STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366396	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Athens, The	70 Columbus Circle Athens, OH 45701

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** 32801 Based on observation, record review, review of a facility self-reported incident, facility investigation review, interviews, and policy review the facility failed to prevent misappropriation of resident narcotics. This affected one Resident (Resident #28) of one resident reviewed for misappropriation. The facility census was 94. Findings included: Review of Resident #28's medical record revealed an admitted to the facility on [DATE] with diagnoses including Alzheimer's, dementia with other behavioral disturbances, aphasia (difficulty understanding what is being said or difficulty formulating speech due to injuries to certain parts of the brain), anxiety, depression, insomnia, and cardiovascular disease. Review of Resident #28's fluctuation in mood plan of care initiated on 12/21/20 and revised on 06/19/24 revealed the resident had fluctuations in mood related to dementia, anxiety, mood disorder, insomnia, and reactive agitation for mood stabilizer. Her anxiety included anxiousness, pacing back and forth and wringing hands. The resident's interventions included administering medication as ordered and observe and report any acute changes to the social worker or physician. Review of Resident #28's active orders dated 05/2024 revealed the resident was ordered Ativan 1 milligram (mg) by mouth three times daily for anxiety. There was no evidence of orders to monitor Resident #28's behaviors. Review of Resident 28's Medication Administration Record (MAR) dated 05/24 revealed Ativan 1 mg was administered three times daily from 05/01/24 to 05/31/24 at 8:00 A.M., 2:00 P.M., and 8:00 P.M. Review of a facility submitted self-reported incident form with tracking number 248027 dated 05/28/24 revealed on 05/27/24 during the 7:00 P.M. shift change, Resident #28's Ativan 1 mg card (30 count) was missing from the narcotic box (located in the medication cart under double lock and only the nurse assigned to that medication cart has the keys/access to the medication cart and the narcotics within that medication cart). The facility searched for the missing medication on 05/27/24 and 05/28/24 without success. Resident #28 was not able to provide meaningful information and had severe cognition impairment. The resident resided on the long-term care unit and had diagnoses including dementia with behaviors, aphasia with impaired communication, anxiety, and depression. The resident had a physician order to receive Ativan 1 mg three times per day for anxiety. (continued on next page)

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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(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	Review of the facility investigation revealed Registered Nurse (RN) #186 was interviewed and verified that her count was correct at 7:00 A.M., at shift change, and she doesn't know what happened to the medication (Ativan). The RN verified that she didn't give her keys to anyone else during the shift. Her general practice was to lock the cart when not in sight and she does not remember leaving any medication on her cart. The RN stated she did dispose of empty non-narcotic (medication) cards and maybe it was stuck to one of those, but she was not sure. The medication carts, medication room, shred bins (bin used to collect papers for shredding), and trash were searched but the facility was unable to locate the medication card containing the medication, Ativan. The on-call nurse manager arrived at the facility and RN #186 was removed from her assignment and supervised by RN #192 until the Director of Nursing (DON) arrived at the facility. There were no signs RN #186 was impaired. Resident #28 was calm and denied any pain or needs. RN #186 was suspended pending the outcome of the investigation. The narcotic count was completed, and no further discrepancies were noted. RN #186 completed a drug screen on 05/28/24 (the drug screen was completed on 05/29/24 per the lab results). Staff on duty 05/27/24 during dayshift were interviewed and verified they did not notice the medication cart being unlocked or medication on top of the nurse's cart during their shift. On 05/28/24 all current narcotic sheets and shift logs were reviewed. Audits were completed to ensure medication were stored properly and medication carts were locked when not in view of the nurse with no discrepancies identified. RN #186's personnel file was reviewed with no concerns related to medication administration noted. The RN's license was verified and active with no board action. Review of Licensed Practical Nurse (LPN) #123's typed statement, dated 05/27/24 and signed by the Director of Nursing (DON), revealed during the narcotic count with RN #186, they discovered there was a missing card of Ativan. LPN #123 stated she notified the on-call nurse on 05/27/24. Review of RN #186's statement, dated 05/27/24 and signed by the DON, revealed the RN verified that her count was correct at the 7:00 A.M. shift change (on 05/27/24), and something happened during her shift, but she doesn't know where the medication is or what happened. Nurses verified that she did not give her keys to anyone else during the shift, her general practice was to lock the cart when not in sight and she does not remember leaving any medication on (top of) her cart. The RN stated she had disposed of empty non-narcotic (medication) cards and maybe it was stuck to one of those, she didn't see it and threw the medication away. The RN stated the trash from her cart was taken out twice on her shift. She searched the trash and could not find the missing card of medication. She was unable to locate the trash bag taken out to the dumpster. Further review revealed when giving narcotic medication she would pull the cards out to review to make sure she had the right card and maybe left one (card) on the cart with the empty cards. She had given the resident the Ativan at 2:00 P.M. and the Ativan and cards were present at that time. The RN was questioned if she took the medication from the cart and she stated, I did not remove the medication from the cart and if I did, it was not intentional. The RN then stated she had been thinking about what could have happened and the only thing she could think of was when she gave the resident her afternoon medication, she had sat it down with her throw aways on the right side of her cart and threw it in the trash (the full 30 count card of Ativan from the narcotic drawer). (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Included in the investigation were typed statements dated 05/28/24 from the direct care staff that were all the same, except the staff members' names were changed for each statement. The statements read staff member (name) interviewed regarding observation of medication carts being left unlocked or any medications being left on top of carts with staff member denying seeing either occur during her/his scheduled shift. Staff member stated he/she did not see anyone around the cart except the assigned nurses. The statement was signed by the staff member conducting the interview (not the person being interviewed). The Director of Housekeeping/Laundry #213 wrote a statement dated 05/27/24 with her staff members' names and wrote out the to the side saw no medication out on cart. Review of RN #109 and RN #115's typed statements dated 05/27/24 revealed they didn't notice any medication carts being unlocked when not in a nurse's view or any medications laying on top of the medication carts during their shift. The statements were typed by the DON and not signed by the staff member providing the statement. Review of Activity Assistant #183 and #184's typed statement dated 05/27/24 revealed they didn't see any medication carts unlocked or medication sitting on top of the carts. Review of typed statements from the therapy department dated 05/28/24 revealed all the statements were the same except the name of the therapy staff being interviewed, was changed. Interviewed (name) was asked if she/he had noticed any medication carts being unlocked when not in nurses view or any medications laying on top of the medication carts during their shift. Staff denied seeing any medication carts unlocked or medications laid out while she was on duty. Review of the police report dated 05/28/24 at 6:56 P.M. revealed the police were dispatched to the facility for a theft. The Administrator advised the incident occurred on 05/27/24 at 7:00 P.M., the end of the shift. The RN was in charge of the resident on 05/27/24 from 7:00 A.M.to 7:00 P.M. The Administrator stated the resident was on Ativan and the medication came in a pack/card of 30. The Administrator reported the medication count was correct in the morning, but the discrepancy happened in the evening. The resident received the last dose at 2:00 P.M. on the 27th. The Administrator advised they needed (a copy of this report) for this whether it was stolen or missing because it was required by the Board of Pharmacy. The Administrator reported she doesn't suspect the RN of taking the medication because there had been no issues with the RN before and she just recently got her nursing license. Review of RN #186 drug screen revealed a local clinic collected the urine drug screen on 05/29/24 (not 05/28/24 as reported to the nursing board and state agency) because of a post-accident. The test came back negative. Review of the Dietary Mangers #190 typed statement dated 05/30/24 revealed he had personally spoken to the staff that were present on 05/27/24 and none of them reported seeing any medication when they were rounding or on any of the trays/carts that came back to the kitchen that day. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #186 controlled drug record dated 05/15/24 revealed on 05/15/24 90 Ativan (three cards with 30 pills in each) were delivered and one control drug record was available. On 05/27/24 there was a note verifying card three was missing and an x was marked through 1-30 sign out slots on the controlled drug record. The second column, 31-60, was marked card #1, and the fist column 61-90 was marked card #2. Review of the same control drug record revealed staff signed out Ativan #66 on 05/28/24 at 6:40 A.M and then crossed through #65 and re-numbered it with #35, #64 with #34, #63 with #33, #62 with #32, and #61 with #31. Card #1 was now assigned slots 1-30 andcard#3 slots were crossed through with an X. Review of RN #186's employee disciplinary record dated 05/27/24 revealed the RN was suspended pending investigation of 30 Ativan missing from the medication cart while she was on duty. Review of RN#186's employee disciplinary record dated 06/03/24 revealed the RN violated the rule by failing to properly secure narcotic medications resulting in 30 missing Ativan on her shift. The RN was counseled on following medication pass policy, medication administration policy and would secure her medication cart and narcotic medication on her cart. Failure to follow the policy would lead to termination. Reconciliation of 300 medication cart on 07/30/24 at 10:45 A.M. with LPN #151 and the DON revealed Resident #26 had 25 Methadone 5 mg in the blister packet, however the control drug record sheet indicated the resident should have 26 Methadone 5 mg. LPN #151 confirmed findings and reported she had administered a Methadone to Resident #26 this morning around 8:00 A.M., however she must have not signed it out on the control drug record sheet. Further observation revealed the medication cart had two locks. One lock opened the medication cart and there was a separate fixed metal box inside the cart with another lock that contained the narcotics where Resident #28's Ativan was stored. Interview on 07/30/24 at 9:27 A.M., with the Administrator and DON regarding the SRI confirmed on 05/27/24 RN #186 and LPN #123 was reconciling medication, and it was discovered that a card of 30 Ativan 1 mg were missing. At 7:00 A.M. the count was done by RN #186 and LPN #127 and there were no discrepancies at the beginning of the shift. RN #186 thought maybe she threw the Ativan away when she threw away some non-narcotic medication in the trash. Around 8:29 P.M. RN #192 arrived first and verified the Ativan card was missing. The DON confirmed Resident #28 had three cards (30 pills in each) of Ativan 1 mg and staff were using card #2 and cards #1 and #3 were not used. The DON confirmed card #3 was missing. The DON confirmed the reconciliation sheet was crossed out for 1 to 30 slots for card three and re-numbered. The Administrator reported the police report was inaccurate and she did not state the RN was a new nurse. (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 07/30/24 from 12:00 P.M. to 1:00 P.M. with an anonymous Resident #504 on 300-400 hall revealed they would like to remain anonymous. The resident reported when asked if she received medication timely and as order and she replied she only had concerns with one nurse (and named RN #186 by name). The resident reported the RN administers medication late especially around dinner time and occasionally she doesn't administer all the medication as ordered. The resident reported they were not on controlled medications, but it was still concerning since a lot of the residents had cognition impairment on the unit. The resident reported she would like to remain anonymous because the nurse works on the 300-400 unit frequently. Interview on 7/30/24 at 12:24 P.M., with the Administrator, revealed she was still investigating why RN #186 was not drug tested on [DATE] as originally reported. The Administrator reported housekeeping staff work from 6:00 A.M. to 2:00 P.M. and they were usually the ones that remove the trash from the soiled linen room. The Administrator reported she advised the staff not to go into the dumpster. The Administrator confirmed she did not call the disposal company to come out and remove the trash so it could be inspected. The Administrator reported she didn't know the days the disposal company empties the dumpsters. The Administrator confirmed RN #186 reported she last seen the Ativan at 2:00 P.M. and it was discovered missing five hours (7:00 P.M) later and it was not in the shred box or the trash in the soiled utility room. If housekeeping leaves at 2:00 P.M., then the trash should not have been taken to the dumpster, but she could not confirm the trash wasn't taken to the dumpster. Interview on 07/30/24 1:02 P.M., with RN #192 confirmed she was the nurse on call on 05/27/24 and arrived at the building first. RN #192 confirmed RN #186 showed no signs of impairment. RN #186 first reported she didn't leave her medication cart unlocked then she reported maybe she did leave it unlocked. RN #192 confirmed RN #186 was helping search for the missing Ativan and when the DON arrived, the DON told her to follow RN #186. RN #186 had already gone outside to look in the dumpster but by the time she got out there the RN was coming back inside so she didn't believe she had time to look in the trash in the dumpster. The staff opened the shred box, looked in the medication cart, resident rooms and trash inside the building and was not able to find the missing card of Ativan. RN #192 confirmed she works the floor frequently and the medication cart trash is taken to the soil room for disposal and not to the dumpster outside. Review of the facilities policy titled Narcotic Count undated revealed narcotics would be counted at the beginning and end of every shift with two nurses present. Assure that all medications were accounted for. Once you sign the sheet you are taking responsibility for the medication. If the count was off at any time the DON must be notified immediately. If a medication was signed out on the narcotic count sheet it MUST be signed out on the MAR (no exceptions). Narcotic sound sheets should not be modified. We should not be crossing out numbers and rewriting new numbers in. On the shift-to-shift count sheet turn the sheet over and write the date the number of cards removed, resident name, prescription number, name of medication, and two nurse's signs. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Medication/Treatment Cart Use dated 08/15/23 revealed the medication cart and its storage bins would be kept locked until the specified time of medication administration. No medications are to be kept on the top of the cart. If more than one unit-dose card per prescription was dispensed, the cards are numbered to identify the individual card and the total number of cards making up that prescription (1 of 3, 2 of 3, 3 of 3, etc.). The first card is placed in the storage bin in the medication cart and the remaining cards are stored in the medication room until they were needed. This prevents overcrowding of the medication cars and prevents recording when adequate stock is still on hand. The medication notebook contains all individual control drug records. Review of facilities policy titled Controlled Substance dated 10/26/23 revealed when a controlled substance was delivered complete the controlled substance proof of use sheet and place the medication in the medication cart-controlled substance lock box and file the form in the appropriate binder. All controlled substances would be stored in the medication cart. The medication cart and controlled substance drawer would always be locked when not within view of the nurse who is responsible for the cart. Any discrepancies would be reported to the DON or the Administrator if the DON was not available. The DON and/or Administrator would initiate an investigation regarding the discrepancy as soon as the error was identified. Review of the facilities policy titled Abuse Prohibition Policy dated 10/14/22 revealed it was the facilities staff's responsibility to provide a safe environment for the residents to ensure they were free from abuse. Misappropriation means deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Reportable allegations of misappropriation of resident property include by not limited to missing prescription medication or diversion of a resident's medication, including but not limited to, controlled substances for staff use or personal gain. The DON or designee would complete an assessment of the resident and document findings in the medical record. The investigation may consist of an interview with the person reporting the incident, interview with residents, review of the resident medical record, interview with staff member having contact with resident during the shift of the alleged incident, interviews with resident's roommate, family members, visitors, and a review of all the circumstances surrounding the incident. Review of the facilities policy titled Substance Abuse and Testing dated 12/05/23 revealed the facility may initiate substance abuse testing for the following reasons including resident drug diversion is suspected by one or more staff members or any other behaviors that give reasonable cause.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on record review, review of a self-reported incident, review of the facilities investigation for the self-reported incident, observation, interviews, and policy review the facility failed to ensure an allegation of misappropriation of controlled medication was thoroughly investigated. This affected one Resident (Resident #28) of one resident reviewed for misappropriation. Findings included: Record review revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, dementia with other behavioral disturbances, aphasia, anxiety, depression, insomnia, and cardiovascular disease. Review of Resident #28's fluctuation in mood plan of care initiated on 12/21/20 and revised on 06/19/24 revealed the resident had fluctuations in mood related to dementia, anxiety, mood disorder, insomnia, and reactive agitation for mood stabilizer. Her anxiety included anxiousness, pacing back and forth and wringing hands. The resident intervention included administering medication as ordered and observe and report any acute changes to the social worker or physician. Review of Resident #28's active orders dated 05/2024 revealed the resident was ordered Ativan 1 milligram (mg) by mouth three times daily for anxiety. There was an additional order written on 05/31/24 to give Ativan 1 mg by mouth one time only for anxiety on 05/31/24. There was no evidence of orders to monitor Resident #28's behaviors. Review of Resident 28's Medication Administration Record (MAR) dated 05/2024 revealed Ativan 1 mg was administered three times daily from 05/01/24 to 05/31/24 at 8:00 A.M., 2:00 P.M., and 8:00 P.M. The resident received an extra dose of Ativan on 05/31/24 for anxiety. There was no evidence the resident's anxiety behaviors were monitored. Review of Resident #28's nursing note dated 05/12/24 revealed the resident was having increase anxiety. Review of Resident #28's nursing note dated 05/31/24 at 10:00 A.M., revealed the resident noted with increased anxiousness. One on one and redirection unsuccessful. Physician rounding in house with new orders. Review of Resident #38's nursing notes dated 06/10/24 to 06/29/24 revealed no evidence the resident had behaviors/anxiety. Review of self-reported incident form (tracking #248027) revealed dated 05/28/24 revealed on 05/27/24 during 7:00 P.M. shift change Resident #28's Ativan 1 mg card (30 count) was missing from narcotic box. The facility searched for the missing medication on 05/27/24 and 05/28/24 without success. Resident #28 was not able to provide meaningful information and has severe cognition impairment. The resident resides on the long-term care unit and has diagnoses including dementia with behaviors, aphasia with impaired communication, anxiety, and depression. The resident had a physician order to receive Ativan 1 mg three times per day for anxiety. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) #186 was interviewed and verified that her count was correct at 7:00 A.M. at shift change and she doesn't know what happened to the medication. The RN verified that she didn't give her keys to anyone else during the shift. Her general practice was to lock the cart when not in sight and she does not remember leaving any medication on her cart. The RN stated she did dispose of empty non-narcotic cards and maybe it was stuck to one of those, but she was not sure. The medication carts, medication room, shred bins, and trash were searched but unable to locate the medication card. The on-call nurse manager arrived at the facility and RN #186 was removed from her assignment and supervised by RN #192 until the Director of Nursing (DON) arrived at the facility. There were no signs RN #186 was impaired. Resident #28 was calm and denied any pain or needs. RN #186 was suspended pending investigation. The narcotic count was completed, and no further discrepancies noted. RN #186 completed a drug screen on 05/28/24 (date inaccurate due to the drug screen was completed on 05/29/24). Staff on duty on 05/27/24 dayshift were interviewed and verified they did not notice the medication cart being unlocked or medication on top of the nurse's cart during their shift. On 05/28/24 all current narcotic sheets and shift logs were reviewed. Audits were completed to ensure medication were stored properly and medication carts were locked when not in view of the nurse with no discrepancies identified. RN #186 personnel file was reviewed with no concerns related to medication administration noted. The RN's license was verified and active with no board action. There was no evidence residents were interviewed or assessed that RN #186 had provided care to that day except for Resident #28 to ensure they received medication as ordered or had increase behaviors. Review of the police report dated 05/28/24 at 6:56 P.M. revealed the police were dispatched to the facility for a theft. The Administrator advised the incident occurred on 05/27/24 at 7:00 P.M., the end of the shift. The RN was in charge of the resident on 05/27/24 from 7:00 A.M.to 7:00 P.M. The Administrator stated the resident was on Ativan and the medication came in a pack/card of 30. The Administrator reported the medication count was correct in the morning, but the discrepancy happened in the evening. The resident received the last dose at 2:00 P.M. on the 27th. The Administrator advised they needed to report for this whether it was stolen or missing because it was required by the Board of Pharmacy. The Administrator reported she doesn't suspect the RN of taking the medication because there had been no issues with the RN before and she just recently got her nursing license. Review of the facility's investigation revealed a copy of the daily staffing assignment sheet dated 05/27/24 that had check marks by the day shift staff with additional notes at the bottom with therapy, activity, housekeeping and dietary. Review of Licensed Practical Nurse (LPN) #123 typed statement dated 05/27/24 and signed by the Director of Nursing (DON) revealed during the narcotic count with RN #186, they discovered there was a missing card of Ativan. LPN #123 stated she notified the on-call nurse on 05/27/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of RN #186 statement dated 05/27/24 and signed by the DON revealed the RN verified that her count was correct at 7:00 A.M. shift change, and something happened during her shift, but she doesn't know where the medication is or what happened. Nurses verified that she did not give her keys to anyone else during the shift, her general practice was to lock the cart when not in sight and she does not remember leaving any medication on her cart. The RN stated did dispose of empty non-narcotic cards and maybe it was stuck to one of those, but she didn't see it and threw the medication away. The RN stated the trash from her cart was taken out twice on her shift. She searched the trash and could not find the missing card of medication. She was unable to locate the trash bag taken out in the dumpster. When giving narcotic medication she would pull the cards out to review to make sure she had the right card and maybe left one on the cart with the empty cards. She had given the resident the Ativan at 2:00 P.M. and the Ativan and cards were present at that time. The RN was questioned if she took the medication from the cart and she stated, I did not remove the medication from the cart and if I did it was not intentional. RN #186 was re-interviewed on 05/28/24 regarding the usage of pain medication for Resident #69. The RN stated it was because of her diagnoses and when she gets up, she would give her a pain pill when she asked and she says she's hurting and after she was up for a while, she would sit up in the chair and in the dining room with others. She would have them lay her back down in the afternoon and ask her if she's hurting and she generally says yes, and she would give her a pill in the afternoon. The RN then stated she had been thinking about what could have happened and the only thing she could think of is when she gave the resident her afternoon medication if she had sat it down with her throw aways on the right side of her cart and threw it in the trash. Included were typed statements dated 05/28/24 from the direct care staff that were all the same, except the staff member names were changed for each statement. The statements read staff member (name) interviewed regarding observation of medication carts being left unlocked or any medications being left on top of carts with staff member denying seeing either occur during her/his scheduled shift. Staff member stated he/she did not see anyone around the cart except the assigned nurses. The statement was signed by the staff member conducting the interview (not the person interviewed). The Director of Housekeeping/Laundry #213 wrote a statement dated 05/27/24 with her staff names and wrote out the to the side saw no medication out or cart. Review of RN #109 and RN #115 typed statements dated 05/27/24 revealed they didn't notice any medications carts being unlocked when not in nurses view or any medications laying on top of the medication carts during their shift. The statements were typed by DON and not signed by the staff members. Review of Activity Assistance #183 and #184 typed statement dated 05/27/24 revealed they didn't see any medication carts unlocked or medication setting on top of carts. Review of typed statements from therapy department dated 05/28/24 revealed all the statements were the same except the name was changed. Interviewed (name) was asked if she/he had noticed any medication carts being unlocked when not in nurses view or any medications laying on top of the medication carts during their shift. Staff denied seeing any medication carts unlocked or medications laid out while she was on duty. (continued on next page)

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	366396	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Athens, The	70 Columbus Circle Athens, OH 45701

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Dietary Mangers #190 typed statement dated 05/30/24 revealed he had personally spoken to the staff that were present on 05/27/24 and none of them reported seeing any medication either on the floor near the services when they were rounding or on any of the trays/carts that came back to the kitchen that day. Review of Licensed Practical Nurse (LPN) #121 typed statement dated 05/29/24 revealed on 05/27/24 she was working another unit and wasn't around the other cart that day. Interview on 07/29/24 at 2:49 A.M., with the Administrator and Director of Nursing (DON) confirmed Resident #28 was not interviewed, however she was assessed for behaviors. The Administrator and DON confirmed residents were not interviewed or assessed as part of the investigation to ensure they received medication from RN #186 because no other residents were affected due to when staff completed the initial audit on 05/27/24 there were no other discrepancies with the narcotic count. Interview on 07/30/24 at 9:27 A.M., with the Administrator and DON regarding the SRI confirmed she provided the surveyor with the complete investigation and copied everything out to the SRI folder including information requested by the Attorney General's office. The Administrator and DON reported on 05/27/24 RN #186 and LPN #123 was reconciling medication, and it was discovered that a card of 30 Ativan 1 mg were missing. At 7:00 A.M. the count was done by RN #186 and LPN #127 and there were no discrepancies at the beginning of the shift. RN #186 thought maybe she threw the Ativan away when she threw away some non-narcotic medication in the trash. Around 8:29 P.M. RN #192 arrived first and verified the Ativan card was missing. The DON confirmed the surveyor didn't have a copy of LPN#123 statement and she would provide it to the surveyor. The Administrator reported all staff were asked the same question about carts be observed unlocked and medication left out to ensure all interviews were conducted the same. The Administrator confirmed the investigation reported the RN was drug tested on the 28th, however the drug screen was not completed until the 29th (two days later). The DON confirmed Resident #28 had three cards (30 pills in each) of Ativan 1 mg and staff were using card 2 and cards 1 and 3 were not used. The DON confirmed card 3 was missing. The DON confirmed the reconciliation sheet was crossed out for 1 to 30 for card three and renumbered. The Administrator reported the police report was inaccurate and she did not state the RN was a new nurse. Interview on 07/30/24 from 10:45 A.M. to 4:00 P.M., with staff who would like to remain anonymous (#500 and #501) revealed there had been concerns reported to them regarding RN #186. Anonymous staff #500 confirmed resident's had voiced concerns to staff that they don't get medication timely or as ordered when RN #186 was working. Staff have noticed she had been administering narcotics as needed to residents that usually don't get narcotics. Anonymous staff member #500 reported they were not interviewed as part of the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Anonymous staff #501 reported they were interviewed as part of the investigation and work with RN #186; however, they were only asked if they seen the medication cart unlocked or medication on top of the medication cart. They were not asked about RN #186 or any concerns they might have. The Anonymous staff member reported just a few weeks ago a new nurse would not accept the keys from RN #186 due to concerns with the narcotic book. Residents have complained to her regarding not receiving medications as ordered or timely. The staff member reported the RN #186 usually works 300 and 400 hall and most of the resident had cognition impairment and can't stand up/speak for themselves. The anonymous staff member feels RN #186 was verbally aggressive with the resident and staff. The anonymous staff member reported there were staff members that refused to work with her. The anonymous staff member reported she feels the resident were more agitated/anxious when RN #186 worked compared to other nurses. Interview on 07/30/24 from 12:00 P.M. to 1:00 P.M. with an anonymous Resident #504 on 300-400 hall revealed they would like to remain anonymous. The resident reported when asked if she received medication timely and as order and she replied she only had concerns with one nurse (and named RN #186 by name). The resident reported the RN administers medication late especially around dinner time and occasionally she doesn't administer all the medication as ordered. The resident reported they were not on controlled medications, but it was still concerning since a lot of the residents had cognition impairment on the unit. The resident reported she would like to remain anonymous because the nurse works on the 300-400 unit frequently. Interview on 7/30/24 at 12:24 P.M., with the Administrator, revealed she was still investigating why RN #186 was not drug tested on [DATE] as originally reported. The Administrator reported housekeeping staff work from 6:00 A.M. to 2:00 P.M. and they were usually the ones that remove the trash from the soiled linen room. The Administrator reported she advised the staff not to go into the dumpster. The Administrator confirmed she did not call the disposal company to come out and remove the trash so it could be inspected. The Administrator reported she didn't know the days the disposal company empties the dumpsters. The Administrator confirmed RN #186 reported she last seen the Ativan at 2:00 P.M. and it was discovered missing five hours (7:00 P.M) later and it was not in the shred box or the trash in the soiled utility room. If housekeeping leaves at 2:00 P.M., then the trash should not have been taken to the dumpster, but she could not confirm the trash wasn't taken to the dumpster. Interview on 07/30/24 1:02 P.M., with RN #192 confirmed she was the nurse on call on 05/27/24 and arrived at the building first. RN #192 confirmed RN #186 showed no signs of impairment. RN #186 first reported she didn't leave her medication cart unlocked then she reported maybe she did leave it unlocked. RN #192 confirmed RN #186 was helping search for the missing Ativan and when the DON arrived, the DON told her to follow RN #186. RN #186 had already gone outside to look in the dumpster but by the time she got out there the RN was coming back inside so she didn't believe she had time to look in the trash in the dumpster. The staff opened the shred box, looked in the medication cart, resident rooms and trash inside the building and was not able to find the missing card of Ativan. RN #192 confirmed she works the floor frequently and the medication cart trash is taken to the soil room for disposal and not to the dumpster outside. RN #192 reported RN #186 has issues with some of the staff, but she had never witnessed her be verbally aggressive towards the residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facilities policy titled Abuse Prohibition Policy dated 10/14/22 revealed it was the facilities staff's responsibility to provide a safe environment for the residents to ensure they were free from abuse. Misappropriation means deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Reportable allegations of misappropriation of resident property include by not limited to missing prescription medication or diversion of a resident's medication, including but not limited to, controlled substances for staff use or personal gain. The DON or designee would complete an assessment of the resident and document findings in the medical record. The investigation may consist of an interview with the person reporting the incident, interview with residents, review of the resident medical record, interview with staff member having contact with resident during the shift of the alleged incident, interviews with resident's roommate, family members, visitors, and a review of all the circumstances surrounding the incident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32801 Based on observation, interview, and policy review revealed the facility failed to ensure controlled medication were signed out when administered and medication were properly labeled and packaged. This had the potential to affect all residents residing on 100, 200, 300, and 400 halls. Findings included: 1. Observation on 07/30/24 at 10:45 A.M. of 300 medication cart with Licensed Practical Nurse (LPN) #151 and the Director of Nursing (DON) revealed Resident #26 had 25 Methadone 5 mg in the blister packet however the control drug record sheet indicated the resident should have 26 Methadone 5 mg. LPN #151 confirmed findings and reported she had administered a Methadone to Resident #26 this morning around 8:00 A.M., however she must have not signed it out on the control drug record sheet. Further observation of 300 medication carts revealed there were two whole pills and 6.5 1/2 tablets lying in the medication cart loose and unpackaged. LPN #151 confirmed the pills were not packaged and labeled and she would dispose of them. 2. Observation on 07/30/24 at 10:55 A.M. of 400 medication carts with LPN #151 revealed there were two loose unpacked pills in the bottom lying in the medication cart. LPN #151 confirmed the pills were unpackaged and not labeled. 3. Observation on 07/30/24 at 11:15 A.M of 100 medication cart with RN #109 revealed there were three loose pills unpacked in the medication cart. RN #109 confirmed there were three loose pills unpackaged and not labeled in the medication cart. 4. Observation on 07/30/24 at 11:20 A.M. of 200 medication carts with LPN #116 revealed there were 4 loose unpacked pills and unlabeled in the medication cart. LPN #116 confirmed the pills were loose and unpackaged. Review of the facilities policy titled Narcotic Count undated revealed if a medication was signed out on the narcotic count sheet it MUST be signed out on the MAR (no exceptions). Review of the facilities policy titled Medication Management dated 09/22/23 revealed Medication is stored and dispensed in a manner to ensure safety and conformance with state and federal laws. Medication received should comply with state and federal regulations for packaging and labeling.