Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101366	A. BUILDING _____ B. WING _____	R-C 07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{P 000}	Initial Comments A Desk Review Revisit was initited on 07/23/2024 and concluded on 07/25/2024. It was determined the facility had achieved substanial compliance on 07/12/2024 as alleged. Based upon the implementation of the acceptable Plan of Corretion, the facility was deemed to be in compliance on 07/12/2024, as alleged.	{P 000}		

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

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101386	A. BUILDING: _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments AMENDED An Abbreviated Survey was conducted on 06/07/2024. The facility was found to not to be in substantial compliance with 902 KAR 20:036 4(1)(g)1-7. Survey Dates: 06/07/2024 Survey Census: 66 Sample Size: 2 A deficiency was related to KY00042487 at P0215.	P 000		
P 215	902 KAR 20:036 4(1)(g)1-7 Section 4. Provision of Services (1) Basic health and health related services. (g)1. Controlled substances. A PCH or SPCH shall not keep any controlled substances or other habit forming drugs, hypodermic needles, or syringes except under the specific direction of a prescribing practitioner. 2. Controlled substances shall be kept under double lock, for example, stored in a locked box in a locked cabinet. 3. There shall be a controlled substances bound record book with numbered pages that includes: a. Name of the resident; b. Date, time, kind, dosage, and method of administration of each controlled substances; c. Name of the practitioner who prescribed the medications; and d. Name of the. (i) Nurse who administered the controlled substance, or	P 215	**1. What specific measures were utilized to correct the violation?** • Residents R1 & R2 were assessed by the Acting Director of Health Services with neither resident experiencing any adverse effects from the incident. The resident's family and MD were notified as to the event with no new orders. • LPN8 was terminated on 05/10/2024 for failure to meet nursing expectations on the shift of 05/04/2024-05/05/2024, • The Clinical Support Nurse completed re-education with the Director of Health Services on 7/1/24 regarding regulation P 185 902 KAR 20:036 4 (a) 1-4 Provision of services, "Guidelines for Medication Error Reporting," "Guidelines for Narcotic Count," "Medication Administration Times Procedural Guidelines," "Resident Rights," "Medication Administration Guidelines," & our "Drug Screening Policy."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Shumate — TITLE: DVP — (X6) DATE: 7/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101388	A. BUILDING: _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 215	Continued From page 1 (II) Staff member who supervised self-administration by a resident whose medical record includes a written determination from a health care practitioner that the resident is able to safely self-administer a controlled substance under supervision. 4. A staff member with access to controlled substances shall be responsible for maintaining a recorded and signed: a. Schedule II controlled substances count daily; and b. Schedule III, IV, and V controlled substances count at least one (1) time per week. 5. All expired or unused controlled substances shall be disposed of, or destroyed in accordance with 21 C.F.R. Part 1317 no later than thirty (30) days: a. After expiration of the medication; or b. From the date the medication was discontinued. 6. If controlled substances are destroyed on-site: a. The method of destruction shall render the drug unavailable and unusable; b. The administrator or staff person designated by the administrator shall be responsible for destroying the controlled substances with at least one (1) witness present; and c. A readily retrievable record of the destroyed controlled substances shall be maintained for a minimum of eighteen (18) months from the date of destruction and contain the: (I) Date of destruction; (II) Resident name; (III) Drug name; (IV) Drug strength; (V) Quantity;	P 215	2. What specific measures were utilized to ensure the violation will not recur? • The Director of Health Services conducted an audit of current resident's medication administration records to ensure medications were administered per physician orders. • The Director of Health Services also conducted an audit of the Medication carts, EMAR, and Narcotic Log to ensure expired and/or unused medications were disposed of and destroyed. Staff with access to controlled substances log were reviewed to ensure compliance with maintaining a recorded and signed controlled medication log in accordance with P 185 902 KAR 20:036 4 (a) 1-4 Provision of services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101366	A. BUILDING: _____ B. WING _____	C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 215	Continued From page 2 (vi) Method of destruction; (vii) Name of the person responsible for the destruction; and (viii) Name of the witness. 7. A PCH or SPCH that stores and administers controlled substances in an emergency medication kit (EMK) shall comply with the: a. Requirement for licensed personnel established by 201 KAR 2:370, Section 2(4)(i); b. Requirements for storage and administration established by 902 KAR 55:070, Section 2(2), (5), (7), (8), and (9); and c. Limitation on the number and quantity of medications established by 902 KAR 55:070, Section 2(6) This requirement is not met as evidenced by: AMENDED The facility failed to provide basic health and health related services that included ensuring controlled medications that were expired or unused were disposed of or destroyed and staff with access to control substances failed to be responsible for maintaining a recorded and signed controlled medications for two of 10 sampled residents, Residents (R1, R2). The findings include: Review of the facility policy revised date 05/10/2016, "Guidelines for Medication Error Reporting," indicated in the event of a medication error, nursing personal should first take whatever immediate action is necessary to protect the	P 215	• The Director of Health Services provided re-education to licensed nurses and medication aides regarding regulation P 185 902 KAR 20:036 4 (a) 1-4 Provision of services, "Guidelines for Medication Error Reporting," "Guidelines for Narcotic Count," "Medication Administration Times Procedural Guidelines," "Resident Rights/Abuse," & "Medication Administration Guidelines," by 7/5/24. • The Director of Health Services will perform random audits of five resident's EMARS and narcotic logs to ensure medications are administered per physician's order and the narcotic logs are maintained and recorded with signed controlled medications, four times per week, for a period of 5 weeks, then 5 resident records, three times per week, for 5 weeks, then 5 resident records, two times per week, for a period of 5 weeks.	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101388	A. BUILDING: _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	328 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 215	Continued From page 3 resident's safety and welfare. Guidelines for the immediate measure that need to be taken after a medication error takes place. Review of the facility policy revised date 08/02/2016, "Guidelines for Narcotic Count," revealed to provide guideline for tracking narcotic distribution. At the time one nurse or other staff qualified to pass medications relinquishes the keys to the medication cart to another staff member the narcotics shall be reconciled by comparing the medications in the cart to the count sheets. Both staff members shall sign that the narcotic count is accurately reconciled. Review of the facility policy revised date 12/01/2021, "Medication Administration Times Procedural Guidelines," revealed to ensure medication is administered in resident centered fashion and documented in medical record. Trilogy Health Services honors the resident's right to self-determine their schedule and care choices and to maintain an environment and routine similar to their pattern prior to residing at the campus. The nurse shall give the resident options of administration to ensure appropriate spacing of administration. Review of the facility policy revised date 03/2024, "Drug Screening Policy," revealed if an employee is suspected of impairment due to illegal substance, Employee Services should be contacted to discuss the possibility of administering a drug and/or alcohol screen. If an employee is suspected of stealing medication/pharmaceutical drugs, Employee Services should be contacted to discuss the possibility of administering a drug screen. Review of the facility policy revised date	P 215	• The Director of Health Services will also perform five random audits of the medication carts to ensure controlled medications that were expired or unused were removed and disposed of or destroyed in accordance with the above referenced violation. • The above-mentioned audits will be reviewed by the campus interdisciplinary team during their monthly QAPI meeting to determine the frequency as to the monitoring plan. Findings suggestive of 100% compliance may result in cessation of the monitoring plan. 3. By what date will the violation be corrected? • Completion date 07/12/2024 (This date must be placed in the Completed Date section.) RECEIVED JUL 23 2024 CHFS Office of Inspector General Division of Health Care - AIB Received by	7/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101366	A. BUILDING: _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 215	Continued From page 4 08/11/2016, "Assisted Living Resident Right Guidelines," revelaed to ensure resident rights are respected and protected and provide an environment in which they can be exercised. Our residents have the right to be treated with dignity and respect. Be free from physical, verbal fiduciary or psychological abuse from staff, family, and other residents. Review of the facility policy revised date 08/11/2016, "Assisted Living Medication Administration Guidelines," revealed to provide a mechanism for residents to receive their ordered medications. A controlled substance shall not be set up for later administration and be kept in the original container in which it was dispensed by the pharmacy or other authorized dispensing practitioner bearing the original prescription label. Further review of "Resident Face Sheet" revealed the facility admitted Resident (R13) on 02/19/2024 with diagnoses that included hyperlipidemia, arthritis, osteoporosis, Chronic Obstructive Pulmonary Disease (COPD), and anxiety. Review of "Resident Progress Notes" for R13 revealed the note, dated 05/05/2024 at 3:33 PM, written by Director of Health Services (DHS) "nurse completed assessment on resident, no changes in condition at this time." Review of "Resident Prescription Order" for R13 revealed the note, dated 04/09/2024 at 4:02 PM, written by Medical Doctor and signed off by another Licensed Practical Nurse to discontinue medication on 04/11/2024 for Gabapentin at three times per day, discontinue on 04/28/2024 for Gabapentin pro re nata (PRN), three times per day.	P 215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101366	A. BUILDING: _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 215	Continued From page 5 Review of "Resident Face Sheet" for R14 revealed the facility admitted Resident (R14) on 06/01/2024. Review of "Resident Progress Notes" for R14 revealed the note, dated 05/06/2024 at 3:41PM, written by Director of Health Services (DHS) "nurse completed assessment on resident, no changes in condition at this time." Review of "Medication Administration History: 6/17/2022 - 06/06/2024" revealed the following medication, Gabapentin 100 mg twice a day as ordered to administered to R14. During an interview, on 06/07/2024 at 8:10 AM, former Acting Director of Health Services (DHS) stated she received a call from Certified Resident Medical Assistant (CRMA)13 and Licensed Practical Nurse (LPN)7 that they discovered missing medication after the count with LPN8 who had already left the facility. DHS stated when she arrived at the facility, they re-counted the medication and completed an assessment on the residents who were missing the medications. The missing medication was Gabapentin for Resident R14. DHS continued to state that R14 no longer takes the medication Gabapentin, and it should have been destroyed within three days of being discontinued and should have not been on the medication cart. Furthermore, DHS stated during the investigation process LPN8 had been reported to the police but unsure if she has been reported to Kentucky Board of Nursing (KBN). During an interview, on 06/07/2024 at 8:35 AM, CRMA13 stated at shift change with LPN8 she thought the medication count was correct however about 30 minutes later she discovered	P 215		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101366	A. BUILDING: _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 215	Continued From page 8 the narcotic count was wrong. She called the acting DHS to inform her about the medication error. DHS stated she was on her way and would contact the Executive Director (ED). Once the DHS and ED had arrived at the facility, statements were taken, and the narcotic count was re-counted. It was verified that two Gabapentin pills were missing. It appeared that the pills were still in the container because it had tape over it. All narcotics was taken out to make sure the pills were not in the drawer since the foil was thin, however the pills were never found. Continued interview with CRNA13 stated R14's Gabapentin was discontinued about two weeks but was still on the medication cart. She stated once a medication was discontinued the nurse sent an order to DHS to remove the medication from the medication cart. The medication was either destroyed or given to the resident to take at discharge. CRNA13 stated the following day LPN8 was 45 minutes late for the start of her shift. It took at least three separate times to count the medication cart. LPN8 was distracted, she was swaying back and forth, and dropping some of the pills during the count. LPN8 was struggling to count the pills. LPN8 reported everything was fine while giving a report but she did not give 4 residents their medications. Residents were upset with LPN8, complained about the time of night LPN8 gave out medications at 3:00 AM, waking up residents to administer medications or/and to obtain blood pressure readings. CRNA13 stated she noticed discrepancies on resident's medications. Either medications were given or not given. During interview, on 06/07/2024 at 9:33 AM, LPN7 reported she is a voyager (the facility agency services), so she is not familiar with staff	P 215		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101366	A. BUILDING: _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 215	Continued From page 7 and that was the first and only weekend she had worked at the facility. When she arrived at the facility, she completed the medication count which included the narcotic count with LPN8 at shift change. LPN7 stated her medication cart was, "a mess." LPN8 gave a report stating she did not have time to give four residents their medication. However, it was discovered it was a whole hall. LPN7 stated documentation stated LPN8 gave medication at odd times, 1:00 AM, 2:00 AM, 3:00AM. Some medications were still on the cart, pre-package that stated it had been given. CRMA13 reported that the Gabapentin count was off and one of the resident's Gabapentin was missing a pill although it was discontinued but still on the cart. DHS was notified by CRMA13. Continued interview with LPN7 reported that the DHS and ED arrived at the facility. They printed off the medication orders to compare what was given or not, completed vitals on resident and looked for potential medication errors. The ED also took statements and interviewed residents. This incident was potential harm for residents with heart related problems who did not receive their medications. Residents reported ringing their call lights all night for assistance or/and medication but did not receive them. LPN7 stated she was unsure if or when to give medications because she did not want to overdose the residents. It was decided to skip medications and give medications at the next opportunity to be on the safe side. LPN7 stated that LPN8 was ready to leave and stated it was a "crazy" night but did not say what happen to make it "crazy." She stated she got behind on given out medications but did not say when or how she got behind such as a fall or an	P 215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101366	A. BUILDING _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 215	Continued From page 8 accident with a resident. LPN7 reported that CRMA13 had found R15's medication fully intact in its pre-package in the trash can on her medication cart. In the system, it was documented that resident's medication was given. During interview, on 06/07/2024 at 10:35 AM, R15 reported that last month she used her call light all night long to request her medication however she did not receive her medication until the following morning around 10:00 AM. That night she had to argue with the nurse about receiving her medication. The nurse stated she had given R15 her medication however she had not. R15 stated she was very disturbed by this because she knew she did not receive her night medication. The nurse came into her room to give her eye drops but not her oral medication. This made her mad. Finally, the nurse admitted she had not given R15 her medication. R15 stated she thinks the nurse was having "some kind of problem." During interview, on 06/07/2024 at 10:45 AM, R16 reported she requested that her medication be given before she went to bed and the latest is 9.00 PM. R16 reported that the night nurse had woken her up after midnight to give her medications and it was hard for R16 to go back to sleep. R16 stated she had spoken to management about this issue, and it had gotten better. R16 stated she could not identify the staff member. During interview, on 06/07/2024 at 12:12 PM, R13 reported she had been woken up out of her sleep at 6.00 AM to be given medication however the staff member is no longer here. R13 stated	P 215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101366	A. BUILDING: _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	325 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 215	Continued From page 9 she does not remember if she had missing or had missed any medications; it had been so long ago. During interview, on 06/07/2024 at 12:12 PM, the Executive Director (ED) reported on Sunday May 5, 2024, at approximately 9:30 AM-10:00 AM, he received a call from the acting DHS stating there was a medication error, and she was on her way to the facility to gather information from staff members, LPN7 and CRNA13 who were working on the personal care side. ED reported once he arrived, they started the investigation. Staff stated that LPN8 told them she was tired from planning a party for the last couple of days. She explained that she had missed 3-4 resident's medications however once they logged into EMAR, it was observed that LPN8 had not given medications to more than double than what she had reported. They started to do an audit of the medications for those residents, notified the physician, notified family, and completed an assessment to make sure there was not advise actions to the residents. Continued interview with ED stated that LPN8 was PRN and it was noted that she had a prescription for Gabapentin. Staff members reported that LPN8 had behaviors out of her normal such had an unsteady gait, dropping pills, miscounting pills, not given a detailed report at shift change, loopy, and residents reporting giving out medications at odd times at night. It was reported that some thought LPN8 was under the influence but could not smell anything. ED reported there had been about eight to nine residents affected by medications either administrated incorrectly or not given that night. There was one pill that had popped out the	P 215		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101366	A. BUILDING: _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOPER TRAIL SENIOR LIVING	326 LINCOLN WAY BARDSTOWN, KY 40004

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 215	Continued From page 10 package and the back of the package was taped back. The other pill we never found. There was a total of two pills missing. There was another resident's medication found in the trash can on the medication cart. There was no explanation of why the medication was missing or why the medication was in the trash. ED reported that LPN8 was reported to the local Police Department however a report was not completed due to the brand of the drug did not meet the terms of an investigation. LPN8 was not reported to KBN, and a drug test was not completed although the facility has a policy for drug testing employees. During interview, on 06/11/2024 at 11:29 AM, Resident Care Associate (RCA4) reported she was on the Personal Care side as a floater and carried a pager. She received several complaints from the residents on LPN8 about being waken up to be given medications. One resident asked, "what is wrong with that girl." LPN8 was not acting like herself, she was not responsive and not acting like normal. Review of "Personnel Action Form" for LPN8 revealed the note, dated 05/10/2024 revealed she was terminated from employment for failure to meet nursing expectations on the shift of 05/04/2024-05/05/2024, signed by ED. RCA4 stated while she was working with LPN8, she was dropping medications and told her she had missed given resident medications. She stated she witnessed LPN8 stumbling over her words, her speech was slow, and her eye was blinking like crazy, and she was stumbling when she was walking. I even texted CRMA13 stating LPN8 was "looped up."	P 215		