STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395484	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kadima Rehabilitation & Nursing at Luzerne	463 North Hunter Hwy Drums, PA 18222

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of employee personnel files and select facility policy and interviews with facility staff, it was determined the facility failed to demonstrate that licensed nurses possess the necessary competencies and skills to accurately prepare and administer prescribed medications to residents for 1 out of 5 residents reviewed. (Resident A1) Findings include: According to the American Nurses Association the Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, out- comes identification, planning, implementation, and evaluation. Nurses' responsibility for medication administration includes ensuring that the right medication is properly drawn up in the correct dose and administered at the right time through the right route to the right patient. A review of a facility policy entitled Medication Administration - General Guidelines that was last reviewed by the facility on September 16, 2024, indicated that medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Medications are administered at the time they are prepared and are not pre-poured. The person who prepares the dose for administration is the person who administers the dose. A review of Resident A1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes, anxiety, neuropathy, depression, and chronic pain. A review of Resident A1's quarterly Minimum Data Set assessment dated [DATE], (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) revealed that the resident was cognitively intact with a BIMS (brief interview for mental status - a tool to assess cognitive function) score of 15 (13-15 indicates intact cognition). A review of Resident A1's physician's orders revealed an order dated August 28, 2024, for oxycodone HCL (a narcotic pain medication used to manage moderate to severe pain) tablet, give 5 mg by mouth two times a day for pain management and to be administered at 8:00 AM and at 9:00 PM. (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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility investigation completed by the Nursing Home Administrator (NHA) on October 2, 2024, at approximately 9:55 PM, revealed that Employee 1, a Registered Nurse (RN), notified the Director of Nursing (DON) of a medication error and possible medication diversion (is the illegal distribution or abuse of prescription drugs or their use for unintended purposes). According to Employee 1, RN's statement, Employee 2, a Licensed Practical Nurse (LPN), had prepared Resident A1's scheduled 9:00 PM medications and requested Employee 1, RN administer the medications to this resident because Employee 2 and this resident had a negative intervention in the past. Employee 1, RN proceeded to prepare to administer the medications to resident A1 however, she noticed and confirmed the medications in the medication cup that was pre poured by Employee 2 were Bactrim (an antibiotic) and Glipizide (an oral diabetic medication that helps to control blood sugar levels) which the resident was not prescribed. Employee 1 did not administer these mediations to the resident The medication at that time should have been oxycodone however there was no oxycodone 5mg (narcotic medication used for pain relief) present in the medication cup at that time. Employee 1 reviewed the resident's medication orders and obtained the medications from the facility's emergency medication box. The resident received his medications as prescribed. Employee 1, RN, and Employee 2 LPN reviewed the narcotic medications and determined the medications were accounted without any discrepancies. According to the findings of the facility investigation, the facility immediately suspended both nursing staff involved and completed a five-panel drug screening that were both negative. Pharmacy was contacted and notified and did a review of narcotics and the narcotic counts were correct. An immediate audit of the medication cart was completed, and the narcotics were counted and all accounted for and free from tampering. The Attorney General's office was notified and local police. The facility conduced immediate staff re-education for licensed staff performing medication administration. The facility concluded the findings of misappropriation of resident A1's narcotic medication, could not be substantiated. Employee 2, LPN failed to submit a statement and was terminated. A review of Employee 1 RN's employee file revealed that she was hired on September 9, 2024. A medication skills checklist, competencies for medication administration was signed as completed on September 9, 2024. A review of Employee 2 LPN's employee file revealed that she was hired on July 14, 2021. A medication skills checklist, competencies for medication administration was signed as completed on April 9, 2024. During an interview with the NHA and DON, and in the presence of the regional NHA, on November 15, 2024, at approximately 1:00 PM, revealed that all licensed nursing staff responsible for administering medications and completing treatments were expected to provide nursing services consistent with professional standards of quality as defined by the PA Code Title 49, Professional and Vocational standards. Additionally, the NHA and DON confirmed that on October 2, 2024, during the 7:00 PM to 7:00 AM shift, Employee 1 and Employee 2 failed to follow the facility's medication administration policies and procedures by pre-pouring medications and ensuring that prepared medications were administered by the licensed nursing staff preparing the medication in efforts to prevent a potential drug diversion and medication errors. The facility failed to ensure that nursing staff had the demonstrated the competencies and skills sets to accurately administer resident medications. (continued on next page)

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