Survey Deficiency Summary

18 Facilities Surveyed **Surveys Taken 5/5/23-6/30/23**

E004 Develop EP Plan, Review/Update Annually

D The facility failed to review and update the emergency preparedness plans annually. The EP plan, policies, evacuation agreements and risk assessment had not been updated since 2018.

F550 Resident Rights/Exercse of Rights

D The facility failed to ensure resident communication and access to persons and services outside the facility when a phone outage occurred at the facility. A family member of one resident attempted to reach the resident by phone and was unable to. The family member called the police for a wellness check. The family member stated the facility did not let anyone know that their phones were down.

F578 Request/Refuse/Discontinue Treatment;Formulate Adv Directives

D The facility failed to inform or provide written information regarding a resident's right to formulate an advance directive for twelve residents. None of the twelve residents had an advance directive upon admission. There was no documentation to indicate the resident or the resident's representative were informed of or provided with written information regarding their right to formulate an advance directive.

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

G The facility failed to notify the resident's physician and the resident's representative of a fall. The failure resulted in the delay of treatment for surgical repair of an acute right hip fracture causing actual harm to
the resident. The CNA responded to the resident's room and was gathering supplies to provide incontinence care for the resident. While the CNA was gathering the supplies, the resident attempted to stand at the bedside and fell back on his buttocks before the CNA was able to reach the resident. The resident was evaluated for injury and no injury was identified. The incident report indicated the resident denied pain and had no limitation in ROM. The nurse attempted to notify the physician by phone but was unsuccessful. The following day, the resident was noted with swelling and external rotation of the hip. The physician was notified and ordered an Xray. The Xray was positive for a hip fracture. The resident was transferred to the hospital and had surgery the following day. The resident's spouse stated she knew nothing about the fall until the day the resident was transferred to the hospital. The nurse who cared for the resident on the day the fracture was discovered reported not being informed in shift report of the resident's fall. The investigation revealed the resident had sustained prior falls and did not have appropriate interventions to prevent additional falls.

F583 Personal Privacy/Confidentiality of Records

D The facility failed to provide privacy during a treatment for one resident. The wound nurse performed wound care for the resident’s wounds on both lower legs. The nurse did not pull the privacy curtain or close the door before beginning wound care.

D The facility failed to maintain privacy and confidentiality of resident medical records for one resident. The surveyor observed the nurse leave the medication cart with an opened computer screen with the resident’s electronic medical record visible.

F584 Safe/Clean/Comfortable/Homelike Environment

E The facility failed to provide a safe, clean, and homelike environment for one resident. The facility failed to maintain the upkeep of painted walls in two hallways, failed to maintain the integrity and cleanliness of two specialty chairs. The facility failed to provide a safe, clean, and homelike environment in the dining room and in one shower room. The surveyor observed the following: the resident’s bathroom had dark brown debris around the baseboard, one working bulb in the bathroom light fixture, a gap between the AC unit and the wall in the resident’s room, scrapes along the bottom portion of the walls in two hallways, a specialty chair had a ripped armrest and another was observed to have non-adhesive gauze wrapped on the top of the left arm rest and the foam cushion had colored debris. A sit to stand transfer lift was in the hallway with white residue on the handles and copious amounts of brown residue on the floor plate, the shower room floor had debris and discoloration of the grout between the tiles, the lens of the light fixture was dangling and not affixed to the light fixture, the dry wall ceiling in the dining room was cracked for the entire length of the room, a retractable louvered panel from the kitchen to the dining room had thick residue, there was a gap between the counter plate of the access door and the cinder block wall.

F585 Grievances

D The facility failed to make prompt efforts to resolve grievances for missing personal belongings for two residents. Residents reported having missing personal belongings. The facility had made no effort to locate the items.

F600 Free from Abuse and Neglect

D The facility failed to prevent abuse for one resident. Two residents were involved in an altercation. One resident hit the other with their fist in the chest. The residents were separated. There were no injuries.

D The facility failed to prevent abuse for one resident. A resident was cursing at another resident. The other resident grabbed the resident’s arm and caused a bruise.

F609 Reporting of Alleged Violations

E The facility failed to report the investigative outcome within five working days of the alleged violation for three allegations of abuse. Residents #44 and #62 were involved in a verbal altercation when Resident #62 grabbed Resident #44 on their back and told them to shut-up. Resident #64 hit Resident #820 on the cheek without provocation. There was no documentation that the outcome of the facility's investigation was reported to the SSA within five working days. Resident #241 reported to his daughter that a nurse threw pudding on his clothing when giving his medications. There was no documentation that the facility had reported the findings of the investigation to the SSA within five working days of the alleged violation.

F610 Investigate/Prevent/Correct Alleged Violation

D The facility failed to investigate an allegation of abuse for one resident. A resident reported witnessing an act of abuse toward a resident by two staff members. The DON spoke with the resident who was allegedly abused but did not speak with the complainant. The resident denied being abused by staff to the DON and the DON did not investigate further. The Social Services Director did not investigate the complaint.

F625 Notice of Bed Hold Policy Before/Upon Transfer

D The facility failed to provide a written bed-hold notice to the resident and the resident's representative for five residents who had been hospitalized.

F640 Encoding/Transmitting Resident Assessments

D The facility failed to complete the MDS admission assessment within the required time frame. The assessment was completed and submitted seven weeks after the required time frame.

F641 Accuracy of Assessments

D The facility failed to accurately assess two residents for hospice. Both residents were under the care of a hospice agency but their most recent MDS was not coded for the residents having hospice care.

D The facility failed to accurately assess residents for bowel management and indwelling catheters for two residents. One resident's MDS did not have a rating to address bowel movements. The MDS Coordinator acknowledged the MDS was not coded correctly. The second resident had an indwelling urinary catheter. The resident's MDS was coded as "always incontinent of urine". The MDS was coded incorrectly for always being incontinent with indwelling foley catheter use.

F644 Coordination of PASARR and Assessments

D The facility failed to resubmit a PASRR after one resident had the addition of a new mental health diagnosis. The resident had a diagnosis of Psychotic Disorder with Delusions and Delusional Disorder added after admission.

F655 Baseline Care Plan

E The facility failed to provide an accurate baseline care plan for four residents. The baseline care plans were missing items such as care of a PICC line for two residents, a third resident's physician's dietary orders and a fourth resident's Accordion drain for drainage of an abscess.

F656 Develop/Implement Comprehensive Care Plan

G The facility failed to implement care plan interventions for use of the mechanical stand-up lift for one resident. The failure resulted in actual harm for the resident when the resident sustained a bruise to her right cheek following a transfer with the stand-up lift. The resident's care plan indicated two staff members were required to transfer the resident. When the accident causing the bruise occurred, the resident had been transferred with one staff member. The strap slipped off and hit the resident in the face. The DON was made aware the following day and in interview with the surveyor stated she did not get a statement from the staff member involved and did not know which staff member assisted the resident to transfer. When the staff member was interviewed, she stated she had not had any recent training on the use of the lift and there was no CNA care plan indicating the care instructions for the resident. The DON confirmed that their policy required two staff members to use the stand-up lift. The resident's care plan did not have any information regarding the resident's bruising.

E The facility failed to provide an accurate and revised comprehensive care plan for four residents. The first resident's care plan did not include interventions for the resident's NG tube, PICC line, and indwelling Foley catheter. The resident was only to have ice chips by mouth. The restriction was not included in the resident's care plan. Resident #2's care plan did not include interventions for the resident's anticoagulant therapy and dysphagia diet. Resident #3's care plan did not include interventions for the PICC line and the resident's IV antibiotic therapy. Resident #4's care plan did not include interventions for the resident's Accordion drain for drainage of an abscess.

D The facility failed to follow the comprehensive care plan for one resident. The resident had a care plan for two staff members to transfer with the mechanical lift. A CNA transferred the resident without any assistance per interview with the surveyor.

F657 Care Plan Timing and Revision

E The facility failed to revise and update the care plan to include fall interventions and communicate to staff the residents with a fall risk for seven residents. Resident #1 had two falls. There was no documentation of the first fall or interventions. An Xray conducted four days after the second fall showed a fractured ankle. The resident received non-surgical treatment. There was no revision to the care plan. The resident was observed without the boot that had been ordered for the affected foot/ankle. When the nurse noticed the resident wasn't wearing the boot, the nurse put it on the resident's foot incorrectly. Resident #2 had a fractured humerus. The physician ordered a sling to be worn. The care plan had no documentation of the sling. There was no communication to the staff that the sling should be worn by the resident. The resident had been assessed as high risk for falls. There was no communication to the staff or interventions for the fall risk. Resident #3 was assessed as high risk for falls. The resident sustained a fall and had no documentation of the fall or the interventions for the fall. The resident had an Xray of the right hand indicating the resident had degenerative joint disease. The DJD was not included in the resident's care plan. When a CNA was interviewed and asked by the surveyor how they determine a resident is at risk for falls, the CNA responded that nothing is written down and it is "hit or miss". Resident #5, #7 and #8 had falls. Their care plans were not updated to include interventions for the falls.

D The facility failed to update a care plan for one resident related to behavior. Facility documentation indicated the resident made inappropriate remarks toward staff and had impulse issues and sexual thoughts. The care plan was not updated with interventions for the inappropriate behaviors.

D The facility failed to have a care plan conference meeting with six residents or their representative. There was no documentation of a care plan conference for each quarter for the residents.

D The facility failed to conduct care plan meetings for three residents and failed to revise the care plan for one resident. The facility was unable to provide documentation that quarterly care plan meetings were held for the three residents. One resident with a significant weight loss did not have a care plan revision or intervention to address the weight loss.

D The facility failed to revise the comprehensive care plan for one resident with a pressure ulcer. The resident had physician's orders for a heel boot and for sure-prep drying skin protectant. Neither intervention was included on the resident's care plan.

F677 ADL Care Provided for Dependent Residents

D The facility failed to ensure two residents received their showers/bed baths per their schedule. Both residents were missing documentation of a bed bath or shower on multiple days over a three-month period prior to the survey.

F678 Cardio-Pulmonary Resuscitation (CPR)

J The facility failed to initiate CPR according to one resident's wishes. The resident was found on the floor unresponsive, without respirations. The resident's code status was full code. The facility failed to perform CPR for the resident. The failure resulted in Immediate Jeopardy. The resident was found on the floor beside her bed at shift change. EMS was notified and responded. Per interview with the EMS attendant, the resident was alone on the floor and did not have any staff members present. The nurse stated she was attempting to determine the resident's code status. The EMS attendant indicated CPR would not have been initiated due to the apparent extended length of time the resident had been expired. The EMS attendant reported when he questioned the facility regarding when the resident was last seen, they changed their response to at least four different time periods. The EMS reported the resident's pulse was checked and heart was checked for a rhythm. The resident was in asystole. In an interview, a CNA reported the nurse did not know what to do with the resident, was unsure of the resident's code status and could not locate the documentation.

F684 Quality of Care

D The facility failed to monitor blood glucose levels as prescribed for one resident. The resident was to have blood glucose monitoring four times per day. There were multiple days over four months prior to the survey with missed blood glucose results.

D The facility failed to ensure medication parameters were monitored in accordance with professional standards of practice for two residents. One resident was administered Metoprolol Tartrate by the nurse. The nurse did not check the resident's pulse prior to administration. When asked by the surveyor, the nurse stated the resident had no hold parameters ordered. The DON stated hold parameters would be required if ordered. The NP was interviewed and identified the parameters for holding the medication were ordered but were not transferred to the MAR. The second resident had an order for long-acting insulin at bedtime. The resident had no blood glucose parameters in the order and no sliding scale insulin ordered. The resident had a documented incident of a blood glucose level of 488 and no notification to the physician and no recheck. The information was not recorded on the facility 24-hour report sheet. When asked about the facility's protocol for hyperglycemia, the nurse stated they were to notify the doctor if over the indicated parameters. The nurse stated she failed to document the recheck of the blood sugar that was 488, failed to put it on the report sheet and failed to notify the physician. The surveyor requested a copy of the 24-hour report and noted the blood sugar reading of 488 had been added. The nurse stated she had been requested to add the information to the 24-hour report after it was questioned by the surveyor.

D The facility failed to follow a physician's order for the administration of oxygen for one resident. A resident who was having shortness of breath had an order to receive oxygen 5L/Nasal Cannula. The nurses progress notes indicated the resident was receiving 4L/Nasal Cannula.

- D The facility failed to follow physician’s orders for three residents. Resident #1 did not receive a Speech Therapy consult as ordered by the physician. Resident #2 had physician’s orders for one-to-one supervision for meals and oral care after meals. The CNA set up the resident’s meal tray and left the room, leaving the resident without the ordered one-to-one supervision. Resident #4 had physician’s orders for administration of an IV antibiotic every eight hours. The was a missed dose on one day.

F685 Treatment/Devices to Maintain Hearing/Vision

- D The facility failed to ensure proper treatment and assistive devices to maintain vision for one resident reviewed for a visual decline. The resident’s care plan included an intervention of “resident has impaired visual function. Arrange consultation with eye care practitioner as required. There was a physician’s order for an optometrist/ophthalmology consult. The resident did not get his vision checked.

F689 Free of Accident Hazards/Supervision/Devices

J The facility failed to maintain secure exits on two units resulting in the elopement of one resident, an ambulatory, cognitively impaired resident with a history of wandering. The failure placed the Resident in Immediate Jeopardy when the resident exited the facility through an alarmed door in which the alarm malfunctioned and did not sound. The resident then entered another wing of the facility undetected and proceeded to a delayed egress door with a malfunctioning magnetic locking system and exited the facility again. The resident was found by staff members outside in the rear of the facility within ten minutes of the last time she was seen inside the facility. The resident was assisted back into the building by staff members. The facility determined the alarmed door was in the off position and therefore did not alarm. The alarm was replaced with a switch that was super-glued into the on position to avoid future occurrences. The delayed egress door malfunctioned due to misalignment of the magnetic locking mechanism. When the resident was returned to the facility she was examined for injury and no injury was identified. The resident representative, the MD and the psychiatric NP were notified. No changes to the resident's medical regime were made. The resident was placed on one-to-one observation and then transitioned to every 15-minute checks for three days. The resident's path of egress was identified. The doors were secured. All other exits were checked with no irregularities identified. The door alarms and all other doors were checked by the Maintenance Director. The misalignment on the delayed egress door was corrected. A secondary alarm was added. A door contractor was contacted to evaluate the door. An ad hoc QA meeting was held with all department heads and facility leadership. A root cause analysis was initiated. Additional interventions to address all other residents potentially impacted were initiated. Corporate leadership was notified. Mandated reporting procedures were initiated, and interviews of all staff were completed. The resident's elopement risk assessment was updated. The care plan was reviewed and enhanced with additional interventions for wandering. Staff education was provided regarding the revised care plan. The resident's medications were reevaluated, and the medical record was reviewed. The resident was assessed by the MD. Elopement drills and in-service retraining was initiated regarding the missing resident procedure. Training was provided regarding the door alarms. Door alarm checks were initiated. Elopement risk assessments were completed on all other residents. Any residents at risk for elopement were added to the elopement risk book and additional care plan revisions were completed. All residents at risk for elopement were provided with yellow identification bands. Elopement drills were continued on all shifts for the week and included all shifts with continued training of staff regarding the facility policy and procedure for missing persons. Elopement drills were reduced to once per day. Door alarm checks continued. A second QAPI Committee meeting was held to review progress regarding corrective actions. Systemic measures implemented included replacement of the delayed egress door by the contractor. Offices for the activities therapy department and the Admission Coordinator were moved from the front of the building to increase monitoring/visibility of the unoccupied section of the building. Convex mirrors were installed near the nurses' station to improve visibility of the impacted door. Another convex mirror was ordered and installed on another wing. The QAPI Committee added the event to the agenda for follow up for the next three meetings. Staff were provided with portable radios. Stop signs and secondary audible alarms were added to facility exit doors. The facility altered its employee entrance/exit procedures. Staff were educated regarding the employee entrance/exit procedures. The facility was cited with

Past Noncompliance. A plan of correction was not required.

- G The facility failed to notify the resident's physician and the resident's representative of a fall. The failure resulted in the delay of treatment for surgical repair of an acute right hip fracture causing actual harm to
  the resident. The CNA responded to the resident's room and was gathering supplies to provide incontinence care for the resident. While the CNA was gathering the supplies, the resident attempted to stand at the bedside and fell back on his buttocks before the CNA was able to reach the resident. The resident was evaluated for injury and no injury was identified. The incident report indicated the resident denied pain and had no limitation in ROM. The nurse attempted to notify the physician by phone but was unsuccessful. The following day, the resident was noted with swelling and external rotation of the hip. The physician was notified and ordered an Xray. The Xray was positive for a hip fracture. The resident was transferred to the hospital and had surgery the following day. The resident's spouse stated she knew nothing about the fall until the day the resident was transferred to the hospital. The nurse who cared for the resident on the day the fracture was discovered reported not being informed in shift report of the resident's fall. The investigation revealed the resident had sustained prior falls and did not have appropriate interventions to prevent additional falls.
- G The facility failed to ensure staff were trained to use the mechanical lifts correctly and failed to conduct a thorough investigation following an accident with the stand-up lift. The facility failed to complete neuro checks after the accident involving the stand-up lift resulted in a strike to the resident's face. The failure resulted in actual harm to the resident when the resident sustained a bruise as a result of a transfer with the stand-up lift with one staff member. The resident's care plan indicated two staff members were required to transfer the resident. When the accident causing the bruise occurred, the resident had been transferred with one staff member. The strap slipped off and hit the resident in the face. The DON was made aware the following day and in an interview with the surveyor stated she did not get a statement from the staff member involved and did not know which staff member assisted the resident to transfer. When the staff member was interviewed, she stated she had not had any recent training on the use of the lift and there was no CNA care plan indicating the care instructions for the resident. The DON confirmed that their policy required two staff members to use the stand-up lift. The resident's care plan did not have any information regarding the resident's bruising.
- D The facility failed to investigate a fall for one resident. The resident was observed sitting on the floor three months prior to the survey. There was no documentation to indicate the fall was investigated. The nurse stated she did not investigate the fall because she did not consider it a fall since the resident stated he sat on the floor and the resident was not injured.

F690 Bowel/Bladder Incontinence Catheter, UTI

- D The facility failed to follow their policy to obtain a physician's order for an indwelling catheter for one resident and failed to include the bulb size in the physician's order for another resident with an indwelling urinary catheter. The facility was unable to locate a physician's order for the catheter for the first resident and the order for the second resident's indwelling urinary catheter did not include the bulb size.

- D The facility failed to have a physician's order for a urinary indwelling catheter, an assessment for removal of the catheter, and had nothing to demonstrate that the continued catheterization was necessary for two residents. One resident did not have an order for the indwelling catheter, did not have a plan for removal and had no documentation to support the continued need. Resident #2 did not have a plan of care to assess for removal of the catheter as soon as possible, voiding attempts per the urology consult, and had no documentation to support the continued need of the indwelling catheter.

F692 Nutrition/Hydration Status Maintenance

- D The facility failed to follow physician's orders for a therapeutic diet for one resident. The resident had an order for nectar thickened liquids. The resident was observed by the surveyor with a drink of regular consistency.
- D The facility failed to follow their own policy for monitoring weights for two residents. The first resident had a physician's order for monthly weights. The resident was not weighed in three of the six months prior to the survey. The second resident was to be weighed upon readmission to the facility. The weight was not obtained. The resident had a significant weight loss and was to have weekly weights. The weekly weights were not obtained.

F694 Parenteral/IV Fluids

- E The facility failed to follow professional standards of practice for infusing medications through a PICC line for three residents. The residents had no orders for the PICC lines, had no orders for the maintenance of the PICC line with flushes or dressing changes. One resident did not have an order for an IV antibiotic.

F695 Respiratory/Tracheostomy care and Suctioning

- D The facility failed to ensure one resident received appropriate respiratory and trach care. The facility did not have an emergency trach kit, an ambu bag or a suction machine at the bedside for the resident. The facility was to provide trach care every shift and was to monitor for signs and symptoms of respiratory distress. There was no documentation provided for either.

F757 Drug Regimen is Free From Unnecessary Drugs

- D The facility failed to adequately monitor for side effects or behaviors for one resident. The resident had signs and symptoms of depression and was receiving Remeron. There was no documentation of monitoring for the side effects of the drug or for behaviors.
- D The facility failed to monitor for side effects of antipsychotic medications for two residents. Neither resident had any documentation of monitoring for the side effects.

F761 Label/Store Drugs & Biologists

- D The facility failed to ensure medications were properly labeled and stored in one medication storage area. There was no documentation of monitoring of the drug refrigerator temperatures for a two-week period. An insulin pen did not have the resident's name or the expiration date of the pen.

F773 Lab Svs Physician Order/Notify of Results

D The facility failed to notify the physician of abnormal laboratory results for one resident. The physician ordered a BMP (Basic Metabolic Panel) and a CBC (Complete Blood Count) in order to obtain a baseline. The oncoming nurse was instructed to obtain the lab results as soon as possible and provide the results to the on-call MD/NP. The lab was ordered to be drawn STAT (Immediately). The results were high sodium, chloride, BUN, creatinine. There was no documentation to indicate the MD or NP was notified of the results. The NP stated in an interview with the surveyor that she was not notified of the results and if she had been, she would have ordered IV fluids. No results were provided to the NP or MD and no intervention was implemented. The resident required hospitalization two days later.

F800 Provided Diet Meets Needs of Each Resident

D The facility failed to maintain and serve hot food at or greater than 135 degrees for one meal. The hot food item temperatures were 129-130 degrees.

F803 Menus Meet Res Needs/Prep in Advance/Followed

D The facility failed to ensure food preferences and menu choices for two residents were honored. The two residents were observed with their meal trays. The trays did not contain the food selections the resident had made. Items from the list were missing.

F806 Resident Allergies, Preferences and Substitutions

D The facility failed to accommodate dietary preferences for five residents. The residents complained that they continued to receive items on their food tray that are specifically on their dislike list. Resident preferences for food items were not honored.

F812 Food Procurement Store/Prepare/Serve - Sanitary

F The facility failed to maintain a sanitary environment in the kitchen. The surveyor made the following observations: the stove, the convection oven, and the mobile steam tray cart had brown food debris. There was a copious amount of breadcrumbs beside two loaves of bread on the shelf of the mobile steam tray cart. The sugar bin was 1/3 full and a scoop was present on top of the sugar in the bin.

F The facility failed to ensure expired food items were discarded and failed to ensure food was properly stored in a walk-in freezer. In the freezer, one box of food was open to air and two boxes of food were touching the ceiling and blocking the sprinklers. Two loaves of bread had an expiration date of 14 days prior to the observation, and four packs of English muffins had an expiration date of three weeks prior to the observation. One package of English muffins was unsealed and open to air.

D The facility failed to maintain and clean the range hoods in the kitchen. The surveyor observed the range hood covered with clear and shiny debris.

F814 Dispose Garbage & Refuse Properly

D The facility failed to ensure garbage and refuse was properly contained. The dumpster had a large trash bag of refuse extending out the top of the dumpster.

F842 Resident Records - Identifiable Information

E The facility failed to maintain accurate medical records related to bed bath and/or shower documentation on three residents. There were multiple days over the three months prior to the survey that the three residents had no documentation of a bed bath and/or shower.

F880 Infection Prevention & Control

D The facility failed to maintain an effective infection control program for three residents. The facility's policy indicated that Legionella is included in their infection control surveillance activities and as part of the infection control program, all cases of pneumonia diagnosed 48 hours after admission are to be investigated for possible Legionnaire's disease. Three residents' chest Xray results were #1 a mild right lung base infiltrate, #2 Bibasilar pneumonia atelectasis and #3 Infiltrate right lung base could be acute or chronic. The Infection Control Surveillance data for all three residents was written as "Antibiotic, Treatment Pneumonia". The surveyor asked the Administrator if the facility had an effective Legionella surveillance and detection program. The Administrator stated "no". NOTE: The deficiency does not clearly state the deficient practice. A better understanding of the reason behind the facility's policy would be helpful for clarification.

D The facility failed to ensure appropriate hand hygiene practices were followed during meal service. A CNA was observed retrieving two meal trays from a cart and delivering to the residents without performing hand hygiene.

F908 Essential Equiptment, Safe Operating Condition

D The facility failed to ensure kitchen equipment was maintained in good repair in the kitchen. One can opener was observed with a frayed blade with the potential to introduce metal shards into the canned food.

K211 Alcohol Based Hand Rub Dispensers

D The facility failed to maintain the means of egress. The exit stair door was difficult to open and had to be forced open. The exit discharge sidewalk was obstructed by tables.

K222 NFPA 101 Egress Doors

D The facility failed to maintain the egress doors. There was no sign on the door stating "Push until alarm sounds. Door can be opened in 15 seconds" on one delayed egress door.

K321 Hazardous Areas; Enclosure

D The facility failed to maintain the hazardous area enclosures. The soiled linen room had a door gap of ¼ inch.

D The facility failed to protect the hazardous areas. The dry goods storage room door did not latch within the frame.

K324 Cooking Facilities

D The facility failed to protect the cooking facilities. The surveyor identified a louver (transfer grille) installed in the wall above the double doors to the kitchen at the service corridor.

K353 Sprinkler System; Testing and Maintenance

D The facility failed to maintain the sprinkler system. The facility was unable to provide documentation for the quarterly sprinkler inspections for the third and fourth quarters of 2022.

K521 HVAC

D The facility failed to maintain the HVAC system. The facility was unable to provide documentation of a four-year fire damper test.

N1216 Resident Rights

The facility failed to maintain privacy and confidentiality of resident medical records for one resident. The surveyor observed the nurse leave the medication cart with an opened computer screen with the resident's electronic medical record visible.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

The facility failed to conduct all required disaster drills. The facility could not provide documentation of an earthquake drill completed prior to March 2023.

N301 Disciplinary Procedures

The facility was found to be out of compliance with federal nursing home Conditions of Participation.

The facility failed to maintain compliance with the Federal LTC ROP on 5/26/23.

The facility was found out of substantial compliance with nursing home Conditions of Participation.

N421 Administration; Verification of Personnel Licensure

The facility failed to notify the resident's physician and the resident's representative of a fall. The failure resulted in the delay of treatment for surgical repair of an acute right hip fracture causing actual harm to
the resident. The CNA responded to the resident's room and was gathering supplies to provide incontinence care for the resident. While the CNA was gathering the supplies, the resident attempted to stand at the bedside and fell back on his buttocks before the CNA was able to reach the resident. The resident was evaluated for injury and no injury was identified. The incident report indicated the resident denied pain and had no limitation in ROM. The nurse attempted to notify the physician by phone but was unsuccessful. The following day, the resident was noted with swelling and external rotation of the hip. The physician was notified and ordered an Xray. The Xray was positive for a hip fracture. The resident was transferred to the hospital and had surgery the following day. The resident's spouse stated she knew nothing about the fall until the day the resident was transferred to the hospital. The nurse who cared for the resident on the day the fracture was discovered reported not being informed in shift report of the resident's fall. The investigation revealed the resident had sustained prior falls and did not have appropriate interventions to prevent additional falls.

N424 Administration; Filed Documentation of Abuse Registries

The facility failed to ensure staff were trained to use the mechanical lifts correctly and failed to conduct a thorough investigation following an accident with the stand-up lift. The facility failed to complete neuro checks after the accident involving the stand-up lift resulted in a strike to the resident's face. The failure resulted in actual harm to the resident when the resident sustained a bruise as a result of a transfer with the stand-up lift with one staff member. The resident's care plan indicated two staff members were required to transfer the resident. When the accident causing the bruise occurred, the resident had been transferred with one staff member. The strap slipped off and hit the resident in the face. The DON was made aware the following day and in an interview with the surveyor stated she did not get a statement from the staff member involved and did not know which staff member assisted the resident to transfer. When the staff member was interviewed, she stated she had not had any recent training on the use of the lift and there was no CNA care plan indicating the care instructions for the resident. The DON confirmed that their policy required two staff members to use the stand-up lift. The resident's care plan did not have any information regarding the resident's bruising.

The facility failed to maintain secure exits on two units resulting in the elopement of one resident, an ambulatory, cognitively impaired resident with a history of wandering. The failure placed the Resident in Immediate Jeopardy when the resident exited the facility through an alarmed door in which the alarm malfunctioned and did not sound. The resident then entered another wing of the facility undetected and proceeded to a delayed egress door with a malfunctioning magnetic locking system and exited the facility again. The resident was found by staff members outside in the rear of the facility within ten minutes of the last time she was seen inside the facility. The resident was assisted back into the building by staff members. The facility determined the alarmed door was in the off position and therefore did not alarm. The alarm was replaced with a switch that was super-glued into the on position to avoid future occurrences. The delayed egress door malfunctioned due to misalignment of the magnetic locking mechanism. When the resident was returned to the facility she was examined for injury and no injury was identified. The resident representative, the MD and the psychiatric NP were notified. No changes to the resident's medical regime were made. The resident was placed on one-to-one observation and then transitioned to every 15-minute checks for three days. The resident's path of egress was identified. The doors were secured. All other exits were checked with no irregularities identified. The door alarms and all other doors were checked by the Maintenance Director. The misalignment on the delayed egress door was corrected. A secondary alarm was added. A door contractor was contacted to evaluate the door. An ad hoc QA meeting was held with all department heads and facility leadership. A root cause analysis was initiated. Additional interventions to address all other residents potentially impacted were initiated. Corporate leadership was notified. Mandated reporting procedures were initiated, and interviews of all staff were completed. The resident's elopement risk assessment was updated. The care plan was reviewed and enhanced with additional interventions for wandering. Staff education was provided regarding the revised care plan. The resident's medications were reevaluated, and the medical record was reviewed. The resident was assessed by the MD. Elopement drills and in-service retraining was initiated regarding the missing resident procedure. Training was provided regarding the door alarms. Door alarm checks were initiated. Elopement risk assessments were completed on all other residents. Any residents at risk for elopement were added to the elopement risk book and additional care plan revisions were completed. All residents at risk for elopement were provided with yellow identification bands. Elopement drills were continued on all shifts for the week and included all shifts with continued training of staff regarding the facility policy and procedure for missing persons. Elopement drills were reduced to once per day. Door alarm checks continued. A second QAPI Committee meeting was held to review progress regarding corrective actions. Systemic measures implemented included replacement of the delayed egress door by the contractor. Offices for the activities therapy department and the Admission Coordinator were moved from the front of the building to increase monitoring/visibility of the unoccupied section of the building. Convex mirrors were installed near the nurses' station to improve visibility of the impacted door. Another convex mirror was ordered and installed on another wing. The QAPI Committee added the event to the agenda for follow up for the next three meetings. Staff were provided with portable radios. Stop signs and secondary audible alarms were added to facility exit doors. The facility altered its employee entrance/exit procedures. Staff were educated regarding the employee entrance/exit procedures. The facility was cited with

Past Noncompliance. A plan of correction was not required.

N682 Pharmaceutical Services; Storage of Medications

The facility failed to follow the comprehensive care plan for one resident. The resident had a care plan for two staff members to transfer with the mechanical lift. A CNA transferred the resident without any assistance per interview with the surveyor.

N688 Nursing Services; Restraints

The facility failed to ensure two residents received their showers/bed baths per their schedule. Both residents were missing documentation of a bed bath or shower on multiple days over a three-month period prior to the survey. One of the two residents was observed to have dried brown debris underneath their fingernails.

N689 Nursing Services; Physical Restraints

The facility failed to follow physician's orders for a therapeutic diet for one resident. The resident had an order for nectar thickened liquids. The resident was observed by the surveyor with a drink of regular consistency.

N752 Nursing Services; Therapeutic Diet

The facility failed to follow physician's orders for a therapeutic diet for one resident. The resident had an order for nectar thickened liquids. The resident was observed by the surveyor with a drink of regular consistency.

N768 Basic Services; Social Work Services

The facility failed to maintain and serve hot food at or greater than 135 degrees for one meal. The hot food item temperatures were 129-130 degrees.

N831 Building Standards

The facility failed to maintain the condition of the physical plant and the overall nursing home environment. The gate outside of the dining room exit had a magnetic lock requiring a key code to unlock it. The lock was installed without the approval of the Tennessee Health Facilities Commission.

The facility failed to maintain the physical plant. In a room occupied by two residents, the PTAC cover and control knobs were missing.

The facility failed to maintain the physical plant. There were penetrations in the one-hour fire rated ceiling that were not properly fire stopped in 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. There was a new smoke shed that had been constructed behind the nursing home. The shed was constructed of wood and was 5.5 feet from the building. A resident room was being used for storage. The Tennessee Health Facilities Commission had no record of approval of the smoke shed or the use of the room for storage.