Survey Deficiency Summary

10 Facilities Surveyed **Surveys Taken 9/29/22-10/26/22**

F553 Right to Participate in Planning Care

D The facility failed to ensure care plan conference meetings were held at least quarterly for one resident. There were no care plan meetings with the resident for the prior three quarters.

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

D The facility failed to notify the resident representative of a skin tear for one resident. The resident sustained a skin tear on each hand while being assisted with ADLs. The facility could not provide documentation of notification of the resident's representative.

F584 Safe/Clean/Comfortable/Homelike Environment

D The facility failed to provide effective housekeeping services and maintenance services to maintain a sanitary, orderly, and comfortable environment. The surveyor observed trash and debris lying on the floors, sticky floors with a buildup of dirt and grime, dust, and cobwebs in the corner behind a door, exposed wires, dirty fall mats and overbed table bases, telephones lying on the floor, dirty bathroom floors and toilet, missing privacy curtains and a fan covered in thick gray dust in seven resident rooms.

F600 Free from Abuse and Neglect

J The facility failed to promote the residents' rights to be free from abuse and neglect for five residents. The facility's failure to ensure the residents' right to be free from abuse and neglect resulted in Immediate Jeopardy when the facility failed to identify allegations that a facility staff member was supplying illegal drugs to two residents, failed to identify an incident of sexual abuse between a staff member and a resident and failed to provide adequate supervision of residents resulting in abuse when a cognitively impaired resident was beaten by a cognitively intact and ambulatory resident. One resident was sent to the hospital for altered mental status and had a drug screen positive for illegal drugs. The resident was discharged back to the facility with a diagnosis of Substance Abuse. The hospital documents noted the resident had reported to hospital staff the drugs were obtained from a staff member. The resident also reported the employee provided illegal drugs to other residents and was attempting to have sexual contact with another resident. The facility did not discover the hospital notes and initiate an investigation until three days after readmission. A second resident was confirmed receiving illegal drugs from the same staff member as well as other staff members. A third resident who was reported to have an inappropriate sexual relationship with the staff member had no revisions to their plan of care. The resident reported the sexual contact was consensual. Another cognitively impaired resident with a history of physical aggression toward others triggered by being in the area of residents who smoke who are waiting to go outside. The resident's care plan included an intervention to be conscious of the resident's position when in groups or activities. The resident's medical record included a note that the resident was found in the activity room with another resident standing over him with a fist. The resident had reddened skin on his forehead and eyes. There were no staff members present when the altercation occurred. There were no neuro checks completed immediately after the assault and review of the neuro check sheet indicated the facility policy for the frequency of neuro checks was not followed. Video surveillance reviewed by the surveyor revealed the resident sustained several closed fist strikes to his head by the other resident for 58 seconds and the assault lasted approximately 10 minutes before staff entered the room and intervened. The physically aggressive resident was removed. No one assessed the resident who had received the strikes to the head for 19 minutes. The first neuro checks were completed 2 hours and 10 minutes after the incident. The aggressive resident did not have a care plan for physical aggression prior to the incident. However, the resident had nurses' notes that indicated the resident was verbally aggressive toward his roommate and was throwing items.

F610 Investigate/Prevent/Correct Alleged Violation

J The facility failed to ensure incidents of elopement were thoroughly investigated for one resident. The failure resulted in immediate jeopardy when a cognitively impaired resident exited the facility without the staff knowledge, walked approximately 6.5 miles from the facility, was found in a stranger's driveway on a cold day. The resident was brought back to the facility after being gone for approximately one hour and forty minutes. Ten days later, the resident exited the facility without staff knowledge, through a facility window in the resident's room and was found 0.7 miles from the facility in a local tobacco store, one hour later. A progress note indicated the resident was required to have a yellow bracelet. The bracelet was not on the resident the day prior to the elopement and the bracelet was not replaced because the bracelets were locked away. There was no documentation the bracelet was replaced prior to the first elopement. The facility's investigation did not include interviews and statements from the stranger or the family member who brought the resident back to the facility, possible routes with mileage the resident could have traveled, what the resident was wearing, the weather condition, whether or not the police were notified, an investigation regarding the missing yellow bracelet and did not have a root cause analysis. For the second elopement, the investigation did not contain statements from staff on each shift, did not describe the resident's appearance or condition of the clothing, did not include an interview of the person at the store where the resident was located and did not include a review of the store's video surveillance.

J The facility failed to complete a thorough investigation of elopement incidents for two residents. The failure resulted in immediate jeopardy for the residents when one resident exited the facility without staff knowledge or supervision and for the second resident when the facility failed to initiate a thorough investigation when the resident was missing for an undetermined amount of time and was found locked in a lobby bathroom of the facility. The first resident was sitting in their wheelchair in the lobby unsupervised. The resident stood from the wheelchair, exited the front door, and walked directly to the Security Guard's truck. The guard strapped the resident in the seat, locked the vehicle doors, entered the building to get assistance and left the resident unsupervised in the truck. The resident's wander guard bracelet was on the resident's wheelchair. Upon return to the facility, the resident was placed on one-to-one observation and had an order to verify the placement of the wander guard bracelet each shift. There was no documentation of the wander guard bracelet verification. The Administrator confirmed there were no staff members in the lobby when the resident exited the facility and confirmed the Security Guard was a contractor and not a facility staff member. In interview with the surveyor, the agency CNA reported having knowledge of the resident's wandering behaviors and reporting a concern with the wander guard bracelet placement on the wheelchair to the nurse earlier in the shift. The agency CNA reported having an assumption that the resident had been sent to the hospital when the resident was not in their room and denied doing frequent checks on the resident after the resident was returned to the room. The second resident's medical record had documentation by the nurse of being made aware of the resident not being in their room. The nurse searched for 5-10 minutes unsuccessfully and then initiated the facility procedure for a missing resident. After five minutes, the resident was located in the front lobby bathroom. The resident was confused. In an interview by the surveyor with the facility Administrator, the Administrator confirmed an investigation was not initiated and interviews were not completed due to the resident not being missing for a long time. The Administrator reported staff found the resident quickly and did what they were supposed to do. Staff reported not placing a wander guard on the resident and not providing one-to-one care. The facility was unable to provide documentation that an investigation was conducted and failed to determine the last time the resident was seen in the facility prior to the incident.

J The facility failed to thoroughly investigate injuries of unknown origin resulting in a skin tear and fractured hand for one resident. The failure resulted in Immediate Jeopardy for one cognitively impaired resident who was injured with a skin tear and discovered with a fracture 25 days later. The resident was sent to the ER for evaluation of the skin tear with bleeding and was returned with no sutures. The investigation did not include staff statements, interviewable resident statements, skin audits, staff training or education or an inspection of the resident's room for hazards. There was no reasonable effort made to determine the root cause of the skin tear. There was no investigation to determine the origin of the fracture that was identified 25 days later.

F622 Transfer and Discharge Requirements

D The facility failed to convey resident information to the receiving provider during a transfer for one resident. The resident was transferred to the ER for altered mental status and hypotension. The facility did not telephone the ER with a report and when the ER attempted to contact the facility, the ER was left on hold with no answer for greater than ten minutes. No records were sent with the resident. The facility was unable to provide the surveyor with a copy of the documentation that was sent with the resident.

F636 Comprehensive Assessment & Timing

D The facility failed to complete a discharge MDS timely, within 14 days of discharge, for one resident. The resident was discharge three months prior to the survey date. There was no discharge MDS assessment completed.

F640 Encoding/Transmitting Resident Assessments

D The facility failed to complete and submit a discharge MDS for one resident. The resident was discharged four months prior to the survey. There was no discharge MDS completed for the resident.

F641 Accuracy of Assessments

D The facility failed to accurately complete a MDS for one resident. The resident had a diagnosis of Peripheral Artery Disease (PAD). The most recent quarterly MDS was not coded for the diagnosis.

F656 Develop/Implement Comprehensive Care Plan

G The facility failed to implement care plan interventions for three residents with falls resulting in actual harm for the residents. One resident did not have care plan interventions of bed bolsters and fall mats in place. The resident fell and sustained a head injury. Another resident fell from the bed to the floor resulting in a contusion to the hip. The bed was not in the lowest position as care planned. Another resident fell from the bed and sustained a laceration to the head and a subdural hematoma. The bed was not in the lowest position as care planned.

F657 Care Plan Timing and Revision

D The facility failed to revise the care plan for one resident with weight loss. The care plan did not include the resident's weight loss or recommended additional approaches.

F684 Quality of Care

D The facility failed to obtain orders for ice/cold therapy treatments for two residents. The residents were receiving ice/cold therapy for knee pain without an order. The PTA confirmed the residents should have had an order for an on/off schedule for ice/cold therapy prescribed by the physician.

D The facility failed to ensure interventions were implemented to maintain nutritional status for two residents reviewed for nutrition and failed to ensure skin assessment documentation was completed for one resident. The surveyor observed a resident attempting to eat from her meal tray but was unable. The CNA took the resident's tray without offering to assist the resident. The resident was unable to eat. Another resident had weekly weights ordered. The facility could not produce documentation of weekly weights for two of the three weeks since the order was written. Another resident with a bruise present on admission did not have any follow up documentation of the condition of the resident's skin or the appearance of the bruise.

F689 Free of Accident Hazards/Supervision/Devices

J The facility failed to ensure a safe environment to prevent incidents of elopement for one resident reviewed for elopement and failed to complete an incident report and implement interventions after falls for one resident. The failure to prevent elopement placed one resident in immediate jeopardy. A cognitively impaired resident exited the facility without the staff knowledge, walked approximately 6.5 miles from the facility, was found in a stranger's driveway on a cold day. The resident was brought back to the facility after being gone for approximately one hour and forty minutes. Ten days later, the resident exited the facility without staff knowledge, through a facility window in the resident's room and was found 0.7 miles from the facility in a local tobacco store, one hour later. A progress note indicated the resident was required to have a yellow bracelet. The bracelet was not on the resident the day prior to the elopement and the bracelet was not replaced because the bracelets were locked in a secure place. There was no documentation the bracelet was replaced prior to the first elopement. The medical record included a progress note dated five months prior to the first elopement indicating the resident was wandering, exit seeking and verbalizing a desire to leave the facility. A quarterly evaluation indicated the resident was at significant risk for getting to a dangerous place and the resident had a yellow elopement bracelet. The bracelet was not on the resident the day prior to the elopement and the bracelet was not replaced because the bracelets were locked away. There was no documentation the bracelet was replaced prior to the first elopement. There was no psychosocial assessment completed by social services after the elopements. Various staff members interviewed by the surveyor reported having no training regarding the appropriate response to an elopement, no knowledge of the elopement book or other elopement procedures, no abuse/neglect training, and no training after the elopement incidents including no elopement drills. In interview it was determined a family member had obtained the code to the exit door. The staff were educated to protect the door codes and avoid giving the codes to visitors. Staff member reported the facility Code "W", was not announced when the second elopement occurred. The surveyor inspected the elopement books and determined they were not up to date. Another resident fell while attempting to go to the bathroom. An incident report was not completed and the resident's care plan was not updated with a new intervention.

J The facility failed to ensure appropriate supervision and a safe environment to prevent an incident of elopement for one resident. The resident exited the facility without authorization or supervision through the front door. The delayed egress on the front door had been reprogrammed from 15 seconds to 50 seconds without TDOH approval. The facility failed to provide a safe environment to prevent a missing resident incident for another resident when the resident was found in the front lobby bathroom. The failures resulted in immediate jeopardy for both residents. The first resident was sitting in their wheelchair in the lobby unsupervised. The resident stood from the wheelchair, exited the front door, and walked directly to the Security Guard's truck. The guard strapped the resident in the seat, locked the vehicle doors, entered the building to get assistance and left the resident unsupervised in the truck. The resident's wander guard bracelet was on the resident's wheelchair. Upon return to the facility, the resident was placed on one-to-one observation and had an order to verify the placement of the wander guard bracelet each shift. There was no documentation of the wander guard bracelet verification. The Administrator confirmed there were no staff members in the lobby when the resident exited the facility and confirmed the Security Guard was a contractor and not a facility staff member. In an interview with the surveyor, the agency CNA reported having knowledge of the resident's wandering behaviors and reporting a concern with the wander guard bracelet placement on the wheelchair to the nurse earlier in the shift. The agency CNA reported having an assumption that the resident had been sent to the hospital when the resident was not in their room and denied doing frequent checks on the resident after the resident was returned to the room. The second resident's medical record had documentation by the nurse of being made aware of the resident not being in their room by the CNA. The nurse searched for 5-10 minutes unsuccessfully and then initiated the facility procedure for a missing resident. After five additional minutes of searching, the resident was located in the front lobby bathroom. The resident was confused. In an interview by the surveyor with the facility Administrator, the Administrator confirmed an investigation was not initiated and interviews were not completed due to the resident not being missing for a long time. The Administrator reported staff found the resident quickly and did what they were supposed to do. Staff reported not placing a wander guard on the resident and not providing one-to-one care. The facility was unable to provide documentation that an investigation was conducted and failed to determine the last time the resident was seen in the facility prior to the incident.

J The facility failed to effectively monitor and provide a safe and secure environment, and failed to prevent, identify, and thoroughly investigate injuries of unknown origin which contributed to bodily injury of a resident, when the resident sustained a skin tear and a fracture of the hand. The failure resulted in Immediate Jeopardy for one cognitively impaired resident who was injured with a skin tear and discovered with a fracture 25 days later. The resident was sent to the ER for evaluation of the skin tear with bleeding and was returned with no sutures. The investigation did not include staff statements, interviewable resident statements, skin audits, staff training or education or an inspection of the resident's room or wheelchair for hazards. There was no reasonable effort made to determine the root cause of the skin tear. The resident's care plan was not updated with interventions for the skin tear. There was no investigation to determine the origin of the fracture that was identified 25 days later. The facility failed to assess, investigate, and monitor for accident hazards for three residents and one resident reviewed for elopement. One resident had a fall resulting in bruising to the right arm. There was no follow-up documentation in the medical record for 72 hours as required by the facility policy and no discussion regarding the fall or bruising in the IDT meeting. The facility was unable to provide quarterly and annual Fall Risk assessments. Another resident's nurses' notes indicated the resident exited a side door into the courtyard and was assisted back into the facility. There was no documentation of wander guard checks for two days after the resident exited the facility and no documentation of an elopement risk assessment for four days after the incident. The facility failed to implement interventions timely to prevent the resident from exiting the facility and failed to complete elopement assessments at least quarterly. Another resident sustained a fall and sustained a laceration to the forehead. The facility was unable to provide documentation of monitoring of the resident every shift for 72 hours per policy and could not provide a skin/wound note for after care of the laceration. There were no notes to indicate the fall was discussed at the IDT meeting. The facility could not provide quarterly and annual fall risk assessments. Another resident with a fall did not have timely fall risk assessments and did not have an investigation completed in a timely manner. No documentation of 72 resident monitoring was provided.

G The facility failed to protect three residents from falls with injury resulting in actual harm to the residents. One resident did not have care plan interventions of bed bolsters and fall mats in place. The resident fell and sustained a head injury. Another resident fell from the bed to the floor resulting in a contusion to the hip. The bed was not in the lowest position as care planned. Another resident fell from the bed and sustained a laceration to the head and a subdural hematoma. The bed was not in the lowest position as care planned.

D The facility failed to prevent a potential accident for two residents. The residents were receiving ice/cold therapy for knee pain. Staff reported having no formal training on the application of ice/cold therapy. THE DON confirmed that no formal training had been provided. Staff were not following manufacturer's guidelines for a barrier between the resident's skin and the barrier pad. The staff reported receiving the machines from the hospital and the patient was trained at the hospital. The staff reported that sometimes the hospital sends an instruction sheet.

D The facility failed to prevent a fall for one resident. While a CNA assisted the resident with a transfer, the resident's leg became weak, and the CNA lowered the resident to the floor. The resident's care plan intervention required the resident to transfer with the assistance of two staff members.

D The facility failed to implement an intervention to prevent falls for one resident. The resident had an intervention on their care plan for safety mats at the bedside. The mats were not at the resident's bedside when the surveyor observed the resident in bed.

F690 Bowel/Bladder Incontinence Catheter, UTI

D The facility failed to provide care and services to maintain an indwelling urinary catheter. The resident did not have an order, had no documentation of catheter care and no documentation of urinary output.

F695 Respiratory/Tracheostomy care and Suctioning

D The facility failed to properly store nebulizer equipment for three residents. The residents' nebulizer equipment was on the bedside tables uncovered.

D The facility failed to monitor oxygen administration and oxygen tubing maintenance for one resident. The resident had an order for oxygen at 2L/NC. There was no documentation of monitoring of the oxygen and maintenance of the oxygen cannula. The resident had a humidification bottle for the oxygen, but it was dry.

F725 Sufficient Nursing Staff

K The facility failed to ensure a sufficient number of licensed staff were available to provide care and services to all residents based on physician's orders. One LPN worked alone in the facility for approximately six hours and medications, including Insulin and antibiotics, were not administered timely. The medications were administered up to 7 hours and 25 minutes late. The DON reported medications were not timely if given over one hour after the scheduled time.

J The facility failed to provide sufficient staffing to ensure the safety and supervision of wandering residents. The failure resulted in immediate jeopardy for one resident. A cognitively impaired resident exited the facility without the staff knowledge, walked approximately 6.5 miles from the facility, was found in a stranger's driveway on a cold day. The resident was brought back to the facility after being gone for approximately one hour and forty minutes. Ten days later, the resident exited the facility without staff knowledge, through a facility window in the resident's room and was found 0.7 miles from the facility in a local tobacco store, one hour later. In interview, a staff member agreed with the surveyor that staff should know where the residents are at all times. The staff member reported having insufficient staffing to ensure they knew where the residents were on the day of the second elopement due to having only to CNAs for the facility that day. The Medical Director reported having not been notified of the elopement. The Medical Director also confirmed the facility was having a staffing crisis, had no steady DON an and indicated there was not a steady DON resulting in the problem with elopement.

F726 Competent Nursing Staff

K The facility failed to ensure nursing staff were competent and proficient in practices to maintain residents' well-being and to prevent the potential spread of infection when three nurses did not have competency validation prior to administering care and services. The three nurses and one CNA had no documentation of an orientation. The facility's failure to ensure competent and properly trained staff resulted in Immediate Jeopardy when the multi-use blood glucose meters were not cleaned and disinfected to prevent cross-contamination of bloodborne pathogens for six residents. The nurses failed to perform hand hygiene between glove use and failed to change gloves and perform hand hygiene after touching potentially contaminated objects in residents' rooms for nine residents. The nurse failed to disinfect the blood glucose meter before and after use, failed to place a barrier on the residents' overbed tables and failed to change gloves and perform hand hygiene before or after administering medications or checking blood glucose with the blood glucose meter.

F740 Behavioral Health Services

D The facility failed to address and obtain necessary services for behavioral health needs of the residents in order to attain the best practicable mental well-being for one resident. The resident's medical record included a narrative regarding the resident becoming aggressive toward staff, both physically and verbally. The resident attacked staff physically when attempting to provide care for incontinence. The resident refused medications. The Clinical Psychologist was not aware of the incident and reported "only hearing about residents depending on which staff were present". There was no documentation of an interdisciplinary team meeting following the incident, physician notification, or of a transfer to the hospital for inpatient evaluation of behavior and medication adjustment. The resident had no cognitive impairment.

F761 Label/Store Drugs & Biologists

D The facility failed to label and date the enteral feeding for one resident. The resident had a continuous enteral feeding with no label.

F812 Food Procurement Store/Prepare/Serve - Sanitary

F The facility failed to maintain dietary equipment in a sanitary manner. There was pink debris on the edges of the vertical plastic covering in the ice machine.

F The facility failed to ensure food was handled, prepared, and served under sanitary conditions placing all residents at risk for foodborne illness. Observations included: a dietary aide, a nurse and a housekeeper failed to wear gloves and failed to perform proper hand hygiene. A Dietary Manager used their bare hands to pick up food from the steam table, eat the food and lick their fingers with personal items on the food prep table. Staff failed to check food temperatures before sending the food out of the kitchen. Kitchen staff failed to inspect delivered items for safe transport and quality upon receipt when frozen items were not placed in the freezer for 42 minutes after delivery and were not inspected before putting into the freezer.

F835 Administration

K The facility Administration failed to effectively monitor and provide a safe environment to prevent, identify, and thoroughly investigate injuries of unknown origin for one cognitively impaired resident who sustained a skin tear and a fracture to the hand. The facility Administration failed to ensure staff follow policies and procedures when the nursing staff failed to perform hand hygiene during medication administration and failed to clean multi-use blood glucose meters with an EPA approved
disinfectant that is effective against HIV, Hepatitis and other blood borne pathogens. The failures resulted in Immediate Jeopardy for eleven residents.

J The facility Administration failed to provide oversight to ensure systems and processes were developed and consistently followed, failed to provide oversight of nursing staff, failed to identify the root cause for incidents identified in the facility and failed to ensure systems and processes were developed and consistently followed by facility staff. Administration failed to provide oversight that established and implemented policies and procedures to ensure a safe and secure environment when one resident exited the facility unsupervised and without staff knowledge, got in the security guard's vehicle, and was left unsupervised in the vehicle while the security guard entered the facility to notify facility staff. The facility failed to conduct a thorough investigation of incidents and obtain statements from all direct care staff. Administration failed to ensure an incident report was completed when the resident exited the facility unsupervised and without staff knowledge. The Administration failed to investigate an incident of another resident who was found in a locked lobby bathroom for an undetermined amount of time. The failures resulted in immediate jeopardy when the front entrance/exit door delayed egress was reprogrammed from 15 seconds to 50 seconds. Reprogramming the emergency delayed release greater than 30 seconds without prior authorization was in violation of LSC NFPA.

D The facility failed to ensure the facility was administered in a manner to effectively maintain the highest practicable, physical, mental, and psychosocial wellbeing for one resident. The resident's medical record included a narrative regarding the resident becoming aggressive toward staff, both physically and verbally. The resident attacked staff physically when attempting to provide care for incontinence. The resident refused medications. The Clinical Psychologist was not aware of the incident and reported "only hearing about residents depending on which staff were present". There was no documentation of an interdisciplinary team meeting following the incident, physician notification, or of a transfer to the hospital for inpatient evaluation of behavior and medication adjustment. The resident had no cognitive impairment.

F837 Governing Body

K The facility's Governing Body failed in their responsibility for ensuring the facility implemented effective systems and processes regarding the management and operation of the facility. The Governing Body failed to ensure the facility implemented effective policies and procedures for investigation of injuries of unknown origin to ensure one cognitively impaired Resident was properly assessed and monitored, when the resident sustained a skin tear and a fracture to the hand. The Governing Body failed to provide oversight to ensure the facility nursing staff followed policies and procedures for appropriate hand hygiene during medication pass and disinfect multi-use blood glucose meters with disinfectants that are effective against HIV, Hepatitis, and other bloodborne pathogens. The Governing Body failed to provide oversight to ensure consistent facility Administration. The Governing Body failed to maintain oversight to ensure the establishment and implementation of policies and procedures to ensure an effective Quality Assurance and Performance Improvement (QAPI) program. The failures resulted in Immediate Jeopardy for eleven residents.

F842 Resident Records - Identifiable Information

D The facility failed to ensure medical records contained a complete and accurately documented representation of resident incidents for two residents reviewed for incidents and accidents. The facility failed to ensure an accurate medical record for one resident related to ADLs and an incomplete nurses note related to an incident. The medical record was incomplete for another resident related to missing documentation of verification of wander guard bracelet placement and inadequate documentation of an elopement.

D The facility failed to maintain accurate and complete medical records for one resident. The electronic record physician's orders and the resident's care plan indicated the resident's code status was Full Code. The resident had a POST form in their record with a code status of DNR.

F867 QAPI/QAA Improvement Activities

K The facility's QAPI Committee failed to ensure an effective QAPI program that identifies opportunities for improvement related to resident safety and infection control and failed to implement performance improvement activities in order to provide a safe environment for residents, prevent the spread of infections and communicable disease, and ensure systems and processes were in place and were consistently followed by staff and administration. The QAPI Committee failed to provide oversight to ensure the establishment and implementation of policies and procedures to assure the facility is
administered in a manner to use its resources effectively and efficiently. The QAPI Committee program failed to identify the root cause of injuries of unknown origin and failed to ensure a severely cognitively
impaired Resident was properly assessed and monitored following injuries of unknown origin resulting in a skin tear and a fracture of a resident's hand. The QAPI Committee failed to provide oversight to ensure the establishment and implementation of policies and procedures that ensure licensed nursing staff perform hand hygiene during medication administration, blood glucose monitoring and failed to ensure multi-use blood glucose meters were cleaned with disinfectants that are effective against HIV, Hepatitis and other bloodborne pathogens. The failures resulted in Immediate Jeopardy for eleven residents.

F880 Infection Prevention & Control

K The facility failed to ensure practices to prevent the potential spread of infection were maintained when multi-use blood glucose meters were not cleaned and disinfected to prevent cross-contamination of bloodborne pathogens for six residents, when facility nursing staff failed to perform hand hygiene between glove use and failed to change gloves and perform hand hygiene after touching potentially contaminated objects in residents' rooms for nine residents. The facility failed to follow CDC infection control guidelines to ensure practices were implemented to prevent the potential spread of COVID-19 when 28 staff members failed to complete screenings for active infection, symptoms, or exposure to COVID-19 prior to work. The facility's failures to ensure staff properly disinfected the multi-use blood glucose meter used for multiple residents placed residents at risk for contamination with bloodborne pathogens and placed the residents in Immediate Jeopardy.

E The facility failed to prevent the spread of infection for three residents with nebulizer equipment and failed to maintain dietary equipment in a sanitary manner. The resident's nebulizer equipment was found on the bedside tables uncovered. There was a pink debris on the edges of the vertical plastic covering in the ice machine.

K211 Means of Egress - General

D The facility failed to maintain the means of egress and keep it free from obstruction. The emergency sidewalk was obstructed with large mats and rugs.

K222 NFPA 101 Egress Doors

D The facility failed to maintain the egress doors. Observations included: barrel latches on bathroom doors in two resident rooms and the 15-second delayed egress was not working on one door.

K232 Aisle, Corridor or Ramp Width

D The facility failed to maintain the corridor width. The surveyor observed linen carts and trash carts in the same locations for greater than two hours in the corridor.

K291 Emergency Lighting

D The facility failed to maintain the emergency lighting. The facility could not produce documentation of the 30 second testing of the emergency lights and exit signs for nine months prior to the survey.

K324 Cooking Facilities

D The facility failed to maintain the cooking facilities. The facility could not produce documentation of a kitchen hood cleaning and could not produce documentation of an inspection of the hood suppression system for the first half of the prior year.

K345 Fire Alarm System; Testing and Maintenance

D The facility failed to maintain the fire alarm system. There was no documentation of a two-year smoke sensitivity test or semiannual visual inspections of the smoke detectors for the prior year.

K351 Sprinkler System; Installation

D The facility failed to maintain the sprinkler system. The surveyor observed mixed response sprinklers in the kitchen outside the dry good storage room.

K353 Sprinkler System; Testing and Maintenance

D The facility failed to maintain the sprinkler system. Corroded sprinklers were identified in three locations.

D The facility failed to maintain the sprinkler system. The facility had no documentation of a three full flow trip test on the dry sprinkler system. There was a corroded sprinkler in the boiler room.

K741 Smoking Regulations

D The facility failed to maintain the smoking area. There were cigarette filters covering the ground of the smoking area and the metal can was full of trash and filters.

K761 Maintenance, Inspection & Testing - Doors

D The facility failed to ensure fire door assemblies were inspected annually. The facility had no documentation of the annual fire door inspection for the prior year.

K912 Electrical Systems

D The facility failed to maintain the electrical system. A broken receptacle cover plate was identified in two resident rooms.

K920 Electrical Equipment; Power Cords and Extension Cords

F The facility failed to maintain power cords. The surveyor observed power strips in 15 resident rooms.

D The facility failed to maintain the electrical equipment. One resident room had an unapproved power strip in use to power personal electronics. The power strip was not UL 1363 listed.

K923 Gas Equipment - Cylinder and Container Storage
Container Storag

D The facility failed to comply with oxygen storage regulations. The surveyor observed 16 “E” sized oxygen cylinders stored within five feet of combustible materials in the hydrotherapy room. There were no oxygen storage signs posted on the door and the door was not secured against unauthorized access.

N1207 Resident Rights

This is a Type A Penalty with Suspension of Admissions. The facility failed to thoroughly investigate injuries of unknown origin resulting in a skin tear and fractured hand for one resident. The failure resulted in Immediate Jeopardy for one cognitively impaired resident who was injured with a skin tear and discovered with a fracture 25 days later. The resident was sent to the ER for evaluation of the skin tear with bleeding and was returned with no sutures. The investigation did not include staff statements, interviewable resident statements, skin audits, staff training or education or an inspection of the resident’s room for hazards. There was no reasonable effort made to determine the root cause of the skin tear. There was no investigation to determine the origin of the fracture that was identified 25 days later.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

The facility failed to provide documentation for the annual flood, tornado, earthquake drills/inservices for 2022.

N401 Administration

This is a Type A Penalty with Suspension of Admissions. The facility Administration failed to effectively monitor and provide a safe environment to prevent, identify, and thoroughly investigate injuries of unknown origin for one cognitively impaired resident who sustained a skin tear and a fracture to the hand. The facility Administration failed to ensure staff follow policies and procedures when the nursing staff failed to perform hand hygiene during medication administration and failed to clean multi-use blood glucose meters with an EPA approved disinfectant that is effective against HIV, Hepatitis and other blood borne pathogens. The failures resulted in Immediate Jeopardy for eleven residents.

N424 Administration; Safety Policies and Procedures

This is a Type A Penalty with Suspension of Admissions. The facility failed to ensure appropriate supervision and a safe environment to prevent an incident of elopement for one resident. The resident exited the facility without authorization or supervision through the front door. The delayed egress on the front door had been reprogrammed from 15 seconds to 50 seconds without TDOH approval. The facility failed to provide a safe environment to prevent a missing resident incident for another resident when the resident was found in the front lobby bathroom. The failures resulted in immediate jeopardy for both residents. The first resident was sitting in their wheelchair in the lobby unsupervised. The resident stood from the wheelchair, exited the front door, and walked directly to the Security Guard's truck. The guard strapped the resident in the seat, locked the vehicle doors, entered the building to get assistance and left the resident unsupervised in the truck. The resident's wander guard bracelet was on the resident's wheelchair. Upon return to the facility, the resident was placed on one-to-one observation and had an order to verify the placement of the wander guard bracelet each shift. There was no documentation of the wander guard bracelet verification. The Administrator confirmed there were no staff members in the lobby when the resident exited the facility and confirmed the Security Guard was a contractor and not a facility staff member. In an interview with the surveyor, the agency CNA reported having knowledge of the resident's wandering behaviors and reporting a concern with the wander guard bracelet placement on the wheelchair to the nurse earlier in the shift. The agency CNA reported having an assumption that the resident had been sent to the hospital when the resident was not in their room and denied doing frequent checks on the resident after the resident was returned to the room. The second resident's medical record had documentation by the nurse of being made aware of the resident not being in their room by the CNA. The nurse searched for 5-10 minutes unsuccessfully and then initiated the facility procedure for a missing resident. After five additional minutes of searching, the resident was located in the front lobby bathroom. The resident was confused. In an interview by the surveyor with the facility Administrator, the Administrator confirmed an investigation was not initiated and interviews were not completed due to the resident not being missing for a long time. The Administrator reported staff found the resident quickly and did what they were supposed to do. Staff reported not placing a wander guard on the resident and not providing one-to-one care. The facility was unable to provide documentation that an investigation was conducted and failed to determine the last time the resident was seen in the facility prior to the incident.

This is a Type A Penalty with Suspension of Admissions. The facility failed to effectively monitor and provide a safe and secure environment, and failed to prevent, identify, and thoroughly investigate injuries of unknown origin which contributed to bodily injury of a resident, when the resident sustained a skin tear and a fracture of the hand. The failure resulted in Immediate Jeopardy for one cognitively impaired resident who was injured with a skin tear and discovered with a fracture 25 days later. The resident was sent to the ER for evaluation of the skin tear with bleeding and was returned with no sutures. The investigation did not include staff statements, interviewable resident statements, skin audits, staff training or education or an inspection of the resident's room or wheelchair for hazards. There was no reasonable effort made to determine the root cause of the skin tear. The resident's care plan was not updated with interventions for the skin tear. There was no investigation to determine the origin of the fracture that was identified 25 days later. The facility failed to assess, investigate, and monitor for accident hazards for three residents and one resident reviewed for elopement. One resident had a fall resulting in bruising to the right arm. There was no follow-up documentation in the medical record for 72 hours as required by the facility policy and no discussion regarding the fall or bruising in the IDT meeting. The facility was unable to provide quarterly and annual Fall Risk assessments. Another resident's nurses' notes indicated the resident exited a side door into the courtyard and was assisted back into the facility. There was no documentation of wander guard checks for two days after the resident exited the facility and no documentation of an elopement risk assessment for four days after the incident. The facility failed to implement interventions timely to prevent the resident from exiting the facility and failed to complete elopement assessments at least quarterly. Another resident sustained a fall and sustained a laceration to the forehead. The facility was unable to provide documentation of monitoring of the resident every shift for 72 hours per policy and could not provide a skin/wound note for after care of the laceration. There were no notes to indicate the fall was discussed at the IDT meeting. The facility could not provide quarterly and annual fall risk assessments. Another resident with a fall did not have timely fall risk assessments and did not have an investigation completed in a timely manner. No documentation of 72 resident monitoring was provided.

N601 Performance Improvement Program

This is a Type A Penalty with Suspension of Admissions. The facility's QAPI Committee failed to ensure an effective QAPI program that identifies opportunities for improvement related to resident safety and infection control and failed to implement performance improvement activities in order to provide a safe environment for residents, prevent the spread of infections and communicable disease, and ensure systems and processes were in place and were consistently followed by staff and administration. The QAPI Committee failed to provide oversight to ensure the establishment and implementation of policies and procedures to assure the facility is administered in a manner to use its resources effectively and efficiently. The QAPI Committee program failed to identify the root cause of injuries of unknown origin and failed to ensure a severely cognitively impaired Resident was properly assessed and monitored following injuries of unknown origin resulting in a skin tear and a fracture of a resident's hand. The QAPI Committee failed to provide oversight to ensure the establishment and implementation of policies and procedures that ensure licensed nursing staff perform hand hygiene during medication administration, blood glucose monitoring and failed to ensure multi-use blood glucose meters were cleaned with disinfectants that are effective against HIV, Hepatitis and other bloodborne pathogens. The failures resulted in Immediate Jeopardy for eleven residents.

N620 Infection Control

This is a Type A Penalty with Suspension of Admissions. The facility failed to ensure practices to prevent the potential spread of infection were maintained when multi-use blood glucose meters were not cleaned and disinfected to prevent cross-contamination of bloodborne pathogens for six residents, when facility nursing staff failed to perform hand hygiene between glove use and failed to change gloves and perform hand hygiene after touching potentially contaminated objects in residents' rooms for nine residents. The facility failed to follow CDC infection control guidelines to ensure practices were implemented to prevent the potential spread of COVID-19 when 28 staff members failed to complete screenings for active infection, symptoms, or exposure to COVID-19 prior to work. The facility's failures to ensure staff properly disinfected the multi-use blood glucose meter used for multiple residents placed residents at risk for contamination with bloodborne pathogens and placed the residents in Immediate Jeopardy.

N645 Nursing Services

The facility failed to provide effective housekeeping services and maintenance services to maintain a sanitary, orderly, and comfortable environment. The surveyor observed trash and debris lying on the floors, sticky floors with a buildup of dirt and grime, dust, and cobwebs in the corner behind a door, exposed wires, dirty fall mats and overbed table bases, telephones lying on the floor, dirty bathroom floors and toilet, missing privacy curtains and a fan covered in thick gray dust in seven resident rooms. This is a Type C Pending Penalty #19.

N661 Nursing Services; Responsibilities of DON

This is a Type A Penalty with Suspension of Admissions. The facility Administration failed to effectively monitor and provide a safe environment to prevent, identify, and thoroughly investigate injuries of unknown origin for one cognitively impaired resident who sustained a skin tear and a fracture to the hand. The facility Administration failed to ensure staff follow policies and procedures when the nursing staff failed to perform hand hygiene during medication administration and failed to clean multi-use blood glucose meters with an EPA approved disinfectant that is effective against HIV, Hepatitis and other blood borne pathogens. The failures resulted in Immediate Jeopardy for eleven residents.

N685 Basic Services; Resident's Clothing Clean

The facility failed to prevent a potential accident for two residents. The residents were receiving ice/cold therapy for knee pain. Staff reported having no formal training on the application of ice/cold therapy. THE DON confirmed that no formal training had been provided. Staff were not following manufacturer’s guidelines for a barrier between the resident’s skin and the barrier pad. The staff reported receiving the machines from the hospital and the patient was trained at the hospital. The staff reported that sometimes the hospital sends an instruction sheet.

N707 Medical Records; Record Maintenance

The facility failed to ensure medical records contained a complete and accurately documented representation of resident incidents for two residents reviewed for incidents and accidents. The facility failed to ensure an accurate medical record for one resident related to ADLs and an incomplete nurses note related to an incident. The medical record was incomplete for another resident related to missing documentation of verification of wander guard bracelet placement and inadequate documentation of an elopement.

N766 Food and Dietetic Services; Freezer Temperature

The facility failed to maintain dietary equipment in a sanitary manner. There was pink debris on the edges of the vertical plastic covering in the ice machine.

N831 Building Standards

The facility failed to maintain the physical plant. The following observations were made by the surveyor: Glass without a fire rating label in the 1 ½ hour fire rated doors in the two-hour fire barrier walls and at the kitchen.

The facility failed to maintain the overall environment. There was damaged gypsum board in five resident rooms, the laundry room, and the kitchen. There were four unsealed one-inch conduits in the rated hard ceiling of the laundry room.

N835 Building Standards; Approval of New Construction

The facility failed to obtain prior written approval from the Health Facilities Commission before making alterations to the nursing home. Three rooms were used for storage and did not have approval.