STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366008	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grande Pointe Healthcare Commu	Three Merit Dr Richmond Heights, OH 44143

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45442 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based on medical record review, review of a facility self-reported incident (SRI) investigation, observation, staff and resident interviews, and review of the facility Abuse, Neglect and Misappropriation policy, the facility failed to ensure controlled substances were stored and discarded properly to prevent misappropriation. This affected seven residents (#256, #257, #258, #259, #260, #261, and #262) of seven residents reviewed for misappropriation. The facility census was 156. Findings include: Review of the closed medical record for Resident #256 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to sepsis, type II diabetes with polyneuropathy and chronic kidney disease. Review of Resident #256's physician orders dated 04/26/24 revealed an order for Percocet (oxycodone) oral tablet 5-325 milligrams (mg). Give one tablet by mouth every morning and at bedtime for moderate pain. Review of the closed medical record for Resident #257 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to fracture of the neck of the left femur, chronic kidney disease, alcohol dependence, generalized anxiety disorder. Review of Resident #257's physician orders dated 12/09/23 revealed an order for Morphine Sulfate Solution 10 mg per five milliliters (ml). Give 3.75 ml by mouth every four hours as needed for pain for three days. Review of the physician orders dated 12/01/24 revealed an order for Fentanyl Transdermal Patch 25 microgram/hour. Apply one patch in the morning every three days for pain. Review of the closed medical record for Resident #258 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to displaced fracture of base of left femur, aftercare following explanation of hip joint prosthesis, and neuropathy. Review of Resident #258's physician orders dated 05/07/24 revealed an order for hydrocodone-acetaminophen (APAP) oral table 5-325 mg. Give one tablet by mouth every four hours as needed for pain. Review of physician orders dated 05/07/24 revealed an order for hydrocodone-acetaminophen oral table 5-325 mg. Give one tablet by mouth every six hours as needed for pain. (continued on next page)

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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the closed medical record for Resident #259 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to palliative care, stage III chronic kidney disease and senile degeneration of brain. Review of Resident #259's physician order dated 11/19/23 revealed an order for lorazepam (Ativan) oral table 0.5 mg. Give one table orally every four hours as needed for anxiety. Review of the closed medical record for Resident #260 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to end stage renal disease, malignant neoplasm of prostrate and unspecified severe protein-calorie malnutrition. Review of Resident #260's physician orders revealed an order dated 05/23/24 for oxycodone HCL oral capsule five mg. Give one table by mouth every six hours for pain. Review of the closed medical record for Resident #261 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to metabolic syndrome, cirrhosis of the liver, and depression. Review of Resident #261's physician order dated 05/10/24 revealed an order for oxycodone HCl oral tablet 10 mg. Give one tablet by mouth every six hours as needed for pain. Review of the closed medical record for Resident #262 revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included but were not limited to emphysema, end stage renal disease and osteoarthritis. Review of Resident #262's physician order dated 01/30/24 revealed an order for as needed (prn) Tramadol HCl oral tablet 50 mg. Give one table by mouth every 12 hours as needed for pain for seven days. Review of Self-Reported Incident (SRI) Number 249080 with an initiation date of 06/26/24 revealed a suspicion of misappropriation. The SRI indicated there was potential misappropriation of medications of discharged residents. The SRI identified Residents #256, #257, #258, #259, #260, #261, and #262 as being the residents involved. The summary of missing medications indicated regarding Resident #256, no narcotic sheet was found, no medications were found nor listed on the destruction list. Resident #256 was noted to be missing 27 oxycodone pills. Regarding Resident #257, four Fentanyl patches were found in the drawer, no Fentanyl narcotic sheets were found. A Morphine bottle with 16 ml was found with no narcotic sheet. Regarding Resident #258, oxycodone narcotic sheet was found with no medication or destruction log. Thirty tablets were noted to be missing. Hydrocodone narcotic sheet was found, no destruction log and two pills were noted to be missing. Regarding Resident #259, an Ativan as needed narcotic form was found. Medications were missing and not listed on the destruction log. Twenty pills were noted to be missing. Regarding Resident #260, an oxycodone narcotic form was found, no medications or destruction log was found. Twenty pills were noted to be missing. Regarding Resident #261, an oxycodone narcotic form was found, no medications were found nor destruction log. Twenty-seven pills were noted to be missing. Regarding Resident #262, a Tramadol narcotic sheet was found, no medications were found nor a destruction log. Twenty-three pills were noted to be missing. Interview on 07/08/24 at 10:39 A.M. with the Director of Nursing (DON) revealed she found multiple narcotic sheets for seven discharged residents (Residents # 256, 257, #258, #259, #260, #261 and #262) and the medications were missing from Unit Manager (UM) #7's desk. UM #7 was immediately suspended pending investigation. The DON stated when interviewed, UM #7 did not have an explanation of the whereabouts of the missing medications. The missing narcotics could not be located, and the DON was unsure what happened to them. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 07/09/24 between 12:07 P.M. and 12:32 P.M. with the DON revealed there were no narcotic sheets found for Resident #256 and no medications were found nor listed on the destruction list. Resident #256 was missing 27 oxycodone pills; Resident #257's narcotic sheets were missing and unable to be reviewed. Resident #258's narcotic sheets dated 05/27/24 revealed no medications were signed off for hydrocodone (oxycodone-APAP) and the narcotic sheet dated 05/21/24 for oxycodone-APAP revealed no medications were signed off. The DON stated they found the medication card for the oxycodone-APAP which had 10 left so there were two missing from the medication card that were unaccounted for; Resident #259's narcotic sheet dated 11/14/22 revealed no Ativan was signed out. The DON confirmed no Ativan was signed off as having been administered and 20 pills were missing; Resident #260's narcotic log for oxycodone dated 05/23/24 revealed 20 pills were missing; the oxycodone narcotic sheet for Resident #261 dated 01/31/24 revealed all doses were given and matched the medication administration record indicating the oxycodone was administered. The DON confirmed Resident #261's oxycodone medication card dated 02/07/24 revealed no doses were given but the oxycodone dispensed by the pharmacy was missing, and the Tramadol 50 mg narcotic sheet for Resident #262 dated 01/31/24 indicated 23 pills were missing. Review of the witness statement for UM #7 dated 06/26/24 confirmed narcotic sheets were found in her office during her vacation and medications were identified as missing. UM #7 indicated she had recently been sloppy with her job duties and had misplaced several narcotics and took full responsibility for her actions. Review of the police report dated 06/26/24 timed at 4:17 P.M. revealed the DON filed a theft of narcotics report concerning Unit Manager #7. The stolen medications included Percocet, oxycodone, and Ativan. The report was forwarded to the Ohio Board of Health and the Pharmacy Board. Phone interview on 07/08/24 at 3:54 P.M. with UM #7 confirmed she had pulled medications for the identified discharged residents and had not properly stored or disposed of them but denied stealing them. Review of the employee file UM #7 revealed an employee termination letter was mailed to her on 07/02/24 after attempts to reach her by phone and text on 07/01/24 and 07/02/24 were not responded to. Review of the facility policy Discontinued Medications with a revision date of August 2020 revealed when medications were discontinued by the prescriber or the resident was discharged and medications were not sent with the resident, the medications were to be marked as discontinued and stored in a secured and separate area from the active medications until destroyed per facility policy or returned to the pharmacy when permissible by state regulations. Residents whose medications were sent home on discharge would be provided medications in accordance with state laws and regulations, and according to discharge medication policies. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Controlled Substance Disposal with a revision date of August 2020 revealed the DON, in collaboration with the consultant pharmacist, was responsible for the facility's compliance with federal and state laws and regulation in the handling of controlled medications. All controlled substances remaining in the facility after a resident was discharged or an order was discontinued were to be disposed of in the facility by the DON and consultant pharmacist or other licensed personnel or returned to the Drug Enforcement Administration (DEA) or by sending to the appropriate state agency, as directed by state laws, regulations, and/or by the DEA. Disposition was to be documented on the facility's drug Destruction log. The witnessing licensed nurse would ensure that at a minimum, the following information was entered on the facility's Drug Destruction log or similar form: date of destruction, resident's name, name and strength of medication, prescription umber, amount of medication destroyed and signature of witness. Review of the facility policy OHIO Abuse, Neglect and Misappropriation with a revision date of 04/01/19 revealed misappropriation of resident property was defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The deficient practice was corrected on 07/02/24 when the facility implemented the following corrective actions: On 06/26/24 the facility's corporation, police, pharmacy, and medical director were notified, and an investigation was started. An SRI was filed on 06/26/24 at 2:56 P.M. Unit Manager #7 was suspended pending investigation on 06/26/24. All residents had pain assessments completed on 06/27/24 by the DON and Unit Managers with no negative findings. All nursing staff interviews were conducted from 06/26/24 through 07/01/24 by the DON. The DON/designee completed a 30 day look back of any delivered narcotics and validated narcotic sheets and medications on 06/27/24 with no negative findings. The DON provided one on one in-service with clinical management team on chain of custody and Pathway to Narcotic Management on 07/01/24. The DON provided one on one education to all licensed nurses and Certified Medication Technicians between 06/26/24 and 07/01/24. This one-on-one education included education and expectations as it related to chain of custody and Pathway to narcotic management to ensure proper procedures followed Beginning on 06/27/24 the facility implemented a plan for the DON/designee to check medication carts in facility one time per week for four weeks or until compliance was maintained to ensure recognition and proper reporting process was being followed for any potential misappropriation instances. Beginning 06/27/24, all narcotic destruction to be completed by the DON weekly along with another member of management until further notice. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Beginning on 06/27/24 the DON and another nurse would collect discontinued narcotics weekly from each medication cart. UM #7 was terminated on 07/01/24; the termination letter was mailed on 07/02/24. The Ohio Board of Nursing was notified on 07/10/24 that there was a narcotic discrepancy, and the Unit manager could not account for the location of those medications belonging to the narcotic sheets that she was in possession of. The Administrator/designee to present the results of the audits monthly to the Quality Assurance Performance Improvement (QAPI) committees for no less than three months. Any patterns that identified would have an action plan initiated. The QAPI committee to determine when 100 percent compliance is achieved, or if ongoing monitoring was required. This deficiency represents non-compliance investigated under Self -Reported Incident Control Number OH00155404.