Survey Deficiency Summary

15 Facilities Surveyed **Surveys Taken 6/23/21-7/21/21**

E004

Facility failed to review the emergency preparedness plan annually.

Facility failed to review the emergency preparedness plan annually for the year 2020.

E013

Facility failed to annually review the emergency policies and procedures.

E039 EP Testing Requirements

Facility failed to conduct exercises to test the emergency plan at least annually per the requirements of Federal CFR 483.73(d)(i).

F550 Resident Rights/Exercse of Rights

E Facility failed to maintain or enhance patient dignity and respect when four staff members failed to knock before entering a patient's room and did not use courtesy titles to address patients.

E Facility failed to maintain or enhance patient dignity and respect when five staff members did not use courtesy titles to address patients in the dining room. One LPN failed to provide dignity for a patient during medication administration.

D Facility failed to promote and maintain patients' dignity when staff failed to provide a privacy bag for two patients with indwelling catheters.

D Facility failed to promote and maintain patients' dignity when staff failed to provide a privacy bag for two patient with indwelling catheters.

D Facility failed to cover a catheter bag for one patient.

D Facility failed to maintain the patient's right to attend bible study/church activities.

F558 Reasonable Accomidations of Needs/Preferences

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

F578 Request/Refuse/Discontinue Treatment;Formulate Adv Directives

D Facility failed to honor the patient representative directives for vaccine administration for one patient.

F582 Medicaid/Medicare Coverage/Liability Notice

E Facility failed to provide an appropriate notice to the patient and/or legal representative in writing when skilled services were terminated for one patient and failed to refund the patients funds within 30 days of death or discharge.

F583 Personal Privacy/Confidentiality of Records

D Facility failed to maintain privacy and confidentiality of patient medical records for three patients. The MAR was left open and unattended on the computer monitor screen on the medication cart.

F584 Safe/Clean/Comfortable/Homelike Environment

E Facility failed to provide effective housekeeping services to maintain a sanitary, orderly and comfortable environment s evidenced by a strong urine odor in two hallways.

D Facility failed to maintain a sanitary environment for two patient rooms when there were sheets with yellow and brown stains, a wheelchair with brown stains and odors in the rooms.

D Facility failed to ensure patient personal property was maintained for two patients.

F600 Free from Abuse and Neglect

K Facility failed to ensure adequate supervision of patients and ensure interventions were implemented for patients with physically aggressive and wandering/exit seeking behaviors for five patients reviewed for abuse. This resulted in immediate jeopardy when one patient willfully pushed another patient to the floor, hit his head and began having seizures and was transferred to the hospital where he died. Another patient who was not assessed as an elopement risk was found on another floor in the facility unsupervised. And another patient had inappropriate sexual behaviors.

F607 Develop/Implement Abuse/Neglect, etc. Policies

D Facility failed to implement and follow their abuse policies when employee background checks were not performed for two staff members.

F610 Investigate/Prevent/Correct Alleged Violation

E Facility failed to thoroughly investigate an injury of unknown origin for one patient identified with discolorations to their skin and failed to identify, document or investigate bruising for two patients.

F623 Notice Requirements Before Transfer/Discharge

D Facility failed to notify the ombudsman of emergency transfers for two patients.

F636 Comprehensive Assessment & Timing

D Facility failed to complete a comprehensive assessment, using the CMS specific RAI process within the regulatory time frames for one patient.

F641 Accuracy of Assessments

D Facility failed to ensure the accuracy of the MDS related to oxygen and pressure ulcers for two patients.

F656 Develop/Implement Comprehensive Care Plan

D Facility failed to provide a comprehensive care plan related to anticoagulants and diuretics for two patients.

D Facility failed to ensure care plan interventions were implemented and followed for two patients.

F657 Care Plan Timing and Revision

D Facility failed to revise a care plan based on the needs fo the patient and in response to current interventions for oxygen, pressure ulcers, unnecessary medications, and behaviors for four patients.

D Facility failed to revise a care plan related to dialysis for one patient reviewed for dialysis care and services.

F677 ADL Care Provided for Dependent Residents

E Facility failed to provide showers at least twice weekly, failed to provide dressing assistance and failed to provide assistance with shaving for eight patients.

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

E Facility failed to complete weekly skin assessments for three patients with pressure injuries.

E Facility failed to provide care and services for the treatment of pressure ulcers when facility staff failed to complete accurate assessments and document treatments as ordered for three patients.

F689 Free of Accident Hazards/Supervision/Devices

D Facility failed to ensure the patient environment remained as free of accident hazards as possible, when plastic cutlery was not provided for two patients reviewed for accident hazards. One of the patients was using the stainless steel cutlery as a weapon.

D Facility failed to implement neurological checks after an unwitnessed fall for one patient.

D Facility failed to follow the policy for incidents and accidents when they failed to complete a timely fall investigation for one patient.

F690 Bowel/Bladder Incontinence Catheter, UTI

E Facility failed to ensure patients with urinary incontinence received appropriate and timely incontinence care for seven patients.

D Facility failed to ensure a patient's indwelling urinary catheter bag did not touch the floor.

F693 Tube Feeding Management/Restore Eating Skills

D Facility failed to ensure one nurse administered medications through a PEG tube by gravity.

D Facility failed to ensure a continuous tube feeding was administered at the ordered rate, and failed to ensure the patient's head of the bed was elevated 30 degrees while a continuous feeding was infusing for one patient.

D Facility failed to ensure one nurse checked for placement of a PEG tube, failed to administer medications separately, and failed to flush the tubing before and after administration of the medications through the tubing.

F695 Respiratory/Tracheostomy care and Suctioning

E Facility failed to ensure respiratory equipment was stored properly and covered for four patients.

F725 Sufficient Nursing Staff

E Facility failed to provide sufficient staffing levels to attain and maintain the highest practicable physical, mental and psychosocial well-being of each patient.

F726 Competent Nursing Staff

K Facility failed to ensure nurses and CNAs had the knowledge and skills necessary to assess patients, prevent abuse, and provide appropriate care to meet the patients needs for five patients with physically aggressive and wandering/exit seeking behaviors. This failure lead to immediate jeopardy when on patient willingly pushed another patient and he fell to the floor, hit his head, began having seizures and was transferred to the hospital where he ultimately died.

F730 Nurse Aide Perform Review - 12 Hr/Year In - Service

D Facility failed to ensure eight CNAs employed for a full year received at least 12 hours of in-service training.

F732 Posted Nurse Staffing Information

F Facility failed to document the total number of actual hours worked by licensed and unlicensed nursing staff directly responsible for patient care.

F744 Treatment/Service for Dementia

K Facility failed to meet each patient's dementia care and behavior needs for six patients. This resulted in immediate jeopardy when a physical altercation occurred between two patients. One patient pushed the other who landed in the floor hitting his head, began having seizures, was transferred to the hospital and ultimately died.

F757 Drug Regimen is Free From Unnecessary Drugs

D Facility failed to monitor blood sugar levels for two sampled patients.

F759 Free from Medication Error Rates of 5% or More

D Facility failed to ensure two nurses administered medications with a medication error rate less than 5 percent. The error rate was 7.41 percent.

F760 Residents Are Free of Significant Med Errors

D Facility failed to ensure residents were free from significant medication error when two nurses failed to administer insulin within the proper time frame related to the administration of insulin.

D Facility failed to ensure patients were free from significant medication errors when one nurse failed to provide a substantial snack, or meal within 15 minutes of insulin administration. This was a significant medication error.

F761 Label/Store Drugs & Biologists

D Facility failed to ensure medications were stored properly when expired medications were in one medication storage area.

D Facility failed to properly store and maintain medications safely when one nurse left medications unattended and out of sight during medication administration.

D Facility failed to properly store and maintain medications safely when one nurse left medications unattended and out of sight during a medication pass observation.

D Facility failed to properly store and maintain medications safely and securely when one medication storage area had a large hole in the third drawer from the top of the cart.

F802 Sufficient Dietary Support Personnel

F Facility failed to deliver meal trays to patients in a timely manner resulting in late meals.

F809 Frequency of Meals/Snacks at Bedtime

E Facility failed to deliver meal trays to patients in a timely manner resulting in delayed mealtimes on the 400 hall.

F812 Food Procurement Store/Prepare/Serve - Sanitary

F Facility failed to ensure the low temperature dish machine reached the required wash temperature of 120 degrees.

F Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by undated food items, a dirty deep fryer, meal slicer and mixer.

F Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by dust particles on the wall near the steam table and over a tray of dietary bowls, and rust and dust particles on the vents over the steam table. Food items were stored opened and undated in the walk-in cooler, walk-in freezer and the reach-in freezer and food was stored past the open dates in the walk-in refrigerator.

E Facility failed to ensure food was stored, prepared and served in a sanitary manner when three staff failed to put on proper PPE and failed to perform hand hygiene during dining.

E Facility failed to ensure practices to prevent the potential spread of infection were followed during dining when three staff members failed to perform hand hygiene after touching contaminated objects while serving patients.

E Facility failed to ensure food was served under sanitary conditions when six staff members failed to put on PPE when entering a contact isolation room, failed to perform hand hygiene after touching potentially contaminated objects before serving patient meals, used their bare hands to handle a patient's food, failed to perform hand hygiene before and after glove use, failed to perform hand hygiene between serving patients and used long acrylic nails to open a carton of milk.

E Facility failed to ensure three staff members served food under sanitary conditions during dining as evidenced by staff touching food with their bare hands and used their fingernails to open milk cartons.

F835 Administration

K Facility administration failed to administer the facility in a manner that enabled the facility to use its resources effectively and efficiently to attain the highest practicable well-being of the patients with behaviors and dementia. The administration failed to provide oversight and training of staff to prevent abuse and provide appropriate care to meet patients needs with behaviors and dementia. These failures resulted in multiple immediate jeopardy citations.

F867 QAPI/QAA Improvement Activities

K Facility QAPI committee failed to ensure an effective QAPI program that recognized concerns related to the patient to patient abuse, failed to perform follow up on monitoring of patients with behaviors, failed to evaluate and re-evaluate interventions implemented for patients with behaviors and failed to ensure nursing staff were competent to provide care to patients with behaviors and dementia. The committee failed to ensure systems and processes were in place and consistently followed by staff to address quality concerns related to abuse, patients with dementia and behaviors and competent nursing staff. These failures resulted in immediate jeopardy.

F880 Infection Prevention & Control

E Facility failed to ensure appropriate infection control practices were followed when two nurses failed to put on proper PPE in isolation rooms, an indwelling catheter bag was on the floor and a contaminated oxygen tubing was reconnected.

E Facility failed to ensure practices to prevent the potential spread of infection were followed when two patients reviewed for transmission based precautions were not quarantined. Also an LPN washed a patient's hands with a cleansing wipe then used the same wipe to wipe down the dining table, when oxygen tubing was on the floor and hand hygiene was not performed during wound care.

E Facility failed to ensure measures to prevent the potential spread of infection were followed when an indwelling urinary catheter bag was on the floor for one sampled patient. Two staff members also entered the front door of the facility and walked throughout the facility prior to being screened.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained for one patient in isolation when the patient was observed out of the room with other patients.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained when two nurses placed a clean glucometer their pocket and placed medication cups on top of each other, contaminating the medications in each cup.

D Facility failed to ensure practices to prevent the potential spread of infection were maintained when one nurse failed to perform hand hygiene during medication administration.

F909 Resident Bed

D Facility failed to ensure the mattress and bed were compatible for one patient.

F919 Resident Call System

D Facility failed to provide a functioning call light for one patient which had the potential to result in unmet care needs.

F925 Maintains Effective Pest Controls Programs

E Facility failed to provide effective pest control as evidenced by flies being present in the common areas and patient rooms.

K324 Cooking Facilities

D Facility failed to protect the cooking facilities.

K345 Fire Alarm System; Testing and Maintenance

D Facility failed to ensure the proper operation of the fire alarm system.

K355 Portable Fire Extinguishers

D Facility failed to conduct required monthly inspections of portable fire extinguishers.

D Facility failed to conduct monthly inspections on portable fire extinguishers.

K372 Subdivision of Building Spaces; Smoke Barriers

D Facility failed to ensure penetrations in the smoke barriers are protected.

K374 Subdivision of Building Spaces -
Smoke Barrie

D Facility failed to ensure the smoke barrier doors properly close.

K712 Fire Drills

D Facility failed to in-service all staff for required fire drills.

D Facility failed to conduct all required staff in-service training for fire drills.

D Facility failed to conduct all required fire drills/in-services.

K781 Portable Space Heaters

D Facility failed to prohibit portable space heating devices with heating elements that do not exceed 212 degrees.

K920 Electrical Equipment; Power Cords and Extension Cords

D Facility failed to prohibit the use of unapproved power cords and extension cords.

D Facility failed to provide proper power strips for personal and medical equipment.

D Facility failed to ensure the proper use of approved UL listed power strips.

D Facility failed to provide approved power strips for patients' personal electronic devices.

N001 Initial Comments

N1216 Resident Rights

Facility failed to maintain privacy and confidentiality of patient medical records for three patients during medication administration.

N1404 Disaster Preparedness; Emergency Electrical Power

Facility failed to provide documentation of weekly inspections and monthly exercises for the emergency generator.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

Facility failed to provide documentation of the required in-services for earthquake, flood and tornado disasters conducted for all staff.

N1535 Nurse Aide Training; Performance Reviews

Facility failed to ensure eight CNAs employed for a full year received at least 12 hours of in-service training. This was a type C pending penalty.

N645 Nursing Services

Facility failed to maintain a sanitary environment for two patient rooms when there were sheets with yellow and brown stains, a wheelchair with brown stains, and odors in the rooms. This was a type C pending penalty.

Facility failed to provide effective housekeeping services to maintain a safe, orderly and comfortable environment as evidenced by strong urine odors in two halls, odors and dirty floors in nine patient rooms and dirty shower rooms.

N727 Pharmaceutical Services

Facility failed to properly store and maintain medications safely and securely when one medication storage area had a large hole in the third drawer from the tope of the cart. This is a type C pending penalty.

N728 Basic Services; Pharmaceutical Services

Facility failed to properly store and maintain medications safely when one nurse left medications unattended and out of sight during medication administration. This was a type C pending penalty.

Facility failed to properly store and maintain medications safely when one nurse left medications unattended and out of sight during a medication pass observation. This was a type C pending penalty.

N766 Food and Dietetic Services; Freezer Temperature

Facility failed to ensure practices to prevent the potential spread of infection were followed during dining when three staff members failed to perform hand hygiene after touching contaminated objects while serving patients. This was a type C pending penalty.

Facility failed to ensure food was served under sanitary conditions when six staff members failed to put on PPE when entering a contact isolation room, failed to perform hand hygiene after touching potentially contaminated objects before serving patient meals, used their bare hands to handle a patient's food, failed to perform hand hygiene before and after glove use, failed to perform hand hygiene between serving patients and used long acrylic nails to open a carton of milk. This was a type C pending penalty.

Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by undated food items, a dirty deep fryer, meal slicer and mixer. This was a type C pending penalty.

Facility failed to ensure food was stored and distributed in a manner to prevent the spread of infection wen three staff members failed to wear appropriate personal protective equipment (PPE) and perform proper hand hygiene when delivering meal trays and failed to perform hand hygiene in the kitchen and dining room.

Facility failed to ensure food was stored, prepared and served under sanitary conditions as evidenced by dust particles on the wall near the steam table and over a tray of dietary bowls, and rust and dust particles on the vents over the steam table. Food items were stored opened and undated in the walk-in cooler, walk-in freezer and the reach-in freezer and food was stored past the open dates in the walk-in refrigerator. This was a type C pending penalty.

N766 Food and Dietetic Services; Perishable Food Temperature

Facility failed to ensure food was stored, prepared and served in a sanitary manner when three staff failed to put on proper PPE and failed to perform hand hygiene during dining. This was a type C pending penalty.

N831 Building Standards

Facility failed to maintain the physical plant. Some of the sprinkler heads had been painted.

Facility failed to maintain the physical plant. Several of the required inspections were not done including the fire dampers and fire doors.

Facility failed to maintain the physical plant. There were bent sprinklers in two areas.

Facility failed to maintain the physical plant. There were no records for the fire damper inspection.

Facility failed to maintain the physical plant. No records of fire door inspections were available for the past 2 months.

Facility failed to maintain the overall environment.

Facility failed to maintain the physical plant. There was water damage to the ceiling in multiple places.

Facility failed to maintain the physical plant. The 45 minute fire doors to the former records room would not latch when closed.

Facility failed to maintain the physical plant and the overall nursing home environment. There were obstructed electrical panels and junction boxes with missing covers.

Facility failed to maintain the physical condition of the plant. There were multiple stained ceiling tiles and some penetrations in patient room walls.

N835 Building Standards; Approval of New Construction

Facility failed to obtain prior written approval from the Tennessee Department of Health before making alterations to the nursing home.

Facility failed to obtain prior written approval from the Tennessee Department of Health plans review before changing a patient room to a storage room.

N902 Elimination of Fire Hazards

Facility failed to protect the nursing home from fire hazards. There was a pallet of carboard boxes and a hospital bed with a mattress stored under the canopy by the laundry room. It was not sprinklered.

Facility failed to protect the nursing home from fire hazards. There were cigarette butts and ashes in the plastic trash can, as well as cigarette butts on the ground.