STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365048	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF WESTLAKE	26520 CENTER RIDGE RD WESTLAKE, OH 44145

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, the facility failed to ensure an allegation of misappropriated medications was reported to the state survey agency as required. This affected three residents (Resident #20, #41 and #49) of four reviewed for medications. Finding included: 1. Record review of Resident #49 revealed an admitted [DATE] with [DIAGNOSES REDACTED]. The Minimal Data Set (MDS) revealed the resident had intact cognition and occasional pain. The August, 2020 physicians' order revealed an order for [REDACTED].#49's [MEDICATION NAME]es would be delivered. The pharmacy said they were delivered on 08/01/20. The pharmacy was contacted by the facility and an investigation was initiated. The pharmacy delivery Receipt dated 08/01/20 revealed Registered Nurse (RN) #206 signed for the delivery, however Resident's #49's [MEDICATION NAME]es were not listed on the delivery receipt. 2. Record review of Resident #41 revealed an admitted [DATE] with [DIAGNOSES REDACTED]. The Minimal Data Set (MDS) revealed the resident had intact cognition, no pain and used anti-anxiety medications. The August, 2020 physicians' order revealed an order for [REDACTED].# 41's [MEDICATION NAME] count was short by one. The blister card stated 15 pills and the control sheet from the pharmacy had 14. The pharmacy delivery sheet dated 08/08/20 revealed a card of 30 [MEDICATION NAME] and a card of 15 [MEDICATION NAME] were received. Review of RN #104's witness statement revealed the card appeared to be tampered with and the control sheet was changed to 14 pills without a cosigner. Review of Licensed Practical Nurse (LPN) #206's witness statement dated 09/02/20 revealed she changed the Resident's #41 count on the control sheet by herself because there was close to her to co-sign. 3. Record review of Resident #20 revealed an admitted [DATE] with [DIAGNOSES REDACTED]. The Minimal Data Set (MDS) revealed the resident had intact cognition and receives scheduled and as needed (PRN) opioid pain medication. The August, 2020 physicians' order revealed an order for [REDACTED]. Review of the Control Sheet revealed [MEDICATION NAME] was administered two times on 08/16/20, 08/17/20, 08/19/20, 08/23/20 and one time on 08/28/20. Interview with the DON on 08/31/20 at 3:50 P.M. revealed while conducting audits on LPN #122 for administration of controlled medications, pain medications that are addictive, revealed Resident's #20's Medication Administration Record [REDACTED]. On 08/31/20 at 4:00 P.M., interview with Resident #20 revealed she didn't recall taking two [MEDICATION NAME] a day recently however, there was one day not long ago she did take two in one day. Review of the Ohio Department of Health's Gateway system on 08/31/20 revealed no self-reported incident related to the allegation of unaccounted controlled medications for Resident #20, #41 and #49. Interview with the Administrator on 09/02/20 at 1:46 P.M. verified she did not initiate a self-reported incident for Resident #20, #41 and #49 medication misappropriation. Review of the facility's policy titled Protection of Resident: Reducing the Threat of Abuse and Neglect dated 05/15/20 revealed misappropriation of resident property is to be reported to the Administrator of the facility and to other officials including the State Survey Agency in accordance with State law through established procedures. This deficiency is cited as an incidental finding to Complaint Number OH 324.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure a complete and thorough investigation was completed for allegations of missing and misappropriated medications. This affected one of four residents reviewed for misappropriation (Resident #49). Finding Included: Record review of Resident #49 revealed an admitted [DATE] with [DIAGNOSES REDACTED]. The Minimal Data Set (MD'S) revealed the resident had intact cognition and occasional pain. The August, 2020 physicians' order revealed an order for [REDACTED].#194 that she called pharmacy to see when Resident #49's [MEDICATION NAME]es would be delivered. The pharmacy said they were delivered on 08/01/20. The Director of Nursing (DON) called the pharmacy in regard to the missing [MEDICATION NAME]es. The pharmacy initiated an investigation on their end and filed a report with the Drug Enforcement Agency (DEA). The pharmacy delivery receipt dated 08/01/20 revealed Registered Nurse (RN) #206 signed for the delivery, however, Resident's #49's [MEDICATION NAME]es were not listed on the delivery receipt. There was no evidence of witness statements or interviews from staff in regard to missing medication or the delivery of [MEDICATION NAME]es. There was no evidence the courier was interviewed. Interview with the Administrator on 09/02/20 at 1:46 P.M. verified there were no additional witness statements and a thorough investigation was not completed. This deficiency is cited as an incidental finding to Complaint Number OH 324.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to ensure pharmacy services were met with the acquisition of medications and facility staff failed to accurately document and reconcile controlled medications. This affected three residents (Resident #20, #41 and #49) of 31 residents who receive controlled medications Finding Included: 1. Record review of Resident #49 revealed an admitted [DATE] with [DIAGNOSES REDACTED]. The Minimal Data Set (MDS) revealed the resident had intact cognition and occasional pain. The August, 2020 physicians' order revealed an order for [REDACTED]. Review of the facility's investigation revealed on 08/03/20 the nurse called the pharmacy to see when Resident #49's [MEDICATION NAME]es would be delivered. The pharmacy said they were delivered on 08/01/20. The facility contacted the pharmacy and an investigation was initiated. Review of the pharmacy delivery receipt dated 08/01/20 revealed Registered Nurse (RN) #206 signed for the delivery, however, Resident's #49's [MEDICATION NAME]es were not listed on the delivery receipt. Interview on 09/01/20 at 8:55 A.M. with RN #206 revealed on 08/01/20 she met the courier at the door and wanted to reconcile the medications, however, the courier refused and asked for her name to sign the I-pad. The I-pad receipt showed RN #206's name and a place to sign. The receipt did not list any medications being delivered. RN #206 was unaware the pharmacy was to deliver Resident #49's [MEDICATION NAME]es on 08/01/20. RN #206 stated when meeting the courier for medications she takes another nurse to verify the delivery. Interview on 08/31/20 at 12:08 P.M. with the Pharmacist revealed she was contacted by the facility stating that they never received Resident #49's [MEDICATION NAME]es. The pharmacy started an investigation and did not locate the missing [MEDICATION NAME]es. A report was filed with Drug Enforcement Agency (DEA). The pharmacist pulled video of the [MEDICATION NAME]es being filled and believes they were sent. The pharmacist verified the delivery receipt for the [MEDICATION NAME]es was signed by RN #206 on 08/01/20 at 3:57 P.M. Interview on 08/31/20 at 4:05 P.M. with the Corporate Clinical Director revealed she contacted the pharmacist and was told the pharmacy could not verify the patches left the pharmacy. The investigation identified another incident occurred when the courier dropped off medications with a State tested Nursing Assistant (STNA) and asked for the name of her nurse. Review of the facility's policy titled

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Pharmacy Infection Control Delivery Service dated 03/25/20, revealed staff will meet the courier outside the building and after transfer of the medications the courier will obtain the name of staff member receiving the delivery for documentation. 2. Record review of Resident #41 revealed an admitted [DATE] with [DIAGNOSES REDACTED]. The Minimal Data Set (MDS) revealed the resident had intact cognition, no pain and received anti-anxiety medications. The August, 2020 physicians' order revealed an order for [REDACTED]. Review of the facility's investigation revealed the Director of Nursing (DON) was notified that during shift change Resident # 41's [MEDICATION NAME] count was short by one. The blister card stated 15 pills and the control sheet from the pharmacy had 14. The pharmacy delivery sheet dated 08/08/20 revealed a card of 30 [MEDICATION NAME] and a card of 15 [MEDICATION NAME] were received. A picture of the card was sent to pharmacy for examination. The pharmacist stated they believe they only sent 14 pills. Review of RN #104's witness statement revealed the card appeared to be tampered with and the control sheet was changed to 14 pills without a cosigner. Review of Licensed Practical Nurse (LPN) #122's witness statement dated 09/02/20 revealed she changed Resident's #4's count on the control sheet by herself because there was no one close to her to co-sign. Interview on 08/31/20 at 3:50 P.M. with the DON revealed on 08/23/20 LPN #206 signed out an [MEDICATION NAME] on the control sheet with marker. The original number on the control sheet was changed from 15 to 14 tabs with the same marker and there was no cosign to verify the change. Any discrepancies with narcotics need to be verified and signed off with another nurse. LPN #206 was suspended pending an investigation. Interview on 09/01/20 at 12:08 P.M. with the Pharmacist revealed she believes the facility got a card of 30 and 15 [MEDICATION NAME] for Resident #41 and was signed as received. The pharmacy conducted a count on [MEDICATION NAME] and the count was accurate. 3. Record review of Resident #20 revealed an admitted [DATE] with [DIAGNOSES REDACTED]. The Minimal Data Set (MDS) revealed the resident had intact cognition and receives scheduled and as needed (PRN) opioid pain medication. The August, 2020 physicians' order revealed an order for [REDACTED]. Review of the Medication Administration Record (MAR) for August, 2020 revealed five [MEDICATION NAME] tablets was signed out on 08/01/20, 08/02/20 and 08/28/20. Review of the Control Sheet revealed [MEDICATION NAME] was administered two times on 08/16/20, 08/17/20, 08/19/20, 08/23/20 and one time on 08/28/20. Review of the facility's investigation revealed the MAR and the Control Sheet for [MEDICATION NAME] did not reconcile. Resident #20 was interviewed by the DON about her pain and stated she didn't recall taking two [MEDICATION NAME] a day recently however, there was one day not long ago she did take two in one day. Licensed Practical Nurse (LPN) #122 witness statement dated 09/01/20 revealed the job is overwhelming and due to time constraints medications are not signed off. Interview on 08/31/20 at 3:50 P.M. with the DON verified there were [MEDICATION NAME] signed off as administered on the control sheet that was not signed off in the computer electronic medical record (E-MAR). Further interview on 09/02/20 at 12:05 P.M. revealed she had been at the facility for one week and was unaware if prior audits were conducted. This deficiency was cited as an incidental finding to Complaint Number OH 324.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation, interview, review of facility policies, review of information from the Centers for Disease Control (CDC), the facility failed to designate a don and doff area of personal protective equipment (PPE) and failed to ensure high touch areas were cleaned daily. This had the potential to affect 85 of 85 residents. Findings included: 1. Observation of the secure unit #600 on 08/27/2020 at 6:45 A.M. revealed the COVID unit was established at the end of the hall. Surveyor observation revealed the COVID-19 unit had plastic sheeting secured to the ceiling with zip ties. There was a linen cart and over bed table blocking the entrance of the plastic sheeting opening. Staff indicated the items were placed there to prevent the wandering residents on the unit from entering the COVID section. Inside of the plastic sheeting was state tested nursing assistant (STNA) #228, she stated she is the dedicated staff on the unit. She was dressed in a gown, gloves, N95 and goggles and booties. Once she enters the unit she stays there. There were two resident rooms on the unit. Both of the rooms were occupied; Residents #95 and Resident #94. Surveyor noted there were no other rooms on this unit. The surveyor asked the STNA where she donned and doffed PPE, she indicated inside of the protected unit in the hallway between the two rooms. There was no PPE outside of the COVID unit. Interview with the Administrator on 08/27/2020 at 2:40 P.M. verified the above observations. Review of the Centers for Disease Control (CDC), Using Personal Protective Equipment (08/19/20) identified the donning of PPE should be outside of the resident room and doffing of PPE (gowns and gloves) should be inside of the resident room. Review of the facility policy and procedure revised 07/25/19 revealed they would monitor for any occurrences of infection and implement appropriate control measures. 2. Review of the policy and procedure for infection control revised on 07/25/19 revealed high touch areas are to be sanitized at least daily. Observation and interview on 08/27/2020 at 11:19 A.M. with Housekeeper (HKP) #169, regarding what her duties were. She stated that they are to vacuum the hallways, mop and sweep the rooms, clean the bathrooms, and wipe down the surfaces. The surveyor asked HKP #169 if she wipes down and sanitize all high touch surfaces daily. She stated no there isn't enough time to do that. Interview on 08/27/2020 at 2:03 P.M. with HKP#127 revealed there are the only two housekeepers, she stated they don't always get a chance to wipe down the high touch areas. This deficiency substantiates Complaint Number OH 324 and OH 287.
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on interview and observation the facility failed to ensure the staff were properly in-serviced on infection control. This had the potential to affect 85 of 85 residents. Findings included: Interview on 08/27/2020 at 6:05 A.M. with Registered Nurse (RN) #208 revealed staff complain that they do not know how to handle COVID positive residents and which mask to wear and what PPE they should put on. She stated they have been without a director of nursing (DON) for a month. Interview on 08/27/2020 at 6:15 A.M. with RN#206, State tested Nurse Aide (STNA) #235, STNA#239, Licensed Practical Nurse (LPN)#194, and STNA#237, revealed the staff were unsure regarding the infection control screening process. Interview on 08/27/2020 at 6:30 A.M. with LPN#192, STNA#116, STNA#230, and STNA#109 revealed they were unsure what infection protocols they should be following particularly on the 500 unit (unit used for 14 day monitoring of new admits or re-admits). The surveyor asked when they had their last in-service on hand washing and putting on and taking off gloves and gown, they said it was sent over their cell phones. They did not have any return demonstrations. They stated they sign the sign in sheet when they come to work. The surveyor was shown a staff personal cell phone with the in-service on it. On 08/27/20 at 8:00 A.M., the surveyor requested the last in-services and was provided the pictures of hand washing and the sign in sheet. This deficiency is cited as an incidental finding to Complaint Number OH 324.