Survey Deficiency Summary

10 Facilities Surveyed **Surveys Taken 10/11/22-12/9/22**

F550 Resident Rights/Exercse of Rights

D The facility failed to maintain or enhance the residents' dignity and respect when five staff members referred to residents as "feeders", failed to knock prior to entering the residents' rooms and stood over residents while assisting them with dining.

D The facility failed to maintain or enhance resident's dignity and respect when two staff members stood over a resident during dining observations and when one staff member failed to provide privacy during wound care. A resident was left with their buttocks and perineal area fully exposed while the nurse changed the dressing on the resident's ischial wound.

F553 Right to Participate in Planning Care

D The facility failed to ensure residents were involved in developing their care plan and making decisions about their care for one resident. The resident, with a BIMS score of 14, did not attend any of the care plan conferences for the prior year.

F565 Resident/Family Group and Response

D The facility failed to provide privacy for seven residents during a group interview with the Resident Council members. During the interview, a staff member entered the dining room where the group meeting was taking place, sat down at a table and ate lunch. Another staff member entered the dining room and on to the vending machine area during the group interview. The Activities Director confirmed the Resident Council meetings were always held in the dining room and staff used the dining room wall mounted kiosk when completing documentation.

D The facility failed to provide privacy for five residents during a group interview with Resident Council members. The Resident Council meeting with the surveyor was conducted in the Activities Room. The Activities Room is the only place for visitors and staff to enter the facility. A visitor and a staff member passed through the room while the surveyor was conducting the interview.

F567 Protection/Management of Personal Funds

D The facility failed to ensure personal funds were readily available for withdrawal on the weekends. Staff confirmed that residents can only withdraw funds Monday through Friday during regular business hours and no withdrawals can be made on the weekends.

F568 Accounting and Records of Personal Funds

E The facility failed to provide quarterly statements for five residents' trust accounts.

F569 Notice and Conveyance of Personal Funds

D The facility failed to refund a resident's account within 30 days of the resident's death. The resident's account was cleared 55 days after the resident's death. In interview, staff reported the facility did not want to write a check until all balances had cleared.

F578 Request/Refuse/Discontinue Treatment;Formulate Adv Directives

D The facility failed to provide information regarding a resident's right to formulate an advance directive for seven residents. The facility had no documentation of providing the resident or the responsible party with information regarding their right to formulate an advance directive.

F584 Safe/Clean/Comfortable/Homelike Environment

D The facility failed to replace missing personal items for two residents and failed to ensure a clean and sanitary environment when personal items were stored unlabeled and unsecured in one shared bathroom. One resident reported missing clothing items three months prior and the items had not been located or replaced by the facility as of the date of the survey. A second resident reported having a missing wallet and glasses one month prior to the survey and the items had not been replaced as of the date of the survey. The Social Services Director confirmed it was the facility's policy to search for the items and replace the items if they could not be located. In a resident's shared bathroom, the surveyor observed a water pitcher and a wash basin unlabeled. The wash basin was not covered.

F585 Grievances

E The facility failed to have a process in place to inform residents of how to file a grievance and failed to have a process for identifying and resolving grievances. The Social Services Director confirmed there was no formal documentation for missing items and there had been no follow up or resolution for two residents who had reported missing items three months and one month prior to the survey. Resident Council minutes indicated residents had complained regarding food, missing clothing, maintenance and environmental concerns. There was no formal documentation or follow up. The facility denied having any grievances. The residents confirmed they did not know how to file a grievance and had not been given any information regarding the process.

D The facility failed to have a process in place to identify and resolve grievances for two residents. One resident reported having voiced concerns related to baths, food, and family in the past few months to Social Services but had no follow-up. The resident's concerns were not entered into the grievance log. The second resident's nurse's notes contained an entry regarding a family member accusing the nurse of being rude to the resident. The family member's concerns were not entered into the grievance log.

F600 Free from Abuse and Neglect

D The facility failed to prevent abuse of one resident. The resident was observed receiving physical contact from another resident, was removed from the situation and sent to the ER for evaluation. The physically aggressive resident was sent to the hospital and returned and was placed on one-to-one observation. The administrator confirmed the facility failed to prevent abuse of the resident.

F609 Reporting of Alleged Violations

D The facility failed to report investigation outcome findings within five days on one self-reported incident of resident-to-resident abuse.

F610 Investigate/Prevent/Correct Alleged Violation

D The facility failed to thoroughly investigate an allegation of abuse. A nurse was removed from duty after an allegation was made by a resident. The facility did not complete interviews for three of the five interviewable residents identified under the care of the same nurse. The Ombudsman was not notified of the allegation. The facility did not interview the hospice nurse involved in the incident. The facility had not provided any abuse in-services after the allegation was made.

F626 Permitting Residents to Return to Facility

D The facility failed to allow one resident to return to the facility following a hospitalization. The resident had a care plan for a history of attempting to set an electrical fire to a wall unit and plugs, cursing staff and attempting to hit staff. The resident was sent to the ER for threatening homicide, violent behavior and refusing treatment. The resident was evaluated in the ER and cleared for psychological abnormality and discharged. The facility refused to accept the resident for readmission for three days when the hospital was unable to locate an alternative placement. The facility had no documentation of discharge planning, a 30-day discharge notice or discharge summary for the period of time the facility refused the resident's readmission.

F640 Encoding/Transmitting Resident Assessments

D The facility failed to complete a discharge MDS for one resident discharged from the facility five months prior to the survey. The facility completed a 5-day admission MDS assessment after discharge for another resident.

F641 Accuracy of Assessments

D The facility failed to accurately assess residents for restraints and hospice services for three residents. The facility coded two resident's side rails as a restraint on the MDS as well as including it in the care plan. The side rails were not a restraint for the residents and the resident's MDS' were coded inaccurately. One resident receiving hospice care did not have hospice services coded on their MDS.

D The facility failed to accurately code the MDS for one resident with an indwelling urinary catheter. The resident's foley catheter was not coded on the MDS.

A The facility failed to complete an accurate MDS discharge assessment to include an accurate discharge location for one resident. The MDS discharge assessment indicated the resident was transferred to the hospital and was inaccurate. The resident was discharged to their home.

F656 Develop/Implement Comprehensive Care Plan

D The facility failed to follow the comprehensive care plan for two residents. One resident with a gastric tube feeding had an intervention for an abdominal binder in their care plan. When observed by the surveyor, the abdominal binder was not on the resident. Another resident's care plan for falls included interventions for a Dycem pad in the resident's wheelchair, hourly rounds for 36 hours post fall and to keep the resident within eyesight of staff at all times. When observed by the surveyor, the Dycem pad was not in the wheelchair. There was no documentation of hourly rounds for 36 hours after a fall that occurred three months prior to the survey.

D The facility failed to develop a comprehensive care plan for one resident. The resident was receiving a diuretic and an anticoagulant and the care plan did not address either drug. The resident's care plan for fall risk reduction included an intervention for hourly safety checks. The hourly safety check documentation had blanks and was not completed hourly.

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

D The facility failed to ensure residents' skin condition was accurately assessed and documented. One resident had orders for wound cleansing and application of a dressing three times per week. The resident's progress notes indicated the resident had a DTI. Other residents were missing documentation of weekly wound measurements. Another resident had orders for wound care and dressings and a progress note indicated the wound had healed.

F689 Free of Accident Hazards/Supervision/Devices

J The facility failed to ensure a safe environment with adequate supervision to prevent elopement for one resident. The facility's failure to ensure residents were adequately supervised resulted in immediate jeopardy for one resident. The severely cognitively impaired resident with a history of wandering and exit seeking behaviors exited the facility without supervision and was found in the parking lot by a staff member who assisted the resident back into the building. The resident had propelled the wheelchair approximately 100 feet. The resident was not harmed. The facility determined the root cause to be a faulty locking mechanism on the door through which the resident exited. The facility's corrective action plan included every 15 minute checks for the resident, care plan revision, elopement risk assessment revision, evaluation for physical and psychosocial harm, referral to the Psychiatric NP, verification that no other residents had eloped, review/revision of elopement risk assessments for all other residents and new admissions, hourly checks on the faulty door until repaired, checks on all other exit doors, ongoing monitoring of door after repairs completed, in-service education for all staff, elopement drills, notification of the resident's representative, notification of the medical director, QAPI and Governing Body meetings to review investigation, corrective action and monitoring plans and results, and education provided to facility leadership by corporate staff. The surveyor validated all aspects of the facility's swift and comprehensive plan of correction including review of invoices, in-services, meeting minutes, medical records, monitoring results, elopement drill results, staff education, and frequent check logs. The facility's swift and comprehensive corrective action plan was validated by the surveyor, the IJ was removed and categorized as past noncompliance. A plan of correction was not required to be submitted with the CMS 2567.

F690 Bowel/Bladder Incontinence Catheter, UTI

D The facility failed to provide appropriate catheter care for one resident with an indwelling catheter. There was no documentation of catheter care. There was no physician's order for the catheter or for catheter care.

F692 Nutrition/Hydration Status Maintenance

G The facility failed to accurately assess the nutritional status and failed to follow their policy for weight monitoring for one resident resulting in actual harm when the resident had a severe weight loss of 11.13% over a six-month period. The resident had orders for a continuous tube feeding for 22 hours per day. The surveyor observed the tube feeding capped off and not infusing, with 50ml missing from the container that had been hung four hours prior to the observation. The nurse confirmed the tube feeding should have been infusing. Weekly weights were not initiated when the resident began having weight loss. The RD confirmed that no interventions were implemented in response to the weight loss.

F695 Respiratory/Tracheostomy care and Suctioning

D The facility failed to ensure proper storage of oxygen cylinders in a resident's room. There were three "C" size tanks and one "E" size tank in the floor and one "C" size tank on the counter top. The tanks were not secured in a stand or holder.

F727 RN 8 Hrs/7 days/Wk, Full Time DON

D The facility failed to ensure a RN was on duty for eight consecutive hours per day for 16 of 20 days prior to the survey. In interview, the DON confirmed the MDS Coordinator working both jobs “split it up”.

F732 Posted Nurse Staffing Information

D The facility failed to ensure the total number of actual direct care hours worked by licensed and unlicensed nursing staff was documented. There was no documentation of the hours posted for 19 days reviewed.

F759 Free from Medication Error Rates of 5% or More

E The facility failed to ensure a medication error rate of less than 5%. A nurse crushed and combined all but one of the resident’s medications and administered them simultaneously through the resident’s PEG tube. The PEG tube became clogged during administration of the medications. The nurse did not have an order from the physician to mix the medications and administer them together. Another medication was to be given at 7AM but was administered at 9AM and exceeded the facility’s acceptable time parameter. The 15 medication errors for this resident resulted in an error rate of 56%. NOTE: The surveyor did not specify the number of opportunities for medication errors observed during the med pass observation and therefore, the error rate of 56% cannot be validated.

F761 Label/Store Drugs & Biologists

D The facility failed to ensure medications were properly stored and secured. One resident was observed with a tube of skin barrier protective cream, a tube of Dermasil skin treatment cream and a bottle of Dawn mist mouth rinse at the bedside. A bottle of Cranberry tablets and Vitamins were observed by the surveyor on top of a medication cart, unsecured and unsupervised.

D The facility failed to ensure medications were properly stored and secured. One resident had white cream in a medication cup unsecured on a resident’s night stand. A medication cart was left unattended and unlocked.

F812 Food Procurement Store/Prepare/Serve - Sanitary

E The facility failed to ensure food was prepared and served under sanitary conditions. The following observations were made by the surveyor: Dietary staff members failed to perform appropriate hand hygiene during food preparation and serving including failure to remove gloves and perform hand hygiene after touching contaminated surfaces, handling scoops with their bare hands and then using the scoops to plate food, touching multiple food items without changing gloves or performing hand hygiene, and failing to remove gloves and perform hand hygiene after touching dirty dishes and before handling clean dishes. Staff members were observed assisting residents with their meals and failing to remove gloves and perform hand hygiene after touching contaminated surfaces and before handling the resident’s food.

E The facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by opened, unlabeled and undated cookies in the freezer, opened unlabeled bread, build up of a dark, brown slimy substance inside of oven doors, a build up of black round shaped crusty particles inside the stove's ovens, expired shredded cabbage in the refrigerator, a build up of a thick, powdery, gray substance on ice machine filters and an opened undated package of hamburger buns.

E The facility failed to ensure food was stored, prepared and served under sanitary conditions. Two staff members failed to perform hand hygiene when indicated when passing and setting up meal trays. One staff member failed to perform hand hygiene in between glove changes and another failed to perform hand hygiene after touching contaminated environmental surfaces and before setting up a meal tray. There were opened and undated food items in the walk-in freezer and there was carbon build-up on pans in the kitchen. Dietary staff members failed to perform hand hygiene when indicated between glove changes and after touching the dumpster lid and prior to entering the kitchen. A staff member walked through the kitchen to obtain a hair net. The cutting board was not cleaned after use. A dietary staff member was eating and drinking in the food preparation area.

F814 Dispose Garbage & Refuse Properly

D The facility failed to ensure the garbage dumpster lid remained closed. The lid was open when observed by the surveyor.

F849 Hospice Services

D The facility failed to ensure timely and collaborative communication between the hospice provider and the facility for one resident. A hospice resident's code status changed from Full Code to DNR. The hospice provider did not provide the revised POST form to the facility for 26 days.

F880 Infection Prevention & Control

E The facility failed to ensure practices to prevent the potential spread of infection were maintained. Two visitors failed to screen in prior to entering the facility. The facility's policy required screening of all visitors upon entry into the facility. One staff member failed to perform appropriate hand hygiene when administering medications by failing to use a clean paper towel to turn off the water after handwashing. One staff member failed to don the appropriate PPE when entering an isolation room. The resident required contact and droplet isolation precautions and had no sign posted on the door. Staff failed to clean a blood pressure cuff and stethoscope after checking a resident's blood pressure and before returning it to the medication cart. A nurse failed to place a barrier on the overbed table and proceeded to administer medications that had spilled out of the medication cup onto the table, returned a plastic bag containing ointment to the medication cart after placing it directly on the table and failed to perform hand hygiene prior to donning gloves to administer the ointment.

D The facility failed to ensure practices to prevent the spread of infection. Two staff members failed to clean reusable equipment before and after use. The weight lift was used on multiple residents without cleaning in between.

D The facility failed to ensure staff implemented measures to prevent the spread of infection when two nurses failed to perform hand hygiene at the appropriate times during medication administration. One nurse failed to sanitize their hands prior to donning gloves and after removing the gloves and washed their hands for only five seconds after medication administration was complete. Another nurse, while administering medications, dropped an empty medication cup on the floor, picked up the cup, and then donned gloves without performing hand hygiene. After removing the gloves, the nurse washed their hands in the sink for only five seconds. Both nurses turned off the faucet with the same paper towel used to dry their hands.

F886 COVID-19 Testing - Residents and Staff

E The facility failed to develop and implement a tracking system for staff with medical and religious exemptions for COVID-19 vaccine, failed to perform COVID-19 testing for one week for two staff members and failed to provide a contingency plan to mitigate the transmission and spread of COVID-19 for all staff not fully vaccinated.

F888 COVID-19 Vaccination of Facility Staff

C The facility failed to ensure COVID-19 vaccination medical exemption documentation included all required components for two staff members with medical exemptions. The exemption documentation for one staff member with a medical contraindication did not indicate which vaccine was clinically contraindicated. The exemption documentation for a second staff member with a medical contraindication did not indicate which vaccine was contraindicated, the reason for the contraindication or a statement from the Licensed Independent Practitioner recommending exemption from the COVID-19 vaccination requirement for the staff member.

K211 Means of Egress - General

D The facility failed to maintain the means of egress. An exit from the courtyard was obstructed with an old oven, and buckets of cleaning chemicals.

K222 NFPA 101 Egress Doors

D The facility failed to maintain the egress doors. The front entrance door equipped with 15-second delayed-egress hardware did not release in 15 seconds. When tested, the door released in 30 seconds. The signage on the door revealed the door would release in 15 seconds. The facility could not provide documentation of approval from the State of TN for the change from 15 to 30 seconds.

K321 Hazardous Areas; Enclosure

D The facility failed to maintain hazardous areas. The mechanical room had a section of the wall cut out behind the HVAC unit.

K353 Sprinkler System; Testing and Maintenance

D The facility failed to maintain the sprinkler system. The pressure gauge on the fire sprinkler had not been replaced every five years. The date stamped on the gauge was 2016.

K355 Portable Fire Extinguishers

D The facility failed to maintain the portable fire extinguishers. One fire extinguisher was undercharged. Eight fire extinguishers had not been inspected monthly. The fire extinguisher in the smoking area had not had an annual inspection since January 2021.

K712 Fire Drills

D The facility failed to ensure all staff were familiar with the fire plan and could demonstrate the fire plan procedures during fire drills. During the drill conducted by the surveyor, the staff failed to remove two residents from their room as they should have.

K918 Electrical Systems - Essential Electric System Maintenance and Testing

D The facility failed to maintain the essential electrical systems. The facility failed to provide documentation of the specific gravity test on the lead acid batteries on the generator.

N1201 Resident Rights; Privacy in Treatment

This is a Pending Type C Penalty #2. The facility failed to maintain or enhance the residents' dignity and respect when five staff members referred to residents as "feeders", failed to knock prior to entering the residents' rooms and stood over residents while assisting them with dining.

N412 Administration

The facility failed to provide quarterly statements for five residents' trust accounts. This is a Type C Pending Penalty #6.

N424 Administration; Filed Documentation of Abuse Registries

The facility failed to ensure a safe environment with adequate supervision to prevent elopement for one resident. The facility's failure to ensure residents were adequately supervised resulted in a serious and immediate threat to the health and safety of the residents. One severely cognitively impaired resident with a history of wandering and exit seeking behaviors exited the facility without supervision and was found in the parking lot by a staff member who assisted the resident back into the building. The resident had propelled the wheelchair approximately 100 feet. The resident was not harmed. The facility determined the root cause to be a faulty locking mechanism on the door through which the resident exited. The facility's corrective action plan included every 15 minute checks for the resident, care plan revision, elopement risk assessment revision, evaluation for physical and psychosocial harm, referral to the Psychiatric NP, verification that no other residents had eloped, review/revision of elopement risk assessments for all other residents and new admissions, hourly checks on the faulty door until repaired, checks on all other exit doors, ongoing monitoring of door after repairs completed, in-service education for all staff, elopement drills, notification of the resident's representative, notification of the medical director, QAPI and Governing Body meetings to review investigation, corrective action and monitoring plans and results, and education provided to facility leadership by corporate staff. The surveyor validated all aspects of the plan of correction including review of invoices, in-services, meeting minutes, medical records, monitoring results, elopement drill results and education, and frequent check logs. The facility's swift and comprehensive corrective action plan was validated by the surveyor and the IJ was removed prior to the surveyor's exit. A Type A CMP with suspension of admissions was imposed for this deficiency.

N629 Infection Control; Disinfect Contaminated Items

This is a Pending Type C Penalty #31. The facility failed to ensure practices to prevent the spread of infection. Two staff members failed to clean reusable equipment before and after use. The weight lift was used on multiple residents without cleaning in between.

The facility failed to ensure staff cleaned reusable equipment before and after use. Staff failed to clean a blood pressure cuff and stethoscope after checking a resident's blood pressure and before returning it to the medication cart. This is a Pending Type C Penalty #31.

N657 Nursing Services; Physician Notification

This is a Pending Type C Penalty. The facility failed to ensure a RN was on duty for eight consecutive hours per day for 16 of 20 days prior to the survey. In interview, the DON confirmed the MDS Coordinator working both jobs "split it up".

N728 Basic Services; Pharmaceutical Services

The facility failed to ensure medications were properly stored and secured. One resident had white cream in a medication cup unsecured on a resident's night stand. A medication cart was left unattended and unlocked. This is a Pending Type C Penalty #7.

N766 Food and Dietetic Services; Freezer Temperature

This is a Pending Type C Penalty. The facility failed to ensure food was prepared and served under sanitary conditions. The following observations were made by the surveyor: Dietary staff members failed to perform appropriate hand hygiene during food preparation and serving including failure to remove gloves and perform hand hygiene after touching contaminated surfaces, handling scoops with their bare hands and then using the scoops to plate food, touching multiple food items without changing gloves or performing hand hygiene, and failing to remove gloves and perform hand hygiene after touching dirty dishes and before handling clean dishes. Staff members were observed assisting residents with their meals and failing to remove gloves and perform hand hygiene after touching contaminated surfaces and before handling the resident's food.

This is a Type C Pending Penalty #22. The facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by opened, unlabeled and undated cookies in the freezer, opened unlabeled bread, build up of a dark, brown slimy substance inside of oven doors, a build up of black round shaped crusty particles inside the stove's ovens, expired shredded cabbage in the refrigerator, a build up of a thick, powdery, gray substance on ice machine filters and an opened undated package of hamburger buns.

The facility failed to ensure food was stored, prepared and served under sanitary conditions. Two staff members failed to perform hand hygiene when indicated when passing and setting up meal trays. One staff member failed to perform hand hygiene in between glove changes and another failed to perform hand hygiene after touching contaminated environmental surfaces and before setting up a meal tray. There were opened and undated food items in the walk-in freezer and there was carbon build-up on pans in the kitchen. Dietary staff members failed to perform hand hygiene when indicated between glove changes and after touching the dumpster lid and prior to entering the kitchen. A staff member walked through the kitchen to obtain a hair net. The cutting board was not cleaned after use. A dietary staff member was eating and drinking in the food preparation area. This is a Pending Type C Penalty #22.

N831 Building Standards

The facility failed to maintain the physical plant. The surveyor observed two areas with penetrations through the one-hour drywall that were not firestopped with approved firestop systems.

N902 Elimination of Fire Hazards

The facility failed to report a fire to the Health Facilities Commission within seven days. The HVAC unit had overheated causing smoke to enter the management hallway. The staff pulled the fire alarm and the fire department responded. The facility failed to report the event within seven days.