STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365490	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS POST-ACUTE	1578 SHERMAN AVENUE NORWOOD, OH 45212

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, Facility Self reported incident reviews (SRI), facility investigation review, local police report review,employee personal file, employee time punch review, facility abuse policy review and staff interview, the facility failed to ensure a resident was free from physical abuse. This affected one (#01) of three residents reviewed for potential abuse. The facility census was 47. Findings include: Review of the medical record for the Resident #01 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 06/19/20, revealed the resident had moderately impaired cognition. Review of Mood assessment revealed the resident had little interest in doing things 12-14 days of the 2-week assessment period and never feeling bad about self. Resident was assessed with [REDACTED]. Review of the plan of care for behavior problems revised on 06/05/20 revealed Resident #01 had a history of [REDACTED]. Review of the facility SRI dated 07/10/20 at 5:30 P.M., under the heading of any pertinent investigative information revealed Certified Nursing Assistant (CNA) #01 was approached by Resident #01 who asked CNA #01 for Tylenol. CNA #01 told Resident #01 to go back to his room. The incident escalated into an argument at which time CNA #01 was observed by another staff member to strike Resident #01 to the right side of the head with a closed fist. Review of the nurse progress notes dated from 7/10/20 from 5:30 P.M. to 9:05 P.M., revealed the resident showed no signs of pain, denies pain or discomfort, refuses to go to the emergency room for evaluation. The resident stated he felt safe at that time. Resident noted carrying on with normal activity. The attending physician and the responsible parties were notified. Review of the facility investigation dated 07/10/20 at 8:48 P.M., revealed the Administrator returned to the facility as soon as he was notified of the incident and initiated an investigation in a timely manner. Review of the time punch card dated 07/10/20 revealed the CNA #01 was instructed to clock out and did not continue to work during the facility investigation. Review of the local law enforcement report dated 07/10/20 revealed the Administrator wanted to press charges and that since Resident #01 did not wish to press charges no other investigation would take place. Review of the employee files for CNA #01 revealed a date of hire of 04/15/20. The employee record contained no documented evidence of initial staff orientation including abuse prohibition. CNA #01 completed an online CNA class to become a Certified Nurse Aide, but had not been state tested due to the pandemic. The employee file contained no evidence of any employee write ups or disciplinary actions. Observations made on 07/14/20 at 10:40 A.M., of the South unit, revealed Resident #01 seated in his room watching the television then was in the South unit smoking area. There was no evidence of physical injury to the resident's face. Interview on 07/14/20 at 4:25 P.M., with the Administrator verified CNA #01 hit Resident #01 and the resident was not free from abuse. Review of the facility policy titled Abuse Prevention Program dated 2001 and revised 2016, revealed the residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, physical abuse and physical and chemical restraint not required to treat resident's symptoms. This deficiency substantiates Complaint Number OH 079.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on employee personal file reviews, facility policy review and staff interview, the facility failed to implement the facility policy to ensure adequate screening systems were in place for all employees prior to hire and ensure employees received required orientation training. This had the potential to affect 47 of 47 residents who resided in the facility. Findings include: Review of the employee personal files for Certified Nursing Assistant (CNA) #01 with a date of hire of 04/15/20, revealed the file contained six online background checks and no evidence of a national criminal background or a state criminal background check had been completed. The employee file contained no evidence of employee orientation, including abuse training. Review of the employee personal file for CNA #02 with a date of hire of 04/16/20, revealed no evidence of staff orientation including abuse training. Review of the employee personal file for CNA #03 with a date of hire of 06/17/20, revealed the file contained six online background checks and no evidence of a national criminal background or a state criminal background check had been completed. The employee file contained no evidence of employee orientation, including abuse training. Review of the employee personal file for the former Director of Nursing with a date of hire of 02/10/20, revealed no evidence of a national criminal background or a state criminal background check had been completed. The employee file contained no evidence of employee orientation, including abuse training. Review of the employee personal file for Dietary Staff #12 with a date of hire of 12/29/19, revealed the file contained six online background checks and no evidence of a national criminal background or a state criminal background check had been completed. The employee file contained no evidence of employee orientation, including abuse training or reference checks being completed, and an application for employment. Interview on 07/14/20 at 4:25 P.M., with the Administrator confirmed the facility did not have evidence of a BCI checks being completed for the national criminal background or a state criminal background check had been completed. The Administrator also verified the employee personal files lack of documentation of the training and reference checks being completed as mentioned. Review of the facility policy titled Abuse Prevention Program dated 2001 and revised 2016, revealed the facility will conduct employee background checks and will not knowingly employee or other wise engage any individual who has: been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, misappropriation of their property,; or have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, misappropriation of resident property. The policy also indicated the required staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management and handling verbally or physically aggressive resident behavior. This deficiency substantiates Complaint Number OH 079.
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 medical record review, observation, staff interview and review of facility policy, the facility failed to ensure one resident's medication was properly discontinued after physician ordered the medication to be discontinued. The affected one (#30) of the four residents reviewed during medication administration. The facility census was 48. Findings include: Review of the medical record for the Resident #30, revealed the resident was admitted on [DATE]. [DIAGNOSES REDACTED].

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

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], revealed the resident was cognitively intact, required two-person physical assist and was dependent or required extensive assistance with activities of daily living. Review of plan of care for Resident #30 dated 08/10/20 revealed resident received a [MEDICAL CONDITION] medication and is at risk for side effects. Interventions included give medication as ordered. Further review of physician's orders [REDACTED].M. for depression. Review of June 2020 MAR indicated [REDACTED]. Review of July 2020 MAR indicated [REDACTED]. Review of August 2020 MAR indicated [REDACTED]. Further review of MAR for 08/24/20, revealed resident received a dose of [MEDICATION NAME] ([MEDICATION NAME]) 50 mg at 9:00 P.M. after LPN #30 verified it should have discontinued on 06/11/20. Review of nurse's progress notes for Resident #30 dated June, July or August 2020 revealed no documentation regarding any indication [MEDICATION NAME] ([MEDICATION NAME]) 50 mg was discontinued. Review of current physician orders [REDACTED].M. revealed the orders for [MEDICATION NAME] 50 mg were still active. Observation of Resident #30's paper chart at the nurse's desk with Licensed Practical Nurse (LPN) #30 on 08/24/20 at 11:50 A.M. revealed a monthly pharmacy note dated 06/10/20 which recommended a gradual dose reduction (GDR) for [MEDICATION NAME] since resident was also on Duloxetine ([MEDICATION NAME]) (for depression) and [MEDICATION NAME] ([MEDICATION NAME]) (for depression). The monthly pharmacy review note was reviewed by Physician #15 and [MEDICATION NAME] 50 mg was ordered to be discontinued on 06/11/20. Interview with LPN #30 on 08/24/20 at 11:51 A.M. stated Resident #30's ([MEDICATION NAME]) [MEDICATION NAME] 50 mg should have also been discontinued per physician orders [REDACTED].#30 verified there were active orders for [MEDICATION NAME] ([MEDICATION NAME]) 50 mg in the electronic health records and resident continued to receive [MEDICATION NAME] ([MEDICATION NAME]) after it was discontinued on 06/11/20. Interview with DON on 08/25/20 at 10:43 A.M. verified Resident #30's [MEDICATION NAME] ([MEDICATION NAME]) should have discontinued on 06/11/20. DON also verified Resident #30 received a dose of [MEDICATION NAME] ([MEDICATION NAME]) 50 mg on 08/24/20 at 9:00 P.M. despite it being verified by LPN #30 that medication should have discontinued per physician's orders [REDACTED]. Interview with DON on 08/26/20 at 3:40 P.M. verified the orders for Resident #30's [MEDICATION NAME] ([MEDICATION NAME]) 50 mg were still active in the electronic health record for Resident #30. Review of a facility policy titled Administering Medications dated 04/01/29 revealed medications will administered in a safe timely manner and as prescribed. Policy also indicated medications will be administered in accordance with prescriber orders, including any required time frame.
F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff and pharmacy review, the facility failed to administer medications per physician orders. One error of 20 opportunities was observed resulting in a five percent medication error. This affected one resident (#11) of fourteen residents observed for medication administration. The facility census was 47. Findings included: Observations on 07/14/20 at 1:32 P.M., during a medication administration, revealed Resident #11 had [MEDICATION NAME] 50 milligrams (mg) ordered by mouth. Licensed Practical Nurse (LPN) # 22 was unable to locate the medication in the medication cart and made note of the missing medication. Interview at with LPN #22 at the time of the observation revealed the resident did not receive the medication. Review of Resident #11's medical record on 07/15/20 revealed [MEDICATION NAME] 50 mg was due at 2:00 P.M. and was documented as not given on 07/14/20 and to see the nursing progress notes. Review of the Nursing Progress Notes date 07/14/20 at 1:34 P.M. revealed the [MEDICATION NAME] was not available and the pharmacy was notified. Interview on 07/20/20 at 9:48 A.M., with the facility Pharmacist #100 revealed the [MEDICATION NAME] for Resident #11 was ordered one week early on 07/14/20. It was next due for delivery on 07/21/20 but the pharmacy received an order to send the medication to the facility a week early. Pharmacist #100 stated here should have been at least seven more days' worth in the facility. It was under the generic name of [MEDICATION NAME] - pregabalin and each card held 60 tablets. The medication had not been sent. This deficiency substantiates Complaint Number OH 079.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observations, staff interviews, and facility policy review, the facility failed to ensure a resident's insulin was administered as physician order [REDACTED]. This affected one (#20) of the four residents observed for medication administration. Facility census was 48. Findings include: Review of the medical record for the Resident #20, revealed the resident was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the most current Minimum Data Set (MDS) assessment, revealed the resident was cognitively intact and required supervision with activities of daily living. Review of Resident #20's plan of care dated [DATE] indicated resident has [DIAGNOSES REDACTED]. Interventions included administer medications as ordered and monitor/document for side effects and effectiveness. Review of Resident #20's physician orders [REDACTED].M., 12:00 P.M. and 5:00 P.M. as a subcutaneous injection per sliding scale (,[DATE] = two units, ,[DATE] = four units, ,[DATE] = six units, ,[DATE] = eight units, and greater than 400 = 10 units and call physician). Review of MAR for Resident #20 dated [DATE], revealed the 8:00 A.M. and 12:00 P.M. doses of [MEDICATION NAME] was recorded with a five, which indicated hold/see nurses notes. Review of nurse's progress notes for Resident #20 dated [DATE] at 10:46 A.M. revealed residents [MEDICATION NAME]was unavailable and pharmacy was called to send a STAT order. Review of he nurses progress notes dated [DATE] at 3:06 P.M. indicated residents [MEDICATION NAME]was unavailable and pharmacy was going to make a STAT delivery of medication. Observation of morning medication administration pass with Licensed Practical Nurse (LPN) #30 on [DATE] from 10:43 A.M. through 11:20 A.M. revealed Resident #20's finger stick blood glucose (FSBG) was noted to be 353 mg/deciliter (dL) at 10:55 A.M. Observation revealed LPN #30 removed [MEDICATION NAME] from the cart and started to draw up [MEDICATION NAME](fast acting insulin) in a syringe. LPN #30 noted the Resident #20's [MEDICATION NAME] vial was recorded as being opened on [DATE] and expired on [DATE]. The [MEDICATION NAME] vial expired 28 days after opening. Observation also revealed Resident #20 did not receive his 8:00 A.M. (breakfast) dose of [MEDICATION NAME] as ordered. Interview with LPN #30 on [DATE] at 11:21 A.M. stated she was late administering morning medications due to being an agency nurse and didn't arrive in facility until 8:45 A.M. LPN #30 stated Resident #20 should have received [MEDICATION NAME]per sliding scale (according to FSBG results) before his breakfast around 8:00 A.M. LPN #30 indicated the resident was scheduled to receive eight units of [MEDICATION NAME] according to the sliding scale but did not receive any [MEDICATION NAME] due to medication being outdated. LPN #30 contacted the Director of Nursing (DON) to search the central supply storage refrigerator but the DON reported she could not find any stock [MEDICATION NAME] for Resident #20. LPN #30 verified Resident #20 did not receive his scheduled eight units of [MEDICATION NAME] as ordered for FSBG of 353 mg/dL. Observation of the afternoon medication administration round with LPN #30 on [DATE] at 11:55 A.M. revealed Resident #20's FSBG was noted to be 353 mg/dL. Observation also revealed there was no [MEDICATION NAME] on hand for Resident #20 to receive for his FSBG reading. Interview with LPN #30 on [DATE] at 12:00 P.M. indicated resident was scheduled to receive six units of [MEDICATION NAME] according to the sliding scale with a FSBG of 353 mg/dL. LPN #30 verified she did not administer Resident #20's 12:00 P.M. [MEDICATION NAME] coverage due to not having any insulin on hand. LPN #30 stated she called the pharmacy and created a STAT (emergency) order and noted there was a four-hour delivery timeframe. Interview with Resident #20 on [DATE] at 2:44 P.M. stated his medications are often late but rarely misses doses. Interview with LPN #30 on [DATE] at 2:52 P.M. indicated she was entering Resident #20's room to recheck his blood sugar. Observation at same time indicated Resident #20's FSBG was noted to be 341 mg/dL. Observation also revealed resident denying any symptoms of [MEDICAL CONDITION] (elevated blood sugar). LPN #30 stated the pharmacy called and stated Resident's [MEDICATION NAME] was en route to facility. Review of a facility policy titled Administering Medications dated [DATE] revealed medications will administered in a safe timely manner and as prescribed. Policy also indicated medications will be administered in accordance with prescriber orders, including any required time frame.

F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record and policy review, the facility failed to discard outdated insulin vials located in the south medication cart. This affected two (#20 and #45) out of four residents reviewed for medications. Facility census was 48. Findings include: Observation of medication administration pass with Licensed Practical Nurse (LPN) #30 on [DATE] from 10:06 A.M. through 11:55 A.M. revealed the south medication cart contained two outdated vials of

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) insulin. Observation revealed a bottle of [MEDICATION NAME] Insulin ordered for Resident #20 was recorded to be opened on [DATE] and expired on [DATE]. The [MEDICATION NAME] vial indicated it expired 28 days after opening. Further observation revealed a bottle of [MEDICATION NAME] ordered for Resident #45 was recorded to be opened on [DATE] and expired on [DATE]. The [MEDICATION NAME] vial indicated it expired 28 days after opening. Interview with LPN #30 on [DATE] at 11:56 A.M. verified Resident #20's [MEDICATION NAME] was outdated and remained in the medication cart. LPN #30 also verified Resident #45's [MEDICATION NAME] was outdated and remained in the medication cart. LPN #30 stated the vials should have been discarded after 28 days of being opened. Review of a policy titled Storage of Medications dated [DATE] revealed the facility stores all drugs and biologicals in a safe, secure and orderly manner.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 medical record reviews and staff interview, the facility failed to maintain documentation of weekly skin assessments in the resident records. This affected three (#02, #08, #09) of three residents reviewed for skin assessments. The facility census was 47 residents. Findings include: 1. Review of the medical record for the Resident #02 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 06/23/20, revealed the resident had no impairment of cognition. The resident was extensive two-person assistance with bed mobility, transfers, and toileting. Extensive one - person assistance with eating and personal hygiene. Review of Mood assessment revealed R#2 had little interest in doing things, feeling down, and trouble sleeping, for 12-14 days of the 2-week assessment period. R#2 was assessed with [REDACTED]. Review of the Electronic Physician order [REDACTED]. Record review of the weekly skin assessments on the Treatment Assessment Record, the Nursing Body Assessment/Observation documentation and the Nursing Progress Notes for June and July of 2020, revealed no evidence of skin assessment for the week of 06/19/20. 2. Review of the medical record for the Resident #08 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the Electronic Physician order [REDACTED]. Record review of the weekly skin assessments on the Treatment Assessment Record, the Nursing Body Assessment/Observation documentation and the Nursing Progress Notes for June 2020 revealed no evidence of skin assessment for the week of 06/13/20. 3. Review of the medical record for the Resident #09 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the Electronic Physician order [REDACTED]. Record review of the weekly skin assessments on the Treatment Assessment Record, the Nursing Body Assessment/Observation documentation and the Nursing Progress Notes for June 2020 revealed no evidence of weekly skin assessment for 06/13/20 and 06/27/20. Interview on 07/21/20 at 12:22 P.M., with the Administrator verified the resident's medical records do not have documented evidence of the weekly skin assessments being completed. This deficiency substantiates Complaint Number OH 079.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on record reviews, observations and staff interviews, the facility failed to staff the COVID 19 isolation unit in such a manner to prevent the risk of exposure to other facility residents. This had the potential to affect 17 (#11, #27, #10, #26, #25, #09, #24, #23, #02, #03, #12, #01, #22, #21, #20, #04, #13)of 17 residents who reside on the South and East unit who are not in isolation. The facility census was 47. Findings include: Observations 07/14/20 between 10:13 A.M. and 12:00 P.M., during a tour of the facility revealed the facility had a designated COVID isolation unit in place with a zippered vinyl screening closing off the last four resident rooms on the East hall (Rooms #60, #61, #62, #63). Interview on 07/14/20 at 11:00 A.M., with the Administrator and the Regional Director of Clinical Services #55 revealed the nurse on the COVID unit (back part of East hall) was staffed by a nurse who also was the nurse for the South hall. During the day one nursing assistant would be assigned to the COVID unit. And one nursing assistant would be assigned to the South unit. Observations and interview on 07/14/20 at 11:40 A.M., during a tour of the COVID Unit, with the Regional Director of Clinical Services #55 verified there was no area outside the unit, when leaving the unit, to doff personal protective equipment (PPE). The Regional Director of Clinical Services #55 requested a trash can placed just inside the zippered closure. The Regional Director of Clinical Services #55 and this surveyor went into an empty resident room just outside the COVID unit to remove PPE before walking through the non COVID unit. Interview on 07/14/20 at 1:12 P.M., with Licensed Practical Nurse (LPN) # 22 verified that she passes medications on the COVID unit as well as the non COVID unit on the same day. Review of the daily nurse staffing sheets revealed the COVID unit did not have a designated staff to solely work the COVID unit. The following dates revealed staff was being shared between both units: On 07/01/20 there was one nurse and 1.5 nurse aides scheduled on the non COVID and the COVID unit, on the night shift there was one nurse and one aide for both units. On 07/02/20, 07/03/20, 07/04/20 and 07/05/20, for night shift, there was one nurse and one aide for both units. On 07/06/20 there was one nurse and one nurse aide scheduled on the both units for the day shift. The night shift had one nurse and one aide for both units. On 07/07/20, 07/08/20, 07/10/20, 07/12/20, 07/13/20, 07/14/20 for night shift, there was one nurse and one aide for both units. On 07/15/20, there was one nurse and 1.5 nurse aides scheduled on the South hall and the Covid unit. Review of the facility policy titled Infection Prevention and Control Program revised on October 2018, revealed the program is based on accepted national infection prevention and control standards. Review of the CDC guidelines for Responding to Coronavirus (COVID-19) in Nursing Homes revealed the facility was to assign a dedicated health care providers (HCP) to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility. To the extent possible, restrict access of ancillary personnel to the unit. This deficiency substantiates complaint number OH 079 and is an example of continued noncompliance from the 06/11/20 survey.