# Survey Deficiency Summary

**23 Facilities Surveyed** **Surveys Taken 8/16/23-11/15/23**

**E006 Plan Based on All Hazards Risk Assessment**

D The facility failed to ensure the emergency preparedness plan was based on, and included, a facility-based and community-based risk assessment using an all-hazards approach including missing residents. The facility was unable to provide documentation of a risk assessment using an all-hazards approach that included missing residents.

**F550 Resident Rights/Exercse of Rights**

D The facility failed to promote care that maintained a resident's dignity, respect, and quality of care when staff failed to provide a privacy bag for one resident with an indwelling urinary catheter. The resident was noted in bed with the urinary catheter collection bag hanging on the right side of the bed, not covered and visible from the open door.

D The facility failed to maintain or enhance resident dignity and respect. Four staff members observed during dining failed to use courtesy titles to address residents, failed to provide privacy while assisting with dining and stood over residents while assisting with dining. Staff members referred to residents as "honey", "sweetheart" and "baby". Staff failed to knock on the door and announce themselves before entering a resident's room. All staff failed to pull the privacy curtain or shut the resident's door to ensure privacy while assisting the resident with their meal. One staff member stood over a resident while assisting the resident with their meal. The DON confirmed in interview the residents should be provided with privacy while staff were assisting with their meal by pulling the curtain. NOTE: Privacy while dining or while being assisted with dining is not a standard of care and is an uncommon finding in deficiencies cited under F550, Resident Dignity.

D The facility failed to maintain and enhance resident's dignity and respect when one nurse failed to provide privacy for a resident when providing wound care. The resident's buttocks were exposed to a window without the blinds closed. There was a resident sitting outside the window in the courtyard.

D The facility failed to ensure respect and dignity was maintained for one resident. The resident primary language was Spanish, and the resident did not understand English. The staff members did not have an effective method to communicate with the resident resulting in frustration for the resident. The translation device provided by the facility was not operable according to staff. Activities did not provide an effective language board and activity calendars were not provided in Spanish. The staff primarily communicated with the resident by pointing toward objects.

D The facility failed to maintain or enhance resident dignity and respect when three staff members failed to knock and/or announce themselves before entering a room, failed to use courtesy titles, and referred to residents as feeders.

**F565 Resident/Family Group and Response**

D The facility failed to provide privacy during one meeting with active Resident Council members. Four staff members were present in the dining room while the meeting was taking place. The Activities Director was seated in her office, adjacent to the dining room, with the door open throughout the meeting.

**F569 Notice and Conveyance of Personal Funds**

F The facility failed to convey resident's funds and failed to have a final accounting of the funds for residents who were discharged, evicted, or expired within 30 days for sixty residents. All sixty residents were still owed a refund by the facility.

D The facility failed to refund five residents' trust accounts within 30 days of discharge. The Administrator stated the refunds were handled by the corporate office and it was an ongoing issue. Refunds were made up to 297 days after discharge.

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

J The facility failed to notify and consult with the physician related to a change in condition after an unwitnessed fall for one resident. The facility's failure to notify and consult the resident's physician to obtain additional orders for immediate care and potential interventions resulted in Immediate Jeopardy. The Resident was found in the floor beside the bed. Staff placed the resident back into the bed without an assessment for injury and did not consult with the physician for further evaluation. There was no documentation of an unwitnessed fall and no documentation of increased pain prior to obtaining X-ray results that were positive for a fracture. The nurse reported that when the staff placed the resident back in the bed immediately after the fall, the resident cried out, but that was normal for the resident. The nurse denied completing an assessment for injury. The resident had symptoms of facial grimacing, moaning, and increased yelling out with movement, the week following the fall. The physician and family were not notified nor was the physician consulted for five days after the fall. Staff obtained an order for an X-ray for bruising and swelling of the resident's thigh and knee. The X-ray was positive for a femur fracture. The DON did not investigate the fall for an additional two days.

D The facility failed to notify a resident's physician and family of a change in condition. The resident had an episode of vomiting in the evening of the second day following readmission from the hospital. Approximately two hours later, the CNA informed the nurse of abnormal vital signs. Messages were left for the family. After returning to the room, the resident was found with no vital signs. The resident's physician and family were not notified when the resident had the episode of vomiting.

D The facility failed to notify the resident's representative and the physician for falls involving two residents and failed to notify the resident's representative for weight loss and a respiratory illness for one resident, and sexual abuse of four residents.

**F600 Free from Abuse and Neglect**

J The facility failed to ensure a resident's right to be free from neglect. The facility's failure resulted in Immediate Jeopardy when the Resident developed a temperature of 106.7 degrees F, a heart rate of 131, a blood glucose of 600. The facility contacted the Post-Acute Care Network, Virtual Rapid Response Telecommunication, and the resident was not transferred to a higher level of care for evaluation of a medical emergency. A head-to-toe assessment was not documented as being performed by the facility or the VRRT, and there was no documented assessment by the primary care physician until the third day, on which the resident died. There was no documentation or evidence that the facility had an RN in the facility 24 hours a day for seven days per week as required per the facility's agreement "SNF Post-Acute Network Participation Agreement). There was no documentation that the Resident had been hospitalized in the 30 days prior to the event. A late entry nurses note documented the resident's vital signs, signs and symptoms and actions taken. There was no documentation that the resident was assessed by the skilled nurse. There was no documentation that the resident was assessed for a higher level of care during the VRRT call, in accordance with VRRT Recommendation Standard of Practice policy/agreement. There was no documentation that the resident was visualized during the VRRT call and there was no documentation of a virtual assessment during the VRRT call. There was no documentation indicating the resident was assessed by a facility RN and no documentation to indicate the resident was assessed or evaluated by a qualified practitioner to determine if the resident needed a higher level of care or could be treated in the facility for the medical emergency of hyperpyrexia. There was no documentation of the resident's vital signs every 30 minutes for three hours then once every four hours for 24 hours in accordance with the policy/protocol/agreement. There was no documentation to indicate the resident was reassessed to determine if the resident was responding to treatment or failed to respond to treatment, requiring a transfer to the hospital. The resident was administered IV antibiotics, IV solution and a one-time dose of Regular insulin. The nurse documented that the MD was updated but there was no documentation of the specific information that was provided to the MD. In an interview, staff reported to the surveyor of having felt upset that the resident was not sent to the hospital and "management" did not want the resident sent out.

J The facility failed to protect a resident's right to be free from abuse and neglect for one resident. The facility failed to provide the necessary structure and processes to meet the care needs of one resident following a fall from a bed with an air mattress. In an interview with the surveyor, the staff reported the mattress was overinflated when the resident fell, and the DON stated the resident should not have been placed back on a faulty mattress after the fall. The resident's care plan was not updated to include safety interventions related to use of an air mattress including ensuring the proper inflation was maintained to prevent pressure wounds or worsening of wounds, to ensure correct positioning in the center of the mattress to prevent slipping from the edge of the mattress during pressure changes, or to ensure proper use of linens to prevent shearing injuries. The resident had an unwitnessed fall from the bed with the air mattress resulting in a fractured femur and Immediate Jeopardy for the resident. The Resident was found in the floor beside the bed. Staff placed the resident back into the bed without an assessment for injury and did not consult with the physician for further evaluation. There was no documentation of an unwitnessed fall and no documentation of increased pain prior to obtaining X-ray results that were positive for a fracture. The nurse reported that when the staff placed the resident back in the bed immediately after the fall, the resident cried out, but that was normal for the resident. The nurse denied completing an assessment for injury. The resident had symptoms of facial grimacing, moaning, and increased yelling out with movement, the week following the fall. The physician and family were not notified nor was the physician consulted for five days after the fall. Staff obtained an order for an X-ray for bruising and swelling of the resident's thigh and knee. The X-ray was positive for a femur fracture. The DON did not investigate the fall for an additional two days.

J The facility failed to prevent nonconsensual sexual contact between Resident #1 and three Residents. A CNA observed Resident #1 and Resident #2 together while Resident #1 was attempting to remove the brief from Resident #2. Resident #2 was resisting the advances. The CNA left the residents alone while going to get assistance to remove Resident #1. The CNA failed to protect Resident #2 from further nonconsensual sexual contact. The nursing staff failed to provide interventions and within four hours, Resident #1 was observed touching Resident #3's genital area. Nursing staff failed to intervene appropriately and within two hours, Resident #1 had nonconsensual sexual contact with Resident #4 by grabbing the Resident and kissing the resident with an open mouth followed by licking Resident #4's face. The facility's failure to prevent Resident #1's continued aggressive sexual behavior placed Residents #2, #3 and #4 in Immediate Jeopardy. Resident #1 had a history of inappropriate sexual contact with other residents. The Social Services Director stated they had not been asked to evaluate the capacity for Resident #2, #3 and #4 to consent to sexual activity and stated the residents had cognitive impairments that would prevent them from being able to consent to sexual contact. The facility failed to ensure two Residents (#5 and #6) were free from verbal abuse. Resident #5 had been served his breakfast tray by a CNA. The CNA left the room, and the resident pressed the call light to request coffee. The resident reported the CNA spoke to him in a mean voice and is not polite. Another resident reported asking the same CNA if they could empty his bag and the CNA responded in a mean tone of voice, "can't you do that yourself?". The CNA had an inappropriate conversation with another CNA in the presence of the resident. The resident reported feeling intimidated and angry.

J The facility failed to ensure two residents were not physically abused. The failure resulted in Immediate Jeopardy for Resident #1 and Resident #2 when a RN physically struck Resident #1 and forcefully took him down to the ground and when Resident #3 physically struck Resident #2 multiple times in the jaw and neck resulting in a lacerated lip. Resident #2 and #3 had a known history of previous verbal altercations and one prior physical altercation. Resident #1 had documentation indicating a fixation on leaving the facility, changes in demeanor, increased facial expressions and speaking with a louder voice. There was no documentation indicating the resident's changes in demeanor and fixation on leaving the facility had been addressed. Another clinical note indicated the resident had attempted multiple times to leave the facility. There was no documentation of interventions to deescalate the resident or address the attempts to leave the facility. A clinical note indicated the resident had an altercation with an RN staff member and was not injured but was sent to the ER for evaluation. Staff interviewed regarding the incident indicated the Resident had repetitive questioning regarding wanting to go home. The RN spoke with him, and the Resident became more agitated, the RN punched the Resident in the face, then "bear hugged" him and threw him to the floor. Once on the floor, the RN's forearm was across the Resident's neck. The RN did not have a job description. There was no orientation or training provided to the RN regarding the Resident population. The RN had no training regarding responding to residents with aggressive behaviors. Resident #2 had a care plan for verbal and physical behavioral symptoms directed toward others and entries in the medical record indicating the resident was having verbal altercations with other residents and staff. Resident #3 had a care plan and entries indicating a history of verbal behaviors including racial remarks toward another resident. Residents #2 and #3 had a history of altercations and name calling towards each other with one notation of Resident #2 striking Resident #3 on the back. An entry in the medical record indicated the residents had another altercation and were separated but left unsupervised. This was followed by Resident #3 approaching Resident #2 and hitting Resident #2 several times in the face resulting in a laceration of the lip for Resident #2. The Corporate Director reported the facility monitored behaviors for the residents but did not look at them overall for tracking and trending. The facility did not have an effective method to communicate specific interventions to CNAs.

D The facility failed to protect the resident's right to be free from physical abuse by another resident. A resident's roommate hit the resident multiple times with the electrical bed control causing bruising to the resident's forearm. The resident was sent to the ER for evaluation of the forearm and no fractures were identified. The other resident was removed from the area and placed on one-to-one observation for a period of time.

D The facility failed to protect the resident's right to be free from verbal abuse for one resident. A dietary staff member used profanity directed toward the resident and called the resident a derogatory name. The resident had a care plan for aggressive behaviors, being very loud and verbally abusive toward staff. The dietary staff member had bumped into the resident's wheelchair with a food cart. The resident cursed at the staff member. The resident stated they were upset because the staff member did not apologize. A witness statement confirmed the staff member walked by the resident several times and did not respond to the resident until the last time when he called the resident the derogatory name.

D The facility failed to protect the resident's right to be free of physical abuse by a contracted staff member. A CNA observed a nurse take a sandwich from a Resident's hand, despite the resident's objection, hold the resident's hands, and forcefully pushed a spoonful of crushed medications into the resident's mouth through the resident's closed lips.

D The facility failed to protect a resident from physical and mental abuse. Resident #1 was sitting in the dining room and was calling out. Resident #2 became agitated and struck out at Resident #1. Staff separated the two residents. Resident #2 was removed from the dining room. Resident #2 had struck Resident #1 on the face according to video surveillance. Resident #1 was upset but quickly calmed down when Resident #2 was removed from the dining room. Resident #1 had a small, reddened area on her right cheek.

**F602 Free from Misappropriation/Explotation**

D The facility failed to ensure narcotic medication was not diverted for one resident. The facility failed to ensure a resident's money was not misappropriated by staff. Resident #1 had an order for Hydrocodone-Acetaminophen 5-325 mg. as needed for pain. The pharmacy filled the order with 30 tablets. The facility's investigation indicated the resident was transferred to the ER. When the nurse was attempting to secure the resident's narcotics, the narcotics had not been logged into the narcotic count sheet or in the medication cart. The nurse on duty at the time the medication was received refused to submit to a drug screen and denied having knowledge of the missing medications. Resident #2 reported they had loaned a staff member $320 five months prior and the staff member had not paid them back. The staff member denied the allegation. The staff member returned the money and was terminated.

D The facility failed to prevent misappropriation of resident's medication for one resident. The resident, under the care of hospice, was prescribed and the pharmacy dispensed Oxycodone-Apap, thirty count. Two nurses had reconciled the medications after the pharmacy had delivered them. Prior to locking away the narcotic card, one nurse, with the card in her possession, got called away for an emergency and left the card unsecured and unattended in the facility nurse charting room. When the nurse returned to the charting room, the narcotic card was missing. A search was conducted, drug screens were collected, notifications were made. The narcotic card was not located. One nurse left the facility prior to the collection of a drug screen. The resident who had the prescription for the narcotic stated she always received pain medication when requested. The medical director and the resident stated in an interview with the surveyor that they were not notified of the missing card. The medication was replaced by the facility pharmacy at no additional cost to the resident. The surveyor asked the Medical Director if the situation should have been considered misappropriation. The Medical Director answered yes.

**F604 Right to be Free from Physical Restraints**

D The facility failed to ensure one resident was free from the use of physical restraints. The facility's policy prohibited the use of restraints. While making rounds, the DON observed a resident in their bed which was placed against the wall and a chair against the bed on the open side. A CNA reported the resident repeatedly attempted to exit the bed and the CNA placed the bed against the wall with the chair on the open side to prevent the resident from getting out of bed and potentially falling. An LPN also confirmed placing the resident's bed against the wall. Both staff members were terminated.

**F609 Reporting of Alleged Violations**

E The facility failed to report allegations of abuse to the SSA within two hours for two residents and failed to report an allegation of neglect to the SSA within 24 hours for one resident. For the first resident, a CNA observed a nurse take a sandwich from a Resident's hand, despite the resident's objection, hold the resident's hands, and forcefully pushed a spoonful of crushed medications into the resident's mouth through the resident's closed lips. The Administrator reported the incident to the SSA the following day. The facility failed to report an allegation of neglect/deprivation of goods and services, within the required 24-hour time frame for the same resident. The Administrator reported the allegation of neglect two days later. The second resident had alleged that staff were not assisting with incontinence care or baths. The Administrator reported the allegation of neglect to the SSA three days later. The third resident had made an allegation of rape. The Administrator reported the allegation to the SSA four hours after the allegation was made.

D The facility failed to report a staff to resident allegation of abuse within the required timeframe for one resident. A resident reported to a staff member that a CNA had been abusive and argumentative during care. The facility was unable to provide documentation that the police were notified or any documentation of an investigation. The CNA was suspended during the investigation but there was no documentation of the suspension in the CNA's personnel file. The Administrator was the abuse coordinator. The Administrator was on vacation when the incident occurred. The allegation did not get reported to the SSA.

D The facility failed to ensure allegations of abuse and injuries of unknown origin were reported to the SSA. A dietary staff member used profanity directed toward a resident and called the resident a derogatory name. The resident had a care plan for aggressive behaviors, being very loud and verbally abusive toward staff. The dietary staff member had bumped into the resident's wheelchair with a food cart. The resident cursed at the staff member. The resident stated they were upset because the staff member did not apologize. A witness statement confirmed the staff member walked by the resident several times and did not respond to the resident until the last time when he called the resident the derogatory name. The Administrator did not report the event to the SSA and stated they felt it was not abuse but more of a customer service issue. The second resident was identified with bruising and swelling on the finger and shoulder. The facility's file did not contain an incident report or a report to the SSA. The Administrator stated it was not reported because it was determined to be due to a fall. The file did not contain information regarding the exact time the Administrator became aware the injury was due to a fall.

D The facility failed to report allegations of abuse and misappropriation for three residents. Review of an incident between Resident #1 and #2, indicated Resident #1 threw a plastic cup at Resident #2 while seated across from each other in the dining room. The residents were immediately separated and examined for injuries. The incident was not reported timely. Resident #3 reported he had loaned a staff member $320 and the staff member had not paid him back. The allegation was not reported to the SSA within the required time frame.

D The facility failed to submit a 5-day investigative summary to the state related to an allegation of neglect for one resident. A resident had reported their incontinence brief had not been changed since the day prior. The Administrator reported the allegation to APS, the Ombudsman, police department and the SSA. The Administrator stated he had not filed a five-day investigative report with the state because APS investigated the allegation and stated there were no issues and the allegation was not substantiated. The Administrator was unaware of the requirement to report the result of the investigation to the state within five days.

D The facility failed to report an allegation of abuse for one resident. The DON was given a report of verbal disrespect to a resident from a staff member. The family also reported the staff member removed the resident's shirt hastily and hurt the resident's eye. The allegation of abuse was not reported to the SSA. The Administrator and the DON did not consider the allegation abusive and did not report. Their investigation indicated the resident had removed the shirt himself.

D The facility failed to report allegations of resident-to-resident sexual abuse to the SSA and APS within the required timeframe. A CNA observed Resident #1 and Resident #2 together while Resident #1 was attempting to remove the brief from Resident #2. Resident #2 was resisting the advances. The CNA left the residents alone while going to get assistance to remove Resident #1. The CNA failed to protect Resident #2 from further nonconsensual sexual contact. The nursing staff failed to provide interventions and within four hours, Resident #1 was observed touching Resident #3's genital area. Nursing staff failed to intervene appropriately and within two hours, Resident #1 had nonconsensual sexual contact with Resident #4 by grabbing the Resident and kissing the resident with an open mouth followed by licking Resident #4's face. The incidents were not reported to the SSA and APS for six days. The former Administrator reported the allegations were not investigated or reported for six days due to learning of the incidents six days afterwards when reading the medical record.

D The facility failed to ensure staff immediately reported an allegation of abuse for one Resident when two CNAs witnessed an alleged verbal abuse incident. A third CNA spoke rudely and used foul language toward a resident. The CNAs did not immediately report the incident and stated they did not know who they should report the incident to.

D The facility failed to ensure staff reported an incident of alleged abuse to administrative staff and to the SSA. An entry in the Resident's medical record indicated that when incontinence care was being provided to the resident, the resident hit two CNAs. After incontinence care was completed, the resident got out of the bed and struck the roommate in the shoulder. The resident was subsequently placed in a wheelchair and kept in the line of sight of staff members and later was transferred to the ER. The facility conducted an investigation. The investigation revealed the CNAs did not report the incident that occurred during incontinence care and a report was made to administration after the resident hit their roommate. Education was provided to staff regarding abuse and reporting. The facility did not report the incident to the SSA.

D The facility failed to ensure an allegation of misappropriation of resident property was reported to the SSA. The resident, under the care of hospice, was prescribed and the pharmacy dispensed Oxycodone-Apap, 30 count. Two nurses had reconciled the medications after the pharmacy had delivered them. Prior to locking away the narcotic card, one nurse, with the card in her possession, got called away for an emergency and left the card unsecured and unattended in the facility nurse charting room. When the nurse returned to the charting room, the narcotic card was missing. A search was conducted, drug screens were collected, notifications were made. The narcotic card was not located. One nurse left the facility prior to the collection of a drug screen. The resident who had the prescription for the narcotic stated she always received pain medication when requested. The medical director and the resident stated in an interview with the surveyor that they were not notified of the missing card. The medication was replaced by the facility pharmacy at no additional cost to the resident. The surveyor asked the Medical Director if the situation should have been considered misappropriation. The Medical Director answered yes. The Administrator was asked by the surveyor why this incident was not considered misappropriation. The Administrator stated the resident was not charged for the medication and the card was replaced and therefore, was not considered to be misappropriated and was not reported to the SSA.

**F610 Investigate/Prevent/Correct Alleged Violation**

E The facility failed to ensure allegations of abuse were thoroughly investigated for three residents. The first resident made an allegation of rape. The facility's investigation did not include interviews with any other staff members, did not have statements from other staff members, a summary of the investigation or steps taken to prevent recurrence. The Administrator stated he had not interviewed male staff members who were not on the shift when the allegation was made. The second resident reported to the therapy staff that a staff member had been rough with them during personal care. The facility's investigation did not include interviews with any other staff members, statements from other staff members, a summary of the investigation or steps taken to prevent recurrence. A third resident alleged the facility failed to provide goods and services/not receiving needed care. The facility's investigation did not include any documentation of the resident's appearance. The DON was unaware of the allegation. The Administrator admitted there was no investigation.

D The facility failed to complete a thorough investigation of an allegation of abuse within the required timeframe. The Administrator was unable to provide any documentation of an investigation of an allegation of abuse made by a resident during the time the Administrator, who was also the abuse coordinator, was away on vacation. A resident reported to a staff member that a CNA had been abusive and argumentative during care. The facility was unable to provide documentation of an investigation or that the police were notified. The CNA was suspended during the investigation but there was no documentation of the suspension in the CNA's personnel file.

D The facility failed to ensure a thorough investigation of an injury of unknown origin was completed for one resident. The resident was identified with bruising and swelling on their finger and shoulder by the CNA who reported it to the nurse. The facility's "soft file" was reviewed by the surveyor. The file did not contain an incident report or a report to the SSA. The Administrator stated it was not reported because it was determined to be due to a fall. The file did not contain information regarding the exact time the Administrator became aware the injury was due to a fall. The DON had interviewed staff regarding how the resident was transferred from the floor to the chair after falling. The DON stated she did not get details regarding how the resident was transferred.

D The facility failed to ensure a thorough investigation was completed for one resident with an allegation of abuse. The DON was given a report of verbal disrespect to a resident from a staff member. The family also reported the staff member removed the resident's shirt hastily and hurt the resident's eye. The facility failed to obtain witness statements from the staff, failed to complete a skin assessment for the resident involved in the allegation as well as other residents under the care of the accused CNA and failed to complete an incident report.

D The facility failed to conduct a thorough investigation for allegations of resident-to-resident sexual abuse for four residents. A CNA observed Resident #1 and Resident #2 together while Resident #1 was attempting to remove the brief from Resident #2. Resident #2 was resisting the advances. The CNA left the residents alone while going to get assistance to remove Resident #1. The CNA failed to protect Resident #2 from further nonconsensual sexual contact. The nursing staff failed to provide interventions and within four hours, Resident #1 was observed touching Resident #3's genital area. Nursing staff failed to intervene appropriately and within two hours, Resident #1 had nonconsensual sexual contact with Resident #4 by grabbing the Resident and kissing the resident with an open mouth followed by licking Resident #4's face. Resident #3 was not included in the investigation of the incidents. The DON denied having knowledge of the nonconsensual sexual contact. All staff members were not interviewed. Skin assessments were not completed for residents who could not be interviewed.

D The facility failed to complete a thorough investigation of misappropriation of a resident's property for one resident. The resident, under the care of hospice, was prescribed and the pharmacy dispensed Oxycodone-Apap, 30 count. Two nurses had reconciled the medications after the pharmacy had delivered them. Prior to locking away the narcotic card, one nurse, with the card in her possession, got called away for an emergency and left the card unsecured and unattended in the facility nurse charting room. When the nurse returned to the charting room, the narcotic card was missing. A search was conducted, drug screens were collected, notifications were made. The narcotic card was not located. One nurse left the facility prior to the collection of a drug screen. The resident who had the prescription for the narcotic stated she always received pain medication when requested. The medical director and the resident stated in an interview with the surveyor that they were not notified of the missing card. The medication was replaced by the facility pharmacy at no additional cost to the resident. Facility in-service records were reviewed and 8 of 90 staff members received education regarding the correct procedure. There were 7 of 90 staff members drug tested and did not include any staff from maintenance, housekeeping or administrative staff who had access to the nurse charting room and did not include visitors. There was no visitor sign-in log. The Administrator confirmed that the local police were notified of the incident and did not complete a police report because there was no probable cause. The investigation did not determine what happened to the missing card and the investigation was closed.

**F623 Notice Requirements Before Transfer/Discharge**

D The facility failed to send a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman for four residents reviewed for transfers. The Executive Assistant was filling in for a vacant Social Services Director position and was not familiar with the procedure.

**F625 Notice of Bed Hold Policy Before/Upon Transfer**

D The facility failed to provide written information regarding the bed hold policy for four residents who were reviewed for transfer. The Corporate staff member confirmed that no bed hold notices were provided to the residents or their representatives when they were transferred.

**F640 Encoding/Transmitting Resident Assessments**

D The facility failed to submit the quarterly MDS within 14 days of completion for one resident. The MDS was submitted 55 days after completion.

**F641 Accuracy of Assessments**

D The facility failed to ensure MDS assessments were accurately completed for two residents. The first resident had a limitation in ROM of one side of the upper and lower extremities. The MDS was coded as the resident having no limitation in ROM. The second resident was noted with wandering behaviors on admission. The admission MDS had no wandering behavior noted during the look-back period.

**F644 Coordination of PASARR and Assessments**

E The facility failed to resubmit a PASRR after the resident had the addition of a new antipsychotic medication and a new mental health diagnosis for four residents.

D The facility failed to resubmit a PASRR after the resident had a new mental health diagnosis and new antipsychotic medication for one resident. The resident had a new diagnosis of Schizoaffective Disorder and a new prescription for Seroquel. An updated PASRR was not completed and submitted.

D The facility failed to provide services specified in the PASARR for one resident. One resident with a diagnosis of Schizophrenia, Bipolar Disorder and Generalized Anxiety Disorder had a Level II determination stating the resident was approved for nursing home services and indicated the resident needed specialized services including mental health case management, medication management evaluation, community resource case management and supportive counseling. A referral was not made for psychiatric services for the resident.

**F655 Baseline Care Plan**

D The facility failed to review the baseline care plan and provide a written summary to one resident. The resident had a history of falling with injury, had comorbidities and was at risk for skin breakdown. The care plan showed no documentation that it was reviewed or that copies were given to the resident or representative. The resident stated she didn't remember reviewing her baseline care plan with nursing on admission.

**F656 Develop/Implement Comprehensive Care Plan**

L The facility failed to update residents' care plans after a fall with new and appropriate interventions for three residents. The failure resulted in the potential for harm for one resident by failing to develop and implement appropriate interventions after a fall with major injury. The resident was sent to the hospital for treatment and upon return, no interventions were implemented. The failure resulted in actual harm for another resident who sustained a right hip fracture after a third fall. The resident's care plan did not show new and appropriate fall interventions after the three falls. The third resident sustained a closed head injury after a fall and fell again the following day. The resident was sent to the ER for an altered mental status. The resident did not have new/appropriate interventions implemented after the falls. The failure resulted in Immediate Jeopardy for the three residents. The facility failed to give CNAs access to the care plans in the EMR and failed to have a person-centered care plan for 11 residents. The DON confirmed the CNAs did not have access to the care plans and were made aware of fall interventions through verbal communication. The DON reported being unaware that fall investigations were not being completed timely and new appropriate interventions were not being documented on the care plan.

E The facility failed to revise care plans for ten residents reviewed for advanced directives, behaviors, and wounds. Review of the care plan for Advance Directives had an intervention to "honor the resident's wishes during stay". The care plan did not reflect the resident's actual code status for the ten residents. One resident's care plan did not include specific instruction regarding areas of the facility the resident was/was not allowed to visit. Another resident's care plan was not revised after maggots were identified in the resident's skin folds.

- D The facility failed to revise care plans for two residents. One resident had an order for supplemental oxygen but had no care plan to address oxygen administration. The second resident had a physician's order for Apixaban for blood clots. The resident's care plan was not revised to include the medication.
- D The facility failed to implement comprehensive care plans for two residents. One resident had a diagnosis of Psychotic Disorder, and the care plan did not include interventions for psychotic features or potential harm to self. The second resident had a care plan to monitor for bleeding due to receiving an anticoagulant. There was no documentation in the medical record that the monitoring was conducted.
- D The facility failed to develop and implement a person-centered care plan for four residents. Resident #1 was admitted with diagnoses of Seborrheic Dermatitis, Depression, and was involved in a nonconsensual sexual episode with another resident. The resident's care plan did not address goals or interventions for Seborrheic Dermatitis, Depression, or the nonconsensual sexual contact. Two other residents involved in a nonconsensual sexual incident did not have a care plan or interventions to address the incident. A fourth resident had diagnoses including Vascular Dementia and an episode of nonconsensual sexual contact. The resident's care plan did not address vascular dementia or the nonconsensual sexual contact.

**F657 Care Plan Timing and Revision**

- D The facility failed to develop an individualized care plan for one resident. One resident required the use of an air mattress. In an interview with the surveyor, the staff reported the mattress was overinflated when the resident had fallen from the bed to the floor. The resident's care plan did not include safety interventions related to use of an air mattress including ensuring the proper inflation was maintained to prevent pressure wounds or worsening of wounds, ensuring the resident was correctly positioned in the center of the mattress to prevent slipping from the edge of the mattress during pressure changes, or ensuring proper use of linens to prevent shearing injuries. The resident had an unwitnessed fall from the bed with the air mattress resulting in a fractured femur. The DON stated the resident should have had a care plan for the use of an air mattress with monitoring for positioning in bed and monitoring for proper inflation.
- D The facility failed to revise the care plan with interventions after a GJ tube had been dislodged seven times resulting in replacement of the tube in the ER for one resident. The care plan did not mention the problem of the GJ tube being dislodged seven times or interventions for nursing staff to follow to protect the GH tube from becoming dislodged when turning and repositioning.

D The facility failed to revise the comprehensive care plan after the comprehensive assessment for three residents. One resident had an order for a knee immobilizer on admission. The care plan did not include the knee immobilizer. A second resident had an order for non-weight bearing for the RLE on admission. The resident's care plan did not include the resident's ADLs. In an interview with the surveyor, the DON stated the resident's care plans were vague and not personalized to include the resident's specific ADL needs. A third resident was admitted with an internal orthopedic prosthetic device, obesity, muscle weakness and abnormalities of gait and mobility. The resident's comprehensive care plan did not address the resident's specific ADL needs. The DON stated she was unaware the MDS assessment was to be used to identify specific resident needs and the care plan was to be updated based on the MDS assessment. The DON confirmed the care plans were generic.

D The facility failed to conduct quarterly interdisciplinary care plan meetings for two residents. The facility was only able to provide documentation of one care plan meeting per year for the past three years for Resident #1. There was no documentation of a care plan meeting during the first two quarters of 2023 for Resident #2.

D The facility failed to conduct quarterly care conference meetings with the resident or the resident's representatives for twelve residents. The twelve residents did not have documentation of care conferences for each quarter since their admission. The executive assistant who was filling in for the vacant SSD position reported the attendance sheets for the conferences were kept in a binder but was unable to provide the binder for surveyor review. The facility also failed to update the care plan with an appropriate intervention(s) for falls involving two residents. One resident did not have care plan revisions following three of their most recent falls and another resident's intervention in the incident report for Dycem slip proof material was not included in the care plan.

**F677 ADL Care Provided for Dependent Residents**

E The facility failed to ensure four residents received assistance with ADLs for bathing/showers, fingernail trimming, cleaning under the fingernails and grooming of facial hair. Three residents were noted with fingernails that were jagged and with dirt underneath the nails. Two residents had oily hair. One resident had a long beard. Another resident reported not having a shower since admission three days prior. In an interview with the surveyor, the fourth resident indicated the staff did not help with ADLs, such as changing his incontinence brief in a timely manner and added once he laid in his waste for 24 hours. The resident stated he was told he would have to wait for help after putting his call light on and usually waited 30 minutes to an hour. The resident stated he preferred a bed bath but didn't always get a bed bath when not given a shower. Documentation of showers/bed baths was inconsistent and was missing on several days. There were no documented refusals of bed baths or showers.

D The facility failed to maintain the personal hygiene for two residents who required assistance. The two residents reported not getting their showers. The surveyor noted inconsistent and missing documentation of the residents' showers.

D The facility failed to ensure ADL assistance was provided for three residents. One resident had no documentation of a shower on multiple days of the two months prior to the survey. The resident was observed with a dark substance around their lips and facial hair. Two residents had long fingernails with a black substance underneath, untrimmed and soiled. A third resident was noted to have a strong odor of urine and had a dried substance around their mouth and eyes.

**F684 Quality of Care**

J The facility failed to ensure residents received treatment and care based on assessments, in accordance with policies, and protocols/agreements, and failed to promptly intervene for an acute change in a resident's condition. The facility's failure resulted in Immediate Jeopardy when the Resident developed a temperature of 106.7 degrees F, a heart rate of 131, a blood glucose of 600. The facility contacted the Post-Acute Care Network, Virtual Rapid Response Telecommunication, and the resident was not transferred to a higher level of care for evaluation of a medical emergency. A head-to-toe assessment was not documented as being performed by the facility or the VRRT, and there was no documented assessment by the primary care physician until the third day, on which the resident died. There was no documentation or evidence that the facility had an RN in the facility 24 hours a day for seven days per week as required per the facility's agreement "SNF Post-Acute Network Participation Agreement). There was no documentation that the Resident had been hospitalized in the 30 days prior to the event. A late entry nurses note documented the resident's vital signs, signs and symptoms and actions taken. There was no documentation that the resident was assessed by the skilled nurse. There was no documentation that the resident was assessed for a higher level of care during the VRRT call, in accordance with VRRT Recommendation Standard of Practice policy/agreement. There was no documentation that the resident was visualized during the VRRT call and there was no documentation of a virtual assessment during the VRRT call. There was no documentation indicating the resident was assessed by a facility RN and no documentation to indicate the resident was assessed or evaluated by a qualified practitioner to determine if the resident needed a higher level of care or could be treated in the facility for the medical emergency of hyperpyrexia. There was no documentation of the resident's vital signs every 30 minutes for three hours then once every four hours for 24 hours in accordance with the policy/protocol/agreement. There was no documentation to indicate the resident was reassessed to determine if the resident was responding to treatment or failed to respond to treatment, requiring a transfer to the hospital. The resident was administered IV antibiotics, IV solution and a one-time dose of Regular insulin. The nurse documented that the MD was updated but there was no documentation of the specific information that was provided to the MD. In an interview, staff reported to the surveyor of having felt upset that the resident was not sent to the hospital and "management" did not want the resident sent out.

E The nursing staff failed to complete ongoing assessments for vomiting, bowel movements and falls for three residents. The first resident had an episode of vomiting in the evening of the second day following readmission from the hospital. Approximately two hours later, the CNA informed the nurse of abnormal vital signs. Messages were left for the family. After returning to the room, the resident was found with no vital signs. The DON confirmed the nursing staff failed to follow the facility policy for "Alert Charting" which should have been completed for 72 hours post readmission. The DON also confirmed the nurse should have documented a better description of the vomiting episode and confirmed the physician was not contacted. The second resident had a period of five days with no documentation of a BM, assessment of bowel sounds or implementation of bowel protocol. The facility's protocol required intervention after the third day. The third resident had nine falls in a three-month period. Of the nine falls, only one was witnessed. The facility failed to complete neuro checks for eight unwitnessed falls when the resident was found on the floor in their room, and it was unknown with certainty whether the resident had hit their head.

D The facility failed to provide skin and wound assessments, and wound treatments for two residents with pressure ulcers. The facility's failure to perform treatments and conduct assessments in accordance with facility policy contributed to the development and deterioration of pressure ulcers/injury for the two residents resulting in actual harm. Resident #1 was admitted with an order for a barrier cream to be applied to the sacral area every shift. The staff did not perform a skin assessment for a two-week period. During that period, the resident developed an unstageable pressure ulcer. For the following three months, the resident's unstageable wound was noted to have worsened. The facility had not performed a skin assessment for a two-week period during each of the months. During the time of the missed assessments, the resident's wound declined each month. The resident also developed a new pressure ulcer which also declined over time. There were multiple omissions of documentation for providing the resident's wound care treatments. Resident #2 was noted with redness to the buttocks in multiple skin assessments. The TAR had no interventions implemented for the redness to the resident's buttocks. Following the documentation of the redness, the facility failed to complete skin assessments over a three-week period. During the three-week period, the resident developed a Stage IV pressure ulcer on the left buttock. Over the following two months, skin assessments were not conducted over two two-week periods. The pressure ulcer declined during both time frames. The Medical Director was asked if the Wound Care Nurse was certified, should the nurse document the measurement and the stage of the wound when identified. The Medical Director stated yes, the Certified Nurse should measure and stage the wound.

D The facility failed to complete 72 hours of neuro checks in accordance with the facility's policy for seven residents. Four residents had unwitnessed falls with uncertainty of whether the resident had hit their head. Three residents had head injuries as a result of the falls. The facility had no documentation of neuro checks for any of the seven residents. The facility failed to ensure medications were administered according to physician's orders for five residents. One residents' medications were documented as not given, and four residents' medications were documented as given but found in their original packaging in the medication cart.

**F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers**

G The facility failed to provide skin and wound assessments, and wound treatments for two residents with pressure ulcers. The facility's failure to perform treatments and conduct assessments in accordance with facility policy contributed to the development and deterioration of pressure ulcers/injury for the two residents resulting in actual harm. Resident #1 was admitted with an order for a barrier cream to be applied to the sacral area every shift. The staff did not perform a skin assessment for a two-week period. During that period, the resident developed an unstageable pressure ulcer. For the following three months, the resident's unstageable wound was noted to have worsened. The facility had not performed a skin assessment for a two-week period during each of the months. During the time of the missed assessments, the resident's wound declined each month. The resident also developed a new pressure ulcer which also declined over time. There were multiple omissions of documentation for providing the resident's wound care treatments. Resident #2 was noted with redness to the buttocks in multiple skin assessments. The TAR had no interventions implemented for the redness to the resident's buttocks. Following the documentation of the redness, the facility failed to complete skin assessments over a three-week period. During the three-week period, the resident developed a Stage IV pressure ulcer on the left buttock. Over the following two months, skin assessments were not conducted over two two-week periods. The pressure ulcer declined during both time frames. The Medical Director was asked if the Wound Care Nurse was certified, should the nurse document the measurement and the stage of the wound when identified. The Medical Director stated yes, the Certified Nurse should measure and stage the wound.

**F689 Free of Accident Hazards/Supervision/Devices**

L The facility failed to follow their falls prevention policy for three residents, failed to develop and implement interventions to prevent falls for the three residents and failed to complete fall risk assessments for them. The facility failed to provide adequate supervision to prevent falls for one of the three residents and failed to complete a thorough investigation to determine a root cause of the falls involving the three residents. The failure to implement an effective fall prevention program for residents at fall risk resulted in major injuries for two residents and multiple falls for the third resident. The three residents were determined to be in Immediate Jeopardy.

J The facility failed to provide an environment that is free from accident hazards over which the facility has control and provides supervision for one resident reviewed. The resident had fallen from their bed with an air mattress to the floor. In an interview with the surveyor, the staff reported the mattress was overinflated and the DON stated the resident should not have been placed back on a faulty mattress after the fall. The resident's care plan did not include safety interventions related to the use of an air mattress including ensuring proper inflation was maintained to prevent pressure wounds or worsening of wounds, ensuring correct positioning of the resident in the center of the mattress to prevent slipping from the edge of the mattress during pressure changes, or ensuring proper use of linens to prevent shearing injuries. The resident had an unwitnessed fall from the bed with the air mattress resulting in a fractured femur and Immediate Jeopardy for the resident. The Resident was found in the floor beside the bed. Staff placed the resident back into the bed without an assessment for injury and did not consult with the physician for further evaluation. There was no documentation of an unwitnessed fall and no documentation of increased pain prior to obtaining X-ray results that were positive for a fracture. The nurse reported that when the staff placed the resident back in the bed immediately after the fall, the resident cried out, but that was normal for the resident. The nurse denied completing an assessment for injury. The resident had symptoms of facial grimacing, moaning, and increased yelling out with movement, the week following the fall. The physician and family were not notified nor was the physician consulted for five days after the fall. Staff obtained an order for an X-ray for bruising and swelling of the resident's thigh and knee. The X-ray was positive for a femur fracture. The DON did not investigate the fall for an additional two days.

J The facility failed to ensure all residents received supervision to ensure a safe environment. The failure resulted in immediate jeopardy for one resident when the resident was assisted to exit the facility with the help of an agency nurse. The Resident was found in the parking lot of another facility, less than one half mile from the facility. The facility was cited with past noncompliance. The resident was cognitively intact with a BIMS score of 13. The resident was not coded on the MDS for exhibiting wandering behaviors. The progress note and incident report indicated the resident was in their wheelchair, was appropriately dressed and was easily redirected and returned by a staff member's personal vehicle. An immediate skin audit/exam was completed, and no injuries were identified. The Resident was placed on 1:1 supervision, a wanderguard was initiated and the resident's spouse and physician were notified. Additionally, the facility's corrective action plan included the following: reassessed elopement risk and updated the care plan, added resident to elopement risk book, educated staff regarding elopement risk, conducted a family conference to discuss safety and any arrangements needed for placement, created timeline for event, 100% check of all residents immediately to ensure all were accounted for, elopement risk assessments for all other residents, 100%, verified resident photos and identifiers list in binders, updated elopement risk care plans, notified family and physician of any residents identified at risk for elopement, door checks immediately and daily for function, proper closure and safety, door codes changed immediately with staff education, IDT to monitor MARS and care plans daily during daily CQI meetings, all staff educated regarding elopement drill, wandering to be addressed as a specific problem on care plans, utilization of an individualized system for at risk residents (pictures, elopement risk binder, wander guards), daily testing of doors, psych services, all staff completed post tests for education provided, missing person/elopement drill during new hire orientation and every three months, 100% audit of all residents assessed at risk for elopement, present audit findings to QAPI Committee. The corrective action plan was validated by the surveyor.

- J The facility failed to provide adequate supervision to prevent an avoidable accident for two residents. The residents moved from a safe environment to an unsafe environment when the residents exited the facility unsupervised. The facility's failure to provide adequate supervision resulted in Immediate Jeopardy for the two residents. The facility also failed to accurately assess 22 residents for wandering/elopement risk. For Resident #1, a CNA reported finding the resident's wheelchair at the door without the resident in it. The door was supposed to alarm when opened but did not due to being in the "off" position. The resident was returned to the facility after being outside for an undetermined amount of time. The video surveillance revealed the resident was sitting outside on a curb that was adjacent to a road. The facility staff were unable to locate the elopement book. The resident's representative reported they were not notified of the resident's elopement. Resident #2 was identified as a risk for elopement. The resident exited the facility and was outside for an undetermined amount of time. The night shift nurse reported the resident had to be redirected all night due to exit seeking behaviors. The resident was found outside at another building on campus. The resident was ordered to have a wanderguard and was placed on the secured unit. The investigation revealed the alarm was not working on the door the resident used for exit. The staff reported having no training on elopement risk assessment and the code for a missing resident. The root cause was determined that the nursing staff failed to recognize the elopement risk and failed to put interventions in place for prevention and maintenance failed to the door alarm was working properly. Several staff members reported being unable to identify residents who were in the wandering/elopement book. Twenty-two other residents were identified with inaccuracies in their elopement risk assessment.
- J The facility failed to ensure a safe environment, provide supervision, and oversight to prevent potential accidents and injuries for four cognitively impaired residents who reside on the secured unit and who were assessed for having wandering behaviors. The failure resulted in immediate jeopardy when a white substance identified as methamphetamine was found by facility staff in a resident's room on two occasions. The DON had found a crystallized white powdery substance rolled up in a $1 dollar bill, later identified as methamphetamine, in the closet of the unoccupied side of the Resident's room. Four days later, two white crystallized rock formed substances, in a box labeled "baking soda" was found in the top of a resident's closet. The substance was later identified as methamphetamine. The police department was notified and conducted testing of the substances on both occasions and identified it as methamphetamine. A sweep of the entire building was conducted, all staff who had worked the hall were drug tested. The police report was not available to the surveyor. No residents were tested. There were no witness statements in the investigation. The family of the resident residing in the room were not notified. The facility could not verify drug tested had been conducted for all staff who had entered the hallway where the drugs were found. There was no visitors log to determine who had visited the secured unit. The Regional Nurse was asked how the facility ensures the safety of the residents. The nurse reported the facility continues to conduct facility searches and the staff know to report any suspicious substances and activity.

G The facility failed to provide adequate supervision to prevent accidents for two residents. The facility's failure to utilize two staff members during the use of a mechanical lift resulted in harm when the resident sustained a distal right femur fracture. The incident report indicated a staff member was attempting to transfer a resident from the bed to a wheelchair using the sit-to-stand mechanical lift when the patient became weak and slid back against the lift harness. After attempts to complete the transfer, the staff member slid the resident to a sitting position and obtained additional help to complete the transfer. The resident did not report pain nor obvious signs of a fracture and sat up in the wheelchair for a while before being placed back into bed. The CNA did not report the fall to the staff. Three days later, the resident complained of knee pain. An Xray was obtained, and a fracture was identified. A second resident sustained nine falls in a three-month period. The facility failed to identify the root cause of the falls, failed to implement new interventions, and analyze patterns.

G The facility failed to implement interventions to ensure a resident's environment remained free of accident hazards. The failures contributed to resident falls with injury and resulted in actual harm to one resident. An event note indicated a resident fell when attempting to retrieve an item that had fallen from the bedside table to the floor. The resident sustained redness to their elbow. The intervention for the incident was to declutter the bedside table, however, the intervention to keep the environment free of clutter had already been included in the resident's care plan. Another event report for the resident indicated the resident was found on the floor on their left side. The resident was sent to the ER and was diagnosed with a left hip fracture. The intervention for the fall was to remove the "fuzzy" socks from the resident's room. The intervention to provide proper, well-maintained footwear was already included in the resident's care plan. The resident had several subsequent falls with injuries such as skin abrasions and difficulty walking. One fall was attributed to the handrail that fell from the wall. The handrail had been installed with screws that were too short. Another fall was attributed to a riser on the resident's toilet that was not of the type the facility typically used, and no one could explain why the riser was in use and how it had been installed.

D The facility failed to ensure proper transfer methods were used for one resident. The Occurrence Report completed by an RN indicated the CNA reported the resident flipped themselves out of their chair. The report revealed during the three hours prior to the fall the resident was restless. The CNA who was with the resident in the dining room stated the resident flipped over the side of the chair onto the floor. The CNA had moved to the back of the chair to pull the resident back into the seat because the resident was leaning forward and that was when the resident flipped out of the chair. Another CNA assisted with transferring back into the chair. The CNAs reported grabbing underneath the resident's arms and stated they should not have transferred the resident in this manner. The DON stated they did not gather details regarding the transfer when interviewing the staff regarding the fall but should have been more specific and the staff should not have "chicken winged" the resident to get them up from the floor.

D The facility failed to perform complete neuro checks, revise the care plan, implement appropriate fall interventions, and notify the physician for three residents. The first resident slid out of the chair onto the floor. The resident was noted with a hematoma on their head. The facility had no documentation of neuro checks after the fall. The resident was severely cognitively impaired but had interventions on the care plan to encourage the resident to call for assistance. The DON confirmed the intervention was not appropriate for this resident. The second resident was noted to have edema, bruising and warmth to the lower leg. The resident was sent to the ER and was diagnosed with a tibial plateau fracture and right fibular head fracture. The resident's care plan was not updated after the fractures were diagnosed. The third resident slid from their recliner to the floor. The intervention after the fall was to encourage the resident to call for assistance. The resident was severely cognitively impaired, and the intervention was not appropriate. The third resident had another unwitnessed fall. There was no documentation of neuro checks post fall, and the only intervention was to encourage the resident to call for assistance. The third resident had another fall, and the only intervention was to encourage the resident to call for assistance. The physician was not notified of any of the three falls for the third resident. A CNA was asked how staff knew that a resident was at high risk for falls. The CNA did not know. There were no visual indicators in the resident's room to indicate which residents were at risk for falls.

**F690 Bowel/Bladder Incontinence Catheter, UTI**

D The facility failed to obtain a physician's order for the continued use of an indwelling urinary catheter and failed to document the medical justification for the use of the catheter. The resident's admission orders included bladder management protocol but did not include routine foley care. The physician's orders did not include an order for the indwelling catheter, the rationale or catheter care. The catheter was included on the resident's baseline care plan. The resident's comprehensive care plan did not address the catheter.

**F693 Tube Feeding Management/Restore Eating Skills**

D The facility failed to implement interventions to anchor a resident's GJ tube properly, in order to prevent repeated dislodgement of the tube, which then required the resident to be transferred to the ER to have the tube replaced. The DON confirmed there was no indication on the care plan of the seven times the resident's tube had been dislodged and there were no interventions on the care plan for the nursing staff to follow regarding anchoring the GJ tube to prevent dislodgement. The progress notes had no documentation of the facility's assessment of what caused the GJ tube to come out each time and didn't assess which staff was providing care for the resident.

D The facility failed to date and label a gastric tube feeding for one resident. The resident had an order for Nutren 1.5. The surveyor observed the enteral feeding bag without the date, time hung or a label. The ADON entered the room and added the date/time hung, rate and name of the solution to the bag. The ADON confirmed that she was not present at the time the enteral feeding system was started and without being present she was unsure what the solution was in the feeding bag. The ADON confirmed that all enteral feeding bags should be labeled, dated, and timed with the name of the solution in the bag.

**F697 Pain Management**

D The facility failed to provide pain management consistent with professional standards of practice and the resident's goals and preferences for one resident. The resident complained of left side, left shoulder, and left arm pain after a fall. The resident's pain evaluation indicated the resident exhibited negative verbalizations, facial expressions, physiological changes, and the resident was in pain. The resident had not been given pain medication as ordered on a PRN basis.

**F699 Trauma Informed Care**

D The facility failed to ensure one 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 of the resident.
Prior to admission to the facility, the resident was a long-term caregiver for her handicapped son. The resident became unable to continue the care due to confusion. The resident's care plan did not address the trauma of the resident's separation from her son or her prior history as a military nurse.

**F700 Bedrails**

K The facility failed to provide a safe environment that prevented an incident of entrapment for one resident. The failure to ensure a safe environment resulted in Immediate Jeopardy when one vulnerable, cognitively impaired resident became entrapped between the assist bar and the mattress. The resident was found on the floor beside the bed with her arm entrapped between the assist bar and the mattress. The nurse assisted the resident to free her arm prior to assisting the resident up from the floor. The resident had C-rails with bed controls to both sides of their bed. There was no side rail assessment and no consent for the use of the side rail for the resident. The facility also failed to try an appropriate alternative prior to installing an assist bar, failed to perform side rail assessments, and failed to obtain informed consent prior to installation of the assist bars for 85 residents. The facility DON confirmed the facility does not perform side rail assessments due to using only "assist bars". The maintenance director reported the facility does not do any routine checks on the assist bars. The staff reported they had not received any training.

F The facility failed to complete side rail assessments for the risk of entrapment and failed to obtain consent for side rails for three residents reviewed for falls. The DON confirmed the facility had not attempted alternatives to the side rails, had not provided the residents with education, did not obtain consent, or assess the residents' risk for entrapment. The VP of Quality and Compliance stated they were not aware of regulations related to side rails.

**F726 Competent Nursing Staff**

G The facility failed to provide nursing staff with the appropriate competencies and skill sets to assure resident safety and physical well being for one resident. The resident had a pain level of 10 and was unable to move their left leg. The DON transferred the resident from the floor to the wheelchair. The resident screamed out in pain as a result of the transfer. The facility's failure to ensure safety for the resident after an accident resulted in actual harm for the resident who experienced severe pain as a result.

D The facility failed to ensure the licensed nurses had the competencies and skill sets necessary to

Document assessments and administer IV medications for one LPN and for one resident receiving antibiotic therapy via the PICC line. The resident had a significant change and there was no nursing assessment completed. The physician ordered IV antibiotics and IV fluids to be administered by PICC line. The LPN was asked if the facility had evaluated her competency and the LPN stated she didn't feel comfortable, and a competency assessment had not been completed. The nurse admitted she had not completed a full assessment on the resident with the change in condition. The facility could not provide documentation of a competency assessment/skills check off for the LPN.

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

E The facility failed to ensure there was RN coverage for eight consecutive hours a day, seven days a week, for 29 days ranging over a seven-month period.

NOTE: This facility has a total licensed bed count of 62. The federal regulations state that when the facility has an average daily occupancy of 60 or fewer residents, the DON may serve as the charge nurse. If the facility's ADC was 60 or less, the DON hours would be counted toward the 8 consecutive hours a day RN requirement.

**F732 Posted Nurse Staffing Information**

D The facility failed to post accurate daily staffing for CNAs, LPNs, and RNs for six days. The DON confirmed the nursing staff posting was inaccurate and had not been updated to reflect staffing changes.

**F741 Sufficient/Competent Staff-Behav Health Needs**

J The facility failed to ensure staff had specific knowledge, sufficient competencies and skill sets necessary to provide appropriate care and services to three residents with behavioral and mental health needs. Fourteen staff members including CNAs, LPNs, Housekeeping Personnel and a RN failed to demonstrate appropriate interventions were implemented to prevent ongoing altercations between Resident #2 and Resident #3 with a history of verbal and physical altercations. An RN failed to implement appropriate interventions for a verbally aggressive Resident when the RN struck the Resident and forced the Resident to the ground. The lack of staff knowledge and failure to implement effective interventions resulted in physical harm to Resident #2 and abuse for Residents #1 and #2. The failure of the staff to demonstrate appropriate competencies to provide care to residents with behaviors and mental healthcare needs and failure to ensure the safety of all residents residing in the facility to be free from abuse resulted in Immediate Jeopardy. Staff denied having a competency checkoff regarding care of residents with behavioral symptoms and denied having any specific education. The facility was asked to provide documentation or evidence of annual competency assessments per job description duties, orientation or training and no documentation was provided.

**F742 Treatment/Svc for Mental/Psychosocial Concerns**

D The facility failed to provide treatments and services for one resident (#1) reviewed for behaviors. The resident's documentation included a note that the resident had exhibited wandering behavior with interventions implemented which included to redirect when wandering, prompt activity attendance to keep the resident occupied and monitoring of the resident's location. The resident as well as another resident (#2) of the facility had a history of a negative encounter. Resident #1 was not allowed in Resident #2's room and was not to be on the hall where resident #2 resided. Staff were polled regarding their knowledge of the restriction for Resident #1. Staff were unaware of the resident's restriction from Resident #2's hallway. The Administrator reported the event occurred 20 years ago. Resident #1's care plan had no mention of restricted areas. Resident #1 had a documented episode of inappropriate comments to female staff and an episode of exposing his genitals to a female resident. The resident was placed on 1:1 observation.

D The facility failed to provide treatment and services for one resident with a history of trauma, psychosocial adjustment difficulty, and behaviors, to attain the highest practicable mental and psychosocial well-being. The resident cared for her handicapped son prior to admission and had a hard time adjusting to placement in the nursing home. The facility had no social services progress notes for more than a year and no psychiatric follow-up visits. The resident had not been provided with any opportunity to visit with her son either in person or virtually.

**F755 Pharmacy Svcs/Procedures/Pharmacist/Records**

D The facility failed to have pharmacy systems in place to ensure medications were administered accurately to two residents. One resident was administered a pain medication in pill form that had been discontinued six days earlier due to the resident's decreased ability to swallow pills, consequently, the resident's sublingual pain medication was not administered. The majority of the medication error report was incomplete/blank including description, date, and time of incident, who found the error, the type of error, the individual who made the error, the dosage form, the reason for the error, side effects and immediate observations. Staff reported the discontinued medication should have been removed from the cart and was not. Another resident was administered her roommate's medications.

D The facility failed to ensure narcotics were not expired, the drug destruction sheets were accurately documented and signed by the pharmacist and DON and failed to double lock and secure accurate inventories of controlled substances on two medication carts. The narcotic destruction logs had only the signature of the pharmacist on the form for reconciling the medications. The pharmacist failed to document an expired controlled substance found on the medication cart and failed to ensure the narcotic count was accurate. The pharmacist failed to review the amount documented on the narcotic sheet and reconcile with the bottle. The narcotic count sheet indicated there was 50ml. The actual amount of the drug in the bottle was 30ml. The pharmacist admitted he did not measure the amount of the drug remaining in the bottle and stated he trusted what the nurse had told him. Two medication carts contained Gabapentin and Ativan but did not have the drugs under double lock and key. When the pharmacist was asked about the location of the narcotic destruction sheets for the prior four months, he stated that he had not completed them. The pharmacist failed to ensure all controlled substances were under double lock and key and failed to accurately check the medication carts for expired drugs and ensure the narcotic count was correct.

D The facility failed to ensure medications were available for administration for one resident. The resident had an order for Flonase for rhinitis. The drug was not available and not administered.

**F758 Free from Unnec Psychotropic Meds PRN Use**

D The facility failed to ensure PRN psychotropic medications were limited to 14 days duration for one resident. The resident had an order for PRN Lorazepam that was written four months prior to the survey date and had been renewed every month. There was no 14-day limitation on the duration of the order.

**F759 Free from Medication Error Rates of 5% or More**

E The facility failed to ensure a medication administration error rate of less than five present. The nurse administered seventeen medications 20 minutes past the time frame allotted according to the facility policy. One antihypertensive medication had a hold parameter with the order. The nurse did not check the resident's vital signs prior to administering the medication. The errors resulted in an error rate of 51.52%.

D The facility failed to maintain a medication error rate of less than 5%. The facility had two medication errors of 27 opportunities for an error rate of 7.4%. One nurse administered multi-vitamin with minerals instead of multi-vitamin. One nurse crushed an enteric coated aspirin for administration to the resident prior to being stopped by the surveyor.

D The facility failed to ensure a medication error rate of less than 5%. One nurse failed to properly administer medications for one resident resulting in a medication error rate of 7.41%. A nurse placed crushed Ativan and crushed Dilantin into the same cup, added water and mixed the medications and administered to the resident. There were no orders to mix the drugs together

**F760 Residents Are Free of Significant Med Errors**

D The facility failed to ensure one resident was free from significant medication errors. On one date, the facility staff administered duplicate doses of insulin to the resident. The medication error had the potential to cause the resident to become hypoglycemic. The nurse administering the first dose of the medication failed to document medication administration after it was administered.

**F761 Label/Store Drugs & Biologists**

D The facility failed to ensure medications were properly and securely stored when a medication was left in a resident's room for two residents. The surveyor observed a medication cup with nine unopened unsecured medications on a resident's overbed table. The second nurse left the resident's medications on the resident's overbed table, unattended and out of sight, while washing their hands in the resident's bathroom.

D The facility failed to ensure medications were properly and securely stored when one nurse left a medication on top of a medication cart, unsecured and unattended. The medication was left in a cup on top of the cart outside of a resident's room.

D The facility failed to ensure medications were properly stored. The facility had opened, undated, expired medications and controlled substances that were not secured behind two locks on the medication carts. One medication cart had an opened, undated, and expired bottle of Diazepam. The following observations were made in the Medication Storage Room: opened and undated insulin pens and Ativan and Gabapentin not stored under double lock and key.

D The facility failed to ensure medications were properly stored in two medication storage areas. A bottle of expired Pantoprazole was found on one of the medication carts. Another medication cart was noted to be unlocked and unattended.

D The facility failed to ensure medications were properly stored and secured. Two staff members left medications unattended and unsecured on resident's overbed tables. External and internal medications were stored together on the medication cart. Santyl and Antibiotic ointment was stored in the same sectioned drawer with oral medications.

**F804 Nutritive Value/Appa, Palatable/Prefer Temp**

E The facility failed to serve food that was palatable and hot. The surveyor requested a test tray in response to resident complaints. The test tray contained baked beans, pulled pork and a piece of toast. The baked beans and pulled pork were mashed together and did not appear appetizing. There were two separate bowls, one containing coleslaw and one fudge pie in the other. There was a container of milk on the tray. Temperatures were taken. The pulled pork was 120 degrees, beans were 100 degrees, and the coleslaw was 70 degrees. The meal was sampled and was determined to be in need of reheating. The coleslaw was too warm.

**F812 Food Procurement Store/Prepare/Serve - Sanitary**

F The facility failed to use good hygiene practices and techniques to change gloves and wash hands between tasks, to keep the ice machine clean and sanitary to prevent contamination of the ice, sanitize visibly soiled equipment associated with ice handling, and to wear hair restraints to prevent hair from contacting food. The surveyor observed the following on two consecutive days of the survey: a pan on the top shelf inside the stand-alone cooler, collecting water dripping from the top of the cooler and food items on shelves underneath the open pan of water. Other observations included: the Dietary Supervisor entered the food prep area without a hairnet, the Kitchen Supervisor touched the hotdog buns with a gloved hand, after touching other food items and food utensils, multiple staff members entered the kitchen without washing their hands and without wearing a hairnet, a kitchen staff member touched the trash can, then rinsed a kitchen utensil, then went to the tray line and stirred food items on the hot bar without washing hands or changing gloved hands, three staff members answered the phone then returned to their meal prep duties in the meal preparation area without handwashing, gnats were flying around the tea machine, pink and black colored debris was noted on the inside of four ice machines.

**F835 Administration**

L The Administration failed to provide effective leadership and oversight to ensure effective systems were in place to address falls which resulted in injuries for three residents. The Administration's failure to identify serious outcomes related to falls, address the concerns in QAPI, ensure direct care staff members had access to the care planned falls interventions, and ensure fall investigations were reviewed and complete resulted in immediate jeopardy for the three residents. CNAs did not have access to resident care plans and were unaware of fall risk reduction interventions for each resident. The QAPI council minutes revealed the falls for the three residents were not thoroughly investigated so root cause analyses and contributing factors were not identified. The falls were not documented in the QAPI minutes to indicate they had been discussed and analyzed by the QAPI program. The falls information presented by the VP of Compliance and Quality and reported to the QAPI council was not individualized or resident specific and contained only the total number of falls and if a fall resulted in injury. No identifiable efforts to obtain a root cause of the incident and no devised plan for implementing interventions was noted in the documentation. During an interview/observation of the QAPI council meeting minutes with the Administrator. The Administrator reported that falls had been an ongoing problem and presently, there was no PIP in place to address fall prevention and there was a lack of effort to implement a project to curtail falls by the QAPI council. Further interview revealed the Administrator confirmed development and/or revision of care plans with appropriate interventions had not been identified as a problem in the QAPI process as related to falls. The Administrator confirmed the facility's QAPI process had been ineffective with prioritizing and identifying problems related to falls, as well as with developing an organized plan to address fall prevention.

**F837 Governing Body**

L The facility’s governing body failed to provide effective leadership, oversight to the Administrator, establish, develop, revise, and implement an effective fall program to include CNA access to care plans and fall interventions, and failed to oversee and maintain an effective QAPI program. The facility's failure placed three residents in immediate jeopardy and had the potential or likelihood to affect all 40 residents in the facility.

F The facility's governing body failed to have an operating system in place to ensure residents were free from neglect for one resident. The resident sustained a major injury with a fractured femur after an unwitnessed fall related to an air mattress. The Governing Body failed to have an operating system in place to ensure the physician was notified and that staff followed policies and procedures related to quality of care. The Governing Body failed to provide oversight that established and implemented policies and procedures to ensure facility staff investigated abuse allegations thoroughly and ensure abuse allegations were reported timely to the respective entities. The Governing Body failed to provide oversight to manage financial responsibilities to ensure five residents received account refunds within 30 days of discharge. The Governing Body failed to have an operating system in place to ensure Administration administered the facility in a manner that enabled the facility to use its resources effectively and efficiently and failed to have an operating system in place to ensure the facility's QAPI Committee identified, developed, and implemented an appropriate plan of action to correct identified quality deficiencies related to quality of a care. NOTE: This is a good example of a "stacked" tag under the Governing Body requirement. The tag should have unique findings related to the Governing Body and the tag should be able to "stand alone". The findings under this tag are duplications of findings of other tags throughout the CMS 2567.

**F865 QAPI Program/Plan, Disclosure/Good Faith Attempt**

D The facility failed to implement a quality assurance plan when concerns were identified related to misappropriation of resident funds and controlled medications for two residents. Resident #1 had an order for Hydrocodone-Acetaminophen 5-325 mg. as needed for pain. The pharmacy filled the order with 30 tablets. The facility's investigation indicated the resident was transferred to the ER. When the nurse was attempting to secure the resident's narcotics, the narcotics had not been logged into the narcotic count sheet or in the medication cart. The nurse on duty at the time the medication was received refused to submit to a drug screen and denied having knowledge of the missing medications. Resident #2 reported they had loaned a staff member $320 five months prior and the staff member had not paid them back. The staff member denied the allegation. The staff member returned the money and was terminated. The Administrator reviewed the QAPI plan in relation to the incidents and agreed there was nothing specific about misappropriation of resident property in the plan. The Administrator stated the identified issue regarding misappropriation of resident property was not taken to QAPI for discussion or follow up.

D The facility failed to ensure that one abuse/neglect investigation was reported and addressed in the facility's QAPI program. There was no mention of the allegation in the QAPI Committee minutes.

**F867 QAPI/QAA Improvement Activities**

L Based on facility policy review, facility documentation review, medical record review, observation and interview, the facility's QAPI committee failed to reassess, monitor ongoing concerns and perform a root cause analysis related to falls for three residents. The facility failed to develop an effective QAPI program that recognized concerns to ensure systems and processes were in place and consistently followed by staff to prevent falls for three residents. The failure of the QAPI Committee to ensure a safe environment and develop corrective action plans for falls resulted in immediate jeopardy for the three residents and had the potential or likelihood to affect all 40 residents of the facility.

F The QAPI Committee failed to ensure an effective QAPI program that identifies quality deficiencies, develops a plan of action and monitors action plans for effectiveness. The QAPI Committee failed to maintain oversight, establish, and implement procedures when they failed to recognize deficiencies related to resident neglect. The facility failed to recognize resident neglect for one resident when nursing staff failed to ensure accident hazard risks were identified with interventions to prevent a fall with major injury, promptly notify and consult the physician after an unwitnessed fall and ensure a care plan was developed/revised to meet resident care needs. The QAPI Committee failed to maintain oversight, establish, and implement procedures to address identified quality deficiencies related to investigation and reporting of allegations of abuse for one resident when administration failed to investigate and report staff to resident abuse. The QAPI Committee failed to ensure resident accounts were refunded within 30 days of discharge from the facility for five residents. In an interview with the Administrator, the Administrator stated the resident's unwitnessed fall with a major injury was not discussed in the QAPI Committee meeting held during the month of the fall due to the meeting addressed concerns from the prior month, but it was discussed in the meeting held during the month after the fall and the month after the abuse allegation. The Medical Director did not attend the QAPI Committee meetings.

**F880 Infection Prevention & Control**

E The facility failed to ensure proper infection control practices when staff members failed to perform hand hygiene during meal pass, failed to clean reusable equipment after administering medications, and failed to place a clean barrier between medications and the surface under it. One staff member touched a resident's milk carton on the spout with their bare hands. One staff member delivered a meal tray, repositioned a resident, donned gloves, repositioned the incontinence pad under the resident, then removed the gloves. The staff member did not perform hand hygiene after removing the gloves and prior to setting up the resident's tray. Multiple staff members delivered trays, repositioned the resident or touched environmental surfaces and continued to set up the meal tray without performing hand hygiene. A nurse failed to place a barrier underneath nasal spray, and an insulin pen and returned them to the cart and back into their bags. Two nurses administered medications through a resident's PEG tube and failed to wash the syringe before placing it back into the bag.

E The facility failed to ensure infection control practices to prevent the spread of infection when three nurses failed to perform hand hygiene and failed to clean equipment during medication administration. While administering medications through a resident's PEG tube, Nurse #1 checked placement of the tube with her stethoscope and placed the stethoscope back around her neck afterwards, failed to clean the medication syringe after use and prior to placing it back into the plastic storage bag, washed her hands for only eight seconds after removing gloves, removed the stethoscope from her neck and placed it on the medication cart and failed to clean the medication cart after leaving the resident's room. The nurse failed to clean the stethoscope before and after use and prior to placing it around her neck and prior to placing it on the medication cart. The nurse was observed by the surveyor on three separate occasions to perform handwashing for only eight or nine seconds instead of the required 20 seconds. LPN #2 washed her hands for only nine seconds after removing gloves and failed to turn the water faucet off with a clean dry paper towel. LPN #3 was observed on three occasions while washing her hands for only 5-13 seconds each time. LPN #3 touched the resident's eye lid with the eye dropper while administering eye drops and failed to clean the medication cart after rolling it out of a resident's room. The nurse failed to ensure the eye dropper was not contaminated before returning it to the medication cart. LPN #4 rolled the medication cart into a resident's room to administer medications and failed to clean the cart after leaving the room. NOTE: There is no standard or regulation that requires healthcare workers to turn the water faucet off with a clean, dry paper towel after handwashing. There is no standard requiring cleaning of a cart after rolling it out of a resident's room unless the room is under isolation precautions or the cart is visibly soiled or contaminated.

E The facility failed to ensure infection control practices to prevent the spread of infection were maintained when two staff members failed to perform hand hygiene during medication administration and wound cart. One nurse failed to perform hand hygiene prior to checking a resident's blood sugar. The same nurse failed to perform hand hygiene before donning and after removing gloves during medication administration for a second resident. Another resident had a sign on their door indicating enhanced barrier precautions were required. There was no isolation cart with PPE. A CNA completed a bed bath and incontinent care for the resident without PPE. Observation of the wound nurse with two different residents indicated the nurse failed to wash their hands for at least 20 seconds, turned off the water faucet with the same paper towel used to dry their hands, failed to perform hand hygiene before donning and after doffing gloves and touched environmental surfaces after donning clean gloves and prior to performing a dressing change.
NOTE: There is no requirement to turn off the water faucet with a clean/dry paper towel after handwashing. Refer to:
CDC MMWR: https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf#page=19
CDC Slides: https://www.cdc.gov/handhygiene/download/hand_hygiene_core.pdf

D The facility failed to ensure infection prevention and control practices to prevent the spread of infection were used when two staff members failed to clean a treatment cart and replace contaminated oxygen tubing. During the survey, the fire alarm was activated, and the treatment nurse pushed the treatment cart into a resident's room, exited the room, closed the door, and went to stand in front of the exit door at the end of the hall. The Treatment cart was left in the resident's room. When the fire alarm was cleared, the staff member retrieved the treatment cart from the resident's room. The staff member wiped down the top of the cart with a Sani-Wipe but failed to clean any other parts of the cart. The Treatment cart was not thoroughly cleaned after it was removed from the resident's room. The resident's room in which the cart was temporarily placed was not an isolation room. NOTE: THCA has requested assistance through AHCA for a review of this deficiency by CMS.

D The facility failed to maintain infection control practices for one resident in TBP and failed to provide hand hygiene assistance for residents prior to their meal on one hallway observed for meal tray distribution. The facility's policy required staff to assist the residents by giving them soap, water, a washcloth, and a hand towel to clean their hands before their meal trays arrive and assist if needed. CNAs were observed delivering trays to the residents and did not offer hand hygiene assistance. Another resident was in a room with TBP (contact isolation) for MRSA. A CNA was observed delivering the resident's tray to the room. The CNA wore gloves but did not wear a gown during the interaction with the resident.

D The facility failed to follow guidelines and wear the proper personal protective equipment when care was provided for one resident who required enhanced barrier precautions. The facility had a policy to ensure additional and appropriate PPE is utilized, when indicated, to prevent the spread of MDROs. The resident had a sign on the door indicating enhanced barrier precautions were required for the resident. The nurse provided wound care without wearing a gown.

D The facility failed to ensure proper infection control practices when one staff member handled the resident's food with their bare hands, when one staff member placed a dirty tray back on the tray cart with clean trays and when one staff member failed to perform hand hygiene during a dining observation. The CNA touched environmental surfaces and picked items up from the floor with their bare hands. The CNA proceeded to set up the resident's tray and did not perform hand hygiene before touching items on the tray.

**F883 Influenza and Pneumococcal Immunizations**

D The facility failed to assess two residents for medical contraindications prior to providing the Influenza vaccine. The section of the consent forms that contained screening questions regarding fever in the last 72 hours, allergies to eggs, history of severe reaction to flu vaccine or Guillain-Barre syndrome, allergies to latex were unanswered.

**F908 Essential Equiptment, Safe Operating Condition**

F The facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition. The stand-alone cooler in the kitchen had water dripping on the inside, a request for repair of two refrigerators were made that included one not holding the appropriate temperature and the other with condensation dripping from the top.

**F909 Resident Bed**

F The facility failed to ensure routine and regular scheduled side rail assessments were completed to identify the risk of entrapment for three residents. The first resident had ½ rails bilaterally on the upper side and a ½ side rail on the left lower side. The DON confirmed the resident required a bariatric bed due to his weight and the bed had been ordered from a rental company. The bariatric bed arrived at the facility with the side rails and an air mattress in place and had not been added by the facility. The DON stated she was unaware if maintenance had performed inspections of bed frames, mattresses, and bed rails. The second resident had bed rails in use bilaterally on the upper portion of their bed. The resident stated they were used to help with mobility. The resident confirmed the facility had not discussed the risks of bed rail use with her. The third resident had bilateral grab bars on the upper part of their bed. The DON stated the grab bars were in place for positioning assistance and were not considered bed rails. The DON stated she was unaware if maintenance had performed an inspection of the bed frames, mattresses, and bed rails. The DON confirmed there had been no accidents or injuries in the facility due to the use of bed rails. The facility did not have a policy related to bed rail usage and were unaware of the federal regulations related to the use of bed rails. The maintenance department confirmed that monthly bed inspections were performed that included the cords, plug, headboard, foot rails, handrails, bed frame, electrical system and locking mechanism and confirmed the handrail inspection involved checking for loose or broken handrails. The Director stated the facility had not considered grab bars and side rails as an entrapment risk and the monthly bed inspections did not include measurements between the mattress and side rails or assessment of entrapment risk.

**F921 Safe/Functional/Sanitary/Comfortable Environment**

D The facility failed to provide a safe, functional, sanitary, and comfortable environment in four resident rooms, a dining room, two hallways, the soiled laundry room and the central supply room, and one elevator. The following observations were made by the surveyor: dried brown matter on the outside of the lower front of a resident's toilet bowl, rust-colored stain in two resident bathtubs, dirty hand sanitizer dispensers, a dirty rug in front of a door, puddles of water on the floor in front of the washing machines, holes in the floor, baseboards off the wall, and broken ceiling tile in the laundry room, the central supply floor was dirty with black footprints, scuff marks and black debris and the bottom shelf was dirty with dust and an open package of paper towels, a brown colored spill in the hallway, a light not working in one shower stall of the shower room, a ball of hair on the floor, rust spots on the handrails, black debris between the floor tiles, and paint chipped off the door frames in the shower room, a window ledge was dirty with dusty gray debris in one hallway, a chair across from the nurses' station had a sharp edge, a resident's room floor was dirty as well as the hallway outside the room and the bathroom floor, in a resident's room a bedside table laminate was partly peeled off, and a build-up of black debris in all four corners of the elevator and shoe prints on the back wall opposite of the door of the elevator. The dining room had food and debris on the floor under the tables.

D The facility failed to ensure a safe, sanitary, and comfortable environment for four residents. The surveyor observed the following on the floors of four resident's rooms: light brown sticky substance and stain, scattered paper, loose hair in the corner, baseboard loose from the wall and food crumbs. An overbed table was dirty, a dark substance was smeared on the wall beside the toilet, and there was dust on the overbed lights.

**F925 Maintains Effective Pest Controls Programs**

E The facility failed to maintain an effective pest control system to ensure the residents' environment was free of pests. Staff reported seeing cockroaches in the housekeeping supply room and in resident rooms. Dead insects, identified as cockroaches, were observed by the surveyor in resident rooms and in one resident's nightstand. The Administrator stated they were not completely free of cockroaches due to family members bringing in personal items and the age of the building. The pest control contractor had sprayed the facility two weeks prior but stated to the surveyor that the spray was not as effective as possible due to the limitations of what chemicals could be sprayed in the facility and the need to move personal belongings which could not be allowed. The contractor also stated residents could not be present during a fogging intervention.

D The facility failed to maintain an effective pest control program and prevent parasites or possible maggots for one resident with wounds. The resident had notations in the medical record regarding refusal of ADL care. A clinical note indicated a nurse identified larvae present on the resident's skin in the skin folds. The maintenance staff member confirmed that flies were found in this resident's room and fly strips were hung for a limited time to control them. Flies were identified on the strips when they were removed.

**K211 Alcohol Based Hand Rub Dispensers**

D The facility failed to maintain the means of egress. The egress door in the dining area was obstructed with dining tables and chairs. There was a barrel latch installed on the bathroom and closet doors of one resident's room.

**K222 NFPA 101 Egress Doors**

F The facility failed to maintain egress doors. The delayed-egress doors in three locations would not release within the required 15-seconds when manually tested and did not release upon activation of the fire alarm.

F The facility failed to maintain the egress doors. The delayed egress doors in five areas did not have the required 15 seconds delayed egress signage.

**K345 Fire Alarm System; Testing and Maintenance**

F The facility failed to conduct fire alarm inspections per the requirements of NFPA 101 2012 Edition and NFPA 72 2010 Edition. The Facilities Director confirmed that visual inspections for the fire alarm system were not conducted semiannually.

D The facility failed to maintain the fire alarm system. The surveyor observed the facility's fire alarm annunciator panel showed a trouble and the system was silenced. The Maintenance Director and other facility staff had no knowledge of the fire alarm system in trouble. The Maintenance Director stated the fire alarm was beeping when he came in that morning be he silenced it.

**K372 Subdivision of Building Spaces; Smoke Barriers**

D The facility failed to maintain smoke barrier walls. The surveyor observed the following: penetrations in the one-hour fire rated smoke barrier wall not properly fire stopped with approved fire stop systems in six areas.

**K521 HVAC**

D The facility failed to maintain the fire dampers. The facility was unable to provide documentation of the fire damper inspection for the prior year. The last documented fire damper inspection was conducted in 2018.

**K741 Smoking Regulations**

D The facility failed to maintain smoking regulations. The smoking areas were not equipped with metal containers with self-closing cover devices.

D The facility failed to enforce smoking regulations. The metal containers with self-closing devices were filled with trash.

**K781 Portable Space Heaters**

D The facility failed to prohibit portable space heaters exceeding 212 degrees F. A portable space heater was noted in the staffing coordinator's office.

**K920 Electrical Equipment; Power Cords and Extension Cords**

D The facility failed to prohibit the use of extension cords used as a substitute for fixed wiring. Extension cords were in use in three locations.

**K923 Gas Equipment - Cylinder and Container Storage**
**Container Storag**

D The facility failed to maintain oxygen cylinders. Three areas were noted with unsecured oxygen cylinders.

**N1102 Records and Reports; Recording of Unusual Incidents**

The facility failed to report a staff to resident allegation of abuse within the required timeframe for one resident. A resident reported to a staff member that a CNA had been abusive and argumentative during care. The facility was unable to provide documentation that the police were notified or any documentation of an investigation. The CNA was suspended during the investigation but there was no documentation of the suspension in the CNA's personnel file. The Administrator was the abuse coordinator. The Administrator was on vacation when the incident occurred. The allegation did not get reported to the SSA.

The facility failed to report an allegation of abuse for one resident. The DON was given a report of verbal disrespect to a resident from a staff member. The family also reported the staff member removed the resident's shirt hastily and hurt the resident's eye. The allegation of abuse was not reported to the SSA. The Administrator and the DON did not consider the allegation abusive and did not report. Their investigation indicated the resident had removed the shirt himself.

The facility failed to ensure an allegation of misappropriation of resident property was reported to the SSA. The resident, under the care of hospice, was prescribed and the pharmacy dispensed Oxycodone-Apap, 30 count. Two nurses had reconciled the medications after the pharmacy had delivered them. Prior to locking away the narcotic card, one nurse, with the card in her possession, got called away for an emergency and left the card unsecured and unattended in the facility nurse charting room. When the nurse returned to the charting room, the narcotic card was missing. A search was conducted, drug screens were collected, notifications were made. The narcotic card was not located. One nurse left the facility prior to the collection of a drug screen. The resident who had the prescription for the narcotic stated she always received pain medication when requested. The medical director and the resident stated in an interview with the surveyor that they were not notified of the missing card. The medication was replaced by the facility pharmacy at no additional cost to the resident. The surveyor asked the Medical Director if the situation should have been considered misappropriation. The Medical Director answered yes. The Administrator was asked by the surveyor why this incident was not considered misappropriation. The Administrator stated the resident was not charged for the medication and the card was replaced and therefore, was not considered to be misappropriated and was not reported to the SSA.

**N1201 Resident Rights; Privacy in Treatment**

The facility failed to maintain and enhance resident's dignity and respect when one nurse failed to provide privacy for a resident when providing wound care. The resident's buttocks were exposed to a window without the blinds closed. There was a resident sitting outside the window in the courtyard.

The facility failed to maintain or enhance resident dignity and respect when three staff members failed to knock and/or announce themselves before entering a room, failed to use courtesy titles, and referred to residents as feeders.

**N1207 Resident Rights**

The facility failed to protect the resident's right to be free from physical abuse by another resident. A resident's roommate hit the resident multiple times with the electrical bed control causing bruising to the resident's forearm. The resident was sent to the ER for evaluation of the forearm and no fractures were identified. The other resident was removed from the area and placed on one-to-one observation for a period of time.

The facility failed to ensure two residents were not physically abused. The failure resulted in Immediate Jeopardy for Resident #1 and Resident #2 when a RN physically struck Resident #1 and forcefully took him down to the ground and when Resident #3 physically struck Resident #2 multiple times in the jaw and neck resulting in a lacerated lip. Resident #2 and #3 had a known history of previous verbal altercations and one prior physical altercation. Resident #1 had documentation indicating a fixation on leaving the facility, changes in demeanor, increased facial expressions and speaking with a louder voice. There was no documentation indicating the resident's changes in demeanor and fixation on leaving the facility had been addressed. Another clinical note indicated the resident had attempted multiple times to leave the facility. There was no documentation of interventions to deescalate the resident or address the attempts to leave the facility. A clinical note indicated the resident had an altercation with an RN staff member and was not injured but was sent to the ER for evaluation. Staff interviewed regarding the incident indicated the Resident had repetitive questioning regarding wanting to go home. The RN spoke with him, and the Resident became more agitated, the RN punched the Resident in the face, then "bear hugged" him and threw him to the floor. Once on the floor, the RN's forearm was across the Resident's neck. The RN did not have a job description. There was no orientation or training provided to the RN regarding the Resident population. The RN had no training regarding responding to residents with aggressive behaviors. Resident #2 had a care plan for verbal and physical behavioral symptoms directed toward others and entries in the medical record indicating the resident was having verbal altercations with other residents and staff. Resident #3 had a care plan and entries indicating a history of verbal behaviors including racial remarks toward another resident. Residents #2 and #3 had a history of altercations and name calling towards each other with one notation of Resident #2 striking Resident #3 on the back. An entry in the medical record indicated the residents had another altercation and were separated but left unsupervised. This was followed by Resident #3 approaching Resident #2 and hitting Resident #2 several times in the face resulting in a laceration of the lip for Resident #2. The Corporate Director reported the facility monitored behaviors for the residents but did not look at them overall for tracking and trending. The facility did not have an effective method to communicate specific interventions to CNAs.

**N1213 Resident Rights**

The facility failed to prevent nonconsensual sexual contact between Resident #1 and three Residents. A CNA observed Resident #1 and Resident #2 together while Resident #1 was attempting to remove the brief from Resident #2. Resident #2 was resisting the advances. The CNA left the residents alone while going to get assistance to remove Resident #1. The CNA failed to protect Resident #2 from further nonconsensual sexual contact. The nursing staff failed to provide interventions and within four hours, Resident #1 was observed touching Resident #3's genital area. Nursing staff failed to intervene appropriately and within two hours, Resident #1 had nonconsensual sexual contact with Resident #4 by grabbing the Resident and kissing the resident with an open mouth followed by licking Resident #4's face. The facility's failure to prevent Resident #1's continued aggressive sexual behavior placed Residents #2, #3 and #4 in Immediate Jeopardy. Resident #1 had a history of inappropriate sexual contact with other residents. The Social Services Director stated they had not been asked to evaluate the capacity for Resident #2, #3 and #4 to consent to sexual activity and stated the residents had cognitive impairments that would prevent them from being able to consent to sexual contact. The facility failed to ensure two Residents (#5 and #6) were free from verbal abuse. Resident #5 had been served his breakfast tray by a CNA. The CNA left the room, and the resident pressed the call light to request coffee. The resident reported the CNA spoke to him in a mean voice and is not polite. Another resident reported asking the same CNA if they could empty his bag and the CNA responded in a mean tone of voice, "can't you do that yourself?". The CNA had an inappropriate conversation with another CNA in the presence of the resident. The resident reported feeling intimidated and angry.

**N1226 Resident Rights**

The facility failed to provide pain management consistent with professional standards of practice and the resident's goals and preferences for one resident. The resident complained of left side, left shoulder, and left arm pain after a fall. The resident's pain evaluation indicated the resident exhibited negative verbalizations, facial expressions, physiological changes, and the resident was in pain. The resident had not been given pain medication as ordered on a PRN basis.

**N1410 Disaster Preparedness; Fire Safety Procedures Plan**

The facility failed to conduct the required disaster drills. The facility was unable to provide documentation of a tornado, earthquake, and flood drill conducted prior to 3/1/23.

**N301 Disciplinary Procedures**

The facility was found out of substantial compliance with federal requirements for LTC facilities. The failure placed the resident's safety and well-being at risk for negative outcomes.

The facility failed to maintain substantial compliance with federal regulations for nursing homes.

The facility failed to maintain compliance with federal Requirements of Participation.

The facility failed to maintain compliance with federal Requirements of Participation.

**N424 Administration; Filed Documentation of Abuse Registries**

The Administration failed to provide effective leadership and oversight to ensure effective systems were in place to address falls which resulted in injuries for three residents. The Administration's failure to identify serious outcomes related to falls, address the concerns in QAPI, ensure direct care staff members had access to the care planned falls interventions, and ensure fall investigations were reviewed and complete resulted in immediate jeopardy for the three residents. CNAs did not have access to resident care plans and were unaware of fall risk reduction interventions for each resident. The QAPI council minutes revealed the falls for the three residents were not thoroughly investigated so root cause analyses and contributing factors were not identified. The falls were not documented in the QAPI minutes to indicate they had been discussed and analyzed by the QAPI program. The falls information presented by the VP of Compliance and Quality and reported to the QAPI council was not individualized or resident specific and contained only the total number of falls and if a fall resulted in injury. No identifiable efforts to obtain a root cause of the incident and no devised plan for implementing interventions was noted in the documentation. During an interview/observation of the QAPI council meeting minutes with the Administrator. The Administrator reported that falls had been an ongoing problem and presently, there was no PIP in place to address fall prevention and there was a lack of effort to implement a project to curtail falls by the QAPI council. Further interview revealed the Administrator confirmed development and/or revision of care plans with appropriate interventions had not been identified as a problem in the QAPI process as related to falls. The Administrator confirmed the facility's QAPI process had been ineffective with prioritizing and identifying problems related to falls, as well as with developing an organized plan to address fall prevention.

The facility failed to ensure a safe environment, provide supervision, and oversight to prevent potential accidents and injuries for four cognitively impaired residents who reside on the secured unit and who were assessed for having wandering behaviors. The failure resulted in immediate jeopardy when a white substance identified as methamphetamine was found by facility staff in a resident’s room on two occasions. The DON had found a crystallized white powdery substance rolled up in a $1 dollar bill, later identified as methamphetamine, in the closet of the unoccupied side of the Resident’s room. Four days later, two white crystallized rock formed substances, in a box labeled “baking soda” was found in the top of a resident’s closet. The substance was later identified as methamphetamine. The police department was notified and conducted testing of the substances on both occasions and identified it as methamphetamine. A sweep of the entire building was conducted, all staff who had worked the hall were drug tested. The police report was not available to the surveyor. No residents were tested. There were no witness statements in the investigation. The family of the resident residing in the room were not notified. The facility could not verify drug tested had been conducted for all staff who had entered the hallway where the drugs were found. There was no visitors log to determine who had visited the secured unit. The Regional Nurse was asked how the facility ensures the safety of the residents. The nurse reported the facility continues to conduct facility searches and the staff know to report any suspicious substances and activity.

**N601 Performance Improvement Program**

The QAPI Committee failed to ensure an effective QAPI program that identifies quality deficiencies, develops a plan of action and monitors action plans for effectiveness. The QAPI Committee failed to maintain oversight, establish, and implement procedures when they failed to recognize deficiencies related to resident neglect. The facility failed to recognize resident neglect for one resident when nursing staff failed to ensure accident hazard risks were identified with interventions to prevent a fall with major injury, promptly notify and consult the physician after an unwitnessed fall and ensure a care plan was developed/revised to meet resident care needs. The QAPI Committee failed to maintain oversight, establish, and implement procedures to address identified quality deficiencies related to investigation and reporting of allegations of abuse for one resident when administration failed to investigate and report staff to resident abuse. The QAPI Committee failed to ensure resident accounts were refunded within 30 days of discharge from the facility for five residents. In an interview with the Administrator, the Administrator stated the resident's unwitnessed fall with a major injury was not discussed in the QAPI Committee meeting held during the month of the fall due to the meeting addressed concerns from the prior month, but it was discussed in the meeting held during the month after the fall and the month after the abuse allegation. The Medical Director did not attend the QAPI Committee meetings.

Based on facility policy review, facility documentation review, medical record review, observation and interview, the facility's QAPI committee failed to reassess, monitor ongoing concerns and perform a root cause analysis related to falls for three residents. The facility failed to develop an effective QAPI program that recognized concerns to ensure systems and processes were in place and consistently followed by staff to prevent falls for three residents. The failure of the QAPI Committee to ensure a safe environment and develop corrective action plans for falls resulted in immediate jeopardy for the three residents and had the potential or likelihood to affect all 40 residents of the facility.

**N629 Infection Control; Disinfect Contaminated Items**

The facility failed to ensure infection control practices to prevent the spread of infection when three nurses failed to perform hand hygiene and failed to clean equipment during medication administration. While administering medications through a resident's PEG tube, Nurse #1 checked placement of the tube with her stethoscope and placed the stethoscope back around her neck afterwards, failed to clean the medication syringe after use and prior to placing it back into the plastic storage bag, washed her hands for only eight seconds after removing gloves, removed the stethoscope from her neck and placed it on the medication cart and failed to clean the medication cart after leaving the resident's room. The nurse failed to clean the stethoscope before and after use and prior to placing it around her neck and prior to placing it on the medication cart. The nurse was observed by the surveyor on three separate occasions to perform handwashing for only eight or nine seconds instead of the required 20 seconds. LPN #2 washed her hands for only nine seconds after removing gloves and failed to turn the water faucet off with a clean dry paper towel. LPN #3 was observed on three occasions while washing her hands for only 5-13 seconds each time. LPN #3 touched the resident's eye lid with the eye dropper while administering eye drops and failed to clean the medication cart after rolling it out of a resident's room. The nurse failed to ensure the eye dropper was not contaminated before returning it to the medication cart. LPN #4 rolled the medication cart into a resident's room to administer medications and failed to clean the cart after leaving the room. NOTE: There is no standard or regulation that requires healthcare workers to turn the water faucet off with a clean, dry paper towel after handwashing. There is no standard requiring cleaning of a cart after rolling it out of a resident's room unless the room is under isolation precautions or the cart is visibly soiled or contaminated.

**N645 Nursing Services**

The facility failed to ensure a safe, sanitary, and comfortable environment for four residents. The surveyor observed the following on the floors of four resident's rooms: light brown sticky substance and stain, scattered paper, loose hair in the corner, baseboard loose from the wall and food crumbs. An overbed table was dirty, a dark substance was smeared on the wall beside the toilet, and there was dust on the overbed lights.

**N666 Nursing Services; Director of Nursing**

The facility DON failed to provide effective leadership and oversight to ensure effective systems were in place to address falls which resulted in falls with injuries for three residents. The DON's failure to identify serious outcomes related to falls, address the concerns in QAPI, ensure direct care staff members had access to the care planned falls interventions, and ensure fall investigations were reviewed and complete placed the three residents in an environment which was detrimental to their health, safety and welfare and had the potential to affect all 40 residents of the facility.

**N669 Nursing Services; Physician Notification**

The facility failed to notify and consult with the physician related to a change in condition after an unwitnessed fall for one resident. The facility's failure to notify and consult the resident's physician to obtain additional orders for immediate care and potential interventions resulted in Immediate Jeopardy. The Resident was found in the floor beside the bed. Staff placed the resident back into the bed without an assessment for injury and did not consult with the physician for further evaluation. There was no documentation of an unwitnessed fall and no documentation of increased pain prior to obtaining X-ray results that were positive for a fracture. The nurse reported that when the staff placed the resident back in the bed immediately after the fall, the resident cried out, but that was normal for the resident. The nurse denied completing an assessment for injury. The resident had symptoms of facial grimacing, moaning, and increased yelling out with movement, the week following the fall. The physician and family were not notified nor was the physician consulted for five days after the fall. Staff obtained an order for an X-ray for bruising and swelling of the resident's thigh and knee. The X-ray was positive for a femur fracture. The DON did not investigate the fall for an additional two days.

The facility failed to notify a resident's physician and family of a change in condition. The resident had an episode of vomiting in the evening of the second day following readmission from the hospital. Approximately two hours later, the CNA informed the nurse of abnormal vital signs. Messages were left for the family. After returning to the room, the resident was found with no vital signs. The resident's physician and family were not notified when the resident had the episode of vomiting.

The facility failed to notify the resident's representative and the physician for falls involving two residents and failed to notify the resident's representative for weight loss and a respiratory illness for one resident, and sexual abuse of four residents.

**N673 Nursing Services; Administration of Medications**

The facility failed to ensure staff had specific knowledge, sufficient competencies and skill sets necessary to provide appropriate care and services to three residents with behavioral and mental health needs. Fourteen staff members including CNAs, LPNs, Housekeeping Personnel and a RN failed to demonstrate appropriate interventions were implemented to prevent ongoing altercations between Resident #2 and Resident #3 with a history of verbal and physical altercations. An RN failed to implement appropriate interventions for a verbally aggressive Resident when the RN struck the Resident and forced the Resident to the ground. The lack of staff knowledge and failure to implement effective interventions resulted in physical harm to Resident #2 and abuse for Residents #1 and #2. The failure of the staff to demonstrate appropriate competencies to provide care to residents with behaviors and mental healthcare needs and failure to ensure the safety of all residents residing in the facility to be free from abuse resulted in Immediate Jeopardy. Staff denied having a competency checkoff regarding care of residents with behavioral symptoms and denied having any specific education. The facility was asked to provide documentation or evidence of annual competency assessments per job description duties, orientation or training and no documentation was provided.

**N682 Nursing Services**

The facility failed to develop an individualized care plan for one resident. One resident required the use of an air mattress. In an interview with the surveyor, the staff reported the mattress was overinflated when the resident had fallen from the bed to the floor. The resident's care plan did not include safety interventions related to use of an air mattress including ensuring the proper inflation was maintained to prevent pressure wounds or worsening of wounds, ensuring the resident was correctly positioned in the center of the mattress to prevent slipping from the edge of the mattress during pressure changes, or ensuring proper use of linens to prevent shearing injuries. The resident had an unwitnessed fall from the bed with the air mattress resulting in a fractured femur. The DON stated the resident should have had a care plan for the use of an air mattress with monitoring for positioning in bed and monitoring for proper inflation.

**N682 Pharmaceutical Services; Storage of Medications**

The facility failed to update residents' care plans after a fall with new and appropriate interventions for three residents. The failure resulted in the potential for harm for one resident by failing to develop and implement appropriate interventions after a fall with major injury. The resident was sent to the hospital for treatment and upon return, no interventions were implemented. The failure resulted in actual harm for another resident who sustained a right hip fracture after a third fall. The resident's care plan did not show new and appropriate fall interventions after the three falls. The third resident sustained a closed head injury after a fall and fell again the following day. The resident was sent to the ER for an altered mental status. The resident did not have new/appropriate interventions implemented after the falls. The failure resulted in Immediate Jeopardy for the three residents. The facility failed to give CNAs access to the care plans in the EMR and failed to have a person-centered care plan for 11 residents. The DON confirmed the CNAs did not have access to the care plans and were made aware of fall interventions through verbal communication. The DON reported being unaware that fall investigations were not being completed timely and new appropriate interventions were not being documented on the care plan.

The facility failed to conduct quarterly interdisciplinary care plan meetings for two residents. The facility was only able to provide documentation of one care plan meeting per year for the past three years for Resident #1. There was no documentation of a care plan meeting during the first two quarters of 2023 for Resident #2.

The facility failed to develop and implement a person-centered care plan for four residents. Resident #1 was admitted with diagnoses of Seborrheic Dermatitis, Depression, and was involved in a nonconsensual sexual episode with another resident. The resident's care plan did not address goals or interventions for Seborrheic Dermatitis, Depression, or the nonconsensual sexual contact. Two other residents involved in a nonconsensual sexual incident did not have a care plan or interventions to address the incident. A fourth resident had diagnoses including Vascular Dementia and an episode of nonconsensual sexual contact. The resident's care plan did not address vascular dementia or the nonconsensual sexual contact.

**N689 Nursing Services; Physical Restraints**

The facility failed to ensure one resident was free from significant medication errors. On one date, the facility staff administered duplicate doses of insulin to the resident. The medication error had the potential to cause the resident to become hypoglycemic. The nurse administering the first dose of the medication failed to document medication administration after it was administered.

The facility failed to follow physician's orders for medication administration and failed to obtain a physician's order to apply a foot strap to a resident's wheelchair. One resident had an order for Alprazolam three times per day for anxiety. The resident missed three doses of the scheduled drug due to unavailability. Another resident was noted to have a Velcro strap on the footrest of their wheelchair. The therapy staff were unaware of the strap. It was determined the resident's son had placed the strap on the footrest to keep the resident's foot from sliding off. There was no physician's order for the strap.
NOTE: Assessment and care planning for the strap should have been included in the resident's record, however, a physician's order is not required for the strap. This is not an invasive procedure or medication that requires a physician's order.

**N690 Basic Services - Nursing Services**

The facility failed to provide baths or showers at least two times each week or more often if requested for two residents. The two residents reported not getting their showers. The surveyor noted inconsistent and missing documentation of the residents' showers.

**N697 Nursing Services; ADLs**

The facility failed to ensure four residents received assistance with ADLs for bathing/showers, fingernail trimming, cleaning under the fingernails and grooming of facial hair. Three residents were noted with fingernails that were jagged and with dirt underneath the nails. Two residents had oily hair. One resident had a long beard. Another resident reported not having a shower since admission three days prior. In an interview with the surveyor, the fourth resident indicated the staff did not help with ADLs, such as changing his incontinence brief in a timely manner and added once he laid in his waste for 24 hours. The resident stated he was told he would have to wait for help after putting his call light on and usually waited 30 minutes to an hour. The resident stated he preferred a bed bath but didn't always get a bed bath when not given a shower. Documentation of showers/bed baths was inconsistent and was missing on several days. There were no documented refusals of bed baths or showers.

**N727 Pharmaceutical Services**

The facility failed to ensure medications were properly and securely stored when a medication was left in a resident's room for two residents. The surveyor observed a medication cup with nine unopened unsecured medications on a resident's overbed table. The second nurse left the resident's medications on the resident's overbed table, unattended and out of sight, while washing their hands in the resident's bathroom.

The facility failed to ensure medications were properly and securely stored when one nurse left a medication on top of a medication cart, unsecured and unattended. The medication was left in a cup on top of the cart outside of a resident's room.

The facility failed to ensure medications were properly stored and secured. Two staff members left medications unattended and unsecured on resident's overbed tables. External and internal medications were stored together on the medication cart. Santyl and Antibiotic ointment was stored in the same sectioned drawer with oral medications.

**N728 Basic Services; Pharmaceutical Services**

The facility failed to ensure medications were properly stored. The facility had opened, undated, expired medications and controlled substances that were not secured behind two locks on the medication carts. One medication cart had an opened, undated, and expired bottle of Diazepam. The following observations were made in the Medication Storage Room: opened and undated insulin pens and Ativan and Gabapentin not stored under double lock and key.

The facility failed to ensure medications were properly stored in two medication storage areas. A bottle of expired Pantoprazole was found on one of the medication carts. Another medication cart was noted to be unlocked and unattended.

**N730 Basic Services - Pharmaceutical Services**

The facility failed to ensure Schedule II drugs were kept behind two separately locked doors at all times for one Resident. The resident, under the care of hospice, was prescribed and the pharmacy dispensed Oxycodone-Apap, 30 count. Two nurses had reconciled the medications after the pharmacy had delivered them. Prior to locking away the narcotic card, one nurse, with the card in her possession, got called away for an emergency and left the card unsecured and unattended in the facility nurse charting room. When the nurse returned to the charting room, the narcotic card was missing. A search was conducted, drug screens were collected, notifications were made. The narcotic card was not located.

**N743 Pharmaceutical Services; Unused Prescriptions**

The facility failed to have pharmacy systems in place to ensure medications were administered accurately to two residents. One resident was administered a pain medication in pill form that had been discontinued six days earlier due to the resident's decreased ability to swallow pills, consequently, the resident's sublingual pain medication was not administered. The majority of the medication error report was incomplete/blank including description, date, and time of incident, who found the error, the type of error, the individual who made the error, the dosage form, the reason for the error, side effects and immediate observations. Staff reported the discontinued medication should have been removed from the cart and was not. Another resident was administered her roommate's medications.

**N831 Building Standards**

The facility failed to maintain the physical plant and overall environment. The surveyor observed the following: the kitchen handwashing sink was leaking at the foot operating valve, loose/missing floor tiles that moved when stepped on with standing water around the floor drain of the dishwashing room and the kitchen 3-bay sink, multiple CPVC pipes loose and not supported under the dishwasher and dish table, paint peeling and loose from the wall, staining of the wall, and the section of wall between the window and AC unit moved when touched and was made of plywood.

The facility failed to maintain the physical plant. Four areas were noted to have penetrations through the one-hour fire rated gypsum board ceiling that were not sealed with an approved fire stop system.

**N835 Building Standards; Approval of New Construction**

The facility failed to obtain prior written approval from the Tennessee Health Facilities Commission before making alterations to the nursing home. The facility had two courtyards with gates that were equipped with locking hardware. The facility failed to obtain prior approval from the Health Facilities Commission prior to adding the gated courtyards.

The facility failed to obtain approval from the Tennessee Health Facilities Commission prior to making alterations to the facility. Four areas were being used as storage rooms.

**N848 Building Standards; Exhaust & Air Pressure**

The facility failed to maintain negative air pressure in required areas. The soiled utility exhaust fan was inoperable.

**N902 Elimination of Fire Hazards**

The facility failed to eliminate fire hazards. The exterior dryer vents from the laundry room were clogged with lint and had heavy lint build-up.