

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Altercare of Canal Winchester Post-Acute Rc		STREET ADDRESS, CITY, STATE, ZIP CODE 6725 Thrush Drive Canal Winchester, OH 43110	

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 - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, review of facility Self-Reported incident (SRI), review of facility investigation, resident and staff interview and policy review the facility failed to prevent the misappropriation of Resident #21's prescribed narcotics. This affected one resident (#21) of three residents reviewed for misappropriation. The facility census was 62.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including myasthenia gravis without exacerbation, anxiety disorder, chronic pain syndrome, peripheral vascular disease, and cognitive communication deficit.</p> <p>Review of Resident #21's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact, was on a scheduled pain medication regime, and reported no pain during the previous five days.</p> <p>Review of Resident #21's plan of care dated 05/07/24 revealed he had an alteration in comfort or pain related to diagnoses of myasthenia gravis and osteoarthritis. Interventions included reminding the resident to report pain early, observe for episodes of breakthrough pain and medicate as ordered, offer nonpharmacological interventions, administer pain meds as ordered, and coordinate with therapy as needed.</p> <p>Review of Resident #21's physician order dated 12/30/22 revealed an order for Hydrocodone-Acetaminophen (opioid-analgesic) 5-325 milligrams (mg) for pain every six hours.</p> <p>Review of Resident #21's Medication Administration Record (MAR) for May 2024, June 2024, and 07/01/24 to 07/09/24 revealed all doses were documented as provided to the resident and there were no concerns related to missing medications.</p> <p>Review of the packing slip dated 05/25/24 revealed four cards with 30 pills each for a total of 120 pills of Hydrocodone-Acetaminophen 5-325 mg were delivered to the facility for Resident #21.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the shift to shift controlled medication inventory log from 05/25/24 to 05/27/24 revealed Resident #21 received four cards of 30 count of Norco (another name for Hydrocodone-acetaminophen) on 05/25/24 during the 7:00PM.-7:00 A.M. shift. Review of the controlled medication inventory log further revealed from 05/25/24 to 05/27/24 the two columns titled total number of cards and total number of narcotic sign off sheets present, had entries that appeared to have been written over, altering the count and making the original entry illegible. There was no documentation (signature or initials of staff) included indicating why the numbers in these two columns had been altered or indicating who altered the numbers. Review of the medication inventory log form revealed adjusted/written over counts were documented as follows:</p> <p>05/25/24 the day shift to night shift narcotic count time documented 41 medication cards present and 41 medications sign out sheets present on the controlled medication inventory log. The log had illegible numbers under the documented number.</p> <p>05/26/24 the count for both the day and night shift narcotic count documented 44 medication cards present and 44 medication sign out sheets present on the controlled medication inventory log. The log had illegible numbers under the documented number.</p> <p>05/27/24 the count for the night shift 05/26/24 to the 05/27/24 day shift narcotic count documented 44 medication cards present and 44 medication sign out sheets present on the controlled medication inventory log. The log had illegible numbers under the documented number.</p> <p>The controlled medication inventory log had no further discrepancies. Agency employee, Registered Nurse (RN) #122's signature was signed on the medication inventory log as the night shift nurse reporting for duty for the 7:00 P.M. shift on 05/25/24, 05/26/24 and 05/28/24 and had signed the controlled medication inventory log on the correlating times to those medication counts.</p> <p>Review of the pharmacy audit dated 06/24/24 revealed Pharmacist #133 completed an audit to ensure all controlled medications were accounted for. Pharmacist #133 identified poor documentation on the 100 and 200 halls and identified one whole card of Hydrocodone Acetaminophen (undocumented dose, amount, and resident) was missing.</p> <p>Review of the witness statement by the Director of Nursing (DON) dated 06/25/24 revealed on that day she reached out to the staffing agency to discuss the concern of RN #122 taking narcotics from the facility. The agency reported they would reach out to the nurse and ask her to come into the office for a drug test. The agency additionally reported they had not had any previous complaints about the nurse. The DON reached out again on 06/28/24 and the agency reported they were still not able to reach RN #122.</p> <p>Review of the SRI initiated 06/26/24 and completed 07/02/24 revealed Resident #21 was the victim and RN #122 was the suspected perpetrator. Narcotics were determined to be unaccounted for and there was insufficient information to determine who or what happened. RN #122 did not respond to attempts for contact. Resident #21 was notified of the missing medication and reported he was unaware of the incident and had not missed any dosages of medications.</p> <p>Review of the police report dated 06/24/24 revealed officers were dispatched to the facility for theft of a narcotic.</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 - Few</p>	<p>Review of the witness statement by Licensed Practical Nurse (LPN) #124 dated 06/28/24 revealed she relieved RN #122 on 05/25/24 and 05/26/24. During the report RN #122 told her that she went to nursing homes that were run down and did not care what you did. RN #122 told her she liked working at those facilities because she was able to do what she wanted. LPN #124 indicated that she did not notice any discrepancies in the narcotic count book, and no counts had been written over. She reported not only had the card of Hydrocodone gone missing but there had been no count sheet for the missing fourth card of pills.</p> <p>Interview on 07/10/24 at 11:42 A.M. with Regional Nurse Manager #135, DON, and Administrator revealed on 06/19/24 staff had called the pharmacy to obtain a refill for Resident #21's Hydrocodone Acetaminophen, at that time they were notified it was too early and they would need to get a new script. They tried to obtain a new script but on 06/21/24 they reported they had not received the script and Resident #21 should have had 30 more pills in the building. They reported from 06/21/24 to 06/23/24 they tried to locate the medication in the facility. On 06/24/24 the pharmacist did an audit and verified the medications were missing. The Administrator, Regional Nurse Manager, and police were notified on 06/24/24. Regional Nurse Manager #135 reported the investigation started on 06/25/24. Based on when the medications were delivered and the narcotic sheet documentation the facility determined RN #122 was responsible for the missing medications. Regional Nurse Manager #135 reported they believed they had sufficient evidence that RN #122 took the medications to report the RN to the nursing board.</p> <p>Review of the policy Abuse, Mistreatment, Neglect, Injuries of Unknown Source, and Misappropriation policy undated, revealed misappropriation was the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.</p> <p>The deficient practice was corrected on 06/27/24 when the facility implemented the following corrective actions</p> <p>On 06/27/24 the staffing agency was informed of the incident and told not to send back RN #122.</p> <p>On 06/27/24 education was provided to nursing staff by the Director of Nursing (DON) regarding shift-to-shift controlled medication count. Including the count was to be done any time a nurse was leaving a shift, a count was not to be altered or written over, how to properly document errors, ensuring no nurse leaves the facility if a discrepancy is noted, and notifying the DON of any unresolved discrepancies. Additionally, education was provided on the abuse policy.</p> <p>On 07/01/24 the DON/designee initiated monitoring to ensure narcotic count sheets matched the number of cards in the medications cart and for discrepancies in the count/sheets The monitoring will continue three times a week for four weeks, and was being completed as scheduled by the facility.</p> <p>There was no current non-compliance identified at the time of the complaint investigation completed on 07/10/23. Review of SRI's and concern logs revealed no missing medication and review of narcotic count sheets revealed no discrepancies.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00155403.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064</p> <p>Based on record review, review of facility Self-Reported incident (SRI), review of facility investigation, resident and staff interview, and policy review the facility failed to timely investigate an allegation of misappropriation. This affected one resident (#21) of three reviewed for misappropriation. The facility census was 62.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #21 revealed an admitted [DATE] with diagnoses including myasthenia gravis without exacerbation, anxiety disorder, chronic pain syndrome, peripheral vascular disease, and cognitive communication deficit.</p> <p>Review of Resident #21's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact, was on a scheduled pain regimen and reported no pain during the previous five days.</p> <p>Review of Resident #21's plan of care dated 05/07/24 revealed he had an alteration in comfort or pain related to diagnoses of myasthenia gravis and osteoarthritis. Interventions included reminding the resident to report pain early, observe for episodes of breakthrough pain and medicate as ordered, offer nonpharmacological interventions, administer pain meds as ordered, and coordinate with therapy as needed.</p> <p>Review of Resident #21's physician order dated 12/30/22 revealed an order for Hydrocodone-Acetaminophen (opioid/analgesic) 5-325 milligrams (mg) for pain every six hours.</p> <p>Review of Resident #21's Medication Administration Record (MAR) for May, June, 07/01/24 to 07/09/24 revealed all doses of Hydrocodone Acetaminophen 5-325 mg were documented as provided to resident #21 and there were no concerns related to missing medications.</p> <p>Review of the packing slip dated 05/25/24 revealed four cards with 30 pills each for a total of 120 pills of Hydrocodone Acetaminophen 5-325 mg were delivered to the facility for Resident #21.</p> <p>Review of the shift to shift controlled medication inventory log from 05/25/24 to 05/27/24 revealed Resident #21 received four cards of 30 count of Norco (another name for Hydrocodone-acetaminophen) on 05/25/24 during the 7:00PM.-7:00 A.M. shift. Review of the controlled medication inventory log further revealed from 05/25/24 to 05/27/24 the two columns titled total number of cards and total number of narcotic sign off sheets present, had entries that appeared to have been written over, altering the count and making the original entry illegible. There was no documentation (signature or initials of staff) included indicating why the numbers in these two columns had been altered or indicating who altered the numbers. Review of the medication inventory log form revealed adjusted/written over counts were documented as follows:</p> <p>05/25/24 the day shift to night shift narcotic count time documented 41 medication cards present and 41 medications sign out sheets present on the controlled medication inventory log. The log had illegible numbers under the documented number.</p> <p>(continued on next page)</p>		

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