The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported 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.

The unit manager has conducted an audit of PRN narcotic medications for Resident #1. All regular and PRN narcotics prescribed for the resident are present and available. Additionally, the hospice nurse reviewed the medication regimen for pain management for resident #1 on August 25, 2011. The hospice nurse concluded that the resident's pain was appropriately managed and did not recommend a change in medication.

Additionally, utilizing the unit manager's notes of interviews conducted in the investigation of the incident, notes of other actions taken during the investigation and other information available, the unit manager, Regional Clinical Director, Interim DON and Administrator completed a summarization of actions taken to investigate the missing medications. Summary includes interviews conducted by the unit manager during the facility's investigation with six nurses who had worked on that unit.
**F 225** Continued From page 1

This **REQUIREMENT** is not met as evidenced by:
Intakes: TN00028633

Based on policy review, medical record review, review of an incident investigation and interview, it was determined the facility failed to ensure that a thorough investigation for an allegation of a missing controlled medication was completed and reported to the State agency within 5 days of the incident for 1 of 14 (Resident #4) sampled residents reviewed.

The findings included:

Review of the facility's "Controlled Drugs" policy documented, "...In Case of a Discrepancy...The D.O.N. [Director of Nursing] initiates an investigation as to whether the dose was administered or refused and the reason for not charting... Complete a medication error report and an incident report identifying the nursing shift involved and efforts to reconcile the discrepancy..."

Review of the facility's "Substance Abuse & [and] Testing" policy documented, "...Employee's Responsibilities... Compliance with the Company's Substance Abuse and Testing Policy is a condition of employment. Failure to cooperate with this policy, including but not limited to... refusing to consent to testing, refusing to submit a specimen for testing when requested by management... Substance Abuse Testing... Types of substance abuse testing used by the Company and covered by this Policy include, but are not limited to... Reasonable Cause:"

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
</table>

**F 225** Summary also includes corrective measures taken to improve the count and management process for narcotics.

**B.**
- A review of incident reports over the previous 30 days was completed by the administrator and Interim DON. No other incidents involving missing medications were identified.
- The unit managers and interim DON or ADON will conduct an audit of all narcotics to assure that medications are available in accordance with the physician orders.

**C.**
- The administrator and Interim director of nursing reviewed the process for ordering and receiving pain medications and for documenting the medication count. A new Narcotics Reconciliation log was implemented and the process for recording the receipt of the medications was adjusted. As the nurse receives any controlled medication she will sign for the medication and place the receipt in a file for reference by
F 225 Continued From page 2

'Reasonable Cause' testing may be required whenever... Medication of a controlled substance nature is missing or believed to be missing, and management reasonably believes that one or more employees to be tested may be responsible...

Medical record review for Resident #4 documented an admission date of 1/22/09 with diagnoses of Hypertension, Anemia, Atrial Fibrillation, Diabetes Mellitus, Renal Failure, Senile Dementia and Failure To Thrive. Review of a physician's order dated 7/22/11 documented, "...Oxycodone 30 mg [milligrams] [symbol for one] po [by mouth] q [every] 4 [symbol for hours] / prn [as needed]..." Review of the Medication Administration Record dated July 2011 and August 2011 documented no administration of Oxycodone 30 mg.

An incident investigation was initiated on 8/24/11 by the facility for Resident #4. The incident investigation documented Nurse #1 discovered there was no Oxycodone 30 mg available for Resident #4 on the medication cart. Nurse #1 contacted the pharmacy, and "...The pharmacy records indicated that the medication was delivered on 8/22/11..." Nurse #1 contacted the nurses by phone who were working on the floor and during the shift the Oxycodone was delivered and the nurse assigned to Resident #4 during the second shift. Nurse #1 searched the medication carts and narcotic boxes, but "...The medication was not located..." No further attempts to resolve the discrepancy were documented. There was no documentation of statements obtained from staff members contacted during the investigation and no documentation that the incident was reported to the unit manager. The nurse will also log the medication onto the Narcotic Reconciliation log that is centrally located. This log will provide the nursing staff with an ongoing count of the total number of medications that should be counted in the medication carts at each change of shift. The nurse will verify at the end of each shift that the narcotics count is correct and that the appropriate number and type of medications have been reviewed and accounted for in accordance with this log.

- The interim Director of Nursing contacted the Tennessee Board of Nursing and informed the individual who spoke with her about the incident. The individual stated that the incident is not a Tennessee Board of Nursing matter and referred her to an investigation division. The interim Director of Nursing then contacted the Investigations Division and spoke with a staff member there. The interim Director of Nursing related to the staff member the
F 225 Continued From page 2

'Reasonable Cause' testing may be required whenever... Medication of a controlled substance nature is missing or believed to be missing, and management reasonably believes that one or more employees to be tested may be responsible...

Medical record review for Resident #4 documented an admission date of 12/2/09 with diagnoses of Hypertension, Anemia, Atrial Fibrillation, Diabetes Mellitus, Renal Failure, Senile Dementia and Failure To Thrive. Review of a physician's order dated 7/22/11 documented, "...Oxycodone 30 mg [milligrams] [symbol for one] po [by mouth] q [every] 4 [symbol for hours] / prn [as needed]..." Review of the Medication Administration Record dated July 2011 and August 2011 documented no administration of Oxycodone 30 mg.

An incident investigation was initiated on 8/24/11 by the facility for Resident #4. The incident investigation documented Nurse #1 discovered there was no Oxycodone 30 mg available for Resident #4 on the medication cart. Nurse #1 contacted the pharmacy, and "...The pharmacy records indicated that the medication was delivered on 8/22/11..." Nurse #1 contacted the nurses by phone who were working on the floor and during the shift the Oxycodone was delivered and the nurse assigned to Resident #4 during the second shift. Nurse #1 searched the medication carts and narcotic boxes, but "...The medication was not located..." No further attempts to resolve the discrepancy were documented. There was no documentation of statements obtained from staff members contacted during the investigation and no documentation that the incident was reported circumstances of the incident and was informed that the incident was not actionable by their organization because a specific individual could not be identified as the responsible party. The interim DON then reviewed with the staff member from the investigations unit the measures taken to prevent future occurrences. The staff member reported that there was nothing more the facility needed to do at this time.

- The Unit managers will be informed by the DON, Interim ADON, nurse manager, or Pharmacy on the appropriate methods and process for completion of an incident report, completion of the narcotic control log and the controlled medication policy.
- Unit managers, the interim DON, DON or ADON or nurse managers will in-service the licensed nurses on the appropriate methods and process for completion of incident reports, completion of the narcotic control log and the controlled medication policy.
F 225  Continued From page 2

'Reasonable Cause' testing may be required whenever... Medication of a controlled substance nature is missing or believed to be missing, and management reasonably believes that one or more employees to be tested may be responsible..."

Medical record review for Resident #4 documented an admission date of 12/2/09 with diagnoses of Hypertension, Anemia, Atrial Fibrillation, Diabetes Mellitus, Renal Failure, Senile Dementia, and Failure To Thrive. Review of a physician’s order dated 7/22/11 documented, "...Oxycodeone 30 mg [milligrams] [symbol for one] po [by mouth] q [every] 4 [symbol for hours] / prn [as needed]...” Review of the Medication Administration Record dated July 2011 and August 2011 documented no administration of Oxycodeone 30 mg.

An incident investigation was initiated on 8/24/11 by the facility for Resident #4. The incident investigation documented Nurse #1 discovered there was no Oxycodone 30 mg available for Resident #4 on the medication cart. Nurse #1 contacted the pharmacy, and "...The pharmacy records indicated that the medication was delivered on 8/22/11...” Nurse #1 contacted the nurses by phone who were working on the floor and during the shift the Oxycodone was delivered and the nurse assigned to Resident #4 during the second shift. Nurse #1 searched the medication carts and narcotic boxes, but "...The medication was not located..." No further attempts to resolve the discrepancy were documented. There was no documentation of statements obtained from staff members contacted during the investigation and no documentation that the incident was reported.

- Additionally unit managers will be in service on appropriate dates for investigating incidents and recording the investigation. This in-service will be completed by the Interim DON/ADON or Regional Clinical Director, Clinical Educator.
- The DON or Interim DON or Assistant Director of Nursing will utilize information available from the Tennessee Board of Nursing website and any other information that may be available from this source to in-service the unit managers on the guidelines and timeframes for reporting incidents of missing narcotics.
- The Human Resources Coordinator will in-service the DON/Interim DON, Unit Managers and ADON on the Substance Abuse policy.
**F 225** Continued From page 3

To the appropriate State agency in the facility's investigation report.

During an interview in the conference room on 9/27/11 at 2:14 PM, Nurse #1 stated that she had called (Name of Pharmacy) and confirmed that a reorder of Oxycodone 30 mg for Resident #4 was delivered to the facility by the pharmacy on 8/22/11. Nurse #1 was asked if she had located the missing medication in the facility. Nurse #1 stated, "...there was none... it wasn't available..."

During an interview in the conference room on 9/27/11 at 3:00 PM, the Administrator was asked if the facility had drug tested any of the employees who might have had access to Resident #4's controlled medications. The Administrator stated, "...no... it was too broad..." The Administrator confirmed that the facility investigation was not reported to the State agency.

The facility failed to thoroughly investigate an allegation of a missing (misappropriation) controlled medication and failed to notify the appropriate State agency of the incident within 5 working days of the incident as required per federal regulations.

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
</table>
| F 22 |            | **D.** Unit manager, ADON, or DON will conduct monthly audits of 10% of residents with narcotic medication orders to assure that the medications are being appropriately managed and ordered. Charts will be selected on a random basis. Target is 100% compliance. The DON to the Quality Assurance Committee will report results of audits. Once 100% compliance has been achieved for 3 consecutive months audits.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This Plan of correction is the Facility's credible allegation of compliance.