STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 03/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(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 000	INITIAL COMMENTS On March 5 - 7, 2018, The Division of Health Service Regulation, Nursing Home, Licensure & Certification Section conducted an onsite complaint investigation. Due to additional information requested and additional investigation, the exit date was extended to March 12, 2018. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of J CFR 483.25 at tag F689 at a scope and severity of J Tag F689 constituted substandard quality of care. Immediate Jeopardy began on 2/20/18 and was removed on 3/7/18. An extended survey was completed.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		3/12/18

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

Electronically Signed | 03/29/2018

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F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on medical record review, an interview with the legal guardian (Department of Social Services (DSS)), the physician, the nurse practitioner (NP), and interviews with staff, the facility failed to immediately notify DSS when 1 of	F 580	1. The facility contacted resident #1's guardian on 2/21/18 and notified her of resident leaving the facility on 2/20/18 and failed to return. In addition to this, the facility continued to assist in filing a	

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F 580	Continued From page 2 4 sampled residents, Resident #1, reviewed for residents with DSS guardianship, left the facility, unauthorized, for a leave of absence (LOA). DSS was not immediately notified when Resident #1 signed himself out of the facility and left the facility on 2/20/18, at 5:15 PM. Resident #1 remained out of the facility for approximately 12 hours before DSS was notified. Immediate jeopardy began on 2/20/18 at 5:15 PM when Resident #1 left the facility, unauthorized, and the facility failed to contact the legal guardian, DSS, immediately. Immediate jeopardy was removed on 3/7/18 at 5:55 PM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 9/22/17 from another skilled nursing facility, per the resident's request. Diagnoses included medical non-compliance, multiple sclerosis relapsing and remitting type, major depressive disorder, adult failure to thrive, tachycardia, chronic pain, general muscle weakness, peripheral vascular disease, hypersomnia (falls asleep easily) due to medical condition, contractures of the right upper extremity and fingers of right hand, bladder spasms/incontinence, chronic tobacco/marijuana usage, incompetent with cognitive deficits, and a history of falling.	F 580	missing person's report with the local law enforcement and cooperating with the guardian to help locate and ensure resident is safe. Resident was located in the emergency room of the hospital unharmed on 2/21/18. 2. 100% audit conducted of all residents with documented DSS guardians appointed to them to ensure that they are safe and remain in the facility and have not left the facility without the guardian's permission on 3/7 by facility Social Worker. 3. 100% in-service education and training provided to all licensed nurses, nurse managers, and facility administrative staff stating that any resident deemed incompetent with guardianship paperwork must have approval from the guardian prior to facilitating any request to leave the facility. The guardian must be immediately notified of all emergent and non-emergent transfers, requests for leave of absence or AMA (against Medical Advice). Resident guardian ship information can be located in the resident's clinical chart, and that chart must be reviewed by the charge nurse, nurse supervisor, DON, or other administrative staff, and guardian contacted prior to resident leaving the facility. To ensure resident safety the DSS or Legal Guardian is the only person authorized to permit resident to leave the facility. The Administrator and the Director of Nursing must be immediately notified of any attempts of a resident to leave the facility. The nurse responsible for resident wishing to leave must	

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F 580	Continued From page 3 Resident #1's medical record documented a DSS Guardian (due to poor insight/judgment) as Legal Guardian/Emergency Contact #1. A Mecklenburg County's Guardianship Policies Memo of Understanding, for Resident #1, signed by the Guardian and the Administrator on 10/4/17, recorded the following, in part: Facility personnel understand that the Clerk of Court has given (named guardian) guardianship responsibilities. By law, she is required to make all decisions regarding the care and maintenance of Resident #1 and any changes that affect the ward (Resident #1). The final decision for these matters legally rests with DSS. DSS must grant permission for out-of-facility visitations. A quarterly Minimum Data Set (MDS) dated 12/19/17, assessed Resident #1 with intact cognition, clear speech/communication skills, and adequate vision/hearing. A nurse's note (NN) dated 2/20/18 at 7:20 PM by Nurse #1 (Unit Manager) recorded Resident #1 went on a LOA from the facility "at about 1700 (5:00 PM)." Nurse #1 educated him on leaving the facility alone due to physical limitations, but he stated he was "catching the bus to visit friends on the west side of Charlotte." The NN documented that Resident #1 signed out and left the facility. There was no documentation of DSS authorization/notification. A NN dated 2/20/18 at 11:08 PM by Nurse #2, documented that Resident #1 signed out of the facility earlier that evening, had not returned to facility and a report was passed to the oncoming	F 580	document in the resident's medical record the name and contact number of person notified and time of notification. 4. In order to ensure that the facility is to remain in compliance for the above cited deficiency, the Director of Nursing or designee to review residents charts with DSS appointed guardianship to ensure no resident with DSS guardianship has been allowed to leave the facility without the guardian's permission, that proper documentation is in the resident's medical record upon times of approved leaves of absence ensuring guardians are notified in the appropriate time frame. This review will be reflected on the Resident Guardian Approval and Notification monitoring tool. These reviews will be conducted daily x5 days, weekly x4 weeks, and monthly x3 months. Upon these dates of review, if any inconsistency is noted it is to be addressed and corrected at that time. Results of these review will be presented to the facility's monthly Quality Assurance Committee for review and any adjustments needed to this plan will be made at the time.	

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nurse.

A NN dated 2/21/18 at 6:52 AM by Nurse #3 documented the facility spoke to DSS after hours (named contact) concerning Resident #1 and notified the Director of Nursing (DON). The NN did not document specifics of the conversations with DSS/DON.

A progress note dated 2/21/18 at 2:41 PM by Social Worker (SW) documented that Resident #1 left the facility on 2/20/18 and had not returned. As a result the SW documented she contacted the police department to file a Missing Persons Report.

Review of the Charlotte - Mecklenburg Police Department Incident Report, dated 2/21/18 at 09:06 AM, revealed Nurse #1 filed a Missing Persons report for Resident #1. The report indicated Resident #1 left the facility on 2/20/18 at 5:15 PM. His incapacity types were listed as mental handicap, physical disability and poor health/illness.

Review of an Emergency Department (ED) transcript revealed Resident #1 presented to the ED 2/21/18 at 1:56 PM with complaints of weakness/fatigue, reported multiple incontinent episodes and smelled of strong urine odor. Resident #1 reported to the ED he had DSS Guardian in place with multiple unsuccessful ED attempts to contact. The ED transcript documented they were unaware if Resident #1 had been declared medically incompetent, and when he became agitated with plans for further assessment, demanded to be released, he discharged from the ED on 2/21/18 at 7:13 PM

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against medical advice.

A telephone interview on 3/5/18 at 2:29 PM with DSS Guardian revealed the facility contacted DSS after hours around 6:00 AM on 2/21/18 to notify that Resident #1 left the facility on 2/20/18 around 5:00 PM and had not returned to the facility. The DSS Guardian stated when she received the message, she called the facility on 2/21/18 between 8:30 - 9:00 AM, spoke to the SW and advised her to call the police to file a Missing Persons Report. The DSS Guardian stated DSS was legally responsible for Resident #1 which required DSS authorization/notification prior to any out of facility visitations. DSS Guardian stated Resident #1 did not have authorization to leave the facility without DSS notification due to his incompetent status and DSS should have been notified immediately when he left the facility on 2/20/18.

An interview was conducted on 3/5/18 at 2:45 PM with Nurse #1, (Unit Manager). Nurse #1 stated she knew Resident #1 had a DSS Guardian, but that she did not notify DSS. Nurse #1 stated "I should have notified DSS because he never signed himself out before, not sure if that's required because I have never dealt with this before." Nurse #1 stated Resident #1 came to the nurse's station on 2/20/18 and stated he wanted to sign out, planned to return that night, and she told him it was not safe to leave the facility alone. Nurse #1 stated she told the DON what Resident #1 wanted to do and the DON stated to make sure Resident #1 signed himself out.

An interview with the Administrator on 3/5/18 at 3:10 PM revealed that on 2/20/18, he was made

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aware in passing by either the SW or a nurse that Resident #1 signed himself out, left the facility, but was expected to return. The Administrator stated Resident #1 had already left the facility when he (the administrator) became aware, he did not notify the DSS Guardian, nor did he instruct his staff to notify DSS because he considered Resident #1 safe to leave the facility based on intact cognition. The Administrator further stated that on 2/21/18 around 9:00 - 9:30 AM, the SW advised him that Resident #1 did not return to the facility, DSS Guardian had been notified and the police had been called. The Administrator stated that if the facility felt there was something wrong or abnormal when Resident #1 left the facility, they would have notified the DSS Guardian, but at the time that was not the case.

An interview with the SW on 3/5/18 at 3:44 PM revealed she reported on 2/20/18 around 4:45 PM to the DON, Administrator, Nurse #1, Nurse #4 and Nurse #5 that she saw Resident #1 being assisted up the hill. The SW stated Nurses #4 and #5 both immediately left the facility going up the hill to find Resident #1, but their efforts were unsuccessful. The SW stated she was aware that Resident #1 had a DSS Guardian, but did not immediately notify DSS because she expected that administration/nurses would contact the DSS Guardian, but stated "I guess I should have."

An interview on 3/5/18 at 3:55 PM with the DON revealed Nurse #1 told her on 2/20/18 around 5:00 PM that Resident #1 wanted to leave facility to go visit friends. The DON stated she was in the facility at the time, but that she did not speak to the Resident, or review his medical record, but

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knew he had a DSS Guardian in place. The DON stated she did not review the DSS Memo of Understanding and therefore was not aware of the need to immediately notify DSS to obtain authorization for Resident #1 to have an out of facility visit. The DON stated she spoke to the SW and they both agreed that due to the Resident's intact cognition, the facility could not force Resident #1 to stay in the facility if he wanted to leave, so she advised nursing staff to allow Resident #1 to sign himself out. The DON stated, the facility did not contact the DSS Guardian until the next day when he did not return. The DON stated that she just read the DSS Memo of Understanding and realized now that the facility should have notified the DSS Guardian to obtain authorization at the time Resident #1 said he wanted to leave the facility.

An interview on 3/5/18 at 4:39 PM with the NP revealed she expected the staff to have contacted the DSS Guardian when Resident #1 left because he was unable to care for himself.

An interview with Nurse #4 occurred on 3/5/18 at 5:23 PM and revealed she was the nurse supervisor for both units on 2/20/18 the day Resident #1 signed himself out and left the facility. Nurse #4 stated the SW advised her that Resident #1 was witnessed being assisted up the hill. She and Nurse #5 went after him. Nurse #4 stated that when they got to the top of the hill, Resident #1 was gone, so they returned to the facility and alerted the DON/Administrator who said that Resident #1 signed himself out and there was nothing the staff could do at that point. Nurse #4 stated she did not notify the DSS Guardian because she was not aware Resident

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#1 had a Guardian. Nurse #4 further stated had she known she would have notified the Guardian because she knew that was required.

An interview on 3/5/18 at 5:38 PM with Nurse #5 revealed she was notified by the SW that Resident #1 was witnessed outside going up the hill with assistance. Nurse #5 stated she had not worked with Resident #1 before and did not know him, but went outside with Nurse #4 to locate him. Nurse #5 stated "when we did not find him, we returned to the facility and told the DON/Administrator" that they did not see Resident #1. Nurse #5 stated she was not aware of the DSS Guardianship, but stated, "If I had known I would have inquired if DSS should be called."

A telephone interview with Nurse #3 occurred on 3/6/18 at 9:34 AM and revealed she routinely worked on the 11 PM - 7 AM shift as the nurse for Resident #1. Nurse #3 stated when she came to work on 2/20/18, she was advised by Nurse #2 that Resident #1 signed himself out of the facility and had not returned. She asked Nurse #2 if she notified DSS and Nurse #3 said no. Nurse #3 stated "That was unusual for him to be gone on my shift." Nurse #3 stated she called the DSS Guardian around 1:00 AM (no answer) and again around 5:00 AM at which time she spoke to the DSS receptionist and advised that Resident #1 was not in the facility when she came on shift at 11:00 PM, that he left the facility on the previous shift around 5:00 PM and had not returned.

A telephone interview on 3/6/18 at 10:43 AM with Nurse #2 revealed she had only worked with Resident #1 a few times before 2/20/18 and she was not aware that he had a DSS Guardian.

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Nurse #2 stated that on 2/20/18 she arrived to the facility around 5:00 PM and Resident #1 was at the nurse's station dressed, in his wheel chair and requested to sign himself out of the facility for a LOA to visit with some friends. Nurse #2 stated she contacted Nurse #1, the supervisor, to get direction because Resident #1 had never left the facility on her shift before. Nurse #2 stated Nurse #1 spoke to the DON who advised to allow Resident #1 to sign himself out, so she got his medical record and allowed Resident #1 to sign the Release of Responsibility for Therapeutic Home Visits sheet to sign out of the facility. Nurse #2 stated he signed out and left the facility, but she was not aware he was a ward of the state. Nurse #2 stated that when she left shift around 11:30 PM, he was not back, she passed report to Nurse #3, but she did not notify anyone else.

An interview with the physician on 3/6/18 at 1:05 PM revealed he expected staff to notify the DSS Guardian for Resident #1 as a courtesy because of their legal responsibility for the Resident.

The Administrator and Director of Nursing were notified of immediate jeopardy on 3/6/18 at 3:55 PM. The facility provided an acceptable credible allegation of compliance on 3/7/18 at 3:11 PM.

Credible Allegation of Compliance:
F580:

In order to correct the deficient practice pertaining to providing the proper notification of necessary guardians upon residents wishing to leave the facility that was cited as an Immediate Jeopardy on March 6, 2018 at 3:55pm, the facility has taken the following steps:

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1. The resident identified as resident #1 was a resident at Complete Care at Charlotte and has been appointed a guardian by the Department of Social Services (DSS). On 2/20/18 he expressed the interest to leave the facility stating that he would return later that evening and was allowed to leave the facility but choose not to return to the facility. The resident's guardian was not notified prior to his departure to the facility, which acted against the guardian's wishes. In order to correct this action, the facility contacted resident #1's guardian on 2/21/18 and notified her of the situation and continued to assist in filing a missing person's report with the local law enforcement and cooperating with the guardian to help locate and ensure resident is safe. Resident was located in the emergency room of the hospital unharmed on 2/21/18.

2. The facility has identified the processes that led to this deficiency was the lack of understanding of the nursing staff that the resident wishing to leave the facility was to be treated as an incompetent individual and the decision to leave the facility could only be authorized by the resident's appointed Department of Social Services (DSS) guardian. To correct this process the facility initially checked all residents with documented DSS guardians appointed to them to ensure that they are safe and remain in the facility and have not left the facility without the guardian's permission on 3/7/18 by facility Social Worker.

3. 100% in-service education and training provided to all licensed nurses, nurse managers, and facility administrative staff stating that any resident deemed incompetent with guardianship paperwork must have approval from the guardian

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prior to facilitating any request to leave the facility. The guardian must be immediately notified of all emergent and non-emergent transfers, requests for leave of absence or AMA (against Medical Advice). Resident guardianship information can be located in the resident's clinical chart, and that chart must be reviewed by the charge nurse, nurse supervisor, DON, or other administrative staff, and guardian contacted prior to resident leaving the facility. To ensure resident safety the DSS or Legal Guardian is the only person authorized to permit resident to leave the facility. The Administrator and the Director of Nursing must be immediately notified of any attempts of a resident to leave the facility. The nurse responsible for resident wishing to leave must document in the resident's medical record the name and contact number of person notified and time of notification.

4. In order to ensure that the facility is to remain in compliance for the above cited deficiency, the Director of Nursing or designee to review residents' charts with DSS appointed guardianship to ensure no resident with DSS guardianship has been allowed to leave the facility without the guardian's permission, that proper documentation is in the resident's medical record upon times of approved leaves of absence ensuring guardians are notified in the appropriate time frame. This review will be reflected on the Resident Guardian Approval and Notification monitoring tool. These reviews will be conducted daily x5 days, weekly x4 weeks, and monthly x3 months. Upon these dates of review, if any inconsistency is noted it is to be addressed and corrected at that time. Results of these review will be presented to the facility's monthly Quality Assurance Committee for review and any

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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 580	Continued From page 12 adjustments needed to this plan will be made at the time. The facility has taken the before mentioned steps and initiated this plan in order to attest that it has met the requirements to alleviate the status if Immediate Jeopardy for providing proper notification effective March 7, 2018. The facility Administrator is to be responsible for implementing this Allegation of Compliance. Immediate jeopardy was removed on 3/7/18 at 5:55 PM when interviews with nursing staff and administrative staff revealed staff were educated on the facility's revised procedures regarding notifying the DSS Guardian when a resident with an appointed DSS Guardian leaves the facility, unauthorized.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to accurately code Section 0800, Behaviors, Rejection of Care, on the Minimum Data Set (MDS) assessment for 2 of 11 MDS assessments reviewed for accuracy. The admission MDS assessment dated 9/29/17 and a quarterly MDS assessment dated 12/19/17 did not code that Resident #1 rejected medication and showers. The findings included:	F 641	1. Resident #1's MDS assessment is to be amended to accurately reflect the resident's condition at the time of the assessment. 2. 100% of all resident's most current MDS assessment will be audited by the Administrator or designee to ensure that the assessment accurately matches the nurse's notes documented in the resident's chart at during the time frame of the assessment. Any inconsistences	3/30/18

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F 641	Continued From page 13 Resident #1 was admitted to the facility on 9/22/17 from another skilled nursing facility, per the Resident's request, and discharged on 2/21/18. Diagnoses included a history of medical non-compliance, incompetent with cognitive deficits, and major depressive disorder, among others. Review of nursing progress notes revealed Resident #1 refused medications on 9/23/17, 9/24/17 and 9/26/17 and showers on 12/18/17 (multiple attempts). Review of a social services progress note, dated 12/15/17 documented that the social worker (SW) visited with Resident #1 that day regarding nursing reports of repeated recent refusals to get out of bed, attend activities or take showers. The progress note documented that Resident #1 continued to refuse these services during the conversation with the SW. Review of the admission MDS assessment dated 9/29/17 and the quarterly MDS dated 12/19/17, revealed Resident #1 was assessed with intact cognition and did not reject care according to section 0800, Behaviors, Rejection of Care, Presence and Frequency. Review of the September 2017 Care Plan revealed these behaviors (refusing medication/showers) were not documented. The Care Plan was last revised on 1/2/18, but did not document these behaviors. Resident #1 was discharged at the time of the	F 641	will be noted on the MDS Accuracy audit tool and the assessment will be amended at that time. Audit to be completed by 3/30/18. 3. 100% education to be provided to all departments responsible for completing sections of the MDS regarding accurately depicting resident behaviors that are documented in the resident's clinical chart on the MDS assessments in order to depict a complete picture of the resident. This is to include but not limited to refusals and aggressive behavior. This education will be given by the Administrator by 3/30/18. 4. Proportions of all assessments conducted in the months following the conclusion of the initial audit will be selected at random by the administrator or designee to be reviewed for accuracy according to the clinical chart. 50% of assessments completed will be reviewed monthly x1, 25% of assessments completed in the following month will be reviewed monthly x1, and 10% of assessments completed in the subsequent month will be reviewed monthly x1. Result from these audits will be brought to the facility's monthly Quality Assurance Committee for review and any changes recognized will be made at that time.	

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F 641	Continued From page 14 survey and unavailable for observation/interview. A telephone interview with the SW occurred on 3/8/18 at 3:10 PM. The SW stated she completed both the MDS assessment dated 9/29/17 (annual) and 12/19/17 (quarterly), section 0800, Behaviors, Rejection of Care for Resident #1. The SW stated she reviewed the Resident's medical record and spoke to the nurses and Resident regarding his refusals to get out of bed, attend activities or take showers and that he continued to refuse these services during her conversation. The SW stated he did not give a reason or express a preference. The SW stated she did not code the MDS assessment regarding these refusals because she thought this behavior was updated on his care plan and it was discussed during department meetings. A telephone interview occurred on 3/8/18 at 3:40 PM with the director of nursing (DON). The DON stated she expected staff to utilize the MDS corporate support and/or come to her as resources when staff completed the MDS assessment and had questions. The DON stated that the admission MDS assessment dated 9/29/17 for Resident #1 should have coded the behavior related to refusing medications as documented in his medical record and been updated on his care plan. The DON further stated had that been done, then the quarterly MDS assessment dated 12/19/17 would not have to code the MDS for rejection of care related to refusing showers.	F 641		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		3/12/18

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F 689	Continued From page 15 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, an interview with the legal guardian (Department of Social Services (DSS)), the physician, the nurse practitioner (NP), a resident (Resident #6) and interviews with staff, the facility failed to supervise and obtain authorization for a leave of absence (LOA) for a ward of North Carolina (Resident #1) assessed with mental/physical disabilities to prevent an unauthorized LOA from the facility. The facility failed to obtain DSS Guardian authorization for Resident #1 on 2/20/18 when he signed himself out of the facility at 5:15 PM with permission of facility staff, left the facility and took public transportation, unsupervised and unauthorized. Resident #1 remained out of the facility for approximately 21 hours when he presented to the Emergency Department (ED) on 2/21/18 at 1:56 PM for weakness/fatigue. This occurred for 1 of 4 sampled residents reviewed with an appointed DSS Guardian of the person. Immediate jeopardy began on 2/20/18 at 5:15 PM when the facility failed to contact the appointed DSS Guardian prior to directing Resident #1 to sign out of the facility when he requested an unsupervised/unauthorized LOA. Immediate jeopardy was removed on 3/7/18 at 5:55 PM when the facility provided an acceptable credible allegation of compliance (AoC). The facility remains out of compliance at a lower scope and	F 689	1. Resident #1□s DSS guardian was contacted on 2/21/18 to inform her of resident signing himself out of the facility on 2/20/18 and failed to return to the facility. The facility proceeded to assist the guardian in pursuing a missing person□s report and helping to locate the resident and verify his safety. Resident was located in the Emergency Room of the hospital unharmed on 2/21/18. 2. To ensure proper supervision is provided to all residents with DSS Guardians in place, the facility initially checked all residents with documented DSS guardians appointed to them to ensure that they are safe and remain in the facility and have not left the facility without the guardian's permission on 3/7 by facility Social Worker. To ensure the safety of all other residents with exit seeking ideations or behaviors the facility has checked all residents with documented wandering and exit seeking behaviors and ensured that they are safe and remain in the facility. The facility□s elopement prevention system was also tested to ensure it was functional and in place on 3/5 by the Administrator. 3. 100% in-service and training provided	

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F 689	Continued From page 16 severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 9/22/17 from another skilled nursing facility, per the resident's request. Diagnoses included medical non-compliance, multiple sclerosis (MS) relapsing and remitting type, major depressive disorder, adult failure to thrive, tachycardia, chronic pain, general muscle weakness, peripheral vascular disease (PVD), hypersomnia (falls asleep easily) due to medical condition, contractures of the right upper extremity and fingers of right hand, bladder spasms/incontinence, chronic tobacco/marijuana usage, incompetent with cognitive deficits, and a history of falling. Resident #1's medical record documented a DSS Guardian (due to poor insight/judgment) as Legal Guardian/Emergency Contact #1. A Mecklenburg County's Guardianship Policies Memo of Understanding, for Resident #1, signed by the Guardian and the Administrator on 10/4/17, recorded the following, in part: Facility personnel understand that the Clerk of Court has given (named guardian) guardianship responsibilities. By law, she is required to make all decisions regarding the care and maintenance of Resident #1 and any changes that affect the ward (Resident #1). The final decision for these matters legally rests with DSS. DSS must grant permission for out-of-facility visitations.	F 689	to all certified nurse□s assistants, licensed nurses, and facility administrative staff stating that the facility has the responsibility to ensure the safety and supervision of residents of the facility in order to prevent accidents. To maintain this supervision, if a resident expresses the intent to leave the facility to a CNA, that aide must immediately notify the charge nurse, nursing supervisor, Director of Nursing, and or Administrator. This is to ensure the resident□s safety and the DSS or Legal Guardian is the only person authorized to permit resident to leave the facility. The guardian must be immediately notified of all emergent and non-emergent transfers, requests for leave of absence or AMA (Against Medical Advice) by the change nurse, nursing supervisor, DON, Administrator, or any member of administrative staff. Resident guardianship information can be located in a resident□s clinical chart, and that chart must be reviewed, and guardian contacted prior to resident leaving the facility. To ensure resident safety the DSS or Legal Guardian is the only person authorized to permit resident to leave the facility. 4. In order to ensure that the facility is to remain in compliance with safe supervision of residents deemed incompetent with DSS guardianship, the Director of Nursing or designee to review residents charts with DSS appointed guardianship to ensure no resident with DSS guardianship has been allowed to	

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F 689	Continued From page 17 A Care Area Assessment dated 9/29/17 identified Resident #1 had functional deficits related to his diagnoses of MS, PVD, general muscle weakness and major depressive disorder. He required maximum - total staff assistance with most of his functional needs, required a mechanical lift for transfers, was at risk for functional decline and received routine antidepressant which placed him at risk for adverse side effects. A quarterly Minimum Data Set (MDS) dated 12/19/17, assessed Resident #1 with intact cognition, clear speech/communication skills, adequate vision/hearing, no behaviors, required extensive/total staff assistance with toileting, hygiene, and bathing. He was independent with feeding abilities and bed mobility, incontinent of bowel, impaired upper extremity range of motion (ROM) on right side, impaired lower extremity ROM on both sides, unsteady with surface to surface transfers and moving on/off the toilet. During the assessment review, Resident #1 did not transfer, move from seated to standing position, walk, or turn around and he received an antidepressant 7 of the 7 days reviewed. Review of the medical record to include nurses notes (NN), occupational therapy notes, physician's orders and the Care Plan (CP), revised 1/2/18, revealed Resident #1 required transfers with a mechanical device, displayed behaviors to include screaming at staff (1/2/18), suicidal ideations with a psychiatric consult (1/24/18) and violation of the facility smoking policy (12/18/17, 1/2/18 and 2/5/18). This violation resulted in a facility issued 30 Day Notice of Transfer/Discharge dated 1/2/18 with discharge	F 689	leave the facility without the guardian□s permission, that proper documentation is in the resident□s medical record upon times of approved leaves of absence ensuring guardians are notified in the appropriate time frame. The resident□s sign out sheets will be reviewed, which is located in the resident□s medical record. This review will be reflected on the Resident Guardian Approval and Notification monitoring tool. These reviews will be initiated 3/8/18 and be conducted daily x5 days, weekly x4 weeks, and monthly x3 months by the Director of Nursing or Designee. Upon these dates of review, if any inconsistency is noted it is to be addressed and corrected at that time. Results of these review will be presented to the facility□s monthly Quality Assurance Committee for review and any adjustments needed to this plan will be made at the time.	

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planned for 2/2/18 (pending placement).

Review of the document Release of Responsibility for Therapeutic Home Visits, kept in the medical record, revealed Resident #1 signed himself out of the facility on 2/21/18 at 5:10 PM. According to multiple staff interviews, the date recorded as 2/21/18 was an error and should have been 2/20/18.

A NN dated 2/20/18 at 7:20 PM by Nurse #1 (Unit Manager) recorded Resident #1 went on a LOA from the facility "at about 1700 (5:00 PM)", Nurse #1 educated him on leaving the facility alone due to the need for assistance with wheel chair ambulation, but he stated he was "catching the bus to visit friends on the west side of Charlotte." The NN documented that Resident #1 signed out and left the facility. There was no documentation of supervision or DSS authorization for this LOA.

A NN dated 2/20/18 at 11:08 PM by Nurse #2, documented that Resident #1 signed out of the facility earlier that evening, had not returned to facility and a report was passed to the oncoming nurse.

A NN dated 2/21/18 at 6:52 AM by Nurse #3 documented the facility spoke to DSS after hours (named contact) concerning Resident #1 and notified the Director of Nursing (DON). The NN did not document specifics of the conversations with DSS/DON.

A progress note dated 2/21/18 at 2:41 PM by Social Worker (SW) documented that Resident #1 left the facility on 2/20/18 and had not returned. As a result the SW documented she contacted the police department to file a Missing

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Persons Report.

Review of the Charlotte - Mecklenburg Police Department Incident Report, dated 2/21/18 at 09:06 AM, revealed Nurse #1 filed a Missing Persons Report for Resident #1. The report indicated Resident #1 left the facility on 2/20/18 at 5:15 PM. His incapacity types were listed as mental handicap, physical disability and poor health/illness.

Review of an Emergency Department (ED) transcript revealed Resident #1 presented to the ED 2/21/18 at 1:56 PM with complaints of weakness/fatigue, reported multiple incontinent episodes and smelled of strong urine odor. Resident #1 reported to the ED he had DSS Guardian in place with multiple unsuccessful ED attempts to contact. The ED transcript documented they were unaware if Resident #1 had been declared medically incompetent, and when he became agitated with plans for further assessment, demanded to be released. He discharged from the ED on 2/21/18 at 7:13 PM against medical advice.

A telephone interview on 3/5/18 at 2:29 PM with DSS Guardian revealed the facility contacted DSS after hours around 6:00 AM on 2/21/18 to notify that Resident #1 left the facility on 2/20/18 around 5:00 PM and had not returned to the facility. The DSS Guardian stated when she received the message, she called the facility on 2/21/18 between 8:30 - 9:00 AM, spoke to the SW and advised her to call the police to file a Missing Persons Report. The DSS Guardian stated DSS was legally responsible for Resident

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F 689	Continued From page 20 #1 which required DSS authorization prior to any out of facility visitations. DSS Guardian stated Resident #1 did not have authorization to leave the facility unsupervised due to his incompetent status, poor decision-making ability, mental capacity and physical limitations/poor health. The DSS Guardian stated Resident #1 should not have been allowed to leave the facility unsupervised, she should have been contacted for authorization regarding a LOA and notified immediately if he left the facility unauthorized. An interview on 3/5/18 at 2:45 PM with Nurse #1, (Unit Manager) revealed she was advised by the SW on 2/20/18 around 5:00 PM that Resident #1 had left the facility. Nurse #1 stated she knew Resident #1 had a DSS Guardian, and that DSS authorization had not been obtained prior to the Resident leaving the facility. Nurse #1 stated "I should have notified DSS because he never signed himself out before, not sure if that's required because I have never dealt with this before." Nurse #1 stated Resident #1 came to the nurse's station on 2/20/18 dressed and stated he wanted to sign out, but planned to return that night. Nurse #1 stated she told him it was not safe to leave the facility alone due to his physical limitations with wheel chair ambulation. Resident #1 responded that his friends would help him. Nurse #1 stated she also felt he was unsafe to leave the facility alone because of his poor decision-making as it related to a 30 Day Discharge Notice that was issued because he violated the facility's smoking policy. Nurse #1 stated she told the DON what Resident #1 wanted to do and the DON stated to make sure Resident #1 signed himself out. Nurse #1 stated when she came to work the next morning before	F 689		

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7:00 AM, Resident #1 had not returned, she called his case worker, advised that he left and had not returned, and received instruction from his case worker to call the police to file a Missing Persons Report, which she did.

An interview with the Administrator on 3/5/18 at 3:10 PM revealed that on 2/20/18, he was made aware in passing by either the SW or a nurse that Resident #1 signed himself out, left the facility alone, but was expected to return. The Administrator stated Resident #1 had already left the facility when he (the administrator) became aware. The Administrator stated that he was not aware that supervision or DSS authorization was required. The Administrator stated he considered Resident #1 safe to leave the facility independently based on intact cognition. The Administrator also stated that "He was alert/oriented, decision-making was intact, but stated "I did not always agree with all of his decision-making, for example he liked to smoke and violated the smoking policy." The Administrator stated as a result Resident #1 was issued a 30 Day Discharge Notice on 1/2/18 and the DSS Guardian was made aware. The Administrator stated Resident #1 had not yet been discharged due to location of placement. The Administrator further stated that on 2/21/18 around 9:00 - 9:30 AM, the SW advised him that Resident #1 did not return to the facility, DSS Guardian had been notified and the police had been called. The Administrator stated that if the facility felt there was something wrong or abnormal when Resident #1 left the facility alone, they would have notified the DSS Guardian, but at the time that was not the case.

An interview with the SW on 3/5/18 at 3:44 PM

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revealed she reported on 2/20/18 around 4:45 PM to the DON, Administrator, Nurse #1, Nurse #4 and Nurse #5 that she saw Resident #1 being pushed up the hill. The SW stated Nurses #4 and #5 both immediately left the facility going up the hill to find Resident #1, but their efforts were unsuccessful. The SW stated she was aware that Resident #1 had a DSS Guardian, but did not immediately contact DSS because she expected that administration/nurses would contact the DSS Guardian. The SW stated "I guess I should have." The SW stated Resident #1 was not safe to leave the facility alone because he required total staff assistance with his nursing care, had difficulty propelling in his wheel chair independently, and had poor decision-making skills based on irrational decisions and violating the facility's smoking policy. The SW stated that when she arrived to work the next day (2/21/18) she called the DSS Guardian, received instruction to call the police and file a Missing Person Report, which she did.

An interview on 3/5/18 at 3:55 PM with the DON revealed Nurse #1 told her on 2/20/18 around 5:00 PM that Resident #1 wanted to leave facility to go visit friends. The DON stated she was in the facility at the time, but that she did not speak to the Resident, or review his medical record, but knew he had a DSS Guardian in place. The DON stated she did not review the DSS Memo of Understanding and therefore was not aware that DSS authorization was required for Resident #1 to have an out of facility visit. The DON stated she spoke to the SW and they both agreed that due to the Resident's intact cognition, the facility could not keep Resident #1 in the facility if he wanted to leave, so she advised nursing staff to

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allow Resident #1 to sign himself out and leave independently. The DON stated, the facility did not supervise him when he left and did not contact the DSS Guardian until the next day when he did not return. The DON stated that she just read the DSS Memo of Understanding and realized now that the facility should have notified the DSS Guardian to obtain authorization at the time Resident #1 said he wanted to leave the facility.

An interview on 3/5/18 at 4:39 PM with the NP revealed she was aware that Resident #1 would be transferring to another facility and that the Guardian was aware, but stated that the staff should have contacted the DSS Guardian when he left because he was unable to care for himself and had a history of drug abuse.

An interview with Nurse #4 occurred on 3/5/18 at 5:23 PM and revealed she was the nurse supervisor for both units on 2/20/18 the day Resident #1 signed himself out and left the facility alone. Nurse #4 stated the SW advised her that Resident #1 was witnessed being assisted up the hill, she and Nurse #5 went after him. Nurse #4 stated that when they got to the top of the hill, it was after 5:00 PM and "the traffic was very heavy", Resident #1 was gone, so they returned to the facility and alerted the DON/Administrator who said that Resident #1 signed himself out and there was nothing the staff could do at that point. Nurse #4 stated she did not notify the DSS Guardian because she was not aware Resident #1 had a Guardian. She further stated had she known she would have notified the Guardian because she knew that was required.

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An interview on 3/5/18 at 5:38 PM with Nurse #5 revealed she was notified by the SW that Resident #1 was witnessed outside going up the hill with assistance. Nurse #5 stated she had not worked with Resident #1 before and did not know him, but went outside with Nurse #4 to locate him. Nurse #5 stated when we did not find him, we returned to the facility and told the DON/Administrator that they did not see Resident #1. Nurse #5 stated she was not aware of the DSS Guardianship, but stated "If I had known I would have inquired if DSS should be called."

A telephone interview with Nurse #3 occurred on 3/6/18 at 9:34 AM and revealed she routinely worked on the 11 PM - 7 AM shift as the nurse for Resident #1. Nurse #3 stated when she came to work on 2/20/18, she was advised by Nurse #2 that Resident #1 signed himself out of the facility and had not returned. She asked Nurse #2 if she notified DSS and Nurse #2 said no. Nurse #3 stated "That was unusual for him to be gone on my shift." Nurse #3 stated she called the DSS Guardian around 1:00 AM (no answer) and again around 5:00 AM at which time she spoke to the DSS receptionist and advised that Resident #1 was not in the facility when she came on shift at 11:00 PM, that he left the facility on the previous shift around 5:00 PM and had not returned.

A telephone interview on 3/6/18 at 10:43 AM with Nurse #2 revealed she had only worked with Resident #1 a few times before 2/20/18 and she was not aware that he had a DSS Guardian. Nurse #2 stated that on 2/20/18 she arrived to the facility around 5:00 PM and Resident #1 was at the nurse's station dressed, in his wheel chair, had a bag packed and requested to sign himself out of the facility for a LOA to visit with some

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friends. Nurse #2 stated she contacted Nurse #1, the supervisor, to get direction because Resident #1 had never left the facility on her shift before. Nurse #2 stated Nurse #1 spoke to the DON who advised to allow Resident #1 to sign himself out, so she got his medical record and allowed Resident #1 to sign the Release of Responsibility for Therapeutic Home Visits sheet to sign out of the facility. Nurse #2 stated he signed out and left the facility alone, but she was not aware he was a ward of the state. Nurse #2 stated that when she left shift around 11:30 PM, he was not back, she passed report to Nurse #3, but she did not notify anyone else.

A telephone interview on 3/6/18 at 11:00 AM with Nurse Aide (NA) #2 revealed she routinely worked with Resident #1 on the 3 - 11 PM shift. NA #2 stated Resident #1 required extensive staff assistance with showers, got up to his wheel chair occasionally, had difficulty self-propelling, and used a mechanical lift for transfers, because he could not bear weight on his lower extremities. NA #2 stated that on 2/20/18, Resident #1 requested assistance to get dressed and to get into his wheel chair because he wanted to take the bus, by himself, to Wilmore Avenue off of West Boulevard in West Charlotte to visit some friends. NA #2 stated she advised him that he would need to talk to his nurse first if he wanted to leave the facility alone and he requested to speak to his nurse. NA #2 stated she got him dressed, per his preference in a pair of shorts, a shirt and a hooded sweatshirt. He packed a small bag which contained clothing, toiletries and his wallet and once he got dressed she propelled him to the nurse's station where he spoke to Nurse #2. Nurse #2 spoke to Nurse #1 regarding his request to leave the facility, he was told he could

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sign out as long as he came back, and NA #2 assisted him to the front office area, and left him. NA #2 stated she was not aware Resident #1 had an appointed DSS Guardian.

A telephone interview occurred on 3/6/18 at 12:37 PM with Resident #6 (assessed with intact cognition) and revealed he witnessed Resident #1 receive assistance from the bus driver to get on a bus at the bus stop near the facility on 2/20/18 around 5:00 - 5:30 PM and drive off. Resident #6 stated he did not know Resident #1 was a resident of the facility, he was dressed in shorts and a "hoodie", and it was sunny and warm outside that day. Resident #6 stated he did not see anyone else with Resident #1. Resident #6 stated when he returned to the facility, he was questioned and told Nurse #5 what he saw.

An interview with the physician on 3/6/18 at 1:05 PM revealed he expected staff to notify the DSS Guardian for Resident #1 as a courtesy because of their legal responsibility for the Resident.

The Administrator and Director of Nursing were notified of immediate jeopardy on 3/6/18 at 3:55 PM. The facility provided an acceptable credible allegation of compliance (AoC) on 3/7/18 at 3:11 PM.

Credible Allegation of Compliance:
F689:

In order to correct the deficient practice pertaining to maintaining the proper supervision to prevent accidents for residents wishing to leave the facility that was cited as an Immediate Jeopardy on March 6, 2018 at 3:55pm, the facility has taken the following steps:

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F 689	Continued From page 27 1. The resident identified as resident #1 was a resident at Complete Care at Charlotte and has been appointed a guardian by the Department of Social Services (DSS). On 2/20/18 he expressed the interest to leave the facility stating that he would return later that evening and resident was allowed to sign himself out and leave the facility and resident did not to return to the facility. Resident's guardian was not notified at the time of incident but was notified the following day when he did not return. This was corrected by contacting the resident's DSS guardian on 2/21/18 and assisting her and cooperating with her in order to help ensure resident was located and safe. This included following the guardian's request to file a missing person's report and help attempt to locate resident. Resident was located in the Emergency Room of the hospital unharmed on 2/21/18. 2. The facility has identified the process that led to this deficiency by allowing resident to sign himself out and leave the facility. The nurse failed to identify that the resident has an appointed legal guardian and lacked the understanding that a resident that has been appointed a DSS Guardian cannot leave the facility premises without the notification and consent of that resident's guardian. To ensure proper supervision is provided to all other residents with exit seeking ideations or behaviors, the facility has also checked all residents with documented wandering and exit seeking behaviors and ensured that they are safe and remain in the facility. The facility's elopement prevention system was also tested to ensure it was functional and in place on 3/5/18 by the Administrator.	F 689		

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3. The plan for correcting the deficient practice of allowing a resident with DSS guardianship who has been deemed incompetent will consist of immediately educating the charge nurse at the time of incident and 100% in-service and training provided to all certified nurse's assistants, licensed nurses, and facility administrative staff stating that the facility has the responsibility to ensure the safety and supervision of residents of the facility in order to prevent accidents. In order to maintain this supervision, if a resident expresses the intent to leave the facility to a CNA, that aide must immediately notify the charge nurse, nursing supervisor, Director of Nursing, and or Administrator. This is to ensure the resident's safety and the DSS or Legal Guardian is the only person authorized to permit resident to leave the facility. The guardian must be immediately notified of all emergent and non-emergent transfers, requests for leave of absence or AMA (Against Medical Advice) by the change nurse, nursing supervisor, DON, Administrator, or any member of administrative staff. Resident guardianship information can be located in a resident's clinical chart, and that chart must be reviewed, and guardian contacted prior to resident leaving the facility. To ensure resident safety the DSS or Legal Guardian is the only person authorized to permit resident to leave the facility.

4. In order to ensure that the facility is to remain in compliance with safe supervision of residents deemed incompetent with DSS guardianship, the Director of Nursing or designee to review residents charts with DSS appointed guardianship to ensure no resident with DSS

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F 689	Continued From page 29 guardianship has been allowed to leave the facility without the guardian's permission, that proper documentation is in the resident's medical record upon times of approved leaves of absence ensuring guardians are notified in the appropriate time frame. This review will be reflected on the Resident Guardian Approval and Notification monitoring tool. These reviews will be initiated 3/8/18 and be conducted daily x5 days, weekly x4 weeks, and monthly x3 months by the Director of Nursing or Designee. Upon these dates of review, if any inconsistency is noted it is to be addressed and corrected at that time. Results of these review will be presented to the facility's monthly Quality Assurance Committee for review and any adjustments needed to this plan will be made at the time. The facility has taken the before mentioned steps and initiated this plan in order to attest that it has met the requirements to alleviate the status if Immediate Jeopardy for providing proper supervision effective March 7, 2018. The facility Administrator is to be responsible for implanting this AOC. Immediate jeopardy was removed on 3/7/18 at 5:55 PM when interviews with nursing staff and administrative staff revealed staff were educated on the facility's revised procedures regarding obtaining DSS Guardian authorization prior to allowing a resident with an appointed DSS Guardian to leave the facility, unauthorized.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency	F 755		3/30/18

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F 755	Continued From page 30 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 §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 staff, pharmacy service representative, pharmacist, physician interviews and record review, the facility failed to provide medication to treat multiple sclerosis (Glatiramer Acetate) for 1 of 5 sampled residents who received medications (Resident #10). The findings included:	F 755	1. All admission medication orders have been reviewed for resident #10. Glatiramer Acetate 40 mg Injections were noted on resident #10 pharmacy admission orders profile. All prior authorization forms from January to March have been reviewed. No prior authorization was identified for resident	

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F 755	Continued From page 31 Resident #10 was admitted to the facility on 01/11/18 with a diagnosis of multiple sclerosis. Admission physician's orders included direction to administer Glatiramer Acetate Solution 40 milligrams (mg.) subcutaneously three times weekly on Monday, Wednesday and Friday evenings. (Glatiramer Acetate is a medication used to treat muscle weakness related to multiple sclerosis.) Review of the admission Minimum Data Set dated 01/18/18 revealed there were no injections of any type administered since admission on 01/11/18. Review of Resident #10's electronic Medication Administration Record (eMAR) revealed no documentation of Glatiramer Acetate administration. The omitted doses occurred from 01/12/18 through 03/02/18, a total of 22 doses. The eMAR transcription listed the subcutaneous injection to be administered on Monday, Wednesday, and Friday at 9:00 PM. Review of a nursing note dated 03/04/18 revealed Resident #10 was discharged to the hospital for evaluation of altered mental status. Interview with Nurse #6, unit manager, on 03/07/18 at 2:42 PM revealed she was not aware Resident #10 did not receive the Glatiramer Acetate injections. During the interview, Nurse #6 placed a call to the facility's pharmacy. After the call, Nurse #6 explained the facility did not receive the ordered Glatiramer Acetate due to a prior authorization required for high cost medication. Nurse #6 reported the Director of Nursing (DON) received prior authorization	F 755	#10. Resident #10 had no negative effect as a result of the alleged deficient practice. Resident #10 was in the hospital for unrelated occurrence during onsite complaint investigation from March 5-7, 2018. 2. All residents needing Prior Approval for high cost meds are at risk to be affected by the alleged deficient practice. 3. Effective March 26, 2018, Education has been provided to all Licensed Nursing staff on the policy and protocols for medication unavailability, obtaining medications from pharmacy, notification of MD/NP and Director of Nursing or designee of unavailable medications, and medication reordering. Education provided to all Licensed Nurses for all orders faxed to the pharmacy to file the faxed confirmations. The faxed confirmations will be kept in a notebook by date at each nursing station. 4. Director of Nursing or designee will review all new admission and current resident's orders 5 days per week to ensure all medications have been delivered to the facility and/ or unavailable medications protocol has been followed to include prior authorization when necessary. Prior Authorizations are also emailed to the Administrator, Director of Nursing, and Assistant Director of Nursing weekly by the pharmacy. The Administrator, Director of Nursing, and/or designee will review all prior authorizations for high cost medications, notify the MD/NP of drug availability, and seek alternative recommended medication and/or order to hold	

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F 755	Continued From page 32 requests. Interview with the DON on 03/07/18 at 2:51 PM revealed she did not receive a prior authorization notice from the pharmacy for the Glatiramer Acetate injections. The DON reported she was not aware until today (03/07/18) of the omitted doses of Glatiramer Acetate. The DON reported the full-time evening shift nurse, Nurse #5, did not notify the physician or nursing management of the medication's unavailability. The DON stated she relied on the pharmacy's notification of inability to dispense medications due to high cost. The DON stated she forwarded prior authorization forms to the physician. Interview with Nurse #5 on 03/07/18 at 3:35 PM revealed she contacted the facility's pharmacy several times regarding the unavailability of the Glatiramer Acetate. Nurse #5 reported she did not document the attempts or notify the unit manager, DON or the physician of the omitted doses due to unavailability. Telephone interview with the physician on 03/07/18 at 3:40 PM revealed he was not aware of the unavailability of the medication. The physician stated he completed prior authorization forms frequently for receipt of high cost medications and relied on the facility and pharmacy to forward prior authorization form. Telephone interview with the facility's pharmacy service representative on 03/07/18 at 4:22 PM revealed the pharmacy had no record of facility requests to fill Resident #10's Glatiramer Acetate injections. A second interview with the DON on 03/07/18 at	F 755	medication if able without negatively affecting resident until medication is approved by insurance and/or available to the facility. Findings will be reported monthly for 3 months to the Quality Assurance Committee for further review and recommendations.	

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F 755	Continued From page 33 4:31 PM revealed the pharmacy did not dispense any doses of the Glatiramer Acetate. The DON reported she expected medications to be available for administration. Telephone interview with the facility's pharmacist on 03/08/18 at 10:40 AM revealed the facility's pharmacy sent notification of prior authorization needs to the DON. The pharmacist was not able to provide documentation of the notification. The pharmacist reported he was not aware of the unavailability of Glatiramer Acetate.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 756		3/30/18

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F 756	Continued From page 34 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff, pharmacist, physician interviews and record review, the facility failed to identify that Resident #10 did not receive medication to treat multiple sclerosis (Glatiramer Acetate) for 1 of 5 sampled residents who received drug regimen reviews (Resident #10). The findings included: Resident #10 was admitted to the facility on 01/11/18 with a diagnosis of multiple sclerosis. The admission physician's orders included direction to administer Glatiramer Acetate Solution 40 milligrams (mg.) subcutaneously three times weekly on Monday, Wednesday and Friday evenings. (Glatiramer Acetate is a medication used to treat muscle weakness related to multiple sclerosis.) Review of the admission Minimum Data Set dated 01/18/18 revealed there were no injections of any type administered since admission on 01/11/18.	F 756	1. All medication orders have been reviewed for resident #10. Due to hospitalization resident #10 medications were removed from the medication cart per facility protocol. Resident #10 had no negative effect as a result of the alleged deficient practice. Resident #10 was in the hospital for unrelated occurrence during onsite complaint investigation from March 5-7, 2018. 2. Pharmacy Director notified by Director of Nursing the oversight of omitted medication by Pharmacy Consultants' drug regimen review and pharmacy recommendations. Contacted Pharmacy Supervisor to perform education with pharmacists to ensure subsequent drug regimen reviews are conducted fully and to comply with state and federal regulations. 3. Facility obtained a different Pharmacy Consultant with expectations of pharmacy drug regimen will be completed monthly	

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F 756	Continued From page 35 Review of the electronic Medication Administration Record (eMAR) revealed no documentation of Glatiramer Acetate administration. The omitted doses occurred from 01/12/18 through 03/02/18, a total of 22 doses. Review of a drug regimen review dated 01/25/18 revealed the pharmacist documented there were no recommendations for Resident #10's medications. The pharmacist documented physician's orders, recent laboratory results and eMAR were reviewed for changes and completeness of documentation. Review of a drug regimen review dated 02/26/18 revealed the pharmacist documented there were no recommendations for Resident #10's medications. The pharmacist documented physician's orders, recent laboratory results and eMAR were reviewed for changes and completeness of documentation. Interview with Nurse #6, unit manager, on 03/07/18 at 2:42 PM revealed she was not aware Resident #10 did not receive the Glatiramer Acetate injections. During the interview, Nurse #6 placed a call to the facility's pharmacy. After the call, Nurse #6 stated the facility did not receive the ordered Glatiramer Acetate due to a prior authorization required for high cost medication. Nurse #6 reported the Director of Nursing (DON) received prior authorization requests. Interview with the DON on 03/07/18 at 2:51 PM revealed she was not aware until today (03/07/18) of the omitted doses of Glatiramer Acetate. The DON reported Nurse #5 who worked full time on	F 756	and immediate notification made to the MD/NP and Director of Nursing and/or designee of any omitted medications documented on the eMAR. 4. Director of Nursing and/or designee will review randomly review all the eMAR's of residents with a monthly drug regimen review of no recommendations from pharmacy for completeness for 3 months. Any deficiencies will be immediately corrected, and findings reported monthly for 3 months to the Pharmacy Director and Quality Assurance Committee for further review and recommendations.	

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F 756	Continued From page 36 the evening shift did not notify the physician nor nursing management of the medication's unavailability Interview with Nurse #5 on 03/07/18 at 3:35 PM revealed she contacted the facility's pharmacy several times regarding the unavailability of the Glatiramer Acetate. Nurse #5 reported she did not document or notify the unit manager, DON or the physician of the omitted doses due to unavailability. Telephone interview with Resident #10's physician on 03/07/18 at 3:40 PM revealed he was not aware of the unavailability of the medication. The physician reported he relied on facility staff and the facility's pharmacy for notification of omitted medications. Telephone interview with the facility's pharmacist on 03/08/18 at 10:40 AM revealed Resident #10's January 2018 eMAR was not available for review when he conducted the 01/25/18 drug regimen review. The pharmacist reported he reviewed the eMAR during the 02/26/18 review but missed the omitted doses. The pharmacist stated he erred. The pharmacist reported if he identified lack of administration documentation, he would have notified the DON and medical director. The pharmacist reported notification did not occur with Resident #10's omitted doses of Glatiramer Acetate.	F 756		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		3/30/18

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F 760	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on staff, pharmacist, physician interviews and record review, the facility failed to follow physician orders by not administering medication to treat multiple sclerosis (Glatiramer Acetate) for 1 of 5 sampled residents who received medications (Resident #10). The findings included: Resident #10 was admitted to the facility on 01/11/18 with a diagnosis of multiple sclerosis. Admission physician's orders included direction to administer Glatiramer Acetate Solution 40 milligrams (mg.) subcutaneously three times weekly on Monday, Wednesday and Friday evenings. (Glatiramer Acetate is a medication used to treat muscle weakness related to multiple sclerosis.) Review of the admission Minimum Data Set dated 01/18/18 revealed there were no injections of any type administered since admission on 01/11/18. Review of the electronic Medication Administration Record (eMAR) revealed no documentation of Glatiramer Acetate administration. The omitted doses occurred from 01/12/18 through 03/02/18, a total of 22 doses. The eMAR transcription listed the subcutaneous injection to be administered on Monday, Wednesday, and Friday at 9:00 PM. Review of a nursing note dated 03/04/18 revealed Resident #10 was discharged to the hospital for evaluation of altered mental status.	F 760	1. All medication orders have been reviewed for resident #10. Resident #10 had no negative effect as a result of the alleged deficient practice. Medication error report was completed. Resident #10 was in the hospital for unrelated occurrence during onsite complaint investigation from March 5-7, 2018. 2. Since all residents receiving medications have the potential to be affected by the alleged deficient practice, an ongoing audit was implemented to ensure all current residents' medication orders are available. Deficiencies immediately corrected by notifying the MD/NP of any unavailable medications and medications reordered from pharmacy. No significant medication errors were identified. 3. Effective March 26, 2018, Education has been provided to all Licensed Nursing staff on the policy and protocols for medication unavailability, obtaining medications from pharmacy, notification of MD/NP and Director of Nursing or designee of unavailable medications, and medication reordering. 4. Director of Nursing and/or designee will randomly audit 10 eMAR's for documentation 3 days per week for 3 months to ensure medications are available and Licensed Nurses are following the policy and protocols for medication unavailability. Any deficiencies will be immediately corrected, and findings of the quality assurance audits reported monthly for 3 months to the Quality	

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F 760	Continued From page 38 Interview with Nurse #6, unit manager, on 03/07/18 at 2:42 PM revealed she was not aware Resident #10 did not receive the Glatiramer Acetate injections. During the interview, Nurse #6 placed a call to the facility's pharmacy. After the call, Nurse #6 stated the facility did not receive the ordered Glatiramer Acetate due to a prior authorization required for high cost medication. Nurse #6 reported the Director of Nursing (DON) received prior authorization requests. Interview with the DON on 03/07/18 at 2:51 PM revealed she was not aware until today (03/07/18) of the omitted doses of Glatiramer Acetate. The DON reported Nurse #5 who worked full time on the evening shift did not notify the physician nor nursing management of the medication's unavailability. The DON reported she expected staff to notify the physician of missed medications and considered the omission of Resident #10's Glatiramer Acetate a medication error. The DON reported she expected staff to administer medications as ordered and report unavailability of medication. Interview with Nurse #5 on 03/07/18 at 3:35 PM revealed she contacted the facility's pharmacy several times regarding the unavailability of the Glatiramer Acetate. Nurse #5 reported she did not document or notify the unit manager, DON or the physician of the inability to administer the medication to Resident #10. Telephone interview with the physician on 03/07/18 at 3:40 PM revealed the omitted doses of Glatiramer Acetate would not harm Resident #10 but was a significant medication error. The physician reported he was not aware of the	F 760	Assurance Committee for further review and recommendations.	

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F 760	Continued From page 39 unavailability of the medication. The physician reported he expected staff to administer medications as ordered. Telephone interview with the facility's pharmacist on 03/08/18 revealed he was not aware of the omitted doses of Resident #10's Glatiramer Acetate, due to unavailability when he conducted the drug regimen review on 01/25/18 and 02/26/18. The pharmacist explained he did not notice the medication error when he reviewed Resident #10's medications.	F 760		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented	F 865	1. Quality Assurance meeting held on 3/21/18 and all cited deficient areas were reviewed and discussed at that time.	3/30/18

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F 865	Continued From page 40 procedures and monitor interventions that the committee put into place in November, 2017. This was for a deficiency cited during the facility's recertification and complaint investigation survey conducted on 10/05/17, F 425. The deficiency was in the area of pharmacy services. The continued failure of the facility to sustain compliance, during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: F 755: Pharmacy Services and procedures to obtain medication. Based on staff, pharmacy service representative, pharmacist, physician interviews and record review, the facility failed to provide medication to treat multiple sclerosis (Glatiramer Acetate) for 1 of 5 sampled residents who received medications (Resident #10). The facility was recited for F 755 for failure to have an injectable medication used to treat multiple sclerosis available for administration. The F 755 was originally cited during a recertification and complaint investigation survey on 10/05/17 for failure to have an ophthalmologic medication available for administration. Interview with the Administrator on 03/07/18 at 5:32 PM revealed the Director of Nursing (DON) monitored medication availability after the 10/05/17 recertification and complaint investigation survey. Interview with the DON on 03/07/18 at 5:35 PM revealed each medication cart received a daily	F 865	Facility is to implement and follow procedures for monthly Quality Assessment and Assurance, QAA, program which involve the added focused review of areas identified to be have repeated deficient practiced noted. This new review system will be implanted by the Administrator and will entail a through process evaluation of identified areas to ensure processes are achieving desired goals and identify areas that require modifications to ensure continued compliance. 2. All residents are at risk for being affected by this alleged deficient practice. Any area identified to have repeated deficient practices will be subject to the process evaluation program to resolve the issues and monitor the solution. 3. All department head staff provided re-education regards the requirements for a QAA committee and the purpose and impact of an effective QAA program in addition to new process evaluation portion added to the program. This education will also include each departments responsibility as it pertains to the committee. The education is to be completed by 3/30/18. 4. The Administrator will develop process evaluation forms and utilize them to conduct and record evaluations and discuss finding during monthly Quality Assurance Committee meeting in addition to all current plans to correct any deficient practices will also be reviewed by the facility administrator to ensure completion. Records will be audited at each meeting to ensure all plans are followed as written	

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F 865	Continued From page 41 audit for medication availability after the October 5, 2017 survey, until the revisit survey on 11/29/17 when the facility achieved compliance in medication availability. The DON explained she audited medication carts on a weekly rotation and progressed to a monthly basis last month (February 2018). The DON reported the audits produced no identified concerns.	F 865	and any corrections will be made at that time.	