STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235182	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LYNWOOD MANOR HEALTHCARE CENTER	730 KIMOLE LN ADRIAN, MI 49221

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 -** Some	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 866 Based on interview and record review, the facility failed to prevent misappropriation of medication for 12 residents (Resident #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #17) of 12 reviewed for misappropriation, resulting in drug diversion and narcotic medication that was unaccounted for. Findings include: Review of the Facility Reported Incident and Investigation, revealed Upon arrival to the facility on [DATE] at approximately 0530, the (Director of Nursing) DON, was approached by (Licensed Practical Nurse (LPN) L). (LPN L) reported that the other nurse on duty, (LPN G) could not stay awake and he was sleeping at the B-Wing Nurse Station. (LPN L) also informed her that earlier in the night the staff could not find him and eventually found him sleeping in his car. The DON went out to the B-Wing Nursing Station and finding (LPN G) asleep, woke him up. After pulling a drug urine test kit from the office, the DON went up to the A-Wing Nurse cart where (LPN G) was standing. (LPN G) was mentally not acting right. He was tapping his fingertips on the top of the medication cart and weaving back and forth. The urine was provided for the drug test by (LPN G). The DON transported (LPN G) via wheelchair, across the street to the emergency room . She communicated to (LPN G) that he was suspended from work pending investigation of his current behaviors. Upon reaching the reception desk (LPN G) could not mentally hold a conversation with the receptionist and she took him back into the ER. The DON returned to the facility. After returning to the facility (ER Nurse Supervisor M) called the DON and requested her presence in the ER. Upon arrival the DON was informed that that (LPN G) was under the influence of Opioids and they were just about to give him [MEDICATION NAME]. Upon returning to the facility, the DON telephoned (Nursing Home Administrator (NHA) A) and made him aware. The Adrian City Police Department was notified, and they dispatched an officer to the facility. The ER completed a search of his backpack and did not find any narcotic medications in it. Upon returning from the ER, the DON began an immediate investigation and completed narcotic reviews of every narcotic on each medication cart that (LPN G) had control over the prior 12 hours. The narcotic review was completed with (Registered Nurse (RN) N). Medications lacked documentation on the MAR and / or narcotic record for the following residents: 1. (Resident #3 (R3)) - (3) [MEDICATION NAME] Tablet 10-325 MG ([MEDICATION NAME]-[MEDICATION NAME]) No documentation of medication given on narcotic sheet or [DATE]. (Resident #4 (R4)) - (2) [MEDICATION NAME] Tablet 15 MG RX 1739 Was missing two. If medication was given at 0000 as ordered there is still one missing. 3. (Resident #6 (R6)) - (2) [MEDICATION NAME] Capsule 300 MG RX 5727 Was missing two if one was given at 2100 as ordered one still remains missing. 4. (Resident #11 (R11))- (2) Pregabalin 300mg No documentation of medication given on narcotic sheet or [DATE]. (R11)- (2) [MEDICATION NAME] 1mg No documentation of medication given on narcotic sheet or [DATE]. (R11) - (2) [MEDICATION NAME] Tablet 10-325 MG ([MEDICATION NAME]-[MEDICATION NAME]) No documentation of medication given on narcotic sheet or [DATE]. (Resident #12 (R12)) - (4) [MEDICATION NAME] ER 30mg RX 6208 - Was missing 2 if one was given one remains missing. RX 0915 - Missing two pills. If the nurse just forgot to sign the 0600 medication out on 11-29-19 there are still 3 missing. 8. (R12) - (1) [MEDICATION NAME] Capsule 300 MG No documentation of medication given on narcotic sheet or [DATE]. (R12) - (2) [MEDICATION NAME] HCL 50 MG No documentation of medication given on narcotic sheet or [DATE]. (Resident #9 (R9)) - (1) [MEDICATION NAME] 2 MG RX 6219 - 11/26/19 there were five tabs 11/29/19 one was signed out at 0300 but wrong count of 3 remaining was written when actually there should be four. One [MEDICATION NAME] 2mg unaccounted for. 11. (Resident #17 (R17)) - (1) [MEDICATION NAME] Tablet 10-325 MG ([MEDICATION NAME]-[MEDICATION NAME]) No documentation of medication given on narcotic sheet or PCC 12. (Resident #13 (R13)) - (4) [MEDICATION NAME] HCL 50 MG No documentation of medication given on narcotic sheet or PCC 13. (Resident #10 (R10)) - (3) [MEDICATION NAME]-acet 5-325 No documentation of medication given on narcotic sheet or PCC 14. (Resident #8 (R8)) - (4) [MEDICATION NAME]-acetamin 7.5-325 No documentation of medication given on narcotic sheet or PCC 15. (Resident #7 (R7)) - (1) [MEDICATION NAME] HCL 50 MG No documentation of medication given on narcotic sheet or PCC 16. (R7)- (1) [MEDICATION NAME] Capsule 800 MG Documented in PCC not signed out on Narcotic sheet 17. (Resident #5 (R5)) - (1) Pregabalin 150mg Documented in PCC not signed out on Narcotic sheet If the nurse gave the medications and just failed to document in PCC and on the narcotic count sheets there still are medications unaccounted for. [MEDICATION NAME] 30mg three tabs unaccounted for [MEDICATION NAME] 15mg one tab unaccounted for [MEDICATION NAME] 2 mg one tab unaccounted for [MEDICATION NAME] 300 mg one tab unaccounted for As part of the investigation, a review of the MARs revealed that (LPN G) had not signed out the 9pm medications as well . Review of Resident #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #17's Medication Administration Records and Controlled Substance Records, revealed the medications listed as missing in the facility's investigation were accurate. In a telephone interview on 8/12/20 at 1:58 PM, LPN L reported the Friday after Thanksgiving, he came into work at 3:00 AM to cover for LPN E who had to leave at 3:00 AM. LPN L reported by 4:00 AM, LPN E walked out and said the other nurse from A hall (LPN G) was sleeping outside. LPN L reported himself, LPN E and a CNA went out to LPN G's car, which was off. LPN L reported they opened the door and woke him up at which time LPN G reported he was tired. LPN L reported he went back inside the B North doors and LPN E left. LPN L reported as he was doing checks and making sure things were done, he saw LPN G outside the door, having trouble getting into the building so LPN L had to let LPN G back inside. LPN L reported he asked LPN G if he was okay to finish his shift at which time LPN G reported he was. LPN L reported LPN G still seemed sleepy and the CNAs got him coffee and LPN G sat down. LPN L reported he told LPN G he would be right back after checking on the B hall residents. LPN L reported then the CNAs came and got me and said he (LPN G) wasn't acting right .CNAs told me when I had left he was trying to eat the phone, talking to them like he was working at a restaurant. LPN L reported he observed LPN G having difficulty opening the medication cart and dropping the keys. LPN L reported he asked LPN G to sit down and then he called the on call unit manager who was on her way to the facility. LPN L stated Told him (LPN G) he had to sit down and couldn't do anything. I didn't feel safe letting him do anything. LPN L reported he went back to B hall and LPN G got up and followed him. LPN L stated He was standing there and falling asleep. Had him sit behind the desk on B hall. Told him he had to wake up. LPN L reported when Director of Nursing (DON) B arrived at the facility at approximately 5:30 AM, he went to her office and told her we had a situation. LPN L stated (DON B) and I stood on back hall as (LPN G) walked and he again did the same thing, shuffling keys, dropped them, holding onto the cart to pick them up. LPN L reported DON B obtained a drug test and took LPN G to the Emergency Department. LPN L reported DON B and Registered Nurse (RN) N counted the medication carts after this. In a telephone interview on 8/12/20 at 2:45 PM, CNA I reported she worked with LPN G the night of 11/28/19. CNA I stated He was so tired .seemed too tired .We were working and he must have taken a break. Other nurse from other hall that was leaving found him sleeping in his car or something like that. Me and the other nurse got him. He came back in and was acting really off the wall, thought he was working in a restaurant. He wasn't making any sense when he was talking to us. I went to other nurse because I wasn't sure what to do. In a telephone interview on 8/12/20 at 2:51 PM, LPN E reported the morning of 11/29/19, she left the facility sometime between 3:00 AM and 4:00 AM. LPN E stated I went out and when getting in my car, I noticed he (LPN G) was slouched over in his car and the car wasn't running. I tapped on the window and he didn't answer. I ran in and got LPN L. CNA I came out with us, car was unlocked. We opened the door and shook (LPN G) and he woke up. He said he needed a minute to gather himself. In an interview on 8/13/20 at 12:23 PM, Dietary Aide

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.

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F 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) (DA) Q reported the morning of 11/29/19, she was scheduled to drive the facility's transport van. DA Q reported LPN G was at the nurses' cart falling asleep. I asked if he was ok. He got up and said what, what did you say. I asked if he was ok. He said he was just tired. I went to get the [MEDICAL TREATMENT] resident, came back up and he was standing in the hall swaying, eyes shut. As I was waiting to get out the door, he was walking into the wall. Two CNAs ended up helping him. In a telephone interview on 8/13/20 at 9:35 AM, LPN G reported he wasn't feeling well that night so the CNAs told me to go to my car and take a short nap. That's where it all ended. When asked about the medications not being signed out as administered, LPN G stated It was in the middle of the shift when all this took place. We were short staffed and almost at capacity. The computer at the med cart had connectivity issues with the Internet. It would work for a couple minutes and then stop. I wasn't able to click anything off. Since I went to the hospital in the middle of the shift, I wasn't able to go back and fix that. When asked why the medications were not signed out on the Controlled Substance Records (which are paper and not electronic), LPN G stated Oh I didn't sign anything out, didn't sign narcs out as I went. when asked why not, LPN G stated I was busy and overwhelmed. LPN G reported that it was not his normal practice to not sign out medications as they were given. When asked about the medications that were still unaccounted for, even if he did administer all medications as ordered and not sign them out, LPN G stated there were PRNs (as needed medications) given during my shift .I know one was [MEDICATION NAME]. I know there was one other one. When told there were numerous medications not accounted for, LPN G stated This was almost a year ago, I can't recall. When asked if his drug screen was positive for opiods, LPN G stated I was having back pain before all this. (Opiods were) Given to me by my best friend. They were his mother's who was on hospice. He gave them to me to get by. When asked what medications were given to him, LPN G stated one was [MEDICATION NAME] and I think one was a lower dose of [MEDICATION NAME]. When asked when he last took opiod medications, LPN G stated after getting off work the day before LPN G reported he was not aware that he received [MEDICATION NAME] in the Emergency Department. LPN G confirmed he was the only nurse who had access to the medication cart until DON B arrived to the facility and took over on 11/29/20. In a telephone interview on 8/13/20 at 10:33 AM, Emergency Department Nurse Supervisor M reported when LPN G came to the Emergency Department, he was pretty much unconscious. Would respond to deep stimulus. We [MEDICATION NAME]'d him. In an interview on 8/13/20 at 11:42 AM, DON B reported during the facility's investigation, they found the narcotic count was correct at the beginning of LPN G's shift on 11/28/19. DON B reported after LPN G was taken to the hospital, herself and RN N counted all controlled medications before anyone went any further. DON B reported there were still narcotic medications unaccounted for even if LPN G did administer all medications that were scheduled/ordered to be given. In a telephone interview on 8/13/20 at 11:53 AM, RN N stated From what I understood, he (LPN G) had been acting a little funny all night, couldn't stay awake. Once I came in, the count was off. Nothing had been written down, no documentation of any meds taken out of cart. DON and myself went through and did count on both carts. (There were) meds not accounted for on both carts. I finished out the shift. I think after we counted, I passed the morning pills. gave report to next nurse around 7 or 7:30. Review of the Shift Change Controlled Substance Inventory Count Sheet revealed on 11/28/19 at 7:00 AM, LPN G signed as on nurse and LPN R signed as off nurse. There was one card (typically up to 30 tablets) of [MEDICATION NAME] taken out for R13. LPN G initialed removing this, but it was not initialed by a second nurse. R13's Controlled Substance Record dated 11/27/19, revealed 60 tablets of [MEDICATION NAME] were delivered, however only 30 tablets were accounted for. On 11/28/19 at 7:00 PM, LPN R signed as the off nurse and LPN N signed as on nurse, however it was LPN G who worked at this time and should have signed as the on nurse. In a telephone interview on 8/13/20 at 12:14 PM, LPN P reported when a narcotic count was done, two nurses had to verify the amounts and both nurses needed to sign off. When asked if she remembered counting with LPN G when he came into work on 11/28/19, LPN P stated I don't remember counting with him. I remember the count was correct. When asked why LPN G did not sign the narcotic count and instead RN N signed, LPN P stated sometimes other nurses don't sign initially when you count .I can't tell you why they dont. Can't tell you why he didn't .I can't verify they sign it right away or not. LPN P reported LPN G did not mention not feeling well and reported that he always complained that he was tired. In an interview on 8/13/20 at 12:32 PM, DON B reported she could not explain why RN N signed the count sheet as the oncoming nurse at 7:00 PM on 11/28/19 instead of LPN G, who was the actual oncoming nurse at that time.