STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

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E 001 SS=D	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to have a complete Emergency Preparedness (EP) plan. The EP plan failed to list services the facility had the ability to provide in an emergency. The EP plan did not address the provision of medical and pharmaceutical supplies, alternate sources of energy to maintain temperatures, emergency lighting, fire detection, extinguishing, and alarm systems, and sewage and waste disposal. The EP plan did not have a system to track the location of on-duty staff and	E 001	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this 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.	3/22/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/22/2019

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E 001	Continued From page 1 sheltered residents in the facility's care during an emergency. The EP plan did not contain information for the safe evacuation from the facility. The EP plan did not have a means of providing information about the facility's occupancy. The EP plan did not have a method for sharing information from the emergency plan with residents and their families. The EP plan did not state where the emergency generator was located and did not contain information for emergency generator inspection and testing. The EP plan did not have information regarding a plan for how the facility would keep emergency power systems operational during the emergency unless it evacuated. The findings included: A. Review of the EP plan revealed the plan did not include the type of services the facility was able to provide in an emergency and the continuity of operations including delegations of authority and succession plans. B. Review of the EP plan revealed the plan did not contain information regarding the provision of medical and pharmaceutical supplies, alternate sources of energy to maintain temperatures to protect resident health and safety, and for the provision of emergency lighting, fire detection, extinguishing, and alarm systems, and sewage and waste disposal. C. Review of the EP plan revealed there was no system to track the location of on-duty staff and sheltered residents in the facility's care during an emergency. If on-duty staff and sheltered residents are relocated during the emergency the facility must document the specific name and	E 001	E001 •¿Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Facility Safety Officer reviewed regulatory requirements of Emergency Preparedness (EP) plan and updated the plan on 3/22/19 to include: 1. services the facility has the ability to provide in an emergency; 2. provision of medical and pharmaceutical supplies, 3. alternate sources of energy to maintain temperatures, emergency lighting, fire detection, extinguishing, and alarm systems, and sewage and waste disposal; 4. system to track the location of on-duty staff and sheltered residents in the facility's care during an emergency; 5. information for the safe evacuation from the facility; 6. information about the facility's occupancy; 7. method for sharing information from the emergency plan with residents and their families; 8. where the emergency generator is located and information for emergency generator inspection and testing; 9. information regarding a plan for how the facility would keep emergency power systems operational during the emergency unless it evacuated. •¿Address how the facility will identify	

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E 001	Continued From page 2 location of the receiving facility or other location. D. Review of the EP plan revealed the plan did not include information regarding safe evacuation from the facility which included consideration of care and treatment needs of evacuees, staff responsibilities, transportation, and identification of evacuation locations and primary and alternate means of communication with external sources of assistance. D. Review of the EP plan revealed the plan did not include a method for providing information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or designee. E. Review of the EP plan revealed the plan did not include a method of sharing information the facility has determined appropriate with residents and their families or representative. F. Review of the EP plan revealed the plan did not state the location of the emergency generator, did not contain information regarding emergency generator inspection and testing, and did not contain information for how it would keep emergency power systems operational during the emergency unless it evacuated. An interview with the Facility Safety Officer who was responsible for coordinating the facility's EP plan on 03/01/19 at 10:35 AM revealed the facility's EP plan was tied in with their affiliated hospital's EP plan and that the above information was not contained in the facility's EP plan. The Facility Safety Officer stated she was going to work on further developing the facility's existing	E 001	other residents having the potential to be affected by the same deficient practice; The Facility Safety Officer reviewed regulatory requirements of Emergency Preparedness (EP) plan and updated the plan on 3/22/19 to include: 1. services the facility had the ability to provide in an emergency; 2. provision of medical and pharmaceutical supplies, 3. alternate sources of energy to maintain temperatures, emergency lighting, fire detection, extinguishing, and alarm systems, and sewage and waste disposal; 4. system to track the location of on-duty staff and sheltered residents in the facility's care during an emergency; 5. information for the safe evacuation from the facility; 6. information about the facility's occupancy; 7. method for sharing information from the emergency plan with residents and their families; 8. where the emergency generator was located and information for emergency generator inspection and testing; 9. information regarding a plan for how the facility would keep emergency power systems operational during the emergency unless it evacuated. •¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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E 001	Continued From page 3 EP plan, gather the missing information, and place the information in a binder.	E 001	Emergency Preparedness Plan education for all staff to include: 1. services the facility had the ability to provide in an emergency; 2. provision of medical and pharmaceutical supplies, 3. alternate sources of energy to maintain temperatures, emergency lighting, fire detection, extinguishing, and alarm systems, and sewage and waste disposal; 4. system to track the location of on-duty staff and sheltered residents in the facility's care during an emergency; 5. information for the safe evacuation from the facility; 6. information about the facility's occupancy; 7. method for sharing information from the emergency plan with residents and their families; 8. where the emergency generator was located and information for emergency generator inspection and testing; 9. information regarding a plan for how the facility would keep emergency power systems operational during the emergency unless it evacuated. For employees who have not received training and education by 3/22/19, they will not be allowed to work until training is received. Emergency Preparedness Plan education will be incorporated into the new staff orientation program. For resident and family education, highlights of the Emergency	

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E 001	Continued From page 4	E 001	Preparedness Plan will be included in the admissions process within the Resident Handbook. For all current patients and residents, a letter will be given including education on the Emergency Preparedness Plan and include an invitation to attend an educational session delivered by the facility's Safety Officer. Resident Representatives will be sent the same letter via USPS providing education on the Emergency Preparedness plan, who to contact with any questions, and invited to attend an educational session delivered by the facility's Safety Officer. Completion 3/22/19. •¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning 3/25/19, the Facility Safety Officer will conduct 5 staff interviews weekly, to include all shifts for 12 weeks, to ensure compliance with the EP plan. Review of compliance includes: 1. where to find the Emergency Preparedness Plan; 2.understanding their role during an emergency; 3. locating emergency supplies; 4. where the emergency generator is located; and 5. utilization of the tracking form during an emergency. Results of the monitoring will be shared with the Safety Committee monthly. Members of the Safety Committee	

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E 001	Continued From page 5	E 001	include: Safety Officer, Administrator, DON, dietary manager, ADON, maintenance, EVS director, and facility educator. Continued monitoring will be determined by the Safety Committee, based on compliance results. Safety Committee representative will provide results to present on the Quality Board, which includes important facility updates pertinent to Patient Safety throughout the monitoring period. Safety Committee representative will present compliance results at the monthly QAPI meeting to present a summary of findings for a period of 90 days, at which time it will be determined by the QAPI Committee if further monitoring and representation needs to occur. •¿Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State. 3/22/19	
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted on 02/25/19 through 03/01/19. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of (J) CFR 483.12 at tag F607 at a scope and severity of (J) The tags F600 and F607 constituted Substandard Quality of Care.	F 000		

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F 000	Continued From page 6 Immediate Jeopardy began on 12/05/18 and was removed on 03/01/19. An extended survey was conducted. On 04/30/19 the facility was provided with an amended Statement of Deficiencies because the IDR process deleted tags F-600 (J) and F-607 (J) which also removed the Immediate Jeopardy and Substandard Quality of Care. Additionally, F-609 (D) was deleted based on the IDR process. Event UCT011.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		3/22/19

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F 609	Continued From page 7 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 record reviews and staff interviews the facility failed to report an allegation of sexual abuse to the state agency within 2 hours when a Nurse Aide (NA) reported an observation of sexual abuse for 1 of 2 residents reviewed for abuse (Resident #316 and Resident #61). The findings included: Resident #61 was admitted to the facility on 12/14/09 with diagnosis which included non-Alzheimer's dementia. Review of the most recent annual Minimum Data Set dated 12/18/18 revealed Resident #61 was cognitively intact for daily decision making and required limited to extensive assistance with most activities of daily living. A review of Resident #61's record revealed she had been seen by the Physician on 01/07/19 for a regulatory visit. The Physician documented there was an incident the week before in which the patient was found in another patient's bed across the hall. The note revealed the residents had a history of this before. The patients were separated upon discovery, families were notified and Resident #61 was placed on frequent monitoring following the incident. A review of Resident #61's record revealed she	F 609	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this 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. F609 Reporting of Alleged Violations Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 1/2/19 NA #1 stated she separated the residents, taking Resident #61 back to her room and notified the Nurse #2 of the incident. On 2/27/19, the Regional Nursing Consultant re-educated the facility's Director of Nursing and Administrator on investigation protocol, including how to conduct a thorough investigation and reporting requirements.	

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F 609	Continued From page 8 had been seen by the psychotherapist on 01/14/19 for sexually inappropriate behaviors. The note stated staff had reported Resident #61 had been going into a male resident's room and undressing. The note stated the male resident was very sick and the incidents were causing distress to Resident #61 and the male resident. A review of Resident #61's record revealed she had been seen by the psychotherapist on 01/28/19 for sexually inappropriate behaviors. The note stated Resident #61 was found in a male patient's room with some of each of their clothing removed. The note stated there were questions of the resident's ability to consent. Resident #316 was admitted to the facility on 01/19/18 and readmitted into the facility on 12/12/18 following an admission into the hospital. Review of the medical record revealed Resident #316 had diagnoses of atrial fibrillation, heart failure, non-Alzheimer's dementia, anxiety. Review of the quarterly MDS dated 10/21/18 revealed Resident #316 was severely cognitively impaired and required extensive assistance with most activities of daily living. Review of a Nursing Assessment form dated 12/05/18 revealed documentation stating Resident #61 was found transferring out of the bed with Resident #316 by staff. The note stated staff reports that the patient was readjusting clothing while transferring out of the bed. An interview was conducted on 02/26/19 at 11:32 with NA #1. NA #1 stated she was working on the 100 hall. She stated she had seen Resident #61	F 609	The notification to HCPI (24-hour/5-day reports) and law enforcement were made on 3/1/19. Address how the facility will identify other resident having the potential to be affected by the same deficient practice; The Regional Nurse Consultant conducted a review of all incident reports within the past 30 days to determine if the incidents should have been reported to HCPI and/or state authorities. Completion 3/22/19. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; On 2/27/19, the DON, ADON, SDC, and charge nurse educated all staff on the facility's abuse prohibition policy. Any staff members who did not receive the education on this date were not allowed to work until the education was received. The education included the definitions of abuse, sexual abuse, verbal abuse, mental abuse, physical abuse, involuntary seclusion, misappropriation of resident's property, neglect, injury of unknown origin, and the investigation, prevention, reporting requirements, and protecting residents. This abuse education is included in the new employee education. On 2/27/19, the Regional Nursing Consultant re-educated the facility's Director of Nursing and Administrator on	

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F 609	Continued From page 9 in December 2018 with her pants down sitting on top of Resident #316 with his pants down. NA#1 stated she separated the residents, taking Resident #61 back to her room and notified Nurse #2. She stated Resident #61 had been seen going into Resident #316's room 6-8 times since September 2018 and sometimes twice in one day in which she intervened separating the residents and notifying the nurse. She stated each time she reported the incidents to the nurse on duty. The interview revealed after Resident #316 expired Resident #61 had attempted to enter his former room where a new resident had been admitted. Resident #61 was redirected to her room. An interview conducted on 02/26/19 at 04:10 PM with the Director of Nursing (DON) revealed the first incident between Resident #61 and Resident #316 occurred in June 2018. The DON stated Resident #316 was found with his hands up Resident #61's shirt, Resident #61 was found during third shift on the same day in Resident #316's room. She stated the second incident occurred on 12/04/18, Resident #61 was found standing beside of Resident #316's bed. The DON stated after each incident the residents were placed on every 15-minute monitoring documented in flowsheets provided to the nurses, the ombudsmen was contacted, and education was provided to staff on how to handle residents with sexual behaviors. She stated a 24hr 5-day report was not completed due to believing the incident was not sexual abuse. She stated Resident #61 had not touched Resident #316 and the incident report dated 01/02/19 was entered in error due to rumors and not facts. An interview conducted on 02/27/19 at 8:17 AM	F 609	investigation protocol, including how to conduct a thorough investigation and reporting requirements. Staff was educated to observe for incidents that fit the abuse criteria and to report to the Director of Nursing and the Administrator. Staff will report any concerns to the Supervisor/Charge Nurse immediately, who then will report it to the Director of Nursing and the Administrator immediately. The information will be documented on incident reports, which notify Risk Management and Operations Leadership when an incident occurs. The incident reports will be shared by DON in the stand-up morning meeting. On 3/1/19, an incident log was developed and implanted, which will be maintained by the DON. This log will contain the date of incident, description of incident, follow up from incident, and whether or not the incident was reportable. The regional nurse consultant will complete a 100% audit of the incident log for 12 weeks. The regional nurse consultant will be present at the monthly QAPI meeting to present a summary of findings. Beginning 3/4/19, the DON will conduct 10 staff interviews for a period of 12 weeks to assess the compliance with the Abuse Prohibition Policy. Review of compliance includes the staff understanding of the definitions of abuse, sexual abuse, verbal abuse, mental abuse, physical abuse, involuntary seclusion, misappropriation of resident's property, neglect, injury of	

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F 609	Continued From page 10 with NA #1 revealed she had caught Resident #61 on top of Resident #316 undressed attempting to have sexual intercourse in December 2018. NA#1 stated she noticed Resident #61 was not in her room nor in activities. She stated she noticed the door closed to room 108 so she knocked on the door and went into the room. She stated Resident #316 was lying in bed turned on his side and Resident #61 was sitting on top of him with her brief down. She stated Resident #316's boxers were pulled down. NA #1 stated Resident #61 and Resident #316 had skin to skin contact. She stated Resident #61 jumped up, assisted Resident #316 pull his boxers up and got in her wheelchair. She stated she assisted Resident #61 back to her room and informed Nurse #2 of the incident. NA #1 stated Nurse #2 was at a medication cart when she told her and stated okay at the end of the conversation. NA #1 stated following the notification of the incident she was given no instructions or interventions to aide in monitoring the two residents. NA #1 stated no administrative staff contacted her following the incident. She stated she had been given training in the past on how to handle residents with sexual behaviors and how to report the incidents. NA#1 stated she told Resident #61's family member of the incident which had occurred the family member stated she did not want her mother going into Resident #316's room because it was inappropriate. On 02/27/19 at 8:37 AM and interview was conducted with Nurse #2. Nurse #2 stated Resident #61 and Resident #316 had a relationship which included Resident #61 going into Resident #316's room and sometimes becoming frisky, attempting to have sexual relations. Nurse #2 stated she did not recall NA	F 609	unknown origin, and the investigation, prevention, and reporting requirements. The DON/Administrator will be present at the monthly QAPI meeting to present a summary of findings. Beginning 3/4/19, weekly, for a period of 12 weeks, the Safety Event Review Team (SERT) which includes, Chief Medical Officer, Chief Nursing Executive, Regional Operations Administrator, Regional Nurse Consultant, Risk Manager, and Director of Quality, will evaluate incident reports for compliance with the investigation protocol and reporting requirements of the Abuse Prohibition Policy/Procedure. The Director of Quality will present at the monthly QAPI meeting any issues found at the weekly Safety Event Review Team meeting. Beginning 3/4/19, the Accreditation Coordinator, a member of the corporate quality team, will complete weekly audits for 12 weeks for any reportable events to determine they are thoroughly investigated and reported according to policy and procedure. The Accreditation Coordinator will be present at the monthly QAPI meeting to present a summary of findings. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Results of the Incident Report monitoring will be shared by the Regional Nurse Consultant with the administrator and DON weekly and with the QAPI	

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F 609	Continued From page 11 #1 telling her she had to separate the two residents in December however she stated NA #1 may have. She stated protocol following an incident would be to write a note, call the family and report it to a supervisor. She stated she had written a note on 12/05/18 regarding the incident and notified the Assistant Director of Nursing. On 02/27/19 at 9:15AM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she remembered a couple of incidents regarding Resident #61 and Resident #316. She stated Resident #316 could not tell staff anything about the incident that happened on 12/05/18. She stated on 12/05/18 she was filling in for the DON, she stated she was told Resident #61 had been found in Resident #316's room but couldn't remember details about the incident. The ADON stated she did not know if the incident should have been investigated so she contacted the DON who gave her instructions to just separate the residents. On 02/27/19 at 9:36AM a follow up interview was conducted with the DON. The DON stated she was not informed on the full details regarding the incident which occurred on 12/05/18 of Resident #61 in bed with Resident #316. The DON stated her expectation was for staff to notify her of the details regarding the incident entirely. She stated if she had been informed of Resident #61 found in Resident #316's bed she would have notified the Administrator, started an investigation and filed a 24 hr report. On 03/01/19 at 9:36AM an interview was conducted with the Administrator. The Administrator stated his expectation of the incident which had occurred on 12/05/18 was for	F 609	Committee monthly. Continued monitoring will be determined by the QAPI committee based on the results. The Director of Quality will present results from the weekly monitoring of incident reports from the Safety Event Review Team at the monthly QAPI Meeting for a period of 3 months. The QAPI Committee will then determine if further monitoring and oversight is needed from the group. The Accreditation Coordinator will present results from audits completed on whether reportable events were investigated and reported according to policy and procedure for a period of 3 months. At the conclusion of the 3 months, the QAPI Committee will determine if further monitoring is needed. Include dates when corrective action will be completed Completion date 3/22/19	

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F 609	Continued From page 12 nursing staff to have had better communication with each other. He further stated there had been a communication breakdown between nursing staff which was the cause for the incident not being investigated and reported properly. The Administrator stated the incident should have been investigated and reported according to the facility policy.	F 609		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 11 sampled residents reviewed for complete quarterly MDS assessments (Resident #4). The findings included: Resident #4's most recent Minimum Data Set (MDS) was a quarterly that was completed on 10/19/18. Review of her computerized medical record revealed that the next MDS which had an assessment reference date (ARD) of 02/07/19 was not completed when reviewed on 02/28/19. An interview with the MDS coordinator was conducted on 02/28/19 at 3:18 PM. The MDS coordinator stated that for the most part, she was able to complete MDS assessments on time,	F 638	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this 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. F638- Quarterly Assessment at Least Every 3 Months •¿Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #4’s Quarterly Assessment was	3/22/19

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F 638	Continued From page 13 however, she stated Resident #4's assessment was not completed on time. She stated Resident #4's due assessment was triggered late and she has not completed the assessment as of this date. The MDS coordinator stated she has found that the computer system was missing a few residents and not notifying her of due dates, Resident #4 being one of those that was not being triggered on time. She stated that although she identified this as a problem she had not informed anyone in management or corporate of the identified problem. A joint interview with the Director of Nursing and the Administrator on 03/01/19 at 9:29 AM revealed that neither had been informed of any computer issues resulting in MDS assessments not being triggered on time. They stated they expected the MDS assessments to be completed within the required time frames. An interview with the secretary on 03/01/19 at 9:44 AM revealed that she kept a manual schedule of due dates for MDS assessments to assist the MDS coordinator keep track of due dates. She showed her system and noted that Resident #4 was scheduled for the quarterly in January 2019 as due but it was scratched off and not done. She was not sure why. She further stated that the computer system did not catch and inform staff that Resident #4's quarterly MDS was due in January. She also stated that she has noticed there was a problem with the computer not triggering required assessments on time but that she has not reported this problem to anyone. She stated she was not sure what happened resulting in Resident #4 not having a quarterly assessment on time.	F 638	completed late per the RAI manual requirements. Resident #4's most recent Quarterly ARD is 02/07/2019 and the previous Quarterly ARD was 10/19/2018 (more than 92 days). Director of Case Mix & Compliance provided education regarding the OBRA Assessment timing per the RAI manual and will ensure #4's next Quarterly assessment reference date is no more than 92 days from the 02/07/19 ARD (will be completed on or before 5/9/19). •¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; MDS Coordinators and/or Director of Case Mix & Compliance will review The Assessment Schedule using the electronic scheduling system for every resident currently in the facility. This method will be used to conduct 100% audit of all OBRA assessments scheduled for March 2019 (Comprehensive & Non-Comprehensive Assessments). The audit ensured no residents have been omitted from the OBRA Schedule based on the current census and also ensured all OBRA assessments scheduled were within 92 days from their previous ARD. This audit was completed on 3/15/19. If more than 92 days passed since the last OBRA assessment, a new OBRA assessment was opened/created immediately. •¿Address what measures will be put into place or systemic changes made to	

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F 638	Continued From page 14	F 638	ensure that the deficient practice will not recur Director of Case Mix & Compliance will provide education regarding OBRA assessment timing per regulation and the RAI Manual. MDS Coordinators will begin to utilize the electronic scheduling system in the electronic medical record system to identify OBRA assessment needs and create assessments timely. The MDS Coordinators will use the general MDS schedule and not attempt to identify assessment needs while viewing an individual resident record as this may not provide a view of the upcoming assessment needs per regulatory requirements. Director of Case Mix & Compliance will develop a manual scheduling method for OBRA Assessment needs that will serve as a “double check” method for the software scheduling system. This manual schedule will be compared with the software system when determining all OBRA assessment ARDs. This will be done by 3/15/19. Going forward all facility personnel not acting as MDS Coordinators currently involved in monitoring and creating the OBRA assessment Calendar will be relinquished of this duty. Effective 03/15/19 the OBRA Assessment Calendar will be monitored, managed, modified and created solely by the MDS Coordinators in the facility. The MDS Coordinators will use this process ongoing to ensure late OBRA assessments will not recur. MDS Coordinators will be expected to use the electronic software schedule as well as a	

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F 638	Continued From page 15	F 638	double check manual version of the OBRA schedule to cross reference OBRA assessment needs. This double check method will decrease the opportunity for missed OBRA assessments or setting assessment ARDs more than 92 days since the prior OBRA assessments. •¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Director of Case Mix & Compliance or designee will conduct 100% audit of all OBRA assessment ARDs scheduled using the electronic schedule on a weekly basis. The audit will ensure ARDs set are within 92 days of their prior ARD. This will continue for a period of 12 weeks beginning week 03/25/19. Any changes needed in setting assessment reference dates will be made at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 12 weeks at which time frequency of monitoring and ongoing designee will be determined by the QAPI Committee. •¿Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State. 3/22/19	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	F 640		3/22/19

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F 640	Continued From page 16	F 640		

§483.20(f) Automated data processing requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer,

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F 640	Continued From page 17 reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to transmit a discharge return anticipated Minimum Data Sets (MDS) assessment in the required time frames for 1 of 4 sampled discharged residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 08/10/18. The admission Minimum Data Set (MDS) dated 08/17/18 was completed. She then had a significant change MDS completed on 09/07/18. Review of the computerized record revealed that Resident #1 was discharged with return anticipated on 10/08/18. Resident #1 was never readmitted to the facility and the discharge MDS was noted to be "ready" for transmission but had not been transmitted as of 02/28/19. An interview with the MDS coordinator was conducted on 02/28/19 at 3:23 PM. The MDS coordinator stated that since October 2018 she has been without the second MDS staff. She further stated that she has been transmitting assessments about every other day. The MDS coordinator stated that she noticed a couple of days ago that the discharge MDS was still open	F 640	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this 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. F640- Encoding/Transmitting Resident Assessment •¿Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #1's Discharge MDS Assessment ARD 10/08/18 was in the MDS system closed and completed but was not transmitted. On 3/1/19, this MDS Assessment was transmitted. •¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	

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F 640	Continued From page 18 so fixed it and it was now ready to be sent. She stated the discharge MDS was completed, just not transmitted. A joint interview with the Director of Nursing and the Administrator on 03/01/19 at 9:30 AM revealed they stated they expected the MDS assessments to be transmitted when completed and on time.	F 640	MDS Coordinators were provided education by the Director of Case Mix & Compliance regarding Federal and State regulation to ensure MDS Assessments are transmitted timely. Completion 03/08/2019. Director of Case Mix & Compliance conducted 100% audit of Discharge MDS Assessments from March 01 to present (March 18, 2019) to ensure all necessary Discharge Assessments were present in the system. All discharge assessments identified as not completed or not transmitted were successfully transmitted by 3/22/19. •¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Beginning 3/25/19 MDS Coordinator will pull Admission, Discharge, Transfer (ADT) information daily to ensure all appropriate assessments can be opened and or completed per regulatory requirements. Beginning the week of 3/25/19 the MDSC will compare opened discharge assessments with weekly ADT data to ensure all appropriate assessments were opened or completed per regulatory requirements. For any assessments not opened or completed appropriately, the MDSC will complete. Beginning the week of 3/25/19, the MDSC	

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F 640	Continued From page 19	F 640	will schedule two days per week to complete submissions/transmissions of MDS assessments (Tuesdays and Fridays). Once the assessments have been submitted, the MDSC will print the validation report for confirmation of a successful transmission. •¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Beginning the week of 3/25/19, 100% of Discharge Assessments will be audited weekly for 12 weeks to ensure successful transmission. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 12 weeks at which time frequency of monitoring and designee will be determined by the QAPI Committee. •¿Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State. 3/22/19	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		3/22/19

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F 656	Continued From page 20 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to develop a comprehensive resident centered care plan to address inappropriate sexual behaviors by a resident (Resident #61)	F 656	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of	

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F 656	Continued From page 21 until after a second incident of resident to resident sexual abuse occurred and failed to implement effective interventions to prevent further inappropriate sexual behaviors for 1 of 3 sampled residents reviewed for abuse (Resident #61). The findings included: Resident #61 was admitted to the facility on 12/14/09 with a diagnosis which included non-Alzheimer's dementia. Review of the quarterly Minimum Data Set dated 09/18/18 revealed Resident #61 was cognitively intact for daily decision making and required limited to extensive assistance with most activities of daily living. Resident #61 was coded for having no behaviors. Review of the quarterly MDS dated 10/21/18 revealed Resident #316 was severely cognitively impaired and required extensive assistance with most activities of daily living. Review of a Nurse note dated 12/05/18 written by Nurse #2 revealed Resident #61 was observed by staff transferring out of the bed with Resident #316. The note stated staff reported Resident #61 was observed readjusting her clothing while transferring out of the bed. An interview was conducted on 02/26/19 at 11:32 AM with Nursing Assistant (NA) #1. NA #1 stated she had seen Resident #61 in early December 2018 with her pants down sitting on top of a male resident with his pants down attempting to have sexual intercourse. NA#1 stated she separated the residents, taking Resident #61 back to her room and notified the nurse on duty whom was	F 656	the truth of the facts alleged or conclusions set forth in this 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. F656- Develop/Implement Comprehensive Care Plan •¿Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Review of Resident #61's care plan revealed it did not address the resident's sexual behaviors staff observed her making toward Resident #316 on 12/05/19 and a plan to address. Resident #61's care plan and interventions for sexual behaviors were developed 01/03/19. •¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; An audit of 100% of residents exhibiting any behaviors was conducted for the presence of a current Plan of Care and appropriate interventions related to identified behaviors. Any identified behaviors without a current plan of care will have a care plan created with appropriate interventions immediately upon identifying the need. Completed 3/22/19. Education for all staff on appropriate	

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F 656	Continued From page 22 Nurse #2. She stated Resident #61 had been seen going into the male resident's room which she intervened separating the residents. She stated each time she reported the incidents to the nurse on duty. On 02/27/19 at 8:37 AM and interview was conducted with Nurse #2. Nurse #2 stated she wrote a note on December 5, 2018 regarding the incident between Resident #61 and Resident #316 and notified the Assistant Director of Nursing. She stated Resident #61 was observed going into Resident #316's room and becoming frisky, attempting to have sexual relations. She stated protocol following an incident was to write a note, call the family and report it to a supervisor. Review of Resident #61's care plan revealed it did not address the resident's inappropriate sexual behaviors staff observed her making toward Resident #316 on 12/05/19 and a plan to address Resident #61's inappropriate sexual behaviors was not developed until 01/03/19. Review of a Nurse note dated 01/02/19 at 1:18AM written by Nurse #1 revealed Resident #61 was observed in a male resident's room with her hands beneath Resident #316's blanket. Both residents stated they were fine, and Resident #61 returned to her room approximately 10 minutes later. Review of the facility incident report dated 01/02/19 at 6:30AM written by Nurse #1 revealed Resident #61 was observed in Resident #316's room. The report stated both residents were observed undressed from the waist down lying in bed.	F 656	identification and reporting of behaviors will be provided by 3/22/19. Director of Case Mix and Compliance will educate the Interdisciplinary Team (IDT) regarding the development and implementation of comprehensive care plans according to regulations, to include the development of the care plan and associated interventions. Completion 3/22/19. •¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Beginning 3/25/19, the 'Behavior Detail Report,' which lists residents with identified behaviors, will be pulled each morning by the social worker prior to the daily stand-up meeting. For residents with identified behaviors, the list will be reviewed by the IDT to determine if there is an appropriate plan of care completed with an appropriate intervention in place to address the behavior(s). For newly identified behaviors, a care plan will be developed immediately. For ongoing behaviors, the plan of care will be reviewed and modifications made as appropriate as determined by the IDT. This will be an ongoing process for the facility in the morning meetings. Education for staff on appropriate identification and reporting of behaviors will be provided in new hire orientation beginning the week of 3/25/19.	

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(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) COMPLETION DATE
F 656	Continued From page 23 Review of the facility incident investigation and action plan revealed an incident dated 01/02/19 at 6:30AM written by the DON. The incident report revealed on 01/02/19 at 6:30AM Resident #61 was found in Resident #316's room standing on the left side of his bed with her panties removed. The report stated the residents were separated and Resident #61 was redirected to her room. Resident #61 was placed on every 15-minute frequent monitoring which was included on Resident #61's care plan dated 01/03/19. Review of the care plan for Resident #61 dated 01/03/19 revealed Resident #61 was observed wandering into a male resident's room. Resident #61 was disrobed beside the male resident's bedside. The goal was for Resident #61 to display fewer sexual behaviors through the next review date. The interventions included: staff discussing a room change with the family, staff will monitor resident every 15 minutes. Ombudsmen referral to evaluate the nature of the sexual behaviors, monitor/observe Resident #61's behaviors and to redirect the resident in a calm tone. The review revealed Resident #61 was not previously care planned for sexual behaviors prior to 01/03/19. Review of a Nurse note dated 01/09/19 revealed Resident #61 was observed leaving Resident #16's room while on every 15- minute frequent monitoring. The note stated Resident #61 was redirected and re-educated on situation and Resident #61 had verbalized understanding. On 02/27/19 at 9:36AM an interview was conducted with the DON. The DON stated her expectation was for Resident #61 to have been care planned for behaviors following the 12/05/18	F 656	•¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Social Worker or Designee will conduct an audit of 100% of residents exhibiting behaviors and ensure a current plan of care is in place for those residents. This 100% audit will continue weekly for 12 weeks beginning the week of 3/25/19. Results of this audit will be provided to the Administrator and Director of Nursing weekly. The social worker will report results from the audits and any trends identified monthly to the QAPI Committee for a period of 3 months. At the end of the 3 months, the QAPI Committee will determine if further monitoring is necessary. •¿Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State. 3/22/19 ¬	

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	345282	A. BUILDING _____ B. WING _____	03/01/2019

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F 656	Continued From page 24	F 656		

incident with Resident #316 to prevent a reoccurrence and for staff to implement the care plan interventions put into place on 01/03/19 to have prevented Resident #61 from entering the male resident's room again on 01/07/19.

On 02/17/19 at 1:03PM an interview was conducted with Social Worker (SW) #1. She stated the social work department had been notified of the incident involving Resident #61 attempting to have sexual intercourse with Resident #316 on 01/02/19. She stated she was not notified of any other incidents of Resident #61 exhibiting sexual behaviors. She stated she was informed on 01/02/19 Resident #61 went into a male resident's room (Resident #316) and was seen with her pants down attempting to get into bed with the resident with sexual intent. She stated Resident #61's care plan had been revised to include sexual behaviors on 01/03/19 and the Ombudsmen had been notified on 01/02/19 with a voicemail left because she could not get in contact with her. The interview revealed Resident #61 was not care planned for inappropriate sexual behaviors prior to 01/03/19.

On 03/01/19 at 9:36 AM an interview was conducted with the Administrator. The Administrator stated his expectation of the incident which had occurred on 12/05/18 was for nursing staff to have had better communication, further stating there had been a communication breakdown between nursing staff. The interview revealed Resident #61 should have been care planned for inappropriate behaviors following the 12/05/18 incident and the interventions in place on 01/03/19 should have been implemented to prevent future incidents of her being alone with Resident #316.

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F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident, and staff interviews, the facility failed to provide shaving of chin hairs and nail care to maintain personal hygiene for 2 of 3 dependent residents (Residents #73 and 105) reviewed for activities of daily living (ADL). The findings included: 1. Resident #73 was admitted to the facility on 10/11/11 with diagnoses which included cerebral vascular accident (CVA) with hemiplegia, diabetes mellitus and others. A review of Resident #73's most recent quarterly Minimum Data Set (MDS) dated 01/10/19 revealed she was cognitively intact for daily decision making and revealed she was dependent on 1 staff person for personal hygiene. A review of Resident #73's care plan dated 01/23/19 revealed she had a care plan for activities of daily living (ADL). The care plan stated Resident #73 was at risk for decline in her ability to participate in daily care due to muscle spasms and severe contractures in all her joints. The goals were for Resident #73 to continue to participate in daily care and for staff to complete bathing, grooming, dressing and incontinence care through the next review. The interventions included among others total assistance with all	F 677	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this 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. F677 ADL Care Provided for Dependent Residents •¿Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #73's chin hair was clipped on 2/28/19. Resident #105's long fingernails were cut on 2/28/19. •¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; 100% audit was completed of all residents at Cleveland Pines on 3/6/19. Any residents identified as needing assistance with their personal hygiene were	3/22/19

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F 677	Continued From page 26 personal hygiene, dressing, toileting and bathing needs. A review of the shower schedule for all residents revealed Resident #73 was scheduled for 2 showers per week on Tuesday and Friday on 1st shift (7:00 AM to 3:00 PM). An observation and interview on 02/25/19 at 11:59 AM with the resident revealed she had visible grey chin hairs that were approximately ¼ inch long. The resident stated she liked for her chin hairs to be trimmed but she could not do it herself. An observation and interview on 02/27/19 at 9:55 AM with the resident revealed she had a bed bath yesterday and stated they had not trimmed her chin hairs after her bath. Resident #73 still had grey chin hairs that were approximately ¼ inch long. An observation and interview on 02/28/19 at 10:57 AM revealed the resident resting in bed and stated she had her bed bath and there were visible powders on her chest and she was dressed in clean matching clothing. Resident #73 stated she did not know why they had not shaved her chin hairs after her bath but stated she would like them trimmed. An interview on 02/28/19 at 11:10 AM with Nurse Aid (NA) #4 revealed she was able to see the chin hairs on Resident #73 and stated she did not think about trimming them after her bath but stated she would trim them now. An observation and interview on 02/28/19 at 3:46 PM with Resident #73 revealed she had her chin	F 677	immediately addressed. •¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 3/17/19, the Staff Development Coordinator (SDC) educated all nurses and nursing assistants (NAs) on checking residents for appropriate personal hygiene, including facial hair and long finger nails with daily care. Beginning the week of 3/25/19, this education will be included with new hire orientation. All leadership team members were educated on identifying any resident needs associated with personal hygiene. Completion 3/22/19. All leadership team members will receive an assigned room list to complete daily rounds to specifically address appropriate ADL care. The assignments will also include a back-up person responsible in the event the leader is out of the facility. The results from the daily rounding will be discussed during the daily stand-up meeting. Any identified issues will be reported to the IDT, DON, and Administrator. Completion of the leadership room rounds will be completed daily Monday through Friday for 12 weeks beginning on 3/25/19. •¿ Indicate how the facility plans to monitor its performance to make sure that	

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F 677	Continued From page 27 hairs shaved and the resident rubbed her chin and stated her chin was so smooth and it felt so good to have it shaved. An interview was conducted on 03/01/19 with the Director of Nursing (DON) and Administrator. The DON stated she would have expected the resident's chin hairs to have been shaved following her bath. The DON stated shaving men and women was a part of their routine hygiene care. 2. Resident #105 was admitted to the facility on 12/05/18 for short term rehab with diagnoses which included a new colostomy, muscle weakness and gastrostomy tube with tube feedings and others. A review of Resident #105's most recent admission Minimum Data Set (MDS) dated 12/12/18 revealed he was severely cognitively impaired for daily decision making, had unclear speech and required extensive to total assistance of 1 to 2 staff with all activities of daily living (ADL). A review of Resident #105's care plan dated 12/07/18 revealed he had a care plan for activities of daily living (ADL). The care plan stated Resident #105 was at risk for decline in his ability to participate in daily care due to cognition and difficulty communicating and weakness. The goals were for Resident #105 to continue to participate in daily care and for staff to anticipate needs and complete bathing, grooming, dressing and incontinence care through the next review. The interventions included among others extensive assistance with all personal hygiene, dressing, toileting, and total care with bathing.	F 677	solutions are sustained. Staff Development Coordinator will conduct observations with 20 residents, for 12 weeks. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. Continued monitoring will be determined by the QAPI Committee, based on compliance results. •¿Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State. 3/22/19	

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F 677	Continued From page 28	F 677		

A review of the shower schedule for all residents revealed Resident #105 was scheduled for 2 showers per week on Monday and Thursday on 1st shift (7:00 AM to 3:00 PM).

An observation and interview on 02/25/19 at 9:53 AM revealed Resident #105 lying in bed with tee shirt and brief on. His tube feeding was infusing via pump. The resident was noted to have long fingernails on both hands with nails extending ¼ to ½ inch beyond the end of his fingers. The left index finger was noted to have brown debris under it and the nail according to the resident had been mashed and injured. The resident stated he could not trim his nails and did not like for them to be long.

An observation on 02/26/19 at 9:43 AM revealed Resident #105 lying in bed and his nails were still long and extending ¼ to ½ inch beyond his fingertips. The resident stated he had his bath yesterday but they had not trimmed his nails.

An observation on 02/28/19 at 9:40 AM revealed Resident #105 was lying in bed with his tube feeding infusing via pump. His sitter was at his bedside and stated the staff usually washed him off about every day and got his dressed. The sitter stated they had washed him up and dressed him but had not cut and cleaned his nails.

An interview with Nurse Aid (NA) #5 and Nurse #3 revealed they had not noticed his fingernails or the debris under his index nail on his left hand. NA #5 stated she would clean under his nails and Nurse #3 stated she would trim his nails. NA #5 and Nurse #3 stated his nails should have been cleaned and trimmed after his bath.

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F 677	Continued From page 29 An interview was conducted on 03/01/19 with the Director of Nursing (DON) and Administrator. The DON stated she would have expected nail care to have been done following his bath/shower. The DON stated nail care was a part of their routine hygiene care.	F 677		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		3/22/19

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F 755	Continued From page 30 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to keep an accurate account of controlled medications on the individual resident ' s controlled substance record for 1 of 5 residents reviewed for unnecessary medications (Resident #71). The findings included: Resident #71 was readmitted to the facility on 01/02/19 with diagnoses which included anxiety, depression and history of deep vein thrombosis. A review of Resident #71's February 2019 orders revealed she had Clonazepam 0.5 mg - take ½ tablet orally daily in the morning and 1 tablet at bedtime. An observation, interview and reconciliation of the narcotic medications on the 300 Front Hall Cart where Resident #71 resided was made on 02/28/19 at 11:30 AM with the treatment nurse who was working the cart. The reconciliation revealed Resident #71 had 29 tablets of Clonazepam 0.5 milligrams (mg) - ½ tablet to equal 0.25 mg on the individual medication card and the individual resident ' s controlled substance record indicated she had 28 (½) tablets. The treatment nurse stated she had counted the narcotics at the beginning of her shift with the off going nurse. She added that the narcotic count was correct at that time. The treatment nurse stated she would notify her supervisor immediately and complete a	F 755	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this 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. F755 Pharmacy Services/Procedures/Pharmacist/Records •¿Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Order for narcotic medication was obtained from Nurse Practitioner, for Resident #71. Nurse administered the narcotic medication, as ordered. •¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The Director of Nursing and Assistant Director of Nursing conducted a 100% audit for all residents receiving narcotic medication(s), to ensure each medication administration record (MAR) and narcotic sign out sheets match. Completion	

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F 755	Continued From page 31 medication error report. Review of the Controlled Drugs Count Record for February 2019 for the 300 Front Hall Cart revealed on 02/28/19 at 7:00 AM the treatment nurse and the off going nurse had signed the sheet indicating the narcotic count was correct at that time. An interview was conducted with the treatment nurse on 02/28/19 at 11:55 AM. The treatment nurse determined that she had signed out a medication to be given at 9:00 AM and had failed to pull it and give it to Resident #71. The treatment nurse stated she was going to locate the Nurse Practitioner (NP) who was in the facility, and get an order to give the medication to the resident now since the resident did not get it at 9:00 AM. An interview was conducted with the NP on 02/28/19 at 3:35 PM. The NP stated she would not consider the late administration of Resident #71 ' s Clonazepam a major medication error. She stated she had given the treatment nurse an order to give the medication when the nurse found the error. The NP stated she expected medications to be given as ordered and at the time ordered. An interview was conducted on 03/01/19 with the Administrator and Director of Nursing (DON). The DON stated she expected the narcotic count to be accurate at all times and for staff to give all medications according to the 5 rights - right resident, right medication, right dose, right route, and right time.	F 755	3/11/19. •¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Staff Development Coordinator conducted nurse education on the documentation process for narcotics to be signed out after given, on the narcotic sheet and the electronic medication administration record, and not before or at the end of the medication pass. Completion 3/18/19. Nurses have been educated to sign out narcotics on the controlled sheet immediately after removal of the narcotic, and to sign off in EMR once given to resident. Completion 3/22/19. Beginning the week of 3/25/19, this education will be included with new hire orientation. •¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Director of Nursing, Assistant Director of Nursing, and/or Pharmacy Consultant, will utilize the Controlled Substance/Medication Pass Observation tool to conduct observations of 10 narcotic administration opportunities per week for 12 weeks. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Pharmacy on a weekly basis and with QAPI monthly. Continued monitoring will be determined by the QAPI	

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F 755	Continued From page 32	F 755	Committee, based on compliance results. •¿Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State. 3/22/19	