Survey Deficiency Summary

31 Facilities Surveyed **Surveys Taken 3/22/23-4/26/23**

F550 Resident Rights/Exercse of Rights

D The facility failed to maintain or enhance resident dignity and respect when two staff members were observed during dining and failed to use courtesy titles to address residents. A CNA referred to one resident as a feeder and called four other residents “darling”. A nurse referred to a resident as “dear”.

D The facility failed to ensure medical information was not visible for two residents. Resident #1 had a sign posted in the room, visible to anyone who entered, that stated “Resident has a cushion that needs to be put into chair when up in chair….”. Resident #2 had a sign posted on the mirror, visible to anyone who entered, that stated “splint to be worn 6-8 hours a day, carrot splint when splint removed at night”. Neither resident’s family had requested the signs to be posted in the rooms.

F557 Respect, Dignity/Right to have Personal Property

D The facility failed to treat the residents’ personal clothing and items with respect by not returning clothing items timely after they were discharged for two residents. The facility failed to have an inventory of personal belongings for three residents. Resident #1 had a fur coat that was stored in the Social Services office. The facility rearranged the office, the coat was taken to storage and then was thrown away by mistake. Resident #2’s personal belongings were located in the facility after the resident had discharged. The personal belongings were not returned to the resident. A Personal Inventory Form was not completed for the two residents and one additional resident on admission per the facility’s policy.

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 one resident. The Social Services director was unable to provide documentation that education was provided to a resident’s representative about an advance directive.

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

D The facility failed to ensure nursing staff applied a bilevel positive airway pressure (BiPAP) mask to a resident, failed to assess and document oxygen saturation levels and failed to notify the MD/NP when a resident who required oxygen therapy was found unresponsive and went into cardiac arrest. A note in the resident's medical record by OT indicated caregiver training was conducted and focused on proper positioning for the resident to increase lung capacity due to desaturation noted with lethargy. There was no documentation of the resident's vital signs including oxygen saturation on that day or the following day. A clinical note on the following day indicated the resident was found unresponsive, lips blue and did not respond to a sternal rub. EMS was notified and the resident was transferred to the hospital. There was no documentation of notification of the MD or NP and no documentation of oxygen saturation. The resident was pronounced dead at the hospital. An LPN indicated in an interview with the surveyor that they had noticed the BiPAP had a bad seal the night before the event and did not report it. The resident did not have BiPAP in place at the time of the transfer. The hospital transfer form was not completed by the agency nurse. The NP reported they were not notified of the desaturation and cardiac arrest. The Medical Director reported being made aware of the event at a later time.

F583 Personal Privacy/Confidentiality of Records

D The facility failed to maintain privacy and confidentiality of one resident's medical record. The surveyor observed an opened laptop on a treatment card with the Resident's electronic medical record visible.

F600 Free from Abuse and Neglect

D The facility failed to protect two residents from physical abuse. Resident #1 was cognitively impaired and had a history of physical aggression towards other residents. Resident #1 was sitting in the hallway outside of their room. Resident #2 approached the resident and attempted to touch Resident #1's personal belongings. Resident #1 struck Resident #2 on the arm. The residents were separated by nursing staff. Resident #3 stopped their wheelchair in front of Resident #4 while adjusting their socks and shoes. Resident #4 struck Resident #3 on the face and knocked their glasses off. No injuries resulted from any of the resident-to-resident altercations. Resident #5 was asleep in their bed when Resident #6 came to the bedside and touched Resident #5's face. Resident #6 woke up and then stood at the bedside. Resident #5 threw a paper back book that was in their hand, hitting Resident #5 in the head.

D The facility failed to ensure one resident was free from abuse. Resident #2 entered the wrong room and hit Resident #4 on the chest and the leg. The staff removed the resident from the room and redirected. Resident #4 was uninjured.

D The facility failed to ensure one resident was free from abuse. Resident #8 approached Resident #9 at the nurse's station and attempted to grab an article of clothing out of their hand. Resident #9 began shaking the shirt and stating "No, that's mine". Resident #8 hit Resident #9 on the lower arm with their fist. Resident #8 was placed on one-to-one monitoring and then sent to the ER for evaluation. Resident #9 had bruising on the lower arm. Xray was negative for fracture.

D The facility failed to prevent abuse of two residents. Resident #6 was seated at their normal position at the dinner table. Resident #5 got up and went and sat in front of the television in the dining room and began to change the channel. Resident #6 began to argue with Resident #5 over the television channel. Resident #6 hit Resident #5 in the arm with the television remote control. Video surveillance revealed both residents made physical contact with each other. The residents were separated and taken back to their rooms. Resident #5 had entries in their medical record regarding episodes of verbal aggression. The same two residents had a prior altercation without physical contact regarding the television.

D The facility failed to prevent abuse for one Resident. Resident #1 was propelling down the hallway and bumped into Resident #2's wheelchair. The wheelchairs became interlocked. Resident #1 yelled and hit Resident #2 with their water pitcher and poured water on them. Staff interviews were consistent regarding the event.

D The facility failed to protect two residents from abuse. Resident #1 struck Resident #2 on the forehead with their fist. Resident #2 had a reddened area on their forehead. Resident #2 had attempted to take Resident #1's cane. Two other residents were involved in an altercation where one resident hit another resident. There were no injuries.

F609 Reporting of Alleged Violations

D The facility failed to timely report allegations of abuse for three residents. Resident #2 entered the wrong room and hit Resident #4 on the chest and the leg. Resident #2 was found in Resident #1's room touching the resident with a pillow. Resident #3 ran over Resident #2's foot with their wheelchair causing injury to Resident #3. An altercation occurred and Resident #2 caused a small red area on Resident #3's cheek. The facility failed to report the allegations of abuse to the State Survey Agency.

D The facility failed to report an allegation of neglect to supervisory staff timely so that the allegation of abuse was reported within the two-hour time frame to the State Survey Agency for one resident. A resident reported to the nurse that a CNA had answered their call light and refused to provide assistance to the bathroom. The CNA was reported to have told the resident it was too early to get up and they needed to wait until 5AM or 6AM. In interview, the CNA stated the resident asked to get up and she was unable to help because of being in the middle of the round, toileting and assisting others. The resident reported it had occurred on a prior occasion as well. The CNA denied the resident asked to go to the bathroom. The Administrator stated it was not reported due to being unable to substantiate neglect.

D The facility failed to report allegations of abuse for two residents. Resident #1 alleged that a CNA was too rough, was mean to her and stated they were fearful of the CNA. A family member alleged that while speaking with Resident #2 on the phone, they heard someone start yelling at the resident and accusing them of calling too many times, after which Resident #2 began to cry. The CNAs were reassigned. One resident was relocated to another room. The DON confirmed that the incidents were not reported to the state and an investigation was not completed.

F610 Investigate/Prevent/Correct Alleged Violation

D The facility failed to investigate allegations of abuse for two residents. Resident #1 alleged that a CNA was too rough, was mean to her and expressed being fearful of the CNA. A family member alleged that while speaking with Resident #2 on the phone, they heard someone start yelling at the resident and accusing them of calling too many times, after which Resident #2 began to cry. The CNAs were reassigned. One resident was relocated to another room. The DON confirmed that the incidents were not reported to the state and an investigation was not completed.

F622 Transfer and Discharge Requirements

D The facility failed to ensure a discharge summary was written within 14 days of discharge for two residents. One resident expired at the facility and the other resident was transferred to the hospital and did not return. The facility was unable to provide documentation of a discharge summary for either resident.

D The facility failed to follow their discharge policies and procedures and failed to meet the requirements for an appropriate discharge for one resident. The resident was interviewed by the surveyor and reported being discharged home abruptly. The resident reported the facility requested to search their room due to smelling marijuana in the area. The resident denied the request. The police were notified and also requested to search the room. The resident denied the request. The resident stated that afterwards, they were called to the Administrator's office and informed of their discharged to home that day. The resident stated the discharge plans were inadequate and they were referred to an outpatient therapy center that did not have parallel bars, which were used in therapy prior to discharge. The resident also complained of having to arrange their own therapy after discharge. The resident claimed of having no understanding of the reason behind the abrupt discharge. In an interview with the surveyor, the Administrator reported smelling marijuana at the resident's room and the resident denied their request for a room search. The Administrator stated the resident was independent with most all ADLs and did not need 24/7 nursing care. When the surveyor asked how much notice the resident was given for the discharge, the Administrator stated the resident was discharged the day the order was given by the Medical Director. The Insurance Case Manager reported the resident was discharged due to illicit drug use. The police officer denied suspecting the resident of drug use.

F626 Permitting Residents to Return to Facility

D The facility failed to permit a resident to return to the facility after transfer to the ER. The resident had been found on the floor beside their bed, eating feces from their incontinent brief. When the nurse asked the resident to stop, the resident became angry and started throwing feces at the nurse. The resident refused any vital signs to be checked, refused incontinence care and was physically aggressive with the staff. The resident also began to eat the bed mattress in small bites. Redirection was not successful. The physician was notified and ordered the resident to be transferred to the hospital ER. The resident's spouse was notified and confirmed the resident had abnormal behaviors at home and requested a restraint for the resident. In an interview with the surveyor, the spouse stated the nurse stated they were "throwing her out", indicating they were sending her to the hospital. In the ER, the resident was found to be covered in feces, including hair, clothing, face, and teeth. The resident was evaluated in the ER and determined to have no acute psychiatric abnormality with symptoms more consistent with vascular dementia. The ER recommended returning the resident to the facility. The facility refused to accept the resident back from the ER and the resident was returned to their home. The spouse stated they were not notified by the facility upon transfer that the resident would not be allowed to return. In an interview with the surveyor, the Administrator confirmed the facility does accept residents with behaviors but does not accept residents with behaviors of threatening staff, eating feces, wandering and eloping.

F641 Accuracy of Assessments

D The facility failed to accurately assess residents for respiratory services and weight loss for two residents. Resident #1 had orders for continuous oxygen therapy. The oxygen therapy was not coded on the resident's most recent MDS. Resident #2 had a weight loss of 5% or more during the month prior to the most recent MDS. The weight loss was not coded on the resident's MDS.

F655 Baseline Care Plan

D The facility failed to develop a baseline care plan within 48 hours for one resident. The facility was unable to provide documentation of a baseline care plan within 48 hours of admission.

D The facility failed to create an effective and person-centered care plan that meets professional standards of quality for one resident. The resident had two occasions of almost falling due to the bed being unlocked. The resident reported the staff were unaware of their recent hip surgery. The baseline care plan was not updated to include the fall risks/unlocked beds.

F656 Develop/Implement Comprehensive Care Plan

G The facility failed to develop and implement care plans for two residents. The failure to implement Resident #1's care plan resulted in actual harm for the resident when there was a critical lab value, requiring transfer to the hospital where the resident was diagnosed with a GI bleed. The resident had orders for anticoagulant therapy and routine PT/INR lab tests. One result was returned without a value and was not repeated. When the PT/INR was drawn again as routinely scheduled, the result was supratherapeutic and the Resident required hospitalization for GI Bleed. The Medical Director confirmed the missed labs contributed to the actual harm for the Resident. The facility failed to develop and implement an individualized person-centered care plan related to activities for Resident #2 who does not speak English. The resident enjoyed watching television and listening to Vietnamese music. The Resident's care plan did not include any specific interventions related to the resident's language, religious and cultural preference.

D The facility failed to develop and implement a person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs for one resident. The resident had alleged that a CNA was verbally abusive. The facility did not complete a trauma informed care assessment and did not revise the resident's psychosocial care plan.

F657 Care Plan Timing and Revision

D The facility failed to ensure residents' care plans were reviewed and revised in a timely manner for five residents. Resident #1 had orders for continuous oxygen therapy. Oxygen therapy was not addressed in the resident's care plan. Resident #2 was readmitted to the facility two weeks prior to the survey. The resident's care plan had no revisions and did not reflect the resident's current status. Resident #3 and Resident #4 had a significant weight loss. The residents' care plans did not address weight loss. Resident #5 was admitted to the facility over two years prior to the survey. The resident's care plan had no revisions beyond the admission date and did not reflect the resident's current status.

D The facility failed to ensure that four residents or their families were invited to participate in planning their care. The facility was unable to provide documentation that a care plan meeting was held with the residents or their families.

F661 Discharge Summary

D The facility failed to ensure the completion of a discharge summary with a recapitulation of the resident's stay for one resident. The resident's discharge summary did not summarize the resident's stay while at the facility.

F676 Activities of Daily Living (ADLs/Maintain Abilities)

D The facility failed to provide interpretation service for one resident. The resident's primary language was Vietnamese. The Resident's daughter assisted at times with translation. Staff were not aware of any translation services that could be used when the daughter was not available.

F679 Activities Meet Interest/Needs of Each Resident

D The facility failed to develop and implement an individualized activities program to meet the needs of a non-English speaking residents whose primary language is Vietnamese. There were no person-centered activities related to the resident's language, religious and/or cultural preference. The resident's activities care plan only included interventions such as "offer 1:1 visits" and "invite resident to out of room activities".

F684 Quality of Care

G The facility failed to ensure the resident's physician was notified of a significant change in a resident who complained of leg pain and swelling due to her leg "getting tangled" in a Hoyer lift pad. The facility's investigation revealed a CNA identified the resident's leg was swollen when providing care at 2AM. The resident reported to the CNA that their leg got caught in the mechanical lift pad when taking a shower three days prior. The CNA notified the nurse who relayed the information to the oncoming shift the following morning. The day shift nurse documented the resident's leg was swollen and painful and notified the NP and the DON. The NP examined the resident after lunch and ordered an Xray. The Xray was positive for a fracture. The NP was notified and ordered the transfer of the resident to the hospital. The DON notified the Administrator. The hospital H&P indicated the resident reported the fracture occurred as a result of getting the leg caught in the Hoyer lift which was due to the CNA's rough handling and moving the resident too fast. The surveyor interviewed the NP, and the NP indicated the communication received regarding the resident's leg was provided in a non-urgent manner by entering the information into the communication book. The NP denied being aware of the residents' report of the fracture occurring as a result of injury during transfer with the mechanical lift. The NP and the facility Medical Director confirmed that notification should have been provided immediately instead of the communication book. The facility staff failed to timely notify the Administrator, DON, and NP of an injury to the resident's leg from the Hoyer lift.

G The facility failed to follow a physician's order to obtain a weekly lab for medication monitoring for one resident. The resident had one weekly specimen (PT/INR) that was rejected by the lab due to clotting of the specimen rendering it unusable. The facility failed to ensure the lab was redrawn. The following week, the resident's PT/INR was at a critical value and contributed to GI Bleeding resulting in hospitalization for the resident.

E The facility failed to document bowel elimination and implement a bowel protocol for three residents. Resident #1 had an order for a laxative for constipation. The drug was not given as ordered. There were multiple days on the "Bowel and Bladder Elimination" record that were blank. The resident had a period of seven days without documentation of a bowel movement. Resident #2 had multiple days without documentation of bowel elimination on the documentation record. The resident had periods of 14 days, nine days, and four days without documentation of bowel elimination. Resident #3 had multiple days over a three-month period that had no documentation on the "Bowel and Bladder Elimination" record.

E The facility failed to ensure resident's medication and nutritional supplements were administered as prescribed for eight residents. There were multiple occurrences of documentation on the MAR of "Code 9", medication unavailable or "Code 5", medication not in stock. Drugs not given included diuretics, anti-diabetic, cardiac, antihypertensive, and antiviral drugs, eye drops for treatment of Glaucoma, nutritional supplements, antianxiety medications, analgesics, inhalers, and anti-reflux medications.

F689 Free of Accident Hazards/Supervision/Devices

J The facility failed to ensure a safe environment with adequate supervision to prevent elopement/wandering behaviors. The facility's failure resulted in Immediate Jeopardy when one severely cognitively impaired resident exited the facility unsupervised when a visitor entered the building through the front door. The resident walked out of the door before it closed and was found by staff sitting on the front porch of the facility. The resident was unsupervised and out of the facility for approximately 58 minutes. The facility was cited with past noncompliance when corrective actions were validated by the surveyor. Corrective actions included: The resident was assisted back into the facility and was assessed for injury with no injury identified. Beginning with the day of the event, staff sat at the front door, until the door code could be changed, and education provided to visitors and families. The responsible party, physician extender and the Medical Director were notified. All staff, including ancillary staff, received in-service training related to Elopement and Tips for Prevention of Elopement. The resident's elopement risk assessment was completed and revised. The resident's information was included in the elopement book. The resident's care plan was revised and included interventions for the risk of elopement including one-to-one activities outside. The resident was placed under one-to-one care for 24 hours, then every 15-minute checks for 72 hours. The receptionist was assigned to monitor the front door and is to ensure someone remains at the front desk at all times. The door code was changed and will be changed every three months. All visitors and families of existing residents were educated regarding door codes. Resident representatives of all new admissions were educated regarding not allowing anyone out the front door. An additional bright colored sign was added to the front door that included wording to avoid letting anyone out of the facility that is not with their family/group. The elopement policy was reviewed. All newly hired staff were educated on the elopement policy. All new admissions will be assessed for elopement and care plans initiated. All residents at risk for elopement were verified to be included in the elopement book. Elopement drills were conducted. An additional QAPI Committee meeting was held to review the incident, interventions, and preventative measures. Elopement was discussed at the following month's QAPI Committee meeting. A monitoring plan was implemented that included auditing new hire orientation/training and current staff quarterly training/education regarding the elopement policy and the location of the elopement book monthly, quarterly auditing of elopement risk assessments and care plans and monthly auditing of signage, kiosk, front office and weekend coverage, automatic evening door locking schedule, monthly call to contact list, and new resident admission education. The elopement drills and doors will be audited monthly and reported to the QAPI Committee. Audits will be conducted monthly and reported to the QAPI Committee monthly. Deficient practice will be reported to the Administrator. Audits will continue until the QAPI Committee determines substantial compliance.

J The facility failed to ensure a safe environment, provide adequate supervision, and reassess a cognitively impaired resident at risk for elopement resulting in Immediate Jeopardy when the resident exited the facility through an unsecured door to an unsafe environment. The door did not have an alarm that sounded when the door failed to close and engage. The resident was found approximately 102 feet from the lobby door, sitting on the ground, legs entangled in the wheelchair, leaning against a tree. The facility staff were unaware the resident had exited the facility. A pizza delivery driver assisted the resident back into the facility, approximately twelve minutes after the resident exited. The resident was approximately 140 feet from an embankment to the street. The temperature outside was 35 degrees. The resident had a fractured rib as a result of the fall from the wheelchair. The resident had a history of exit seeking and previously resided on the secured unit. The resident had been relocated from the secured unit prior to the elopement.

D The facility failed to conduct neurochecks and Fall Risk Assessments following falls for one resident. The resident had unwitnessed falls on two occasions and there was no documentation of neuro checks or Fall Risk Assessments following the falls. The facility failed to ensure the environment was safe and free of accident hazards when hazardous chemicals were left unattended in a resident's room. While touring the facility the surveyor observed a plastic bottle of yellow liquid on the resident's bedside table, unsecured and unattended by staff. The resident was in bed with the bedside table next to the bed. Three minutes after the observation, the surveyor observed the housekeeper enter the room and retrieve the bottle of yellow liquid. The housekeeper indicated the liquid was hydrogen peroxide cleaner. The housekeeper and the Administrator confirmed that housekeeping chemicals should be stored on the housekeeping cart under lock and key and should not be left unsecured and unattended in resident rooms.

D The facility failed to ensure one resident was supervised to prevent resident to resident altercations. Resident #2 entered the wrong room and hit Resident #4 on the chest and the leg. The staff removed Resident #2 from the room and was redirected. Resident #2 was found in Resident #1's room, touching Resident #1 with a pillow. Resident #3 ran over Resident #2's foot with their wheelchair causing injury to Resident #3. An altercation occurred and Resident #2 caused a small red area on Resident #3's cheek. The facility failed to supervise Resident #2 to prevent alleged resident altercations.

D The facility failed to follow physician's orders for one resident reviewed for falls. One resident had a physician's order for a body alarm to be clipped to the resident while in bed. The surveyor observed the resident in the bed without the body alarm on two days of the survey.

F690 Bowel/Bladder Incontinence Catheter, UTI

D The facility failed to provide care and services to maintain and indwelling urinary catheter. The nursing staff failed to obtain a physician's order for the catheter, failed to provide catheter care and failed to record urinary output for one resident.

F692 Nutrition/Hydration Status Maintenance

E The facility failed to monitor the resident's nutritional status in accordance with their policy for obtaining weights for four residents. The residents were not weighed according to admission policy and per orders. There were multiple occasions of missed weights.

D The facility failed to ensure resident weights were obtained and monitored, and nutritional supplements were administered in accordance with facility policy, physician's orders, and dietary recommendations to prevent weight loss for two residents. Resident #1 had a 9.49% weight loss in less than 30 days. The resident was not reweighed, and weekly weights for two weeks were not done as recommended by the IDT. Resident #2 had a 13.9% weight loss over a one-month period. The resident was not reweighed. The dietary recommendation to increase the house supplement to three times daily was not implemented. Weekly weights were inconsistently done.

D The facility failed to follow their policy for monitoring weekly weights for two residents. Both residents were required by policy to have weekly weights. Both residents were missing part of the weekly weight measurements.

F695 Respiratory/Tracheostomy care and Suctioning

D The facility failed to monitor oxygen tubing, nasal cannulas and oxygen humidification for one resident. The facility's policy required oxygen tubing, masks and cannulas to be changed weekly or more often if it becomes soiled or contaminated. The resident had orders for continuous oxygen therapy by nasal cannula. There was missing documentation in the medical record for the changes that were scheduled during the month of the survey and the prior month.

F699 Trauma Informed Care

D The facility failed to ensure a resident received trauma-informed care in accordance with professional standards of practice and accounting for a resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for one resident. The Resident alleged that a CNA was verbally abusive. The facility requested the agency not send the CNA back to the facility. The facility did not complete a trauma informed care assessment after the allegation.

F700 Bedrails

E The facility failed to assess, care plan and obtain consent for the use of side rails in five residents. The residents had physician's orders for side rails for bed mobility or to promote independence. There was no documentation of an assessment, care plan or consent with the risks explained to the resident/resident representative. The facility did not complete quarterly side rail assessments for a period of nin months during 2022.

F710 Resident's Care Supervised by a Physician

G The facility failed to ensure that one resident's medical care was supervised by a physician. The facility's failure to monitor the resident's PT/INR lab results resulted in a critical value of the PT/INR and GI bleeding requiring hospitalization. The resident's blood specimen for a weekly PT/INR was rejected due to clotting. The facility did not redraw the test. The resident required a blood transfusion while in the hospital.

F732 Posted Nurse Staffing Information

B The facility failed to post daily staffing for one day reviewed. The posted staffing sheet was dated three days prior to the observation made by the surveyor.

F760 Residents Are Free of Significant Med Errors

E The facility failed to ensure residents were free from significant medication errors. Medications including anti-diabetic, anticonvulsant, anti-platelets, and cardiac medications were not administered as ordered for six residents. There were multiple occurrences of documentation on the MAR of "Code 9", medication unavailable or "Code 5", medication not in stock.

D The facility failed to ensure residents were free from significant medication errors for one resident. The resident's vital signs were not monitored and documented prior to the administration of Digoxin and Metoprolol.

F761 Label/Store Drugs & Biologists

E The facility failed to ensure medications were stored properly and secured. One staff member left the medication cart unlocked, unattended, and out of sight. Seven of eighteen medication storage areas had expired medications and had external and internal medications stored together. One medication was left at the bedside in a resident's room. The medication was identified as Cholestyramine oral suspension. Expired items identified were: Pulmocare supplement, Boost supplement, Glycerin swab sticks, heparin syringes, hydrogen peroxide, ointment, Silver Nitrate applicators, Iodine solution, antifungal cream, and Vitamin B-12. Insulin bottles were identified with opened dates of greater than 28 days. One bottle of Tuberculin Purified Protein was opened and undated. One medication cart had a heparin syringe in the same drawer as triple antibiotic ointment, batteries, scissors, keys, and goggles.

D The facility failed to ensure medications were properly stored and secured. The surveyor identified one medication cart that was unlocked, unattended and out of sight on one hall.

F812 Food Procurement Store/Prepare/Serve - Sanitary

L The facility failed to ensure food was stored, prepared, and served under sanitary conditions. The facility failed to maintain an effective pest control program as evidenced by live and dead roaches in the kitchen and in food preparation areas. The failure resulted in Immediate Jeopardy for the facility. During an observation and tour of the kitchen, the surveyor observed the following: no hot water and no trash can at the handwashing sink, the cover on the eye wash sprayer was broken off and missing, the walk-in refrigerator contained left over juices but were dated incorrectly according to the Dietary Manager. In the walk-in refrigerator the surveyor observed macaroni and cheese stored unsealed with a torn cover , cheese slices stored uncovered, four cooler bags stored next to food items, the air vent over the food prep area near the wash sink was noted as rusted with peeling paint, food residue was noted on the clean glassware, a spoon and food debris was noted in the handwashing sink, a dirty used glove was lying on the food prep area, the florescent light fixtures were noted to have multiple dead insects, the thermometer in the ice cream storage cooler was broken, there was an employee water bottle in the food prep area, and a live roach was seen crawling up the wall close to the ice cream storage cooler. In the dry storage area, there was a coffee cup containing a dried food substance, two jackets stored near the thickened water and plastic cups, seven of nine coolers were dirty, a serving dish and plastic bowls were stored on the floor, items stored on the top shelf above the fire line, a large amount of dust was on the vent and the sprinkler head, and the flour and corn meal bins were unsealed and open to air. A cell phone was lying on top of the food warmer, personal clothing items and accessories were in the food prep area, trays of apple cobbler in serving bowls were left on a rack, uncovered and opened to air in the food prep area, undated food items in the refrigerator, two coffee carafes had missing lids and were open to air, a staff member pushed an uncovered bin full of trash through the kitchen food prep area, trash was uncovered and overflowing onto the ground at the back door to the kitchen, mice/rat droppings were noted in the clean utensil drawer, the oven door and control dials were noted with a dark, dried food substance and dead roaches were identified behind the control dials, and multiple containers of expired milk was identified in the milk cooler. The Dietary Manager killed a roach with a paper towel in their ungloved hand and then proceeded, without handwashing, to remove the thermometer from the reach in cooler and wipe it on their soiled shirt. The dish room had orange/rusty areas around the floor base. There were multiple live roaches on the clean side of the dish table and on the plate warmer, dark and greasy debris was noted on the table under the flat top grill, equipment electrical boxes, and the back of the stove and the smoker and sink faucet handles. There was thick/dark debris behind the double oven, juice machine spouts had dried debris, the three-compartment sink drain was full with black flaky debris in the water, and dried food debris was observed on the back of the steam table. The walk-in cooler and the walk-in freezer had multiple food items that were unsealed, unlabeled, open to air and partially used. A live roach was noted crawling on the forehead of a surveyor.

F The facility failed to maintain a sanitary kitchen. The surveyor observed cooking pans stacked and stored wet in the kitchen.

D The facility failed to ensure food was served under sanitary conditions when three staff members failed to perform proper hand hygiene during meal service. The staff members touched furniture and other objects in residents' rooms prior to setting up their meal trays. The staff members failed to perform hand hygiene after touching the furniture and other items in the rooms and prior to setting up the meal trays.

F835 Administration

L The facility's Administration failed to manage its resources and operating budget to maintain an effective pest control program after an invoice was not paid to the pest control company which resulted in an interruption of services for a four-month period. There was an outbreak of pests in the kitchen. The leadership failed to address facility concerns resulting in Immediate Jeopardy.

K The facility Administration failed to provide oversight of staff to ensure adequate supervision for a safe environment and develop a root cause for one resident who eloped from the facility. The failure resulted in Immediate Jeopardy for the resident when the resident exited the facility through an unsecured door to an unsafe environment. The door did not have an alarm that sounded when the door failed to close and engage. The resident was found approximately 102 feet from the lobby door, sitting on the ground, legs entangled in the wheelchair, leaning against a tree. The facility staff were unaware the resident had exited the facility. A pizza delivery driver assisted the resident back into the facility, approximately twelve minutes after the resident exited. The resident was approximately 140 feet from an embankment to the street. The temperature outside was 35 degrees. The resident had a fractured rib as a result of the fall from the wheelchair. The resident had a history of exit seeking and previously resided on the secured unit. The resident had been relocated from the secured unit prior to the elopement. The facility Administration failed to ensure facility bowel elimination, the weight assessment and intervention and side rail assessment policies and procedures were implemented and failed to ensure physician's orders for weights and RD orders for nutritional supplements were followed.

F837 Governing Body

L The facility failed to produce evidence of an effective governing body and failed to manage its financial resources to ensure an effective pest control program was maintained. The failure resulted in Immediate Jeopardy for the facility when there was a four-month interruption of services from the pest control contractor and an outbreak of pests occurred in the kitchen.

F841 Responsibilities of Medical Director

F The facility failed to ensure Medical Director duties were coordinated to clearly delineate responsibilities of the facility's two Medical Directors. The facility's failure to implement and coordinate resident care created a conflict between the two Medical Directors and an environment which impaired the nursing staff to effectively provide patient care and services

F849 Hospice Services

D The facility failed to obtain the most recent Hospice plan of care for one resident. There was no documentation of hospice or a hospice care plan in the resident's record.

F867 QAPI/QAA Improvement Activities

K The QAPI Committee failed to ensure residents at risk for elopement received adequate supervision in a safe environment and failed to develop a plan that identified causative factors for the elopement of one resident. The failure resulted in Immediate Jeopardy for the resident when the resident exited the facility through an unsecured door to an unsafe environment. The door did not have an alarm that sounded when the door failed to close and engage. The resident was found approximately 102 feet from the lobby door, sitting on the ground, legs entangled in the wheelchair, leaning against a tree. The facility staff were unaware the resident had exited the facility. A pizza delivery driver assisted the resident back into the facility, approximately twelve minutes after the resident exited. The resident was approximately 140 feet from an embankment to the street. The temperature outside was 35 degrees. The resident had a fractured rib as a result of the fall from the wheelchair. The resident had a history of exit seeking and previously resided on the secured unit. The resident had been relocated from the secured unit prior to the elopement. The QAPI Committee failed to ensure facility bowel elimination, the weight assessment and intervention and side rail assessment policies and procedures were implemented and failed to ensure physician's orders for weights and RD orders for nutritional supplements were followed.

F921 Safe/Functional/Sanitary/Comfortable Environment

D The facility failed to maintain clean, comfortable, sanitary, and homelike conditions for two residents. The failure resulted in unsanitary conditions in resident rooms and bathrooms. The Housekeeping Supervisor confirmed a complaint regarding the conditions in one resident's room shortly after admission and determined the bathroom had not been adequately cleaned. The bathroom was cleaned in response to the complaint. The Administrator confirmed the complaint had been substantiated and corrective action taken. The surveyor observed another resident's room with floor stains and debris near the edges of the tiles near the walls and the floor was sticky. The bathroom was dirty with sticky floors, stained tile, fecal material on the toilet, and a brown/black ring around the entire circumference of the base of the commode. The conditions were unchanged 2 ½ hours later when showing the Administrator.

F925 Maintains Effective Pest Controls Programs

L The facility failed to maintain an effective pest control program. The failure resulted in Immediate Jeopardy for the facility after the facility had a four-month interruption of service from the pest control company resulting in an outbreak of pests in the kitchen area.

N1102 Records and Reports; Recording of Unusual Incidents

The facility failed to report allegations of abuse for two residents. Resident #1 alleged that a CNA was too rough, was mean to her and stated they were fearful of the CNA. A family member alleged that while speaking with Resident #2 on the phone, they heard someone start yelling at the resident and accusing them of calling too many times, after which Resident #2 began to cry. The CNAs were reassigned. One resident was relocated to another room. The DON confirmed that the incidents were not reported to the state and an investigation was not completed.

N1207 Resident Rights

The facility failed to treat the residents' personal clothing and items with respect by not returning clothing items timely after they were discharged for two residents. The facility failed to have an inventory of personal belongings for three residents. Resident #1 had a fur coat that was stored in the Social Services office. The facility rearranged the office, the coat was taken to storage and then was thrown away by mistake. Resident #2's personal belongings were located in the facility after the resident had discharged. The personal belongings were not returned to the resident. A Personal Inventory Form was not completed for the two residents and one additional resident on admission per the facility's policy.

N301 Disciplinary Procedures

The facility was found to be in violation of federal statues or rules and regulations. The facility was not in compliance with F689 due to the facility's failure to ensure a safe environment and provide adequate supervision for one resident. The facility's failure resulted in Immediate Jeopardy when one severely cognitively impaired resident exited the facility unsupervised when a visitor entered the building through the front door. The resident walked out of the door before it closed and was found by staff sitting on the front porch of the facility. The resident was unsupervised and out of the facility for approximately 58 minutes.

The facility was found to not be in substantial compliance with the federal regulations at 42 CFR 483, Requirements for Long Term Care Facilities. The facility's failure to manage it's resources and operating budget to maintain an effective pest control program after invoices were not paid to the pest control company resulted in an interruption of services from the pest control company for a four-month period. The interruption of pest control services resulted in an outbreak of pests. The outbreak was evidenced by the presence of live and dead cockroaches and mice or rats in the kitchen and food preparation areas. The facility failed to ensure food was stored, prepared, and served under sanitary conditions which had the potential to affect all residents of the facility. The facility's failure created a situation detrimental to the health, safety and welfare of residents in the facility.

N401 Administration

The facility's Administration failed to manage its resources and operating budget to maintain an effective pest control program after an invoice was not paid to the pest control company which resulted in an interruption of services for a four-month period. There was an outbreak of pests in the kitchen. The leadership failed to address facility concerns resulting in Immediate Jeopardy.

N424 Administration; Filed Documentation of Abuse Registries

The facility failed to ensure a safe environment with adequate supervision to prevent elopement/wandering behaviors. The facility's failure resulted in Immediate Jeopardy when one severely cognitively impaired resident exited the facility unsupervised when a visitor entered the building through the front door. The resident walked out of the door before it closed and was found by staff sitting on the front porch of the facility. The resident was unsupervised and out of the facility for approximately 58 minutes.

N622 Infection Control

The facility failed to maintain an effective pest control program. The failure resulted in Immediate Jeopardy for the facility after the facility had a four-month interruption of service from the pest control company resulting in an outbreak of pests in the kitchen area.

N645 Nursing Services

This is a Pending Type C Penalty #18. The facility failed to ensure the environment was safe and free of accident hazards when hazardous chemicals were left unattended in a resident's room. While touring the facility the surveyor observed a plastic bottle of yellow liquid on the resident's bedside table, unsecured and unattended by staff. The resident was in bed with the bedside table next to the bed. Three minutes after the observation, the surveyor observed the housekeeper enter the room and retrieve the bottle of yellow liquid. The housekeeper indicated the liquid was hydrogen peroxide cleaner. The housekeeper and the Administrator confirmed that housekeeping chemicals should be stored on the housekeeping cart under lock and key and should not be left unsecured and unattended in resident rooms.

N669 Nursing Services; Physician Notification

The facility failed to ensure the resident's physician was notified of a significant change in a resident who complained of leg pain and swelling due to her leg "getting tangled" in a Hoyer lift pad. The facility's investigation revealed a CNA identified the resident's leg was swollen when providing care at 2AM. The resident reported to the CNA that their leg got caught in the mechanical lift pad when taking a shower three days prior. The CNA notified the nurse who relayed the information to the oncoming shift the following morning. The day shift nurse documented the resident's leg was swollen and painful and notified the NP and the DON. The NP examined the resident after lunch and ordered an Xray. The Xray was positive for a fracture. The NP was notified and ordered the transfer of the resident to the hospital. The DON notified the Administrator. The hospital H&P indicated the resident reported the fracture occurred as a result of getting the leg caught in the Hoyer lift which was due to the CNA's rough handling and moving the resident too fast. The surveyor interviewed the NP, and the NP indicated the communication received regarding the resident's leg was provided in a non-urgent manner by entering the information into the communication book. The NP denied being aware of the residents' report of the fracture occurring as a result of injury during transfer with the mechanical lift. The NP and the facility Medical Director confirmed that notification should have been provided immediately instead of the communication book. The facility staff failed to timely notify the Administrator, DON, and NP of an injury to the resident's leg from the Hoyer lift.

The facility failed to ensure nursing staff applied a bilevel positive airway pressure (BiPAP) mask to a resident, failed to assess and document oxygen saturation levels and failed to notify the MD/NP when a resident who required oxygen therapy was found unresponsive and went into cardiac arrest. A note in the resident's medical record by OT indicated caregiver training was conducted and focused on proper positioning for the resident to increase lung capacity due to desaturation noted with lethargy. There was no documentation of the resident's vital signs including oxygen saturation on that day or the following day. A clinical note on the following day indicated the resident was found unresponsive, lips blue and did not respond to a sternal rub. EMS was notified and the resident was transferred to the hospital. There was no documentation of notification of the MD or NP and no documentation of oxygen saturation. The resident was pronounced dead at the hospital. An LPN indicated in an interview with the surveyor that they had noticed the BiPAP had a bad seal the night before the event and did not report it. The resident did not have BiPAP in place at the time of the transfer. The hospital transfer form was not completed by the agency nurse. The NP reported they were not notified of the desaturation and cardiac arrest. The Medical Director reported being made aware of the event at a later time.

N682 Nursing Services, Care Plan

The facility failed to develop and implement a person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs for one resident. The resident had alleged that a CNA was verbally abusive. The facility did not complete a trauma informed care assessment and did not revise the resident's psychosocial care plan.

N689 Nursing Services; Physical Restraints

The facility failed to follow a physician's order to obtain a weekly lab for medication monitoring for one resident. The resident had one weekly specimen (PT/INR) that was rejected by the lab due to clotting of the specimen rendering it unusable. The facility failed to ensure the lab was redrawn. The following week, the resident's PT/INR was at a critical value and contributed to GI Bleeding resulting in hospitalization for the resident.

The facility failed to ensure residents were free from significant medication errors. Medications including anti-diabetic, anticonvulsant, anti-platelets, and cardiac medications were not administered as ordered for six residents. There were multiple occurrences of documentation on the MAR of "Code 9", medication unavailable or "Code 5", medication not in stock.

N729 Pharmaceutical Services

This is a Type C Penalty #7. The facility failed to ensure medications were stored properly and secured. One staff member left the medication cart unlocked, unattended, and out of sight. Seven of eighteen medication storage areas had expired medications and had external and internal medications stored together. One medication was left at the bedside in a resident's room. The medication was identified as Cholestyramine oral suspension. Expired items identified were: Pulmocare supplement, Boost supplement, Glycerin swab sticks, heparin syringes, hydrogen peroxide, ointment, Silver Nitrate applicators, Iodine solution, antifungal cream, and Vitamin B-12. Insulin bottles were identified with opened dates of greater than 28 days. One bottle of Tuberculin Purified Protein was opened and undated. One medication cart had a heparin syringe in the same drawer as triple antibiotic ointment, batteries, scissors, keys, and goggles.

N766 Food and Dietetic Services; Freezer Temperature

The facility failed to ensure food was stored, prepared, and served under sanitary conditions. The facility failed to maintain an effective pest control program as evidenced by live and dead roaches in the kitchen and in food preparation areas. The failure resulted in Immediate Jeopardy for the facility. During an observation and tour of the kitchen, the surveyor observed the following: no hot water and no trash can at the handwashing sink, the cover on the eye wash sprayer was broken off and missing, the walk-in refrigerator contained left over juices but were dated incorrectly according to the Dietary Manager. In the walk-in refrigerator the surveyor observed macaroni and cheese stored unsealed with a torn cover , cheese slices stored uncovered, four cooler bags stored next to food items, the air vent over the food prep area near the wash sink was noted as rusted with peeling paint, food residue was noted on the clean glassware, a spoon and food debris was noted in the handwashing sink, a dirty used glove was lying on the food prep area, the florescent light fixtures were noted to have multiple dead insects, the thermometer in the ice cream storage cooler was broken, there was an employee water bottle in the food prep area, and a live roach was seen crawling up the wall close to the ice cream storage cooler. In the dry storage area, there was a coffee cup containing a dried food substance, two jackets stored near the thickened water and plastic cups, seven of nine coolers were dirty, a serving dish and plastic bowls were stored on the floor, items stored on the top shelf above the fire line, a large amount of dust was on the vent and the sprinkler head, and the flour and corn meal bins were unsealed and open to air. A cell phone was lying on top of the food warmer, personal clothing items and accessories were in the food prep area, trays of apple cobbler in serving bowls were left on a rack, uncovered and opened to air in the food prep area, undated food items in the refrigerator, two coffee carafes had missing lids and were open to air, a staff member pushed an uncovered bin full of trash through the kitchen food prep area, trash was uncovered and overflowing onto the ground at the back door to the kitchen, mice/rat droppings were noted in the clean utensil drawer, the oven door and control dials were noted with a dark, dried food substance and dead roaches were identified behind the control dials, and multiple containers of expired milk was identified in the milk cooler. The Dietary Manager killed a roach with a paper towel in their ungloved hand and then proceeded, without handwashing, to remove the thermometer from the reach in cooler and wipe it on their soiled shirt. The dish room had orange/rusty areas around the floor base. There were multiple live roaches on the clean side of the dish table and on the plate warmer, dark, and greasy debris was noted on the table under the flat top grill, equipment electrical boxes, and the back of the stove and the smoker and sink faucet handles. There was thick/dark debris behind the double oven, juice machine spouts had dried debris, the three-compartment sink drain was full with black flaky debris in the water, and dried food debris was observed on the back of the steam table. The walk-in cooler and the walk-in freezer had multiple food items that were unsealed, unlabeled, open to air and partially used. A live roach was noted crawling on the forehead of a surveyor.

N835 Building Standards; Approval of New Construction

The facility failed to get prior written approval from the Tennessee Health Facilities Commission before making alterations to the nursing home. The facility was operating as a secured facility with all exit doors equipped with maglocks and keypads that kept the facility locked down. The doors only open with keypad entry, fire alarm activation, or loss of power. The facility was not equipped with smoke detectors in the resident sleeping rooms. The Health Facilities Commission Plans Review office records revealed there was no record of approval for a secured facility.