STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365604	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Meadows Skilled Nursing and Rehab	7770 Columbus Road NE Louisville, OH 44641

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** 34297 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, self-reported incident (SRI) review and interview, the facility failed to ensure medications were not misappropriated. This finding affected two (Residents #20 and #28) of three residents reviewed for medication administration. Findings include: Review of Resident #20's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic pulmonary edema, disorganized schizophrenia and chronic respiratory failure with hypercapnia. Review of Resident #20's physician orders revealed an order dated 02/20/24 for oxycodone oral tablet (narcotic) 5 milligrams (mg) give one tablet by mouth every six hours as needed for pain. Review of Resident #28's medical record revealed the resident was admitted on [DATE] with diagnoses including end stage renal disease, diabetes and chronic gout. Review of Resident #28's physician orders revealed an order dated 02/27/24 for Hydrocodone-acetaminophen (Norco) oral tablet (narcotic) 5-325 mg give one tablet by mouth every six hours as needed for pain. Review of the Misappropriation SRI Tracking #245560 dated 03/24/24 revealed Licensed Practical Nurse (LPN) #826 noticed a missing narcotic card and reported to the concern to the nurse supervisor. On 03/24/24 at approximately 11:00 P.M., LPN #964 contacted the Director of Nursing (DON) to report that she diverted the narcotic card in question. A SRI was submitted to State agency on 03/24/24 at 12:30 A.M.; the police and the Medical Director were notified. An interview was conducted by Criminal Investigator #965 of LPN #964 who admitted to a total of 55 diverted oxycodone narcotic pain medications from Resident #20 and one Norco narcotic pain medication from Resident #28. The SRI was substantiated. Review of the Stark Common Pleas court document dated 05/23/24 revealed a written Plea of Guilty by LPN #964 and the nurse was ordered a period of rehabilitation not to exceed three years under the supervision of the probation department. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/11/24 at 6:53 A.M. with the DON indicated the facility immediately terminated LPN #964, called the police and pressed charges against the nurse. The DON also indicated the Ohio Board of Nursing was contacted to investigate the nurse. The DON stated audits and interviews were completed as well as new procedures to prevent misappropriation of narcotics from reoccurring. The DON confirmed LPN #964 diverted 55 oxycodone narcotic pain tablets from Resident #20 and one Hydrocodone-acetaminophen narcotic pain tablet from Resident #28 prior to termination. Review of the Abuse Prevention Program policy dated 09/21 revealed the residents have the right to be from from abuse, neglect, misappropriation of resident property and exploitation. As a result of the incident, the facility took the following actions to correct the deficient practice as of 03/25/24: LPN #964 clocked out on 03/23/24 at 3:48 P.M. A narcotic count for the B-wing was competed on 03/23/24 at 3:00 P.M. with RN #844 and the narcotic counts were accurate. On 03/23/24 at approximately 10:00 P.M., LPN #826 came into the facility for her shift from 11:00 P.M. to 7:00 A.M. She counted the narcotics on the B-wing with RN #844 and the narcotic counts appeared accurate. As she was doing the count, she realized that Resident #20 should have had a partial oxycodone 5 mg tablet card because she worked two days prior and the narcotic card was missing (could not determine how many narcotic pain tablets were missing because of the missing narcotic flow record). On 03/23/24 at 10:45 P.M., LPN #826 contacted LPN Wound Nurse #966 of possible missing narcotics from B-wing medication cart. LPN Wound Nurse #966 arrived in the facility on 03/23/24 at 11:00 P.M. and noticed the discrepancy in the control log and a partial card of oxycodone 5 mg was missing for Resident #20. LPN #964 contacted the DON via telephone on 03/23/24 at 11:00 P.M. that she had diverted narcotics by taking Resident #20's partial card of oxycodone 5 mg and the correlating narcotic flow record when she left from her shift on 03/23/24 at 3:48 P.M. (she was at home). The DON asked LPN #964 to immediately return the narcotics and the flow record and the nurse stated she destroyed the narcotic flow record and consumed the oxycodone. LPN Wound Nurse #966 contacted the DON on 03/23/24 at approximately 11:04 P.M. for possible narcotic diversion. LPN Wound Nurse #966 started immediate education on 03/23/24 at 11:15 P.M. of abuse, neglect, controlled substance policy and five resident rights policy with staff members including LPNs #826, #952, #960 and RN #968. On 03/23/24 at 11:46 A.M., LPN Wound Nurse #966 notified the Medical Director of misappropriation of narcotics. On 03/24/24 at 12:00 A.M., LPN Wound Nurse #977 removed all narcotic flow records from the floors to decrease the risk of staff manipulating the narcotic records and began auditing these records. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN Wound Nurse #977 called the police who arrived in the facility on 03/24/24 at 12:25 A.M. The police interviewed the staff and then went to LPN #964's house to interview the nurse. On 03/24/24 at 12:33 A.M. LPN Wound Nurse #966 interviewed Resident #20 and no negative findings were identified. The pain assessment was completed with a pain scale of zero (zero was no pain and 10 was the worst pain). On 03/24/24 from 2:00 A.M. to 3:40 A.M., LPN #826 interviewed all residents on the affected wing (B-wing) for pain scales and medication administration. Negative findings were not identified. On 03/24/24 at 1:00 A.M., LPN Wound Nurse #966 began audits on resident records for residents who reside all other units (except B-wing since previously done) to determine if misappropriation occurred. Negative findings were not identified. On 03/24/24 at 6:00 A.M., the DON revised the Sign-In for Narcotics procedure/guidelines from one staff to two staff required to sign and document when narcotics were delivered to the building. The DON, LPN Wound Nurse #966 and RN ADON #967 began educating all other nurses from 03/24/24 at 6:00 A.M. to 03/25/24 around 7:00 P.M. on the five rights, medication misappropriation, policy and procedure for narcotic sign ins (changed way sign in narcotics from pharmacy) On 03/25/24 from 7:00 A.M. to 10:00 A.M., LPN Wound Nurse #966 interviewed the affected wing (B-wing) a second time for pain and medication administration and no concerns were identified. On 03/25/24 from 11:00 A.M. to 2:00 P.M., all residents on the other units were interviewed by Social Service Designee (SSD) #851 for pain and medication administration. Negative findings were not identified. The DON, LPN Wound Nurse #966 and RN ADON #967 completed education from 03/24/24 at 6:00 A.M. to 03/25/24 at 7:00 P.M. for STNAs and nurses on misappropriation and abuse policy. On 03/25/24, the DON contacted pharmacy to ensure each narcotic delivered to the facility had a matching narcotic flow record; a limit of 30 narcotic medications were to be delivered for each resident; and pharmacy was required to send a daily report to the DON's email for each dispensed narcotic from the previous day. On 03/27/24, Criminal Investigator #965 arrived in the facility, and conducted an interview via telephone with LPN #964 (with the DON in attendance) who then admitted to diversion of Resident #26 Norco tablet (one Norco). She confirmed she took a total of 55 oxycodone tablets from Resident #20 and one Norco narcotic tablet from Resident #26. The DON completed ongoing audits staring on for two times a month for four weeks starting 03/27/24 then monthly times two and as needed as indicated. The audits completed were to assess resident records for two signatures obtained at delivery for controlled substances, two signatures noted for entry or removal of narcotic cards, shift to shift count of narcotic counts audited and electronic health record matched controlled substance forms. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Quality Assurance Performance Improvement (QAPI) meeting was held with the Medical Director was completed on 03/25/24 at 3:00 P.M. to discuss medication administration, changes in narcotic deliveries and changes in procedure for delivery of narcotics. This deficiency represents past non-compliance investigated under Complaint Number OH00156035.