STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366199	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY LANE GARDENS REHAB & NURSING CTR	7820 PLEASANTVILLE ROAD PLEASANTVILLE, OH 43148

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure comprehensive care plans were developed and/or revised for residents who required isolation (droplet) precautions related to COVID-19. This affected five residents (#2, #4, #5, #6 and #7) of seven residents reviewed for isolation precautions. Findings include: 1. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Medicare five day Minimum Data Set (MDS) 3.0 assessment revealed the resident exhibited moderately impaired cognition along with long and short term memory loss. Review of Resident #2's care plan dated 03/13/20 to 06/13/20 revealed the resident was non-compliant with wearing a protective mask during COVID-19 quarantine related to mental illness. The care plan revealed the resident would have preventive measures in place to reduce the risk for exposure to [MEDICAL CONDITION]. On 06/11/20 at 7:00 P.M. observation of Resident #2's room revealed a green laminated sign posted on Resident #2's door which indicated to Please see nurse before entering room (which was reflective of the resident being in isolation (droplet) precautions. A three drawer cart located next to resident's room in the hall way which contained personal protective equipment (PPE) was also observed. Record review revealed no evidence Resident #2's plan of care had been updated to reflect the need for isolation (droplet) precautions. On 06/17/20 at 6:30 P.M. interview with the Administrator verified the green laminated sign posted on Resident #2's door indicated the resident was on isolation (droplet) precaution. The Administrator explained Resident #2 was on droplet isolation due to having contact with a staff member who had tested positive for COVID-19 on 06/08/20 and was to remain in isolation for 14 days. The Administrator confirmed a plan of care was not developed for Resident #2 related to the need for isolation (droplet) precautions. 2. Record review revealed Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's care plans, from 06/10/20 with a goal date of 09/18/20 revealed no plan of care had been developed for Resident #4 related to COVID care or droplet isolation care. Review of the current physician's orders revealed an order dated 06/11/20 for staff to monitor for signs and symptoms of COVID and an order dated 06/12/20 for a COVID test to be completed. On 06/11/20 at 7:00 P.M. observation of Resident #4's room revealed a green laminated sign posted on the resident's door indicating to Please see nurse before entering room. A three drawer cart was also observed located next to resident's room in the hall way which contained PPE. Review of Resident #4's admission MDS 3.0 assessment, dated 06/12/20 revealed the resident was cognitively intact with no behaviors noted. On 06/17/20 at 6:30 P.M. interview with the Administrator verified the green laminated sign posted on Resident #4's door indicated the resident was on isolation (droplet) precaution. The Administrator explained Resident #4 was on droplet isolation due to having contact with a staff member who had tested positive for COVID-19 on 06/08/20 and was to remain in isolation for 14 days. The Administrator confirmed a plan of care was not developed for Resident #4 related to the need for isolation (droplet) precautions. 3. Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the current physician's orders revealed an order dated 06/09/20 for staff to assess for signs and symptoms of COVID and an order dated from 06/09/20 to 06/23/30 to maintain strict droplet precautions in private room and to monitor respiratory symptoms. On 06/11/20 at 7:00 P.M. a green laminated sign was observed posted on Resident #5's door which indicated Please see nurse before entering room. A three drawer cart was also observed located next to resident's room in the hall way which contained PPE. Review of Resident #5's care plan dated from 06/10/20 with a goal date of 09/18/20 revealed no care plan had been developed for the prevention of COVID or related to isolation droplet isolation. Review of Resident #5's Medicare five day MDS 3.0 assessment, dated 06/15/20 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11 and exhibited no behaviors. On 06/17/20 at 6:30 P.M. interview with the Administrator revealed the green laminated sign posted on Resident #5's door indicated this resident was on droplet precaution. The Administrator explained Resident #5 was on droplet isolation due to having contact with a staff member who had tested positive for COVID-19 on 06/08/20 and due to being a new admission to the facility. The Administrator revealed the resident was to remain in isolation for 14 days. The Administrator confirmed Resident #5 did not have a care plan in place to reflect care related to isolation droplet precautions and COVID prevention. 4. Review of Resident #6's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #6's care plan dated, 03/12/20 revealed preventive measures in place to reduce the residents risk for exposure to COVID. Review of Resident #6's quarterly MDS 3.0 assessment dated [DATE] revealed the resident had cognitive impairment. On 06/10/20 a physician order was obtained for staff to assess resident for signs and symptoms of COVID. On 06/11/20 at 7:05 P.M. observation revealed a green laminated sign posted on Resident #6's door indicating to Please see nurse before entering room (which was reflective of isolation droplet precautions). A three drawer cart was also observed located next to resident's room in the hall way which contained PPE. Record review revealed no evidence the resident's plan of care was updated/revised to reflect the physician's order on 06/10/20 or the need for isolation (droplet) precautions. On 06/17/20 at 6:30 P.M. interview with the Administrator revealed the green laminated sign posted on Resident #6's door indicated the resident was on droplet precaution. The Administrator explained Resident #6 was on droplet isolation due to having contact with a staff member who had tested positive for COVID-19 on 06/08/20 and was to remain in isolation for 14 days. The Administrator confirmed Resident #6 did not have an care plan in place to reflect care related to isolation droplet precautions. 5. Review of Resident #7's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #7's care plan, dated 03/13/20 revealed a plan indicating the resident would have preventative measures in place to reduce the risk for exposure to COVID. Review of the current physician's orders revealed an order dated 06/11/20 for staff to assess resident for signs and symptoms of COVID, maintain strict droplet precautions in private room and monitor for respiratory symptoms twice a day to rule out COVID. Review of Resident #7's MDS 3.0 assessment, dated 06/11/20 revealed the resident exhibited severe cognitive impairment. On 06/11/20 at 7:10 P.M. observation revealed a green laminated sign posted on Resident #7's door which indicated Please see nurse before entering room (which was reflective of isolation droplet precautions). A three drawer cart was also observed located next to resident's room in the hall way which contained PPE. Record review revealed no evidence the resident's plan of care was updated/revised to reflect the isolation (droplet) precautions. On 06/17/20 at 6:30 P.M. interview with the Administrator revealed the green laminated sign posted on Resident #7's door indicated the resident was on droplet precautions. The Administrator explained Resident #7 was on droplet isolation due to having contact with a staff member who had tested positive for COVID-19 on 06/08/20 and was to remain in isolation for 14 days. The Administrator confirmed Resident #7 did not have an care plan in place to reflect care related to isolation (droplet) precautions. Review of the facility policy titled Isolation-Categories of Transmission-Based Precaution, with a revision date of 01/2012 revealed under Droplet Precautions at Section 9: The facility would also ensure the resident's care plan and care specialist communication system

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) indicated the type of precautions implemented for the resident. This deficiency substantiates Complaint Number OH 300.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review and interview the facility failed to ensure Resident #1's environment was maintained in a safe manner and free of items with the potential to be hazardous by failing to identify the resident had possession of two knifes (one of which was a large bladed knife) while the resident resided in the facility. This affected one resident (#1) of three sampled residents reviewed for safety. Findings include: Review of Resident #1's closed medical record revealed the resident was admitted to the facility on [DATE] and discharged on [DATE]. The resident had [DIAGNOSES REDACTED]. Record review revealed no written evidence an inventory list of Resident #1's personal belongings was obtained at the time of admission or during the resident's stay in the facility. Record review revealed no completed Minimum Data Set (MDS) 3.0 assessment was available to review for Resident #1. A plan of care, dated 06/04/20 revealed the resident had a past traumatic event. On 06/11/20 at 7:10 P.M. interview Licensed Practical Nurse (LPN) #11 revealed she identified Resident #1 had a large bladed knife in his room and also a second knife (the LPN did not provide the date in which she found these items). LPN #11 revealed at the time the items were found the resident agreed to give the knives to staff in exchange for an unscheduled smoke break. Information obtained during the investigation revealed the resident had a history of [REDACTED]. During the resident's stay in the facility, the resident was telling other residents about the knives, so facility staff searched his room. Per LPN #11, the facility had a no weapons on facility grounds policy. During the interview, LPN #11 revealed Resident #1 claimed he did not know he was not allowed to have the knives because no one told him and his personal items were not inventoried upon admission. Review of the resident's nursing progress notes revealed no evidence the incident of LPN #11 finding knives in the resident's room had been documented in the resident's medical record. On 06/11/20 at 7:28 P.M. interview with Assistant Director of Nursing (ADON) #1 revealed when a resident was newly admitted to the facility, staff were responsible for completing an inventory list and placing the document in the resident's paper (hard) chart so when they discharge form the facility it could be reviewed to ensure no items were left behind. On 06/17/20 at 6:30 P.M. interview with the Administrator confirmed all residents were required to have an inventory list completed and confirmed Resident #1 did not have an inventory list completed (which should have identified the possession of the knives). Review of the facility Workplace Violence: Deadly Weapons Considerations policy, revised 2014 revealed the facility would identify everyday objects that could be used as deadly weapons and reduce risk of a deadly weapons event where feasible. Deadly weapons were defined as any items used against someone to cause bodily injury or death and included bladed weapons (sword, dagger, fighting knife). Review of the facility policy titled Personal Property, revised on 09/2012 revealed under Section 5 the resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. This deficiency substantiates Complaint Number OH 300.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 interview the facility failed to establish an effective, accurate and complete system of receipt and disposition for all controlled drugs in sufficient detail to enable an accurate reconciliation and prevent the misappropriation of controlled substance medications. This affected 15 residents (#82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #20, #2, #93 and #94) identified by the facility as part of an internal misappropriation investigation. The facility census was 80. Findings include: Record review revealed on 05/27/20 the facility submitted a self-reported incident (SRI), tracking number 0 related to an allegation of misappropriation (of medications). Information contained in the SRI revealed on 05/26/20 the Director of Nursing (DON) was contacted for an authorization to pull [MEDICATION NAME] (a narcotic pain) medication for Resident #89 as the resident was out of the medication. On 05/27/20 Licensed Practical Nurse (LPN) #56 attempted to reorder the medication and was told by the pharmacy it was too soon to reorder the medication. An investigation was then started which subsequently identified 15 residents, Resident #82, #83, #84, #85, #86, #87, #88, #89, #90, #91, #92, #20, #2, #93 and #94 for whom medications had been misappropriated from February 2020 through May 2020. The facility identified Registered Nurse (RN) #38 as the nurse who was suspect related to misappropriation. At the time of the final SRI submission, on 06/03/20 the facility had substantiated the allegation of misappropriation and indicated their investigation was still ongoing. No additional updates to the SRI were included after 06/03/20. The facility investigation included a review of pharmacy records of medication delivery as well as actual medication cards and administration records. The facility contacted local law enforcement, filed a report and completed an investigation and audit of their controlled substances. The audit identified there were over 750 tablets of missing medications including [MEDICATION NAME] (an antianxiety medication), [MEDICATION NAME] (an controlled substance for pain relief) , Pregabalin (nerve pain medication), [MEDICATION NAME] (an controlled substance to treat pain) and [MEDICATION NAME] (an antiemetic to help with nausea and vomiting). As part of the facility investigation, it was identified RN #38 would often times document a few pills were wasted but there was not a second nurse to sign as a witness to the medication being wasted. It was also determined RN #38 was also documenting complete cards of medications/narcotics were empty and removed, however it was identified through the investigation the full cards of 30 pills were being removed and taken by RN #38. As part of the investigation the facility obtained documents from the Ohio Board of Nursing (from 07/06/06) which indicated RN #38 had her nursing license suspended in another state after RN #38 had removed [MEDICATION NAME] (a narcotic to treat severe pain) from a Pyxis machine (a machine that houses patients ' medication) where she was employed but failed to administer the medication to a resident. A drug screening completed for RN #38 on 07/18/06 revealed the RN tested positive for the medication [MEDICATION NAME]. On 06/17/20 at 6:45 P.M. interview with LPN #32 revealed the protocol for disposing of any empty controlled substance card was to have two nurses sign the controlled log sheet associated with that specific medication and then that sheet was placed in the DON's mail box and the empty medication card was disposed of in the trash. On 06/17/20 at 7:00 P.M. interview with the Administrator confirmed this procedure and confirmed this was the suspected way RN #38 was able to remove all the medication she did. The Administrator confirmed the facility did not have a proper procedure in place at the time of the occurrence to properly and safely dispose of and remove controlled substances. During the survey, the facility was unable to provide any additional written policy pertaining to controlled substances from the time when this incident was identified or throughout the facility investigation. This deficiency substantiates Complaint Number OH 300.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure medical records were complete and contained physician orders for Resident #2 and Resident #4 related to isolation (droplet) precautions. This affected two residents (#2 and #4) of seven residents reviewed for isolation (droplet) precautions. Findings include: 1. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Medicare five day Minimum Data Set (MDS) 3.0 assessment revealed the resident exhibited moderately impaired cognition along with long and short term memory loss. Review of Resident #2's care plan dated 03/13/20 to 06/13/20 revealed the resident was non-compliant with wearing a protective mask during COVID-19 quarantine related to mental illness. The care plan revealed the resident would have preventive measures in place to reduce the risk for exposure to [MEDICAL CONDITION]. On 06/11/20 at 7:00 P.M. observation of Resident #2's room revealed a green laminated sign posted on Resident #2's door which indicated to Please see nurse before entering room (which was reflective of the resident being in isolation (droplet) precautions. A three drawer cart located next to resident's room in the hall way which contained personal protective equipment (PPE) was also observed. Record review revealed no physician orders were in place for Resident #2 to be in isolation (droplet) precautions. On 06/17/20 at 6:30 P.M. interview with the Administrator verified the green laminated sign posted on Resident #2's door indicated the resident was on isolation (droplet) precaution. The Administrator explained Resident #2 was on

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) droplet isolation due to having contact with a staff member who had tested positive for COVID-19 on 06/08/20 and was to remain in isolation for 14 days. The Administrator confirmed Resident #2 did not have an physician's order in place for the droplet isolation. 2. Record review revealed Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's admission MDS 3.0 assessment, dated 06/12/20 revealed the resident was cognitively intact with no behaviors noted. Review of the current physician's orders revealed an order dated 06/11/20 for staff to monitor for signs and symptoms of COVID and an order dated 06/12/20 for a COVID test to be completed. On 06/11/20 at 7:00 P.M. observation of Resident #4's room revealed a green laminated sign posted on the resident's door indicating to Please see nurse before entering room (which was reflection of isolation droplet precautions). A three drawer cart was also observed located next to resident's room in the hall way which contained PPE. Record review revealed there was no physician order in place for the resident to be on isolation (droplet) precautions. On 06/17/20 at 6:30 P.M. interview with the Administrator verified the green laminated sign posted on Resident #4's door indicated the resident was on isolation (droplet) precaution. The Administrator explained Resident #4 was on droplet isolation due to having contact with a staff member who had tested positive for COVID-19 on 06/08/20 and was to remain in isolation for 14 days. The Administrator confirmed there was no physician order in place for Resident #4 to be in isolation (droplet) precautions. This deficiency substantiates Complaint Number OH 300.