out was a card for hydromorphone for another resident, but he/she did not remember for which one. -LPN B kept stating that it was missing and that the card was there when they counted the evening before. He/she told him/her he/she did not remember and he/she asked how he/she could not remember. He/She continued to tell him/her he/she did not remember, and then he/she said he/she knew he/she took it so just to say that he/she did. -He/She told him/her he/she didn't take anything and would do whatever possible to show he/she did not take it. -At that point, he/she had already given report and counted with him/her. -LPN B threw the keys down and said he/she would not take the cart. -He/She told him/her he/she had class that morning and had to leave. At that point, LPN B walked away and he/she left. Review of LPN B's written statement dated 9/3/24 at 10:56 A.M. showed: -On 9/2/24 at 6:35 P.M., he/she counted the medication cart #2. There were 22 cards left in the cart. The night nurse accepted the count and took the keys. -On 9/3/24 around 6:40 A.M. he/she counted the cards and there were only 20 cards. The night nurse said there were 21. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She had not had any issues with that. -LPN B worked the previous day. When LPN A came in that night, they did the count together, and the count was accurate at that time. -LPN A worked the night shift. -LPN B came in the next morning and worked at the same hall with the same medication cart. -He/She heard the two of them talking about a medication card being missing. -LPN A said one of the cards had gone down to zero medications, so he/she removed it. -A card would have the resident's name on it. Normally when the card got down to zero medications, the staff person would sign it and remove it. -LPN B said there was not a page in the narcotic book for the card and the card was not subtracted, so he/she called the DON and told LPN A not to leave. -LPN A said he/she had a class to go to and left anyway. -He/She then did the count with LPN B, which was accurate except for the missing card. -Only the nurse for that medication cart had access to the keys for the cart. The box where the narcotics were kept had a separate key from the cart. During an interview on 9/18/24 at 12:30 P.M., LPN B said: -LPN A came to work at 6:00 P.M. that night. LPN A worked nights and he/she worked days. -They counted the medication cards and there were 21. -The next day, he/she came to work at the same cart and noticed a medication card was missing. -When he/she noticed the card was missing, LPN A did not stay to count the individual pills. -This was possibly LPN A's fourth week at work. He/She had worked at the facility almost 3 years. -He/She had never had this happen before at that facility. -They looked for the missing card and could not find it. -He/She contacted the DON immediately. -The DON asked him to count with RN A, since LPN A had left. -Only he/she and LPN A had access to the medication keys. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The staff were not supposed to let anyone else have the keys. -He/She was called in to the office and he/she wrote a statement and told the DON the same thing. During an interview on 9/18/24 at 1:10 P.M., Resident #2 said: -He/She was getting all of his/her pain medication. -He/She did not know about any missing medications. During an interview on 9/18/24 at 2:00 P.M., RN B said: -When he/she came to work, he/she would not take the cart until the medications are counted. -If there was a discrepancy, they should call the DON. -It would not have been possible for a full card of medications to be missing. -When a card was emptied, it was recorded in the narcotic book. -He/She had three keys, one for the cart and two for the narcotic boxes in the cart. -Each key only worked on a specific drawer. -Cart keys only would open specific carts and did not interchange. -Nobody else would hold his/her keys while he/she was working. -He/She would only give his/her keys to the ADON or DON. -He/She never would take lunch away from the facility premises so he/she would not have to turn the keys over to someone else. Observation on 9/18/24 at 2:00 P.M. with RN B showed a medication cart, narcotic drawers, keys and demonstration of how they worked. During an interview on 9/18/24 at 2:05 P.M., the ADON said: -The day it was reported the narcotics were missing, LPN B realized there was a discrepancy and that a card was missing and the count was off. -The nurses counted the medications every shift. -LPN B did what he/she was supposed to do, which was contact him/her and the DON. -There was no way the card could have been lost. -The medication cart was locked. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the count was wrong, unless the resident left the facility, nothing would be destroyed. -LPN A had just completed orientation. He/She would have been the only one who had access to that cart that night. -If a staff person gave the keys to someone else, they should count the medications together. During an interview on 9/18/24 at 2:15 P.M., LPN A said: -He/She was aware of the missing narcotics. -He/She offered to work that night. -He/She counted the narcotics with LPN B and worked through the night. -He/She passed possible 2-3 as needed medications that night. -His/Her count was right, but LPN B said a card was missing and accused him/her of taking the card. -He/She called the DON and told him/her what LPN B was saying and that it was not his/her place to say that. -His/Her medication cart was visible in the hallway at all times. -He/She had to go to a class that day, so he/she left the facility. -Between 11:00 A.M. and 11:30 A.M., he/she got a call from the DON or the Administrator; he/she could not remember who. -The Administrator asked him/her why he/she didn't stay when he/she got off work and he/she had already told the DON. -They asked him/her a lot of questions. He/She said he/she had to pick up his/her child from school, so he/she had to leave. -He/She did not think anyone had access to his/her keys. He/She had them on the counter when he/she was charting. Only he/she and one other nurse were working that night. He/She did not remember who the other nurse was. -He/She had not really had training specific to the facility for doing the narcotic count. -This was not his/her first night off orientation. -He/She had not heard back from the facility and assumed he/she was fired. During an interview on 9/18/24 the DON said: -LPN A said he/she did not give anyone else the keys. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurses were supposed to count the medication cards; how many cards were added or removed, and then they count the individual pills on each card and compare against the individual residents' narcotic sheets. -LPN B got really agitated because of the missing medication. -He/She did everything he/she was supposed to do and called him/her when he/she found the discrepancy. -They asked LPN A to come to the facility at 10:45 A.M. and he/she didn't come until 12:45 P.M. -This would have been the first shift LPN A worked by him/herself. He//She picked up the extra shift. -There were cameras at the front of the facility. LPN A made multiple trips to his/her car during that shift. He/She worked from 6:00 P.M. to 6:00 A.M. This was not a normal pattern for a nurse. He/She took the keys with him/her. -Every narcotic box had a key with a number on it, and the medication cart had another key with a number and a matching number on the cart,; they are not interchangeable. -There was no master key for the medication carts. -The keys were the nurse's responsibility. MO00241543