Survey Deficiency Summary

7 Facilities Surveyed **Surveys Taken 8/7/23-9/27/23**

F550 Resident Rights/Exercse of Rights

E The facility failed to maintain and enhance the Resident's dignity and respect. Seven staff members failed to knock before entering resident rooms, one nurse stood while assisting a resident with their meal, one nurse failed to use the appropriate courtesy title for the resident by referring to them as a "feeder", and one nurse failed to provide privacy during insulin administration into the resident's abdomen. The resident was visible from the hallway.

D The facility failed to ensure nursing staff maintained the resident's dignity while providing care. The CNA violated the facility's cell phone policy which prohibited use of personal cell phones in residents' rooms and during resident care. The CNA videotaped a Resident and posted it on social media.

D The facility failed to ensure a resident's right to be treated with dignity and respect. The nurse failed to close the blinds of the resident's room while administering medications through the resident's PEG tube.

F584 Safe/Clean/Comfortable/Homelike Environment

D The facility failed to provide effective housekeeping services to maintain a sanitary environment. One resident was using a fan that was heavily coated with a thick layer of dust on the blades. The fan was blowing toward the resident. Another resident's room had brown stains on the floor from the resident's bathroom to the resident's bed. Another room had a strong odor.

F600 Free from Abuse and Neglect

D The facility failed to ensure one resident was free from abuse. The Resident and their spouse alleged a staff member snatched the resident's cell phone from his hand causing it to break. In an interview with the surveyor, the Social Services Director stated the Resident did not report that a staff member had broken the phone and it was only the spouse who made the allegation. The Social Services Director also reported that the facility had intended to replace the phone, however, due to the inconsistent reports, decided against replacing it. There were no statements taken from staff members regarding the incident. The issue was reported to the Administrator, but the Administrator was not informed of the allegation against a staff member.

D The facility failed to ensure a resident's right to be free from verbal and physical abuse. A CNA witnessed a resident's spouse smack the resident on the hand and witnessed the spouse yelling at the resident. The Social Services Director did not gather statements from staff or conduct an investigation after receiving the report from staff.

F609 Reporting of Alleged Violations

D The facility failed to timely report an allegation of abuse for one Resident. The Resident and their spouse alleged a staff member snatched the resident's cell phone from his hand causing it to break. In an interview with the surveyor, the Social Services Director stated the Resident did not report that a staff member had broken the phone and it was only the spouse who made the allegation. The Social Services Director also reported that the facility had intended to replace the phone, however, due to the inconsistent reports, decided against replacing it. There were no statements taken from staff members regarding the incident. The issue was reported to the Administrator, but the Administrator was not informed of the allegation against a staff member. The facility did not report the allegation of abuse to the State Survey Agency.

D The facility failed to report an allegation of abuse for one resident. A CNA witnessed a resident's spouse smack the resident on the hand and witnessed the spouse yelling at the resident. The Social Services Director did not gather statements from staff or conduct an investigation after receiving the report from staff. The allegation was not reported to the SSA.

F610 Investigate/Prevent/Correct Alleged Violation

D The facility failed to provide documentation of an investigation of an allegation of abuse and failed to ensure a thorough investigation was completed. The Resident and their spouse alleged a staff member snatched the resident's cell phone from his hand causing it to break. In an interview with the surveyor, the Social Services Director stated the Resident did not report that a staff member had broken the phone and it was only the spouse who made the allegation. The Social Services Director also reported that the facility had intended to replace the phone, however, due to the inconsistent reports, decided against replacing it. There were no statements taken from staff members regarding the incident. The issue was reported to the Administrator, but the Administrator was not informed of the allegation against a staff member.

D The facility failed to thoroughly investigate an allegation of abuse for one resident. A CNA witnessed a resident's spouse smack the resident on the hand and witnessed the spouse yelling at the resident. The Social Services Director did not gather statements from staff or conduct an investigation after receiving the report from staff.

F641 Accuracy of Assessments

D The facility failed to accurately assess residents for their BIMS score and pressure ulcers. Two residents were coded on the MDS as having unhealed pressure ulcers, but the number of pressure ulcers was left blank for both residents. Another resident was coded as "Yes" for conducting the BIMS interview, but the BIMS score was blank.

F644 Coordination of PASARR and Assessments

D The facility failed to resubmit a PASRR after the resident had the addition of new diagnoses of Delusions, Impulse Disorder and Dementia.

F657 Care Plan Timing and Revision

D The facility failed to conduct care plan meetings which included the Interdisciplinary Team (IDT) for one resident. Review of a care plan conference record from over a year prior to the survey revealed only the Activity Director, Dietary Manager and the Social Service Director signed as attending the meeting. There was no documentation of what was covered in the meeting. There were no other care plan meetings held for the Resident.

D The facility failed to conduct care plan meetings for one resident. The last care plan for the resident was held 17 months prior to the survey.

F658 Services Provided Meet Professional Standards

E The facility failed to report elevated fingerstick blood glucose test results to the physician in accordance with professional standards and facility policy for two residents. The facility's policy stated, "blood sugars found to be below 70 or above 400 will be reported immediately to the physician and the resident's representative". The two residents had blood sugars of greater than 400 on multiple dates during the six months prior to the survey. There was no documentation the physician was not notified although the nurses stated in interview the physician had been notified if parameters were in the physician's order.

F677 ADL Care Provided for Dependent Residents

E The facility failed to ensure that residents with bowel and bladder incontinence received incontinence care. Four residents were observed to be heavily saturated in urine and had not been provided with incontinence care for greater than four hours. The rooms had a strong urine odor. The residents were noted to be wearing two disposable diapers. One staff reported placing two diapers on the resident in case they didn't weren't able to get to the resident timely for incontinence care.

F684 Quality of Care

E The facility failed to follow physician's orders for wound/skin care as prescribed. Two Residents were observed without a dressing that had been ordered by the physician. Another Resident had no documentation of the application of a dressing on the day it was ordered. Another Resident's dressing was dated with a different date than what had been documented on the Resident's treatment record.

D The facility failed to administer medications as prescribed by the physician and as recommended for one resident. An incident report indicated the resident was administered the wrong dose of Valium on one occasion. The Resident's medication for Parkinson's Disease was transcribed incorrectly and the wrong dose was administered for approximately one month. There was no documentation of an evaluation by the MD after the errors were discovered.

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

D The facility failed to ensure weekly wound assessments were completed for two Residents reviewed for pressure ulcers. The first Resident's pressure ulcers were not assessed for six days after readmission from the hospital. The facility failed to document weekly reassessments of the wounds on multiple occasions. The second Resident had incomplete documentation of the wound assessment on the days the Resident was identified with wounds and on other occasions thereafter. There was no stage documented. The facility failed to document weekly reassessments on multiple occasions after they were identified.

F689 Free of Accident Hazards/Supervision/Devices

J The facility failed to ensure a safe environment to prevent serious injury and elopement for four residents. Resident #1 exited the elevator in a motorized wheelchair. The elevator floor was not level with the floor of the hallway causing the Resident to fall out of their wheelchair. The accident resulted in bilateral leg fractures. The resident later expired. Resident #2 fell to the floor in a wheelchair when exiting the unlevel elevator floor resulting in a fractured leg. The resident reported getting his foot caught in the elevator. Resident #6 fell when exiting the elevator and was uninjured. Staff reported the elevator had not been leveling and was at times several inches from the floor. Staff reported that maintenance was aware and would turn it off for a couple of days, correcting the problem temporarily. The Administrator reported having no knowledge of the malfunctioning elevator until after two falls had occurred. Resident #15, a cognitively impaired resident with a history of wandering and exit seeking behaviors eloped from the facility for an undetermined length of time and was found by the police when making routine rounds. The failure to provide a safe environment and failure to prevent elopement placed the four residents in immediate jeopardy. Resident #15's elopement risk assessment indicated low risk. The Resident had an order for a wanderguard. The Resident's care plan did not include any interventions for wandering or a wanderguard. The Resident's BIMS score was 10, moderate impairment. The Resident had documentation on two occasions indicating the resident was expressing a desire to leave the facility and the Resident had packed his clothes. On the date of the elopement, the Resident was found by the police outside, lying in the parking lot. The Resident was confused when escorted into the facility by the police. There were no injuries identified when assessed by the nurse. The nurses' notes indicated the Resident had made several attempts to elope during the day shift and was pacing the floor on the shift prior to the elopement. When the surveyor interviewed staff, the staff reported not hearing an alarm to indicate the Resident had exited the facility. The staff also reported the elopement book needed to be updated. When the surveyor interviewed the Administrator, the Administrator stated that not all staff were interviewed, a root cause was not identified, and the video surveillance was not available for viewing due to cloud storage issues. The Administrator did not see the Resident leave the building on the video when he had reviewed it. The intervention for the Resident was placement on the secured unit. All Residents were reassessed for elopement risk. The Unit Manager came to the facility the night it occurred and checked all doors and did a head count. There was no QAPI meeting to discuss or investigate what happened. The surveyor observed the door next to the time clock and noted the door to close slowly. In an interview with the Resident, the Resident reported exiting through an opened door. The Maintenance Tech reported the door has a 10-12 second delay for closure and if an employee doesn't pay attention, a Resident could get out through the door. The Maintenance Director reported being asked by the Administrator to "back date" a weekly wanderguard test and a door audit and also reported that he had provided the Administrator with a copy of the video surveillance on a jump drive.

F690 Bowel/Bladder Incontinence Catheter, UTI

D The facility failed to provide care and services for an indwelling urinary catheter for two Residents. While performing catheter care, the CNA failed twice to perform hand hygiene after doffing her gloves and prior to donning clean gloves and failed to anchor the catheter tubing. Another CNA was observed by the surveyor while performing catheter care. The CNA washed her hands for only 8 – 10 seconds twice during the procedure, failed to remove soiled gloves and don clean gloves prior to performing catheter care, and wiped back and forth with the same washcloth during catheter and incontinent care.

F755 Pharmacy Svcs/Procedures/Pharmacist/Records

D The facility failed to ensure that medication records were in order and that an account of all controlled medications was maintained and reconciled for five residents. The controlled medication count records did not match the actual number of controlled medications. The medications were not signed out on the count record when administered.

F760 Residents Are Free of Significant Med Errors

D The facility failed to ensure residents were free from significant medication errors. The nurse failed to obtain a pulse prior to administration of a beta blocker medication for high blood pressure. The order for the medication included an order to check the heart rate before the dose and hold if less than 50.

F761 Label/Store Drugs & Biologists

E The facility failed to ensure medications were properly stored and secured. One nurse left a resident's medications unattended at the resident's bedside while returning to the medication cart to mix one medication with water. There were multi-dose vials (Lidocaine and Insulin) that were opened without a date. There was a bottle of eye drops, and two inhalers that were not dated.

D The facility failed to ensure medications were properly stored when opened and undated medications and expired formula were observed in medication storage areas. There was one opened and undated box of Ipratropium Bromide and Albuterol Sulfate and one opened and undated bottle of Potassium Chloride. There were 250 cartons of expired Glucerna in the medication room. NOTE: Nutritional formulas are not medications and are not included in the regulation for storage of medications. There is no requirement to enter the date opened on a medication unless there is a specified shortened end of use date once the medication is opened i.e. multi-dose vials.

F790 Routine/Emergency Dental Services in SNFs

D The facility failed to provide dental services for one resident. The resident had no upper teeth. The Social Services Director did not ask the resident about dental or vision needs.

F812 Food Procurement Store/Prepare/Serve - Sanitary

E The facility failed to ensure food was served under sanitary conditions when five staff members failed to perform hand hygiene during meal services. The CNAs were observed touching environmental surfaces and/or positioning Residents without performing hand hygiene before setting up the Resident's trays. A CNA failed to perform hand hygiene after doffing soiled gloves and prior to donning clean gloves. One CNA touched a Resident's food with their bare hands and without performing hand hygiene.

E The facility failed to ensure food was served under sanitary conditions when two staff members failed to perform proper hand hygiene during meal service and failed to ensure temperatures for the nutrition freezers were documented daily in two nutrition refrigerators. The staff member touched multiple environmental surfaces with their bare hands and failed to perform hand hygiene prior to setting up the resident's meal tray. The same staff member failed to perform hand hygiene before pulling a resident's tray from the meal cart and failed to perform hand hygiene before setting up resident meal trays after assisting a resident to the bathroom and after positioning a resident in bed. Two nutrition refrigerators did not have a temperature log.

E The facility failed to ensure staff changed gloves and sanitized their hands while going back and forth from dirty to clean dishes. Two dietary staff members were observed in the dish room going from dirty to clean areas, then back to dirty, without changing gloves or washing their hands.

F835 Administration

J The facility Administration failed to provide oversight that ensured a safe environment and adequate supervision to prevent serious injuries, failed to ensure a QAPI process of data collection, analysis, interventions, monitoring and follow up, and failed to ensure the highest practicable well being of residents with wheelchair dependency, dementia and wandering behaviors. The facility Administrator failed to ensure the elevator functioned in a safe manner, failed to conduct a thorough investigation related to accidents/hazards involving the elevator and failed to ensure a safe environment to prevent injuries for four Residents. The failure resulted in Immediate Jeopardy for three Residents who fell from the malfunctioning elevator and one Resident who eloped from the facility.

F867 QAPI/QAA Improvement Activities

J The QAPI Committee failed to ensure systems and processes were in place and consistently followed by staff that address quality issues related to a safe environment and adequate supervision to prevent serious injuries. The QAPI Committee failed to implement and monitor effective safety interventions for four residents. The failure resulted in Immediate Jeopardy for three Residents who fell from the malfunctioning elevator and one Resident who eloped from the facility.

F880 Infection Prevention & Control

E The facility failed to ensure infection control practices to prevent the spread of infection were used when four staff members failed to perform hand hygiene during medication administration. Staff members failed to perform hand hygiene prior to preparing resident medications and prior to donning gloves and administering an insulin injection.

E The facility failed to ensure infection control practices to prevent the spread of infection were maintained when four nurses failed to perform hand hygiene during medication administration. The nurses failed to perform hand hygiene before donning gloves, after removing gloves, and prior to administering medications. One nurse touched the Resident's pill with her bare hands.

D The facility failed to ensure infection control practices to prevent the spread of infection were used when two nurses failed to perform hand hygiene during medication administration. One nurse failed to remove soiled gloves after touching environmental surfaces and proceeded to check for tube placement with her stethoscope and administer medications through the Resident's gastric tube. The nurse failed to clean the stethoscope after checking placement. Another nurse failed to perform hand hygiene after touching environmental surfaces and prior to administering a Resident's medication.

F925 Maintains Effective Pest Controls Programs

D The facility failed to maintain an effective pest control program. A fly was observed in the hallway and in two resident's rooms. A fly landed on a resident's forehead while the nurse was administering medications through the resident's PEG tube. Possible maggots were identified in one resident's wound.

K211 Alcohol Based Hand Rub Dispensers

F The facility failed to maintain the means of egress. Five of eight emergency egress doors in the facility had mesh netting across the doors that read "STOP".

D The facility failed to maintain the means of egress. The kitchen service hall was obstructed with food carts, wheelchairs and other miscellaneous storage. There was furniture blocking the egress door on one nursing unit.

K222 NFPA 101 Egress Doors

F The facility failed to ensure that all emergency egress doors and locking arrangements are in compliance with NFPA 101 Life Safety Code. The facility was operating as a secured facility. All but one emergency egress doors of the facility were equipped with mag-locks and keypads that kept the facility locked down. The facility is not equipped with smoke detectors in the resident sleeping rooms and the locked down areas are not constantly monitored. Tennessee Health Facilities Commission Plans Review had no record of the facility having approval to operate as a secured facility. The 15-second delayed egress front entrance door was missing the required 15-second delay signage.

D The facility failed to maintain egress doors. The front entrance delayed egress door was missing the required 15-second delayed egress signage. The hallway 15-second delayed emergency egress door failed to release upon fire alarm activation.

K223 Doors with Self-Closing Devices

D The facility failed to maintain doors with self-closing devices. The self-closing doors failed to self-latch in four areas when manually tested by the surveyor.

D The facility failed to maintain doors with self-closing devices. The 20-minute dietary storage door was not self-latching.

K324 Cooking Facilities

D The facility failed to maintain fire protection in the kitchen. The deep fryer was not centered under the fire suppression system nozzles.

K351 Sprinkler System; Installation

D The facility failed to install sprinklers in accordance with NFPA 13. The kitchen had intermixed sprinkler pendents, one quick response and six standard response. The surveyor observed a missing sprinkler escutcheon in the electrical room. The utility room had storage boxes obstructing the sprinkler pendent.

D The facility failed to meet sprinkler installation requirements. Two areas were missing sprinkler escutcheons.

K353 Sprinkler System; Testing and Maintenance

D The facility failed to maintain the sprinkler system. Four of eleven sprinklers in the kitchen were loaded with debris and grease.

K363 Corridor - Doors

D The facility failed to maintain doors that open to the corridor. Three self-closing corridor doors failed to positive latch when tested.

K511 Utilities - Gas and Electric

D The facility failed to install electrical wiring in accordance with NFPA 70. The surveyor observed a two-gang outlet box with two duplex receptacles installed at the nurses' station. The box was powered by a flexible cord installed through the back of the cabinets and plugged into a receptacle installed above the lay-in ceiling. The surveyor observed splices of electrical wires not contained within an electrical junction box and the wires powering the light were in contact with metal edges of the fixture box above the ceiling mount light fixtures in six locations.

K761 Maintenance, Inspection & Testing - Doors

D The facility failed to maintain all fire doors. Two 45-minute fire rated cross corridor doors would not close and latch. The rating labels had been removed from one cross corridor fire door.

D The facility failed to maintain fire rated doors. One leaf of a 3-hour fire door would not self-latch when tested.

K918 Electrical Systems - Essential Electric System
Maintenance and Testing

D The facility failed to maintain the generator. The facility failed to provide documentation of the annual load bank test for the diesel generator. There was no documentation since 2021.

K920 Electrical Equipment; Power Cords and Extension Cords

D The facility failed to maintain electrical equipment. There was an extension cord in use powering non-temporary equipment. There was a multi-plug adaptor in use in a resident's room.

K923 Gas Equipment - Cylinder and Container Storage
Container Storag

D The facility failed to maintain gas equipment. The surveyor observed intermixed full and empty oxygen cylinders in the central supply oxygen storage closet. Signage was designated for full tanks only.

K929 Gas Equipment Precautions for Handling Oxygen

D The facility failed to use precautions with oxygen cylinders. There were two unsecured oxygen cylinders in the oxygen closet.

N1102 Records and Reports; Recording of Unusual Incidents

The facility failed to timely report an allegation of abuse for one Resident. The Resident and their spouse alleged a staff member snatched the resident's cell phone from his hand causing it to break. In an interview with the surveyor, the Social Services Director stated the Resident did not report that a staff member had broken the phone and it was only the spouse who made the allegation. The Social Services Director also reported that the facility had intended to replace the phone, however, due to the inconsistent reports, decided against replacing it. There were no statements taken from staff members regarding the incident. The issue was reported to the Administrator, but the Administrator was not informed of the allegation against a staff member. The facility did not report the allegation of abuse to the State Survey Agency.

The facility failed to report an allegation of abuse for one resident. A CNA witnessed a resident's spouse smack the resident on the hand and witnessed the spouse yelling at the resident. The Social Services Director did not gather statements from staff or conduct an investigation after receiving the report from staff. The allegation was not reported to the SSA.

N1201 Resident Rights; Privacy in Treatment

The facility failed to maintain and enhance the Resident's dignity and respect. Seven staff members failed to knock before entering resident rooms, one nurse stood while assisting a resident with their meal, one nurse failed to use the appropriate courtesy title for the resident by referring to them as a "feeder", and one nurse failed to provide privacy during insulin administration into the resident's abdomen. The resident was visible from the hallway.

The facility failed to ensure nursing staff maintained the resident's dignity while providing care. The CNA violated the facility's cell phone policy which prohibited use of personal cell phones in residents' rooms and during resident care. The CNA videotaped a Resident and posted it on social media.

The facility failed to ensure a resident's right to be treated with dignity and respect. The nurse failed to close the blinds of the resident's room while administering medications through the resident's PEG tube.

N1207 Resident Rights

The facility failed to ensure one resident was free from abuse. The Resident and their spouse alleged a staff member snatched the resident's cell phone from his hand causing it to break. In an interview with the surveyor, the Social Services Director stated the Resident did not report that a staff member had broken the phone and it was only the spouse who made the allegation. The Social Services Director also reported that the facility had intended to replace the phone, however, due to the inconsistent reports, decided against replacing it. There were no statements taken from staff members regarding the incident. The issue was reported to the Administrator, but the Administrator was not informed of the allegation against a staff member.

The facility failed to ensure a resident's right to be free from verbal and physical abuse. A CNA witnessed a resident's spouse smack the resident on the hand and witnessed the spouse yelling at the resident. The Social Services Director did not gather statements from staff or conduct an investigation after receiving the report from staff.

N301 Disciplinary Procedures

The facility failed to maintain compliance with federal regulations.

N424 Administration; Filed Documentation of Abuse Registries

The facility failed to ensure a safe environment to prevent serious injury and elopement for four residents. Resident #1 exited the elevator in a motorized wheelchair. The elevator floor was not level with the floor of the hallway causing the resident to fall out of their wheelchair. The accident resulted in bilateral leg fractures. The resident later expired. Resident #2 fell to the floor in a wheelchair when exiting the unlevel elevator floor resulting in a fractured leg. The resident reported getting his foot caught in the elevator. Resident #6 fell when exiting the elevator and was uninjured. Staff reported the elevator had not been leveling and was at times several inches from the floor. Staff reported that maintenance was aware and would turn it off for a couple of days, correcting the problem temporarily. The Administrator reported having no knowledge of the malfunctioning elevator until after two falls had occurred. Resident #15, a cognitively impaired resident with a history of wandering and exit seeking behaviors eloped from the facility for an undetermined length of time and was found by the police when making routine rounds. The failure to provide a safe environment and failure to prevent elopement placed the four residents in immediate jeopardy. Resident #15's elopement risk assessment indicated low risk. The Resident had an order for a wanderguard. The Resident's care plan did not include any interventions for wandering or a wanderguard. The Resident's BIMS score was 10, moderate impairment. The Resident had documentation on two occasions indicating the resident was expressing a desire to leave the facility and the Resident had packed his clothes. On the date of the elopement, the Resident was found by the police outside, lying in the parking lot. The Resident was confused when escorted into the facility by the police. There were no injuries identified when assessed by the nurse. The nurses' notes indicated the Resident had made several attempts to elope during the day shift and was pacing the floor on the shift prior to the elopement. When the surveyor interviewed staff, the staff reported not hearing an alarm to indicate the Resident had exited the facility. The staff also reported the elopement book needed to be updated. When the surveyor interviewed the Administrator, the Administrator stated that not all staff were interviewed, a root cause was not identified, and the video surveillance was not available for viewing due to cloud storage issues. The Administrator did not see the Resident leave the building on the video when he had reviewed it. The intervention for the Resident was placement on the secured unit. All Residents were reassessed for elopement risk. The Unit Manager came to the facility the night it occurred and checked all doors and did a head count. There was no QAPI meeting to discuss or investigate what happened. The surveyor observed the door next to the time clock and noted the door to close slowly. In an interview with the Resident, the Resident reported exiting through an opened door. The Maintenance Tech reported the door has a 10-12 second delay for closure and if an employee doesn't pay attention, a Resident could get out through the door. The Maintenance Director reported being asked by the Administrator to "back date" a weekly wanderguard test and a door audit and also reported that he had provided the Administrator with a copy of the video surveillance on a jump drive.

N611 Physician Services; Dental Services

The facility failed to provide dental services for one resident. The resident had no upper teeth. The Social Services Director did not ask the resident about dental or vision needs.

N622 Infection Control

The facility failed to maintain an effective pest control program. A fly was observed in the hallway and in two resident's rooms. A fly landed on a resident's forehead while the nurse was administering medications through the resident's PEG tube. Possible maggots were identified in one resident's wound.

N629 Infection Control; Disinfect Contaminated Items

The facility failed to provide effective housekeeping services to maintain a sanitary environment. One resident was using a fan that was heavily coated with a thick layer of dust on the blades. The fan was blowing toward the resident. Another resident's room had brown stains on the floor from the resident's bathroom to the resident's bed. Another room had a strong odor.

N640 Infection Control

The facility failed to ensure infection control practices to prevent the spread of infection were used when two nurses failed to perform hand hygiene during medication administration. One nurse failed to remove soiled gloves after touching environmental surfaces and proceeded to check for tube placement with her stethoscope and administer medications through the Resident's gastric tube. The nurse failed to clean the stethoscope after checking placement. Another nurse failed to perform hand hygiene after touching environmental surfaces and prior to administering a Resident's medication.

The facility failed to ensure infection control practices to prevent the spread of infection were used when four staff members failed to perform hand hygiene during medication administration. Staff members failed to perform hand hygiene prior to preparing resident medications and prior to donning gloves and administering an insulin injection.

N645 Nursing Services

The facility failed to ensure the building was kept in good repair and safe at all times for three residents. Three Residents fell from the malfunctioning elevator resulting in fractures for two of the three residents. Staff reported the elevator had not been leveling and was at times several inches from the floor. Staff reported that maintenance was aware and would turn it off for a couple of days, correcting the problem temporarily. The Administrator reported having no knowledge of the malfunctioning elevator until after two falls had occurred.

N682 Pharmaceutical Services; Storage of Medications

The facility failed to conduct care plan meetings which included the Interdisciplinary Team (IDT) for one resident. Review of a care plan conference record from over a year prior to the survey revealed only the Activity Director, Dietary Manager and the Social Service Director signed as attending the meeting. There was no documentation of what was covered in the meeting. There were no other care plan meetings held for the Resident.

N689 Nursing Services; Physical Restraints

The facility failed to administer medications as prescribed by the physician and as recommended for one resident. An incident report indicated the resident was administered the wrong dose of Valium on one occasion. The Resident's medication for Parkinson's Disease was transcribed incorrectly and the wrong dose was administered for approximately one month. There was no documentation of an evaluation by the MD after the errors were discovered.

The facility failed to follow physician's orders for wound/skin care as prescribed. Two residents were observed without a dressing that had been ordered by the physician. Another resident had no documentation of the application of a dressing on the day it was ordered. Another resident's dressing was dated with a different date than what had been documented on the resident's treatment record.

N692 Nursing Services; Abnormal Food Intake Recorded

The facility failed to ensure that residents with bowel and bladder incontinence received incontinence care. Four residents were observed to be heavily saturated in urine and had not been provided with incontinence care for greater than four hours. The rooms had a strong urine odor. The residents were noted to be wearing two disposable diapers. One staff reported placing two diapers on the resident in case they didn't weren't able to get to the resident timely for incontinence care.

N727 Pharmaceutical Services

The facility failed to ensure medications were properly stored and secured. One nurse left a resident's medications unattended at the resident's bedside while returning to the medication cart to mix one medication with water.

N766 Food and Dietetic Services; Freezer Temperature

The facility failed to ensure food was served under sanitary conditions when five staff members failed to perform hand hygiene during meal services. The CNAs were observed touching environmental surfaces and/or positioning Residents without performing hand hygiene before setting up the Resident's trays. A CNA failed to perform hand hygiene after doffing soiled gloves and prior to donning clean gloves. One CNA touched a Resident's food with their bare hands and without performing hand hygiene.

The facility failed to ensure food was served under sanitary conditions when two staff members failed to perform proper hand hygiene during meal service and failed to ensure temperatures for the nutrition freezers were documented daily in two nutrition refrigerators. The staff member touched multiple environmental surfaces with their bare hands and failed to perform hand hygiene prior to setting up the resident's meal tray. The same staff member failed to perform hand hygiene before pulling a resident's tray from the meal cart and failed to perform hand hygiene before setting up resident meal trays after assisting a resident to the bathroom and after positioning a resident in bed. Two nutrition refrigerators did not have a temperature log.

The facility failed to ensure staff changed gloves and sanitized their hands while going back and forth from dirty to clean dishes. Two dietary staff members were observed in the dish room going from dirty to clean areas, then back to dirty, without changing gloves or washing their hands.

N831 Building Standards

The facility failed to maintain the physical plant. The surveyor observed penetrations through the one-hour fire rated gypsum board ceiling that were not firestopped with an approved fire stop system in five locations.

The facility failed to maintain the physical plant. Penetrations in the one-hour fire rated ceiling assemblies were identified without approved firestop systems in six locations.

The facility failed to maintain the physical plant. The surveyor identified six areas with penetrations in the one-hour fire rated ceiling assemblies that were not fire-stopped with approved firestop systems.

The facility failed to maintain the physical plant. The surveyor observed penetrations in the one-hour fire rated assembly in three locations that were not fire stopped with approved fire stop systems.

N835 Building Standards; Approval of New Construction

The facility failed to get written approval from the Tennessee Health Facilities Commission before making alterations to the Nursing Home. The facility was operating as a secured facility. The Health Facilities Commission Plans Review had no record of the facility having approval to operate as a secured facility. The facility also failed to get approval to use five rooms as storage rooms.

The facility failed to notify Tennessee Health Facilities Commission Plans Review before making alterations to the nursing home. The MDS office bathroom was being used as a storage room.

N848 Building Standards; Exhaust & Air Pressure

The facility failed to maintain negative air pressure in required areas. The janitor’s closet had an exhaust fan that failed to maintain negative air pressure.