

Survey Deficiency Summary

28 Facilities Surveyed

Surveys Taken 1/23/20-2/26/20

E006 Plan Based on All Hazards Risk Assessment

- D Facility failed to provide a facility-based risk assessment utilizing an all-hazards approach.

E024 Policies/Procedures-Volunteers and Staffing

- D Facility failed to include policies and procedures for the use of volunteers in the emergency preparedness program.

E026

- D Facility failed to include policies and procedures for the 1135 waiver in the emergency preparedness program.

E032 Primary/Alternative Means for Communications

- D Facility failed to include policies and procedures for primary and alternate means for communicating with facility staff, Federal, state, tribal, regional and local emergency management agencies in the emergency preparedness program per the requirements of CFR 483.73.

F550 Resident Rights/Exercise of Rights

- D Facility failed to treat one patient who required an indwelling urinary catheter with dignity related to not covering the patient's catheter bag.
- D Facility failed to treat one patient who required an indwelling urinary catheter with dignity related to not covering the patient's indwelling catheter bag with a privacy cover and failed to treat four patients with dignity who were referred to as "feeders".
- D Facility failed to care for a patient in a manner that maintained or enhanced their dignity. The catheter bag was not covered.

F558 Reasonable Accommodations of Needs/Preferences

- D Facility failed to have a call light in reach for one patient.

F561 Self Determination

- D Facility failed to honor the right of the patient for self-determination related to the patient's choice for bathing.

21-Mar-20

F580 Notify of Changes (Injury/Decline/Room, Etc.)

- D Facility failed to notify the physician when a weight loss occurred for one patient.

F584 Safe/Clean/Comfortable/Homelike Environment

- D Facility failed to provide a comfortable and homelike environment when staff and family members were knocking loudly on the kitchen door on two days of the survey.

F600 Free from Abuse and Neglect

- D Facility failed to ensure three patients were free from patient to patient abuse.
- D Facility failed to prevent abuse for one patient involved in a patient to patient altercation.

F604 Right to be Free from Physical Restraints

- E Facility failed to assess one patient prior to the use of a physical restraint and failed to assess three patients for physical restraint reduction of five patients reviewed.
- E Facility failed to identify and assess restraint use for three patients.

F609 Reporting of Alleged Violations

- F Facility failed to report patient to patient altercations to the state survey agency for six incidents.

F610 Investigate/Prevent/Correct Alleged Violation

- F Facility failed to investigate incidents involving patient to patient altercations for six patients.

F623 Notice Requirements Before Transfer/Discharge

- E Facility failed to send the Ombudsman a notice of transfer for two patients.

F636 Comprehensive Assessment & Timing

- D Facility failed to complete a timely annual MDS for one patient.

F637 Comprehensive Assessment After Significant Change

- D Facility failed to initiate a significant change MDS within 14 days after hospice services were ordered for one patient. Facility failed to ensure an assessment was accurate related to dialysis and hospice for two patients.
- D Facility failed to complete a significant change MDS assessment within the required timeframe for one patient.

F638 Quarterly Assessment At Least every 3 Months

- D Facility failed to complete a timely quarterly MDS for one patient.

F640 Encoding/Transmitting Resident Assessments

- D Facility failed to complete and transmit an MDS assessment within 14 days of the completion date for one patient.
- D Facility failed to complete and transmit a MDS assessment within 14 days for one patient who died.

F641 Accuracy of Assessments

- D Facility failed to ensure an assessment was accurate related to dialysis and hospice for two patients.
- D Facility failed to ensure the MDS was completed accurately for PEG tube use and dialysis for two patients.
- D Facility failed to accurately assess patients for bladder and bowel continence, activities of daily living, cognition and the use of antipsychotics for four patients.
- D Facility failed to ensure MDS assessments were complete and accurate for pressure ulcers for one patient.
- D Facility failed to capture hospice services on the MDS assessment for one patient.

F656 Develop/Implement Comprehensive Care Plan

- K Facility failed to develop and implement a person-centered care plan for three patients placing three patients in immediate jeopardy. One patient experienced a fall which resulted in a C7 fracture and a second fall which resulted in a hip fracture. Another patient had a fall and sustained a subarachnoid hemorrhage and then developed a new onset of seizure activity after the fall. The third patient was left unattended in the bathroom and fell while self-toileting and sustained a left humerus fracture.
- D Facility failed to develop an individualized care plan for bipolar disorder and for the special services provided resulting from the Level II PASRR recommendations.
- D Facility failed to ensure a comprehensive plan of care was developed for a diagnosis of dysphagia for one patient.
- D Facility failed to ensure a comprehensive care plan was developed for an indwelling urinary catheter.
- D Facility failed to develop and implement care plans related to antidepressants, diuretics, suprapubic catheter, nephrostomy tube site and isolation precautions for three patients.

F657 Care Plan Timing and Revision

- D Facility failed to update the care plan for two patients.
- D Facility failed to revise the care plan for nutritional supplements for one patient reviewed for weight loss and nutrition.
- D Facility failed to revise the comprehensive care plan for one patient.

- D Facility failed to revise the care plan to reflect the patients' current status for wounds and the use of a wanderguard for three patients.

F658 Services Provided Meet Professional Standards

- D Facility failed to ensure adequate supply of medications were available for one patient reviewed for medication administration, resulting in staff "borrowing" pain medication from another patient.

F677 ADL Care Provided for Dependent Residents

- D Facility failed to ensure two of the patients received showers according to their schedules and preferences.
- D Facility failed to ensure one patient had clean groomed fingernails.

F679 Activities Meet Interest/Needs of Each Resident

- D Facility failed to provide meaningful activities for one patient on the behavioral health unit.

F684 Quality of Care

- E Facility failed to ensure medications were administered in a timely manner and in accordance to professional nursing standards for six patients.
- D Facility failed to follow physician orders for wound care and failed to follow physician orders for sliding scale insulin for one patient.
- D Facility failed to provide proper positioning while seated in a wheelchair for one patient.
- D Facility failed to implement physician's orders for one patient.

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

- D Facility failed to document treatments for pressure ulcers for one patient.
- D Facility failed to document treatments for one patient with pressure ulcers.

F689 Free of Accident Hazards/Supervision/Devices

- K Facility failed to provide supervision and assistance for three patients reviewed for falls placing them in immediate jeopardy. One patient experienced a fall which resulted in a C7 fracture and a second fall which resulted in a hip fracture. Another patient had a fall and sustained a subarachnoid hemorrhage and then developed a new onset of seizure activity after the fall. The third patient was left unattended in the bathroom and fell while self-toileting and sustained a left humerus fracture. This is also substandard quality of care.
- D Facility failed to use a mechanical lift safely for one patient screened. The patient was left in a mechanical lift unattended.
- D Facility failed to ensure patients' rooms were free from accident hazards when equipment was stored unsafely and a cord was hanging freely from the ceiling in two patient rooms.
- D Facility failed to implement an intervention to prevent falls for two patients.

D Facility failed to implement fall interventions for two patients.

F690 Bowel/Bladder Incontinence Catheter, UTI

- D Facility failed to assess for removal of an indwelling urinary catheter and failed to document medical justification for the use of a urinary catheter for one patient.
- D Facility failed to ensure that an indwelling urinary catheter was secured for one patient.
- D Facility failed to provide care and services to maintain an indwelling urinary catheter for one patient.
- D Facility failed to document the monitoring of the left nephrostomy site for one patient as ordered.

F692 Nutrition/Hydration Status Maintenance

- D Facility failed to assess and monitor weights for one patient.
- D Facility failed to ensure the availability of water at the bedside for one patient.

F695 Respiratory/Tracheostomy care and Suctioning

- D Facility failed to label and date oxygen tubing and store nebulizer tubing in a safe and sanitary manner for two patients.

F700 Bedrails

- D Facility failed to ensure a bedrail was maintained in good working order for one patient.

F710 Resident's Care Supervised by a Physician

- D Facility failed to obtain physician's orders for two patients. The catheter that was ordered by the physician did not contain a size for the tubing or balloon.

F725 Sufficient Nursing Staff

- D Facility failed to maintain adequate staffing levels to meet the care needs of one patient. The patient told the surveyor that he wanted a shower but there was not enough staff and they were too busy to get the second staff member to assist him to transfer to the mechanical lift.

F726 Competent Nursing Staff

- F Facility failed to have competent staff to provide care for all patient residing in the facility related to six CNAs not reviewing the Kardex/Care plans prior to providing individualized patient care needs.
- D Facility failed to provide skills competencies for one CNA. The CNA left a patient suspended in a mechanical lift unattended.

F732 Posted Nurse Staffing Information

- F Facility failed to post complete daily staffing sheets of nursing hours for 18 months.

- E Facility failed to document the total number of actual hours worked by licensed and unlicensed nursing staff directly responsible for patient care on every shift on the staffing postings and failed to have staffing postings completed and available for 24 of 76 days reviewed.
- D Facility failed to have two months of 18 months of daily staffing sheets available from 9/18 to 2/20.

F758 Free from Unnec Psychotropic Meds PRN Use

- E Facility failed to attempt a gradual dose reduction of psychotic medications for one patient and failed to provide a rationale for the continued use of an as needed antianxiety and antipsychotic medication beyond the 14 days for one patient.
- E Facility failed to ensure patients who received psychotic medications were appropriately monitored for side effects and behaviors for five patients.

F759 Free from Medication Error Rates of 5% or More

- D Facility failed to ensure the medication error rate was less than 5 percent. The error rate was 9 percent.

F760 Residents Are Free of Significant Med Errors

- D Facility failed to prevent a significant medication error for one patient reviewed for insulin administration. The insulin was not administered timely for food delivery to the patient.
- D Facility failed to ensure one nurse administered medications free of significant medication errors. The nurse gave the insulin incorrectly in relation to the consumption of food.

F761 Label/Store Drugs & Biologics

- E Facility failed to dispose of expired medications and supplies in two medication storage areas.
- D Facility failed to ensure medications were properly stored when expired medications and opened and undated medications were observed in two medication storage areas.
- D Facility failed to ensure all expired medical supplies had been discarded in one medication storage room.
- D Facility failed to properly store and maintain medications safely when two nurses left medications unattended and out of sight for three patients.

F770 Laboratory Services

- D Facility failed to obtain laboratory tests as ordered by the physician for one patient.
- D Facility failed to obtain laboratory tests as ordered by the physician for one patient.

F791 Routine/Emergency Dental Services in NFs

- D Facility failed to ensure dental services were provided for two patients.

F801 Qualified Dietary Staff

- D Facility staff failed to do an admission dietary assessment for one patient.

F804 Nutritive Value/Appa, Palatable/Prefer Temp

- D Facility failed to provide food at a palatable and safe temperature for one tray delivery cart of three delivery carts reviewed. The trays were delivered within seven minutes, however, the cold pudding had a temperature of 64 degrees F and it should have been 41 degrees or below.

F812 Food Procurement Store/Prepare/Serve - Sanitary

- F Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by a dirty meat slicer, wet nesting of trays, dirty cups, dirty skillets and a plastic container of food sitting on the floor in the kitchen.
- F Facility failed to label, date, correctly store resident foods and discard expired food items.
- F Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by undated and unlabeled food items, no thermometer or temperature logs for a freezer, improper storage of disposable dishware, improper drying of food equipment, expired food items and no dish washer temperature logs.
- F Facility failed to ensure pureed food was prepared and served under sanitary conditions as evidenced by an unclean deep fryer, ice build-up in freezers, carbon build-up on skillets, pureed foods not served at an appropriate temperature, no temperature logs, and for a black substance in one ice machine.
- F Facility failed to ensure food was properly stored and labeled in the kitchen area of the facility. In addition, the dietary staff had not been trained on testing the sanitation levels of the dishwashing machine.
- E Facility failed to ensure food was stored and served under sanitary conditions as evidenced by opened, undated, and unlabeled foods in one refrigerator.
- D Facility failed to ensure expired liquid protein supplements were not available for patient use in one medication cart.
- D Facility dietary department failed to maintain dietary equipment in a sanitary manner in two observations of the dietary department and the facility failed to handle food in a sanitary manner for two patients.
- D Facility failed to ensure food was served under sanitary conditions when one staff member handled food barehanded during dining observations.

F835 Administration

- F Facility failed to ensure investigations were completed and reported for six incidents related to patient to patient abuse.

F842 Resident Records - Identifiable Information

- D Facility failed to ensure a physician had signed the physician's orders for scope of treatment (POST) form.
- D Facility failed to maintain complete and accurate weights for one patient.
- D Facility failed to maintain an accurate medical record for one patient.

F849 Hospice Services

- D Facility failed to obtain and maintain a hospice plan of care and hospice visit notes in the medical record for one patient.

F880 Infection Prevention & Control

- F Facility failed to post signage for one patient on contact isolation. The facility failed to transport and store laundry in a safe and sanitary manner to one clean linen storage room. The facility personnel failed to apply proper PPE before entering one contact isolation room.
- E Facility failed to ensure practices to prevent the potential spread of infection were followed in two isolation rooms, failed to maintain infection control practices for respiratory therapy masks and oxygen tubing for six sampled patients and failed to ensure linens were removed properly from a patient's room.
- E Facility failed to ensure practices to prevent the potential spread of infection were followed in two isolation rooms and failed to maintain infection control practices when two nurses failed to perform proper hand hygiene, failed to clean a stethoscope and failed to protect the feeding tube tip from being contaminated.
- D Facility failed to follow contact isolation precautions for one patient.
- D Facility failed to follow infection control practices for two patients in isolation.
- D Facility failed to store enteral feeding equipment in a safe and sanitary manner for two patients and failed to provide a sanitary environment to help prevent the development and transmission of infection for one patient who required an indwelling catheter.
- D Facility failed to ensure proper procedures for infection control were maintained during catheter care for one patient reviewed for indwelling catheter care.
- D Facility failed to follow isolation procedures for one patient reviewed for isolation precautions.
- D Facility failed to ensure practices to prevent the potential spread of infection were followed when two nurses failed to perform hand hygiene during medication administration.

F908 Essential Equipment, Safe Operating Condition

- F Facility failed to ensure kitchen equipment was maintained in a manner to ensure safe operation and proper food storage.

F921 Safe/Functional/Sanitary/Comfortable Environment

- F Facility failed to ensure flooring in the kitchen area of the facility was maintained to ensure a safe, functional and sanitary environment.
- D Facility failed to provide a safe environment for patients on one hallway. Some of the handrails were loose from the wall.

K211 Alcohol Based Hand Rub Dispensers

- D Facility failed to maintain the means of egress. There was a dresser in the bathroom of one room which obstructed the pathway to the exit access.
- D Facility failed to maintain the means of egress.

K222 NFPA 101 Egress Doors

- E Facility failed to maintain the egress doors. There were 15-second egress doors not releasing upon applying 15lbf of force.
- D Facility failed to maintain the egress doors. The 15-second delayed egress door to the memory care court yard was malfunctioning.
Facility staff failed to know the proper codes to exit doors in the facility for the rapid removal of patients.

K281 Illumination of Means of Egress

- F Facility failed to ensure illumination of means of egress shall be continuously in operation. There were several patient rooms without emergency lighting.

K321 Hazardous Areas; Enclosure

- D Facility failed to ensure hazardous areas were provided with self-closing doors per the requirements of 2012 NFPA 101.
- D Facility failed to maintain the hazardous areas. The corridor door was not self-closing within the frame at several locations.
- D Facility failed to maintain the hazardous area.
- D Facility failed to maintain the hazardous areas. A patient room had been converted to storage and the corridor door was not self-closing within the frame.

K324 Cooking Facilities

- D Facility failed to maintain the cooking equipment. The kitchen hood suppression system report revealed a 12-year hydrostatic test needs to be performed on the kitchen hood suppression extinguisher cylinder.
- D Facility failed to ensure the kitchen hood suppression system was maintained per the requirements.
- D Facility failed to maintain the cooking equipment. The stove in the kitchen was not centered under the fire suppression nozzles.

- D Facility failed to maintain the commercial cooking equipment.
- C Facility failed to ensure the kitchen suppression system was maintained per the requirements of NFPA 101. There was no documentation that the agent distribution piping was verified to be unobstructed.

K345 Fire Alarm System; Testing and Maintenance

- D Facility failed to maintain the fire alarm system.

K353 Sprinkler System; Testing and Maintenance

- F Facility failed to maintain the sprinkler system. There were corroded shower heads in the facility.
- D Facility failed to maintain the sprinkler system. There were corroded shower heads in some parts of the facility.
- D Facility failed to maintain the sprinkler system. There were corroded sprinkler heads in the facility.
- D Facility failed to maintain the sprinkler system. There was a leaky sprinkler in the bathroom of one patient room.
- D Facility failed to maintain the fire sprinkler system. The five year sprinkler obstructive inspections had not been done.
- D Facility failed to maintain the sprinkler system. There were corroded sprinkler heads in the facility.
- D Facility failed to ensure sprinkler heads were free of corrosion per the requirements of NFPA 25.
- D Facility failed to maintain the sprinkler system. Some of the sprinkler heads were corroded.
- D Facility failed to maintain the sprinkler system. The second quarter testing on the water flow and tamper switches was not documented.
- D Facility failed to maintain the sprinkler system. There were sprinklers installed less than six feet in distance from each other.
- D Facility failed to maintain the sprinkler system. The 5-year internal inspection of sprinkler piping was past due.
- D Facility failed to maintain the fire sprinkler system.

K355 Portable Fire Extinguishers

- F Facility failed to ensure ten fire extinguishers had complied with their maintenance and testing requirements of 2012.
- E Facility failed to maintain portable fire extinguishers in accordance with NFPA 10.
- D Facility failed to maintain portable fire extinguishers. The 5-year hydrostatic test of the kitchen K-class fire extinguisher had not been completed.

- D Facility failed to maintain the portable fire extinguishers. The fire extinguisher and bracket had been removed from the wall in the laundry.
- B Facility failed to maintain portable fire extinguishers in accordance with NFPA 10.

K372 Subdivision of Building Spaces; Smoke Barriers

- F Facility failed to maintain smoke barrier walls.
- F Facility failed to maintain smoke barrier walls. There were penetrations in the rated smoke barrier walls not properly fire stopped.
- D Facility failed to maintain the smoke barrier walls. There were unsealed penetrations in the fire wall.
- D Facility failed to maintain smoke barrier walls. There were penetrations in the fire wall.

K500 Building Services - Other

- F Facility failed to maintain the emergency powered diesel generator and fire dampers.

K521 HVAC

- F Facility failed to ensure fire dampers were maintained every four years per the requirements of NFPA 101.
- F Facility failed to maintain the fire dampers.

K524

- D Facility failed to maintain direct vent gas fireplaces. The annual inspection of the vent gas fireplace had not been done.

K712 Fire Drills

- D Facility failed to conduct the required quarterly fire drills.

K741 Smoking Regulations

- D Facility failed to prohibit smoking in non-designated areas.
- D Facility failed to prohibit smoking in non-designated areas.
- D Facility failed to maintain the smoking areas. There were multiple cigarette butts on the campus.
- D Facility failed to prohibit smoking in non-designated smoking areas.

K753 Combustible Decorations

- D Facility failed to ensure combustible decorations were not highly flammable.

K761 Maintenance, Inspection & Testing - Doors

- D Facility failed to maintain the fire door assemblies. The outside gas boiler room metal door was broken at the top and bottom.
- D Facility failed to maintain the fire doors. The annual fire door inspection had not been done.

K781 Portable Space Heaters

- D Facility failed to prohibit portable space heaters.

K918 Electrical Systems - Essential Electric System Maintenance and Testing

- F Facility failed to maintain the emergency powered diesel generator. There was no documentation for an annual fuel quality test in 2019.
- F Facility failed to perform an annual fuel test on the diesel generator.
- D Facility failed to maintain the emergency generator. The emergency generator was not equipped with a manual shut down switch.
- D Facility failed to ensure the emergency generator was provided with a remote manual stop station.

K920 Electrical Equipment; Power Cords and Extension Cords

- E Facility failed to maintain the correct use of power strips.
- E Facility failed to maintain the use of power cords and extension cords.
- D Facility failed to maintain the electrical equipment. There were unapproved power strips being used in the facility.
- D Facility failed to maintain electrical equipment. There were power strips plugged into each other in several locations.

K923 Gas Equipment - Cylinder and Container Storage Container Storage

- D Facility failed to maintain the gas equipment. The oxygen cylinders located in the oxygen storage room were not segregated from full/empty cylinders.

K929 Gas Equipment Precautions for Handling Oxygen

Facility failed to protect the gas equipment. The storage closet across from the secure unit nurses station contained 13 unsecured oxygen cylinders.

N1102 Records and Reports; Recording of Unusual Incidents

Facility failed to report patient to patient altercations to the state agency for four patients.

N1207 Resident Rights

Facility failed to ensure three patients involved in patient to patient altercations were free from abuse.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to conduct disaster drills for all staff prior to March 1, 2019.

Facility failed to conduct external drills in 2019.

Facility failed to conduct the required disaster drills.

Facility failed to conduct disaster drills for all staff prior to March 1, 2019.

N1411 Disaster Preparedness; Fire Safety Drills

Facility failed to conduct a bomb threat drill in 2019.

N611 Physician Services; Dental Services

Facility failed to ensure dental services were provided for two patient reviewed for dental services. This was a type C pending penalty.

N649

Facility failed to post signage for one patient in isolation.

N669 Nursing Services; Physician Notification

Facility failed to notify the physician when a weight loss occurred for one patient.

N682 Pharmaceutical Services; Storage of Medications

Facility failed to develop and implement a person-centered care plan for three patients placing three patients in immediate jeopardy. One patient experienced a fall which resulted in a C7 fracture and a second fall which resulted in a hip fracture. Another patient had a fall and sustained a subarachnoid hemorrhage and then developed a new onset of seizure activity after the fall. The third patient was left unattended in the bathroom and fell while self-toileting and sustained a left humerus fracture.

N728 Basic Services; Pharmaceutical Services

Facility failed to properly store and maintain medications safely when two nurses left medications unattended and out of sight for three patients.

N766 Food and Dietetic Services; Freezer Temperature

Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by a dirty meat slicer, wet nesting of trays, dirty cups, dirty skillets and a plastic container of food sitting on the floor in the kitchen. This was a type C pending penalty.

Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by undated and unlabeled food items, no thermometer or temperature logs for a freezer, improper storage of disposable dishware, improper drying of food equipment, expired food items and no dish washer temperature logs.

Facility failed to ensure pureed food was prepared and served under sanitary conditions as evidenced by an unclean deep fryer, ice build-up in freezers, carbon build-up on skillets, pureed foods not served at an appropriate temperature, no temperature logs, and for a black substance in one ice machine. This was a type C pending penalty.

Facility failed to ensure food was served under sanitary conditions when one staff members handled food barehanded during dining observations.

Facility failed to ensure food was stored and served under sanitary conditions as evidenced by opened, undated, and unlabeled foods in one refrigerator. This was a type C pending penalty.

N831 Building Standards

Facility failed to maintain the physical environment. There were multiple unsealed penetrations in the fire wall.

Facility failed to maintain the physical environment and the overall nursing home environment in such a manner that the safety is assured.

Facility failed to maintain the physical plant. The sprinkler riser system had a hydraulic calculated data plate that was not legible.

Facility failed to maintain the physical plant and the overall physical environment to ensure the safety of the patients.

Facility failed to ensure the building was maintained to ensure patient safety. There were unsealed penetrations in the fire wall.

Facility failed to maintain the physical plant and the overall nursing home environment. The exit door by one room had hardware that was coming loose from the door.

Facility failed to maintain the physical plant. There were water damaged ceiling tiles in the facility.

Facility failed to maintain the physical environment. There were holes in the fire wall.

Facility failed to maintain the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the patients is assured.

N835 Building Standards; Approval of New Construction

Facility failed to gain permission from the Tennessee Department of Health to change the door magnetic locks and keypads.

Facility failed to obtain prior written approval from the Tennessee Department of Health before making alterations to the nursing home. New flooring was installed in some patient rooms.

N848 Building Standards; Exhaust & Air Pressure

Facility failed to maintain negative air pressures. Throughout two halls in all patient restrooms, soiled utility rooms and janitor closet the negative air was not functioning.

Facility failed to maintain negative and positive air pressure in designated rooms.