

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024
NAME OF PROVIDER OR SUPPLIER Highland Square Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1211 W Market St Akron, OH 44313	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42734</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, review of the facility assessment, visitation policy, substance use disorder program contract and interview, the facility failed to properly identify potential risks/hazards for residents with a substance use disorder and provide adequate supervision and/or supervised visitation to prevent intentional/unintentional drug overdoses for residents in the facility. This resulted in Immediate Jeopardy and actual harm on [DATE] when Resident #44 who had known substance abuse history was found unresponsive and required cardiopulmonary resuscitation (CPR) and hospitalization after a Fentanyl and Methadone overdose. The Immediate Jeopardy and actual harm continued on [DATE] when Resident #61 with a known substance abuse history was found unresponsive requiring CPR after a drug overdose. The Immediate Jeopardy continued on [DATE] when Resident #61 was assessed to be difficult to arouse and identified to have an overdose of Fentanyl leading to hospitalization .</p> <p>On [DATE] at 1:55 P.M. the Administrator, Director of Nursing (DON), Regional Director of Operation (RDO) #710, [NAME] President of Clinical Services #750 and Regional Nurse #700 were notified Immediate Jeopardy began on [DATE] following the identification of drug overdoses occurring in the facility. Resident #44 who had known substance abuse history was found unresponsive and required cardiopulmonary resuscitation (CPR) and hospitalization after a Fentanyl and Methadone overdose. The Immediate Jeopardy continued on [DATE] and [DATE] related to drug overdoses involving Resident #61.</p> <p>This affected two residents (#44 and #61) of four residents reviewed for substance use disorder. The facility identified 15 residents with active or current substance use disorders, ten residents with behavioral health needs and 14 residents (#7, #9, #12, #14, #19, #20, #23, #24, #28, #29, #37, #44, #47 and #52) who participated in the facility substance abuse program.</p> <p>The Immediate Jeopardy was removed, and the deficiency was corrected on [DATE] when the facility implemented the following corrective actions:</p> <p>On [DATE] at 9:32 P.M. Licensed Practical Nurse (LPN) #223 called 911 (related to Resident #44).</p> <p>On [DATE] at 9:36 P.M. the Director of Nursing (DON) was notified by LPN #216 of a possible overdose of Resident #44.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 9:38 P.M. Akron City Emergency Medical Services (EMS) arrived at the facility, administered Resident #44 Narcan. MD #800 was notified, orders to monitor resident and complete tox screen. LPN #223 was asked by LPN #216 to witness an interview with Resident #61 about an incident that occurred with Resident #44. When both nurses approached Resident #61's room, they observed the resident lying face down on his floor and unresponsive. LPN #223 initiated CPR and LPN #216 went to the third floor to alert the paramedics that were already in the building.</p> <p>On [DATE] at 9:42 P.M. DON was notified by LPN #223 that Resident #61 was found unresponsive of possibly an overdose.</p> <p>On [DATE] at 9:43 P.M. the DON advised charge nurses LPN #223 and LPN #216 to complete a head count of residents and check the status of all residents. All other residents were accounted for with no concerns. Charge nurses LPN #223 and LPN #216 were directed to obtain statements from all staff in the building regarding the incident.</p> <p>On [DATE] at 9:44 P.M. the DON notified the Administrator two residents (#44 and #61) were found unresponsive from a possible (drug) overdose.</p> <p>On [DATE] at 10:10 P.M. LPN #223 notified MD #800 of Resident #61 being unresponsive.</p> <p>On [DATE] at 10:35 P.M. the DON arrived at the facility. A whole house audit was completed to ensure no other residents had been affected. The DON went to Resident #61's room to check his status. Then, DON went to the third floor to check the status of Resident #44.</p> <p>On [DATE] at 10:45 P.M. Resident #44 and Resident #61 were placed on Q 15-minute safety checks.</p> <p>On [DATE] at 10:55 P.M. the Administrator arrived at the facility.</p> <p>On [DATE] at 11:10 P.M. LPN #223 received an order from MD #800 to complete urinalysis from both residents (#44 and #61).</p> <p>On [DATE] at 11:30 P.M. the Administrator reviewed and made a copy of the visitor log with the findings of a visitor for Resident #44 on [DATE] from 5:10 P.M. to 5:20 P.M.</p> <p>On [DATE] at 12:38 A.M. the DON received a call from nurse LPN #223 for a change in condition for Resident #44. MD #800 was notified and 911 was called and Resident #44 was transferred to the hospital.</p> <p>On [DATE] at 1:15 A.M. RDCS #700, the Administrator and the DON reviewed staff statements, and staffing list for current day. It was determined the root cause of the drug overdose incident was a facility failure to supervise visitation per the facility substance abuse program policy.</p> <p>On [DATE] at 1:00 P.M. education on the facility substance abuse program interventions and monitoring was initiated by the Administrator and DON for all facility staff.</p> <p>On [DATE] at 1:30 P.M. the third-party program residents were provided with their signed contracts in order to review the expectations of the contract by SS #276, the counselor from the program.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:00 P.M. at Quality Assessment Performance Improvement (QAPI) meeting was held with RDO #710 and MD #800 via telephone, RDCS #700, the Administrator, DON, Unit Manager/LPN #201, Medical Records (MR) #204, Admissions Director (AD) #205, Business Office Manager (BOM) #202, Human Resources (HR) #203, and Therapy Director (DOR) #720, to discuss the incidents on [DATE].</p> <p>On [DATE] at 7:00 P.M. Resident #44 returned to the facility and agreed to participate in individual and case management services through the third-party program. Resident #44 had participated in the third-party program from [DATE] through [DATE] and then again began participation on [DATE].</p> <p>On [DATE] at 9:44 P.M. LPN #216 notified the DON of concern for Resident #61 appearing under the influence due to resident being difficult to arouse and not acting like self. The nurse then called MD #800 and EMS to transport the resident to the hospital. EMS arrived at the facility with police due to concern of possible overdose. Staff at the facility searched Resident #61's room with police officers. Inside his notebook a folded-up bus pass was located with a black substance in it. Officers tested the substance which was positive for Fentanyl.</p> <p>On [DATE] at 3:55 A.M. Resident #61 returned to the facility after testing positive for Fentanyl in hospital.</p> <p>On [DATE] at 9:45 A.M. the facility clinical team met with SS #276 to discuss the incident that occurred on [DATE] involving Resident #61.</p> <p>On [DATE] at 10:00 A.M. the Administrator held a QAPI meeting to discuss the root cause of the [DATE] incident and determined facility failure to conduct adequate room searches. Staff in attendance at the QAPI meeting included RDO #710 and MD #800 via telephone, RDCS #700, the Administrator, the DON, Unit Managers LPN #201 and LPN #200, MR #204, AD #205, BOM #202, HR #203, and DOR #720.</p> <p>On [DATE] at 11:00 A.M. the Administrator and RDO #710 completed room searches for all residents in the substance use disorder program with no additional negative findings. Residents were observed at this time for any changes in behaviors such as slurring of words, change in cognition, increase in agitation and avoidance of eye contact or conversation. No concerns noted at this time.</p> <p>On [DATE] at 1:26 P.M. Resident #61 discharged from the facility. The resident was given discharge instructions and summary. MD #800 was in agreement with the resident's discharge.</p> <p>On [DATE] at 2:30 P.M. RDO #710 educated the department head team which included the Administrator, the DON, Unit Managers LPN #200 and LPN #201, MR #204, AD #205, BOM #202, HR #203 and DOR #720 on the facility's substance abuse disorder program policy with emphasis on random room searches, random search of any delivered packages and supervised visitation.</p> <p>On [DATE] at 6:00 P.M. department head (BOM #202, DON, the Administrator, HR #203, AD #205, Unit Manager/LPN #201, MR #204, Activities Director (AD) #208, and Minimum Data Set nurse (MDS) #207) education was provided regarding the substance abuse contract completed by RDO #710.</p> <p>On [DATE] at 6:20 P.M. all staff education was completed regarding the substance abuse contract by the department heads BOM #202, DON, the Administrator, HR #203, AD #205, Unit Manager/LPN #201, MR #204, AD #208 and MDS #207.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 6:30 P.M. Front desk staff receptionist (RCP) #265, RCP #266 and RCP #267 were re-educated on the process of supervised visitation by the Administrator:</p> <ol style="list-style-type: none"> 1. Visitation would be conducted in the main lobby and would be supervised by the receptionist or designee. 2. In the event the phone rings during a visit, the phones would not be answered by the receptionist and would roll over to the floors. 3. If assistance was needed, notify another staff member. 4. In the event of needing to leave the desk notify another staff member to cover. <p>At least once a week the administrator and clinical team meet with SS #276, the third-party counselor, on Wednesdays and as needed. During this meeting a discussion of all residents who were active with attending groups through third-party program. Discussion of the residents, discharge plans, meeting goals, progress, or any concerns such as decreased participation, changes in behaviors or at risk. The bed board was present to discuss any residents who were not active in the program for reassessment and encouragement to participate. At the time of this meeting, it would be discussed for room searches and random tox screens to be completed with the third-party program and at the facility level. Communication between the Administrator and the third-party program/counselor would be continuous and as needed if any concerns arise.</p> <p>On [DATE] the facility implemented a plan for the Administrator/designee to audit the visitation log, to include monitoring of the sign in book (for completion) and to ensure visitations five times per week for four weeks and then randomly thereafter. Discrepancies would be reviewed in QAPI and revised as needed.</p> <p>On [DATE] the facility implemented a plan for the Administrator/designee to audit to ensure random room searches of residents participating in the substance use disorder program were completed for three residents weekly for four weeks and then randomly thereafter. All audit findings would be submitted to QAPI for recommendations and review.</p> <p>Findings include:</p> <p>Review of the facility assessment dated [DATE] reflected 15 residents with active or current substance use disorders and ten residents with behavioral health needs. The assessment reflected the facility managed the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identified and implemented interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. The facility made available a third-party program for case management and counseling for residents with substance use disorders.</p> <p>1. Review of Resident #44's medical record revealed an admitted [DATE] with diagnoses including encephalopathy, multiple sclerosis, nicotine dependence and other psychoactive substance abuse.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #44's medical record revealed a signed consent for the facility's Substance Use Disorder Program dated [DATE].</p> <p>Review of the initial care plan dated [DATE] revealed Resident #44 had mood and behavior problems related to anxiety, depression, substance abuse and recent placement at facility. Interventions included consulting behavioral health as needed and educating the resident/family on expectations of treatment. The resident's plan of care was revised on [DATE] to reflect a third-party program which offered case management and counseling for residents with substance use disorder. The goal was for Resident #44 to remain substance free for duration of the stay. Interventions included the resident must adhere to the program's rules, have no leave of absences (LOAs), participation in the program's group activities and completing homework for the program.</p> <p>Review of a progress note dated [DATE] dated 1:28 A.M. and authored by LPN #223 revealed within the 9:00 P.M. hour (on [DATE]), Resident #44 was observed leaning forward in his wheelchair unresponsive to stimuli. LPN #223 initiated code status alert and called 911. LPN #223 wrote Resident #44's airway was patent, she did a sternum rub, bounding pulse noted. LPN #223 stated the response team used Narcan one time. Resident #44 was monitored every 15 minutes. LPN #223 notified MD #800 at 12:40 A.M. concerning the resident having shallow respirations. MD #800 gave an order to send the resident to the emergency room . Administration and DON were notified and had assessed needs until 911 arrived.</p> <p>Review of the incident report dated [DATE] at 9:36 P.M. and authored by LPN #223 revealed Resident #44 was found unresponsive in his wheelchair. LPN #223 checked the resident's pulse and initiated CPR. Airway was noted to be patent. Sternum rub was completed and 911 was called. EMS arrived on the scene and utilized Narcan on Resident #44 one time. EMS relayed since Resident #44 was responsive and vital signs were stable, he did not need to go to the emergency room . In the resident description Resident #44 initially stated he took Fentanyl and Methadone. The immediate action taken per the incident report indicated MD #800, the DON, RDCS #700, RDO #710 and the third-party program counselor were notified. The incident report indicated the predisposing factor was taking narcotic/analgesic. Under the area of other it noted Resident #44 had a history of substance use and a diagnosis of psychoactive substance abuse. The resident was in the facility's program. Resident #44 was not supervised during a visit prior to overdose.</p> <p>Review of the Change in Condition form dated [DATE] at 6:14 A.M. and authored by LPN #223 revealed around midnight Resident #44 had abnormal vital signs, an altered mental status and was unresponsive. MD #800 ordered urinalysis or culture. Under review of findings it was marked as opioid overdose. Family was notified.</p> <p>Review of a progress noted dated [DATE] at 9:24 A.M. and authored by LPN #218 revealed Resident #44 was admitted to the hospital with a diagnosis of urinary tract infection. The resident returned to the facility on [DATE] at 7:03 P.M. Review of a progress note dated [DATE] at 12:35 A.M. and authored by Registered Nurse #217 revealed Resident #44 was given a urine drug test which resulted positive for THC.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 8:20 P.M. with LPN #223 revealed she was present on [DATE] as the third-floor nurse. She stated State tested Nursing Assistant (STNA) #226 found Resident #44 slumped over in his wheelchair in his room. She stated she started CPR and called 911. When EMS took over, LPN #223 stated she went to the second floor to speak to another resident (Resident #61) who Resident #44 hung out with regularly. She wanted to find out if this resident gave Resident #44 drugs. She stated at that time she found Resident #61 on the floor with an apparent drug overdose. She stated there were police who showed up but did not come into the building on [DATE]. During the interview, the LPN indicated the facility substance use disorder program was too much explaining the residents in the program were on all three units instead of one like it used to be. She also stated the facility was not enforcing the visitation policy. She acknowledged receiving education on supervised visits stating visits now had to happen in the lobby for any resident on the facility program.</p> <p>Interview on [DATE] at 8:35 P.M. with LPN #216 revealed she was the nurse on second floor and had been at work on [DATE]. She stated on [DATE] she was called to the third floor to assist with Resident #44's overdose. Once the EMS took over care of Resident #44, she and another nurse thought they should check with Resident #61 to see if he knew what Resident #44 took. Following the incident, LPN #216 stated staff were given education on the facility's (substance abuse) program and the need for enforcement of visitation. She stated the visits would now have to be supervised unlike before.</p> <p>Interview on [DATE] at 2:49 P.M. with the DON revealed she arrived at the facility on [DATE] at 9:50 P.M. after being notified of the resident drug overdoses. She stated Resident #44 had not gone on any type of leave of absences (LOA) prior to the incident, but did have a visitor on [DATE], his father. The DON denied knowing how Resident #44 acquired drugs. She stated Resident #44 initially refused to go to the hospital, but he was sent around 12:00 A.M. and was admitted . The resident returned to the facility on [DATE].</p> <p>Interview on [DATE] at 9:20 A.M. with the Administrator revealed she had requested the EMS report for Resident #44 but had not received it during the survey.</p> <p>Interview on [DATE] at 3:15 P.M. with Regional Director of Operations (RDO) #710 revealed visitation should have always been restricted to common areas (based on the facility substance abuse program). However, this was not enforced until [DATE] and now all visitation was limited to the lobby area. RDO #710 revealed only one resident (#44) had been identified to have a visitor on [DATE] which was how they believed residents obtained the drugs. The residents, including Resident #44, were not being supervised for visitation (as per the facility protocol) prior to [DATE].</p> <p>Interview on [DATE] at 4:54 P.M. with RDO #710 and the Administrator confirmed on [DATE], Resident #44 had an unsupervised visit with his father, and he was not assessed afterwards as per the facility policy. RDO #710 stated the facility's role was to provide a safe, structured environment. The Administrator stated she met with SS #276 every week, usually Wednesdays, and as needed to discuss residents with signed Substance Use Disorder contracts. Both RDO #710 and the Administrator reviewed their contract and indicated they were tightening up the program.</p> <p>2. Review of the closed medical record for Resident #61 revealed an admitted [DATE] and a discharge date of [DATE]. Resident #61 had diagnoses including other psychoactive substance abuse, opioid dependence, cannabis use and nicotine dependence.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the medical record for Resident #61 revealed a signed consent for the facility's Substance Use Disorder Program dated [DATE].</p> <p>Review of the initial care plan dated [DATE] revealed Resident #61 had mood and behavior problems related to anxiety, depression, substance abuse and recent decline in health related to substance abuse. The resident had an order for Naloxone (Narcan) as needed for opioid abuse. Interventions included consulting behavioral health as needed and educating the resident/family on expectations of treatment. The resident's care plan was revised on [DATE] to reflect a third- party program which offered case management and counseling for residents with substance use disorder. The goal was for Resident #61 to remain substance free for duration of the stay. Interventions included, he must adhere to the program's rules, have no leave of absences (LOAs), participation in the program's group activities and completing homework for the program.</p> <p>Review of a progress note dated [DATE] at 9:50 P.M. and authored by LPN #216 revealed the third-floor nurse, LPN #223, knocked on Resident #61's door. There was no response. She discovered the resident was lying on the floor face down and not breathing. The resident was turned over and CPR was initiated. While performing CPR Resident #61 began to breathe as EMS entered the room and took over care.</p> <p>Review of an incident report, noted Resident #61 sustained a fall on [DATE] at 9:50 P.M. The report was authored by LPN #216 and revealed upon entering Resident #61's room the resident was lying face down on the floor, unresponsive and not breathing. The floor nurse and STNA turned the resident over, and initiated CPR until EMS arrived. EMS administered Narcan twice. Resident #61 was responsive and immediately stood up. He refused to go to the hospital. Resident #61's description of what happened revealed he and another resident were smoking the same cigarette before this occurred. The immediate action taken was MD #800, the DON, the Administrator and SS #276 were notified. The predisposing factor was identified as taking narcotic/analgesic. The report revealed Resident #61 had a history of substance use and a diagnosis of psychoactive substance abuse. The resident was currently part of the facility program, and he was not supervised during visit.</p> <p>Review of a progress note dated [DATE] at 9:44 P.M. and authored by the DON revealed the DON received a call regarding Resident #61 being under the influence. The resident was not acting like his normal self but was alert and oriented. The DON instructed the nurse to complete vital signs, a drug test, search his room and do a head count on all residents. The DON was then notified that the resident was not easily arousable/unresponsive. Vital signs were checked again, and the resident's continuous pulse oxygen reflected 90%. The DON instructed staff to give Resident #61 two liters of oxygen, call MD #800 and call EMS. Resident #61 stated he was having sharp pain in his chest. EMS arrived and Resident #61 was taken to the hospital where he tested positive for Fentanyl. The local police were involved and stated Resident #61 would be charged with possession.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the incident report dated [DATE] at 9:44 P.M. and authored by the DON revealed the DON was notified of Resident #61 being under the influence. The resident was not acting like his normal self but was alert and oriented. The DON instructed the nurse to complete vital signs, a drug test, search his room and do a head count on all residents. The DON was notified the resident was not easily arousable/unresponsive. Vital signs were checked again, and his continuous pulse oxygen reflected 90%. The DON instructed to give Resident #61 two liters of oxygen, call MD #800 and call EMS. Resident #61 stated he was having sharp pain in his chest. EMS arrived and Resident #61 was taken to the hospital where he tested positive for Fentanyl. The predisposing factor was identified as taking narcotic/analgesic. The immediate action taken was MD #800, EMS, RDO #700 and DON were notified. EMS arrived and transferred the resident to the hospital where he tested positive for Fentanyl. The police were involved and stated he would be charged with possession. The report revealed Resident #61 had a history of substance use and a diagnosis of psychoactive substance abuse. The resident was currently part of the facility program. Resident #61 was discharged following the incident due to violating the program contract. The resident was discharged on [DATE].</p> <p>Review of the police report dated [DATE] at 10:07 P.M. revealed police were present from 9:30 P.M. to 10:05 P.M. Resident #61 was identified as the suspect and event was identified as an overdose. Offenses listed were possession of drugs (Fentanyl), illegal conveyance of drugs of abuse and unintentional overdose. The police seized 1.56 grams of suspected Fentanyl which was found in folded bus pass.</p> <p>Review of the progress noted dated [DATE] at 3:55 A.M. authored by LPN #216 revealed Resident #61 returned to the facility. EMS stated resident was tested and results were negative with the exception of the Fentanyl results.</p> <p>Interview on [DATE] at 8:20 P.M. with LPN #223 revealed she was present on [DATE] as the third-floor nurse. She stated after STNA #226 found Resident #44 slumped over in his wheelchair and EMS took over care for the resident, she went to second floor to speak to Resident #61 (who Resident #44 hung out with regularly). She stated she wanted to find out if Resident #61 gave Resident #44 drugs. She stated she found Resident #61 on the floor with an apparent drug overdose. She stated there were police who showed up but did not come into the building on [DATE]. She stated she was not present on [DATE] when Resident #61 experienced a second overdose. She stated the substance use disorder program was too much explaining the residents in the program were on all three units instead of one like it used to be. She also stated the facility was not enforcing the visitation policy. She acknowledged receiving education on supervised visits stating visits now had to happen in the lobby for any resident on the facility program.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Highland Square Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1211 W Market St Akron, OH 44313	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 8:35 P.M. with LPN #216 revealed she was the nurse on second floor and present both times Resident #61 overdosed. She stated on [DATE] she was called to the third floor to assist with Resident #44's overdose. Once the EMS took over both she and another nurse thought they should check with Resident #61 to see if he knew what Resident #44 took. She stated they knocked on his door with no answer. They opened the door and found Resident #61 on the floor; he was blue. They started CPR, the STNA was getting a crash cart when Resident #61 started breathing and threw up. The other nurse got EMS who were present in the building on the third floor. They administered Narcan to Resident #61. Resident #61 jumped up and did not know what happened. He denied taking anything and refused to go to the hospital. The LPN revealed she was also working on [DATE] when Resident #61 again overdosed. LPN #216 stated he had been passing snacks with the STNA. Resident #61 came out of his room and his eyes were squinty, slurring speech and wobbly. He had gone to the room next door to visit another resident for a few minutes. When he went back to his room, LPN #216 heard a loud boom. When she checked Resident #61 was standing by his closet. He denied falling, stating it was the closet door. LPN #216 suspected he was reaching up in the ceiling tile. She stated the police found marijuana in a roach clip. The neighboring resident he visited, Former Resident #90, suggested they use Narcan on Resident #61. FSR #90 responded Oh, I don't know when asked why she would suggest Narcan. LPN #216 stated STNA #249 found Resident #61 lying on the foot of the bed perpendicular and not easily aroused. His legs were blue. STNA #249 got LPN #216 who called the DON. LPN #216 assessed Resident #61 who said he had pain. She called 911. EMS stated the resident's pupils were like needle points, but the resident denied drug use. LPN #216 stated she had tried to administer Narcan, but he refused. The resident initially refused to go to the hospital, but the EMS were able to convince him to go to the hospital. Afterwards the police searched the resident's room with staff. LPN #216 stated they found marijuana on a roach clip and a bus pass with black sand, Fentanyl. The police stated he would be charged, and they would get a warrant for his arrest. She stated Resident #61 was to be discharged because of violation of contract. LPN #216 stated they were given education on the facility's program and the need for enforcement of visitation. She stated the visits would now have to be supervised unlike before.</p> <p>Interview on [DATE] at 9:09 P.M. with STNA #249 revealed she was present on [DATE] for Resident #61's second overdose. She stated she found the resident; he was acting differently. She reported to the nurse the resident was turning colors even with oxygen. The nurse called 911. EMS took over. STNA #249 denied ever seeing drug exchanges. She stated she felt there should be more limitations to visitation. She stated she was off work the past two weeks and did not realize the facility had implemented supervised visitation until she returned. She stated the residents were not allowed to go into other residents' rooms and had to visit in common areas.</p> <p>Interview on [DATE] at 10:11 A.M. with SS #276 from the third-party program revealed he was limited on what he could share. He explained residents who come to the facility for the Substance Use Disorder program had to sign a contract prior to admission. Those residents were not required to participate in his program which offered case management and counseling. He stated he met with the facility team to discuss residents weekly and to encourage participation in the program. One of their main focuses was on harm reduction.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 2:49 P.M. with the DON revealed she arrived at the facility on [DATE] at 9:50 P.M. after being notified of overdoses. The DON stated Resident #61 and Resident #44 would hang out with one pushing the other in the wheelchair. She stated Resident #61 did not have any LOAs or visitors. The DON stated following the incidents, they made changes to the visitation for those residents on their program. She stated they used to be able to go to the floors to visit but now they had to stay in the lobby. The receptionists were responsible to monitor and get any assistance as needed from nursing. She stated unfortunately, where there is a will there is a way.</p> <p>Interview on [DATE] at 9:20 A.M. with the Administrator revealed supervised visits were being tightened up. LOAs for medical appointments must be accompanied by staff. Packages for visitors and deliveries were searched. She stated no one on the facility's program had LOA privileges. The Administrator revealed she had been notified of the drug overdoses on [DATE] and then she came into the building. She stated she spoke to Resident #61 first, completed a room search and the resident denied doing any drugs. Resident #61 admitted to sharing a cigarette with Resident #44. The Administrator revealed a room search consisted of checking drawers, bathroom, above lights and the PTAC units. Staff were not permitted to search the resident/person. The Administrator revealed at the time of the incident on [DATE] Resident #61 was treated medically. He initially refused to go to the hospital, however he eventually went. The police called her to say they found (black sand). The police stated Resident #61 would be charged. The resident returned to the facility the next morning but was discharged on [DATE] in the afternoon. She stated she requested the EMS report for Resident #61 but had not received them during the survey.</p> <p>Interview on [DATE] at 3:15 P.M. with the Regional Director of Operations (RDO) #710 revealed visitation should have always been restricted to common areas. It was enforced starting [DATE] and now limited to the lobby area. RDO #710 revealed staff assumed on [DATE], Resident #61 had drugs left from [DATE]. They did not supervise visitation prior to [DATE].</p> <p>Interview on [DATE] at 4:54 P.M. with RDO #710 and the Administrator revealed Resident #61 was not actively participating in the third-party program at the time of the overdoses. RDO #710 stated the facility's role was to provide a safe, structured environment. The Administrator stated she met with SS #276 every week, usually Wednesdays, and as needed to discuss residents with signed Substance Use Disorder contracts. Both RDO #710 and the Administrator revealed the facility was tightening up the program.</p> <p>Review of the facility undated Substance Use Disorder program contract revealed the objective was to decrease potential relapse of substance use disorder. All visitations must occur between the hours of 9:00 A.M. and 5:00 P.M. All visitations would be supervised. The facility could do random searches of any delivered packages.</p> <p>The facility did not provide any other policy and pro [TRUNCATED]</p>		