State of GA Healthcare Facilitv Reaulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000605	A. BUILDING _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THRIVE AT AUGUSTA	2222 INDIGO HALL DRIVE MARTINEZ, GA 30907

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments.	LOOO		

>> >> The purpose of this visit was to investigate intake #GA00218901.

An onsite visit was made to the facility on 11/16/21 to and the investigation was completed on 12/2/21.

EXHIBIT

A

L 709 SS=J	111-8-63-.07(2)(h) Owner Governance.	L 709	

At a minimum, the policies and procedures that are developed must provide direction for the staff and residents on the following: ...
(h) medication management, procurement, the use of certified medication aides and professional oversight provided for such services; ...

This RULE is not met as evidenced by:
>> >> Based on record review and interview the facility failed to ensure staff followed the direction developed on medication management and the required professional oversight for such services. Findings include

A review of the incident report submitted to the Department on 11/1/21 showed two (2) cards of Oxycodone 10-325 mg for Resident #1 with 30 tablets for each card, and two (2) cards of Tylenol 3 with Codeine for Resident #2 with 30 tablets for each card were missing from the locked medication cart on 10/30/21.

A review of the facility policies and procedures on Medication Storage showed, "All controlled medications must be stored under a double locked system. The policy also showed the keys must remain on the premises and on the person performing medication management at all times".

The medication process that Thrive has implemented is within State guidelines. The medication technician did not follow the process that was in place.

Due to the process and oversight from the leadership, Thrive identified the missing medication immediately and began the proper investigation of reporting and responding to the matter according to policy. The community had a new medication system and pharmacy that the team was learning. Education and training was provided to the team members to ensure processes were followed. Due to the missing medication, Thrive has initiated three counts a day per shift to check the medication count and inventory. As of the date of this incident, no other incidents occurred. The team member that was on the medication cart during the incident was removed from the cart and took a position as a caregiver pending further training and demonstrated adherence to compliance protocols. The medication was stored under two locks (the medication cart and the room that it was placed in). At all times there was another medication technician in the room overseeing the carts.

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L 709	Continued From page 1 A review of the facility policies and procedures regarding Narcotic Count Guidelines, showed "Narcotic count is completed whenever there is an exchange in possession of Narcotic keys." "Shift change narcotic sheet must be signed by the on-coming and out-going team member upon completion of each narcotic sheet". During an interview on 11/16/21 at 1:45 pm., Staff A stated that he/she was notified by Staff B that 60 tablets of Oxycodone 10-325 mg for Resident #1 and 60 tablets of Tylenol 3 with Codeine for Resident #2 was missing from the locked medication cart. Staff A stated an internal investigation was completed, that included a search for the missing medications drug screening for staff, missing medications were replaced. Staff A also stated that the residents' families were notified and the law enforcement was notified. Staff A stated they were unsuccessful in locating the missing medications.	L 709	The team member was running late for work And did not count the medications prior to the shift. The team member was held Accountable, retrained, and removed from the Cart . Thrive followed the reporting process.	
L2059 SS=J	111-8-63-.20(12) Storage and Disposal of Medications. Storage and Disposal of Medications. Medications must be stored securely and inventoried appropriately to prevent loss and unauthorized use. Medications must be stored under lock and key at all times whether kept by a resident or kept by the assisted living community for the resident, unless the medication is required to be kept by the resident on his or her person or staff member in close attendance due to the need for physician-prescribed frequent or emergency use. Additionally, for controlled substances, the secure storage must be a locked cabinet or box of substantial construction and a log must be maintained and updated daily by the community	L2059	Medications are stored under two locks (one on the door of the medication room and one on the medication cart). Thrive created a new position to monitor medication Management to ensure this process is Followed. A medication technician was in the Medication room the entire time the door was open.	

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L2059	Continued From page 2 to account for all inventory. This RULE is not met as evidenced by: ****>>>Based on record review and interview the facility failed to ensure residents' medications were stored securely and inventoried appropriately to prevent loss and unauthorized use for 2 of 2 sampled residents(Resident #1 and Resident #2). Findings include: A review of the incident report submitted to the Department on 11/1/21 showed two (2) cards of Oxycodone 10-325 mg for Resident #1 with 30 tablets for each card, and two (2) cards of Tylenol 3 with Codeine for Resident #2 with 30 tablets for each card were missing from the locked medication cart on 10/30/21 at 2:50 p.m. A review of the Controlled Drug Forms (CDF) for Resident #1 and Resident #2 showed the following information: Resident #1: Oxycodone 10-325 mg was prescribed one tablet every six (6) hours, scheduled at 12:00 a.m., 6:00 a.m., etc.. There were three (3) CDFs dated 10/14/21 for **Resident #1 for Oxycodone 10-325 mg with** 30 tablets on each form for a total of 90 tablets from the pharmacy. The CDF #1 with 30 tablets showed Resident# 1 was given Oxycodone 10-325 mg one tablet seventeen (17) times in October 2021 and two(2) in November 2021.. On 10/25/21 at 12:00 am, 6:00 a.m., 12:00 p.m., 6:00 p.m.. On 10/26/21 at 12:00 a.m., 6:00 a.m., 12:00 p.m., 6:00 p.m. On 10/27/21 at 12:00 am, 6:00 a.m., 12:00 p.m., 6:00 p.m., On 10/30/21 at	L2059	The community self reported the missing Medications that were discovered during the shift change. All team members were drug tested and no missing medication have occurred since the incident. Training was re-initiated for the medication technicians, three shift counts a day are overseen by the leader on each shift and a new role was created to manage medications daily.	

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L2059	Continued From page 3	L2059		

6:00 p.m., On 10/31/21 at 12:00 am, 6:00 a.m., 12:00 p.m., 6:00 p.m. and on 11/1/21, two (2) Oxycodone 10-325 mg were given at 12:00 am, and 6:00 a.m.

On 11/1/21, the CDF #1 showed the Oxycodone 10-325 mg had zero tablet left. There were eleven (11) tablets of Oxycodone unaccounted for the 30 tablets on the CDF #1 plus sixty (60) tablets (thirty tablets each for CDF#2 and CDF#3). The total amount for the three CDF's was seventy one (71) unaccounted for.

Resident #2:

Tylenol with Codeine 300-30 mg was prescribed one tablet by mouth every six hours as needed for pain "Max 300 mg APAP/24 hours"..

There were two (2) CDFs for the Tylenol with Codeine 300-30 mg. CDF #1 dated 10/19/21 showed sixty (60) tablets. CDF #2 dated 11/3/21 showed thirty (30) tablets
The CDF #1 with 60 tablets showed Resident #2 was given Tylenol with Codeine 300-30 mg one tablet four (4) times in October 2021 and twenty-two (22) times in November 2021. On 10/30/21 at 8:00 p.m. On 10/31/21 at 9:00 a.m., 9:00 a.m., and 8:00 p.m., On 11/1/21 at 8:00 p.m., On 11/2/21 at 8:00 a.m. and 9:00 p.m., , On 11/3/21 at 8:00 a.m., and 8:00 p.m., On 11/4/21 at 8:00 a.m. and 8:00 p.m., On 11/5/21 at 8:00 a.m. and 8:00 p.m. On 11/5/21 at 8:00 a.m. and 8:00 p.m. On 11/6/21 at 8:00 a.m. and 8:00 p.m., On 11/7/21 at 8:00 a.m., and 9:30 p.m., On 11/8/21 at 8:00 a.m., and 8:00 p.m., On 11/9/21 at 8:00 a.m. and 8:00 p.m., On 11/10/21 at 8:00 a.m., and 8:00 p.m., On 11/11/21 at 8:00 a.m. and 8:00 p.m., and 11/12/21 at 8:00 a.m.

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L2059	Continued From page 4 There were 34 tablets of Tylenol with Codeine 300-30 mg unaccounted for the 60 tablets on the CDF #1 plus thirty tablets (30) for CDF#2 . The total amount for the two CDF's was sixty four (64) unaccounted for. During an interview on 11/16/21 at 2:15 p.m., Staff B stated on 10/30/21 at approximately 7:00 a.m. during narcotic count, Staff C and Staff D verified a correct count of Oxycodone for Resident #1 and Tylenol #3 with codeine for Resident #2. Staff B stated Staff F was assigned the medication cart but did not report for shift until approximately 7:42 am and did not verify During an interview on 11/16/21 at 3:26 p.m., Staff H stated he/she reported for duty on 10/30/21 at 3:00 p.m., and observed the medication room door was propped open. Staff H stated the medication cart and the narcotic box was unlocked the keys were on top of the During an interview on 12/2/21 at 1:00 p.m., F stated on 10/30/21 he/she arrived to work- -- approximately 7:42 a.m. Staff F stated he/she dic any medications. Staff F stated he/she went break at 2:40 p.rn., left the medication keys top of the medication cart and communicated to During an interview on 12/2/21 at 4:38 p.m., Staff C stated a narcotic count was done at the beginning of the shift on 10/30/21 at approximately 7:00 a.m. with Staff D and Staff I. Staff C stated the count was correct. Staff C stated when Staff F arrived at approximately 7:42 a.m. he/she gave the keys to Staff F but	L2059	The team had the medication door open while the med Tech was in the room. The cart was locked.	

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L2059	Continued From page 5 not verify the narcotic count. A review of the facility P&P on Narcotic Count Guidelines, showed "Narcotic count is completed whenever there is an exchange in possession of Narcotic keys." Shift change narcotic sheet must be signed by the on-coming and out-going team member upon completion of each narcotic sheet. A review of a police report dated 10/31/21 showed Staff A stated" unknown person(s) took the listed medications belonging to the residents at the facility". The report showed "video surveillance (facility security camera) was reviewed and no suspects at this time. The report further showed that Staff A stated there was additional video surveillance to be reviewed however, he/she was unable to do so at the time." A review of a police Police Case Supplemental Report (CSR) dated 11/2/21 showed "Staff A was contacted regarding the additional video surveillance footage and any new information that had been revealed since the initial police report. Staff A stated they reviewed the video footage of the medication rooms and they had three more staff to add to their list (possible access to the medication carts). The report showed Staff A stated the staff were sent to the lab for drug screening test for the presence of the controlled substance(Oxycodone). The report showed Staff G failed to take the drug screening test. The report further showed the police report pending staff drug screening results". A review of a police CSR dated 12/9/21 showed there were three unsuccessful phone attempts to contact Staff A. The report showed on 1/4/22 a letter was sent to Staff A requesting he/she contact the assigned officer. The report also	L2059	The team member showed up late to work that day and failed to count the cart. New measures were put in place to have a leader oversee all medication shift counts per shift daily, the team member was removed from the cart, everyone was drug tested that had access, a new role was created to oversee medications No missing medications have occurred since This incident. The new precautions have been successful.	

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L2059	Continued From page 6 showed on 1/10/22 Staff A contacted the assigned officer and stated the facility do not wish to proceed with the case any further. The report further showed the case was closed with a waiver of prosecution. A review of the file for Resident #1, admitted on 4/15/21 showed diagnoses of osteoporosis, increased cholesterol, chronic back pain, and lumbar fracture. Resident #1 used a walker to assist with mobility. A review of the file for Resident #2, admitted on 10/14/21 showed diagnoses of right hip fracture, diabetes mellitus, heart valve replacement, depression, and hypothyroid. Resident #2 used a walker with wheels or a power chair to assist with mobility. Cross reference to 0709	L2059	The President contacted the police and reported that The drug testing came back negative. All team members participated in the drug test and all results were clear.	

State of GA, Healthcare Facility Regulation Division

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L 000	Initial Comments. >>>>The purpose of this visit was to investigate intake GA00219378 and #GA00219336. The intake was opened on 11/30/21 and compled on 12/9/21.	L 000	Community self reported this event	
L 701 SS=D	111-8-63-.07(2) Owner Governance. The governing body is responsible for implementing policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules. This RULE is not met as evidenced by: ****>>>>Based on record review and interview the facility failed to ensure the policies and procedures were implemented in the community that support the core values of the residents in a safe environment. Findings include A review of the incident report submitted to the Department on 11/16/21 showed Resident #1 reported to staff that his/her private paid sitter took $600.00 a day from his/her bank account, and he/she wanted him/her to stop. A review of the facility's policy titled "Visitor and Vendor Screening" , showed all non-employee of the community would sign in and out on the kiosk upon arrival and departure of the facility. A review of the facility's policy titled Standards of Excellence for Outside Providers showed "outside providers must provide a health screening (to include a negative TB screening)	L 701	Thrive has visitor policies and procedures in place that are in compliance with the state requirements. The community is a safe environment, there are significant check in procedures for visitors that include electronic kiosk registration monitored by an outside provider (Accushield) and employee guided screening prior to entrance. Resident voluntarily hired a private care provider from a recommendation by a neighbor. The resident has a diagnosis that aligns with making false accusations regarding his wife and private care provider based on cognitive changes. The ombudsman was notified immediately and has been following his case from the day of move in. The community asked the resident on several occasions if he voluntarily wanted to pay the private care provider and he agreed. The police were called in a previous case to ask him the same question, which he then responded to the police office that he was in agreement with his private care providers pay amount and support. A few months later, he changed his mind that he no longer wished to have the person assist him and made unverified accusations. The police determined that no additional follow up was needed until the person attempted to show back up at the community and was denied access. The community contacted the police to inform the person that they were not permitted entrance to the community.	

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L 701	Continued From page 1 and criminal background check as applicable to the facility. During an interview on 12/9/21 at 10:52 am., Resident #1 stated CC worked as a private duty sitter for him/her in the facility for about 4 to 6 months. Resident #1 stated he/she could not remember how he/she met CC or how CC became to work for him/her. During an interview on 11/30/21 at 10:46 am., Staff A stated all private duty sitters are to submit a criminal background check prior to working with the residents, provide a negative TB screening, and sign in and out of the facility using the kiosk. Staff A stated CC did not provide this information as required by the facility's policy nor did he/she sign in and out on his/her arrival and departure of the facility. During an interview on 12/9/21 at 12:30 pm., Staff A stated the TB screening or criminal background check for CC had not been submitted to the facility.	L 701	The community utilized an outside provider to track and obtain background information and TB testing documentation from private care providers through an electronic registration system called Accushield. When the sate arrived the system was not functioning and we were unable to pull reports from the database to verify the private care providers information. Attached is a copy of the report directly from Accushield indicating that the private care provider was cleared to enter the community. Upon auditing the electronic system, we are now asking for the documentation directly from the private care providers. The community policy states that visitors that are not family related are required to provide documentation up to 30 days from providing support. This is accomplished by using the registration kiosk and a manual collection process that is managed by the front desk director. After 30 days, the community denies access to the private care provider if the documentation is not provided. In this case, the private care provider was granted access because Accushield reported that the person was cleared to enter. With the new process in place to also require documents directly at the community, this will add a second layer to ensure the community has the documents available for state surveyors.	