



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/10/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185463	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/24/2015
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NAME OF PROVIDER OR SUPPLIER  RICHMOND PLACE REHABILITATION AND HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2770 PALUMBO DRIVE LEXINGTON, KY 40509
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to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure an alleged violation of misappropriation of resident property was reported immediately to the State Survey and Certification Agency for one (1) of five (5) sampled residents (Resident #1). Registered Nurse (RN) #2 misappropriated Resident #1's controlled pain medication; however, the facility failed to report the misappropriation to the State Agency as per its policy.

The findings include:  
Review of the facility's policy titled, "Reporting Abuse and Neglect", dated 04/01/11, revealed the Policy defined misappropriation of resident property as "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent".  
Review of the facility's policy titled, "Abuse Investigations", dated 04/01/11, revealed the Administrator would provide a written copy of abuse investigations to the State Survey Agency within five (5) working days of the reported incident.

F 225 the facility and other officials in accordance with state law through the established procedures (including to the state survey and certification agency).

On 3/25/15, the Administrator was educated by the Regional Director of Clinical services regarding the abuse policy and state regulation regarding reporting timely to the state agency as soon as misappropriation or abuse of any kind is suspected.

On 3/25/15, the Administrator re-inserviced the Interdisciplinary Care Plan Team including 3 Unit Coordinators, Assistant Director of Nursing, 3 MDS Coordinators and Dietary Manager regarding the community's policy and state regulation relating to the abuse policy and state regulation regarding reporting timely to the state agency as soon as misappropriation or abuse of any kind is suspected.

Direct care staff (Registered Nurses, Licensed Practical Nurses, and Nurse Aides) were re-inserviced by the 3 Unit Managers (1 RN, 2 LPN).

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F 225	Continued From page 2  Record review revealed the facility admitted Resident #1 on 01/26/15, with diagnoses which included Aftercare for Traumatic Fracture of Bone, Personal History of Recurrent Pneumonia and Dysphagia NOS. Review of Resident #1's Physician's Orders revealed an order for Oxycodone IR (an immediate release narcotic pain medication) 5 milligram (mg) every four (4) hours around the clock for pain dated 01/26/15. Further review of the Physician's Orders revealed a telephone order for oral Morphine (a narcotic pain reliever) solution 2 mg dated 02/01/15.  Review of the Controlled Drug Record for Resident #1 revealed Registered Nurse (RN) #2 signed out four (4) doses of the resident's Oxycodone IR 5 mg. Review revealed on 02/01/15 the Oxycodone was signed out as administered by RN #2 at 2:00 PM, 6:00 PM, and 10:00 PM, and on 02/02/15, RN #2 signed out a dose of Oxycodone for Resident #1 as administered at 2:00 AM. Further record review revealed Resident #1 expired in the facility on 02/02/15 at 3:30 AM.  Interview with Licensed Practical Nurse (LPN) #4 on 03/24/15 at 3:25 PM, revealed on 02/08/15, she was filling in for the Supervisor and found a discrepancy on Resident #1's Medication Administration Record (MAR). LPN #4 revealed on 02/01/15 she had been working day shift on Resident #1's unit, and had attempted to give Resident #1 the Oxycodone IR 5 mg for pain that morning. Per interview, however, Resident #1 was no longer able to swallow pills at that point. Continued interview revealed she called Resident #1's doctor and received an order for oral Morphine solution 2 mg to be given instead of the	F 225	Assistant Director of Nursing (RN) and QA Nurse (LPN) regarding the community's policies relating to the abuse policy and state regulation regarding reporting timely to the state agency as soon as misappropriation or abuse of any kind is suspected by April 30, 2015.  The Administrator and the Assistant Director of Nursing RN will immediately review suspicious situations including suspected misappropriations with the Regional Director of Clinical services for 6 months to ensure any suspicious of abuse in any form including misappropriations are reported to all appropriate state agencies.  Incidents involving reports of abuse including misappropriation will be forwarded to the Quality Assurance Committee, (Medical Director, Director of Nursing, Administrator, Quality Assurance Coordinator, and Pharmacy Consultant) for review to maintain compliance for 6 months  Completion Date: April 30, 2015		

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Oxycodone for pain relief, due to the resident's inability to swallow pills. LPN #4 revealed Resident #1 did not regain the ability to swallow prior to expiring the following morning, 02/02/15. Further interview revealed RN #2 did not work on Resident #1's unit caring for the resident on 02/01/15. Per LPN #4, RN #2 was working on a different unit on 02/01/15, and would not have had access to Resident #1's medications. According to LPN #4, RN #2 signed out Resident #1's Oxycodone medication for times the RN would not have been in the facility, such as, 02/01/15 at 2:00 PM and 6:00 PM. LPN #4 revealed Resident #1's Oxycodone IR 5 mg remained locked in the medication cart following Resident #1's death on 02/02/15, and was noted as having missing doses until the morning of 02/08/15. In addition, LPN #4 stated all of Resident #1's medications had remained in the medication cart until the morning of 02/08/15. She stated she reported the discrepancy when it was discovered on 02/08/15, to the Assistant Director of Nursing (ADON). Per interview, RN #2 never returned to the facility after that.

Interview with the ADON on 03/24/15 at 10:23 AM and 4:09 PM, revealed when she received report from LPN #4 on the morning of 02/08/15, regarding the discrepancy in Resident #1's medications, she informed the Administrator. Per interview, she notified the police, and the staffing agency RN #2 worked for to inform them not to send RN #2 to the facility again. The ADON revealed the police instructed her to wait before making any referrals to the Kentucky Board of Nursing (KBN), as the police wanted to conduct their own investigation without RN #2 being alerted of their involvement. Continued interview revealed other residents were interviewed, and

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F 225	<p>Continued From page 4</p> <p>residents' medical records were reviewed after the discrepancy was noted. The ADON revealed the police charged RN #2 with four (4) counts of controlled substance theft for medications she admitted stealing from the medication cart which were prescribed for Resident #1. The ADON revealed when she interviewed RN #2 following the police investigation, RN #2 told her she had reported herself to the KBN as having a problem with narcotics. However, per the ADON, RN #2 did not admit anything to her regarding theft of Resident #1's narcotic pain medication or any other resident's pain medications.</p> <p>Interview with the Administrator on 03/24/15 at 4:26 PM, revealed once the facility had initiated their investigation, if they suspected abuse, neglect, or misappropriation, they reported it to the State Survey Agency. Per interview, as Resident #1 was already deceased at the time the theft of the narcotic pain medication was discovered, and the other residents potentially affected were private pay residents, the facility determined misappropriation had not occurred. The Administrator revealed no residents were negatively affected by the theft, and as the facility had paid for any medications given or lost, misappropriation had not occurred. Even though the facility's policy defined misappropriation of resident property as "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent".</p>	F 225			