Survey Deficiency Summary

8 Facilities Surveyed **Surveys Taken 11/03/23-1/10/24**

E004 Plan Review and Update Annually

D The facility failed to maintain and review the emergency preparedness plan. The plan had not been reviewed in five years.

E006 Plan Based on All Hazards Risk Assessment

D The facility failed to review and update the risk assessment plan. The facility could not provide documentation of an updated review of the risk assessment for the EPP.

E013 EP Policies and Procedures

D The facility failed to develop and implement policies and procedures based on the EPP. The facility did not have policies and procedures based on the EPP.

E025 Arrangement with Other Facilities

D The facility failed to provide transfer agreements with other facilities. The facility could not provide written arrangements with other providers to receive residents in the event of an emergency.

F550 Resident Rights/Exercse of Rights

E The facility failed to maintain or enhance the residents' dignity and respect during random observations. Staff members failed to use courtesy titles when addressing the residents, failed to knock and/or announce themselves when entering the residents' rooms, and stood to assist with dining.

D The facility failed to provide privacy for one resident. The resident was observed from the hallway, in the bed closest to the door, dressed in a t-shirt and incontinence brief. The resident was uncovered. The CNA stated that was the way the resident preferred to lie in bed. The surveyor observed the privacy curtain not pulled.

D The facility failed to promote and protect the rights of three residents by not treating the residents with respect and dignity when the residents who needed assistance and wanted to be out of bed were not assisted out of bed. The surveyor reviewed the facility's "ADL Transfer" documentation for the three residents. Each resident was missing documentation for getting out of bed during the three months prior to the survey. One resident did not get out of the bed for 22 days in one month, the second resident was not out of the bed for a total of 27 days of the month reviewed, and the third resident had no documentation of transferring out of the bed for 31 days of the month prior to the survey and was not out of the bed for 77 days out of the 92 days prior to the survey. All three residents expressed a desire to get out of bed to the surveyor. The Activities Director reported that residents were unable to attend group activities due to not being out of bed.

F558 Reasonable Accomidations of Needs/Preferences

D The facility failed to provide accessibility to call lights for one resident. The surveyor observed the resident's call light out of reach on three occasions. The surveyor observed the call light hanging over the resident's refrigerator and twice in a pouch attached to the side of the bed. The resident could not reach the call light to activate the call system.

F567 Protection/Management of Personal Funds

F The facility failed to ensure petty cash was readily available after hours and on weekends for 49 residents. In an interview with the surveyor, the Administrator stated he has not had petty cash since 1 ½ years prior to the survey and had to purchase supplies, snacks and other items including personal care items and food for the residents and wait for a refund once receipts had been submitted. The Business Office Manager reported that if she cannot be reached on the weekends, the residents or their POA would not have access to obtain funds.

F569 Notice and Conveyance of Personal Funds

D The facility failed to convey the funds to the estate of a deceased resident within 30 days of the resident's death. The refund was made 54 days after the resident's death.

F578 Request/Refuse/Discontinue Treatment;Formulate Adv Directives

D The facility failed to provide documentation that one resident was provided with education nor offered information regarding advanced directives. The resident nor the spouse was provided with information.

D The facility failed to ensure seven residents were educated or offered information regarding advance directives. The admission documentation indicated the residents did not have an advance directive. There was no documentation to indicate the residents had been offered or provided assistance with completion of an advance directive and/or the Advance Directive Acknowledgment Form was incomplete.

D The facility failed to inform of or provide written information regarding residents' rights to formulate an advanced directive for two residents. There was no documentation for either resident that the resident or their legal representative was informed of/or provided written information regarding the resident's right to formulate an advanced directive.

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

J The facility failed to notify the physician or NP of hypo/hyperglycemia for eight insulin-dependent residents. Nursing staff failed to notify the MD or NP of blood glucose levels less than 60mg/dl or greater than 400mg/dl as ordered. Failure to report critical blood glucose levels could result in acute/chronic conditions that could lead to organ failure, coma, and/or death, and placed the residents in Immediate Jeopardy. The facility was unable to locate any documentation that the physician or NP were notified of multiple critical blood sugar values that were obtained by fingerstick for the eight residents.

F582 Medicaid/Medicare Coverage/Liability Notice

D The facility failed to provide three residents with the Advanced Beneficiary Notice (ABN), CMS 10055, when therapy services were discontinued, and the resident remained in the facility for long-term care services or was discharged from the facility. The failure left residents without information related to the cost of therapy services if they desired to continue the services and did not allow for them to have an informed choice.

F584 Safe/Clean/Comfortable/Homelike Environment

J The facility failed to ensure a resident environment that was safe, clean, and sanitary to prevent the spread of disease-causing organisms and infections when one resident who had wounds infected with maggots, was observed handling linens and propelling throughout the facility with the drainage/maggots leaking onto the floor from his wheelchair resulting in Immediate Jeopardy. The surveyor observed a large brown dried puddle on the floor near the nurses' station. The nurse indicated the resident let his wounds drip all over the facility and maggots were falling from the back of the resident's wheelchair. The resident had a documented history of refusing care and was under the care of hospice. The Social Services notes indicated the resident had refused a condom catheter and was leaving bodily fluids all over the hallway floor and in his room. The resident was observed by the surveyor next to the linen cart, pulling linen onto his lap, scratching himself and leaving a half-dollar sized amount of draining on the floor next to the linen cart and on the floor where the resident was sitting in his wheelchair. The surveyor observed two additional puddles of fluid in the hallway. A nurse reported that other residents were getting the drainage on their hands after rolling through it in their wheelchairs and propelling with their hands. Other residents were interviewed by the surveyor and were asked if they felt the drainage and maggots on the floor were a health hazard. The residents stated they thought it was.

E The facility failed to provide a homelike environment as evidenced by failing to repair areas of chipped paint in three resident rooms and in three hallways, failing to repair holes to trim boards for three resident rooms and in two hallways, failing to repair cracks in the caulking around the heating and air units in two resident rooms and failing to replace the plastic door protector to the entry door of three resident rooms.

D The facility failed to maintain a safe, clean, homelike environment for three residents. The surveyor observed the following: dried white debris on an overbed table, smears of a brown substance on the wall next to a bed and on another resident's siderail.

F600 Free from Abuse and Neglect

J The facility failed to provide goods and services to two residents receiving enteral nutrition that resulted in significant weight loss. The two residents went multiple days with no documented enteral feedings. The two residents received different formulas based on the lack of supplies in the facility. No Registered Dietician was employed in the facility for two months and no oversight was provided for significant weight loss or protein caloric needs for the two residents. The facility's failure resulted in Immediate Jeopardy for both residents. One resident had an order for 2 Cal HN, protein dense nutrition to support volume intolerance. Twenty-six days after the order was written, the resident's order was changed to Jevity 1.5. There was no documentation a RD was consulted regarding the change in the enteral formula. There was no RD employed at the time. Documentation indicated the resident had become ill with an elevated temperature and vomiting. The resident's feeding was stopped, and the resident was transferred to the hospital. Upon readmission, the resident had no order for enteral feeding. The resident remained without an order and enteral feedings for 11 days. The resident had a significant weight loss. The second resident had an order for Glucerna 1.5 enteral feeding, and the order was later changed to Jevity 1.5. There was no documentation in the resident's record of an RD consult for the formula change. The resident had four days of no documentation of an enteral feeding and no documentation of why the order had been changed. The resident had a significant weight loss. The supply clerk was interviewed and stated she could not get the orders filled for the feedings due to nonpayment. The Administrator and CEO were made aware on two occasions. In an interview, a staff member reported the facility was out of the correct enteral feedings and the DON told them to "just give what the facility had available".

F602 Free from Misappropriation/Explotation

J The facility failed to prevent the misappropriation of controlled narcotics for four residents. A nurse observed the ADON consuming two Fiorinal tablets that were ordered for a resident, removing the Controlled Drug Record, and putting it in the shredder box and forging a hand-written copy including random dates and signatures on the Controlled Drug Record. Approximately six months prior to the survey, the DON and the Pharmacist were performing narcotic drug destruction. The destruction log indicated a resident's Morphine Sulfate liquid concentrate bottle, and the Controlled Drug Record sheet were placed in the locked destruction box. When the locked destruction box was opened, the Morphine Sulfate liquid concentrate bottle and the Controlled Drug Record sheet were not in the box. The DON was unable to account for the missing Morphine bottle and Controlled Drug Record sheet. Approximately three months prior to the survey, the hospice nurse and the facility nurse were reconciling a resident's liquid Morphine and identified one ml missing from the bottle. Review of the MAR revealed the nursing staff failed to document a second nurse signature that witnessed the destruction and disposal of a transdermal Fentanyl patch for another resident. The DON failed to investigate or report to the SSA the unaccounted Fiorinal capsules, the missing liquid Morphine, and the failure to properly document the destruction of a Fentanyl patch. The failures resulted in Immediate Jeopardy.

F609 Reporting of Alleged Violations

D The facility failed to report to the SSA two incidents of elopement within 10 minutes of one another, misappropriation of resident narcotics for three residents and an alleged incident of verbal abuse within the two-hour time frame. One resident eloped from the facility through unlocked and unarmed doors on two occasions within 10 minutes. The facility did not investigate or report the incidents to the SSA. The DON failed to investigate or report to the SSA the unaccounted Fiorinal capsules, the missing liquid Morphine, and the failure to properly document the destruction of a Fentanyl patch. A resident alleged that when she fell, a CNA was "hateful" to her and engaged in a "cursing match". The allegation of verbal abuse was not reported to the SSA within two hours.

F610 Investigate/Prevent/Correct Alleged Violation

D The facility failed to investigate two incidents of elopement for one resident. The facility failed to investigate misappropriation of missing narcotics for three residents. One resident eloped from the facility on two occasions within 10 minutes on one day through unlocked and unarmed doors. The facility removed the documentation from the incident note in the medical record and did not investigate or report the incidents. The DON failed to investigate or report to the SSA unaccounted Fiorinal capsules, missing liquid Morphine, and the failure to properly document the destruction of a Fentanyl patch.

F641 Accuracy of Assessments

D The facility failed to accurately complete the MDS for three residents. One resident's MDS was inaccurately coded for the number of falls and the number of falls with injury. Another resident's MDS was coded for a significant weight loss and a physician-prescribed weight loss regime. The resident was not on a physician-prescribed weight loss regime. A resident receiving hospice services was not coded as having hospice services on the MDS.

D The facility failed to accurately complete a MDS assessment for one resident reviewed for MDS assessments. The resident's MDS was coded as if the resident had an indwelling catheter. The catheter had been discontinued approximately six weeks prior to the assessment.

F642 Coordination/Certification of Assessment

E The facility failed to ensure assessments were signed by an RN for twelve residents. The verifications of MDS assessment completion were signed by an LPN.

F644 Coordination of PASARR and Assessments

D The facility failed to resubmit a PASRR for new diagnoses to the state-designated authority for one resident. The resident was admitted to the facility with diagnoses of Major Depressive Disorder, Anxiety Disorder and Bipolar Disorder. The PASRR Level I indicated the resident had no mental health diagnoses.

F656 Develop/Implement Comprehensive Care Plan

D The facility failed to implement the comprehensive care plan for one resident. The resident had an intervention for a bed alarm for fall risk reduction. The resident did not have a bed alarm on their bed.

D The facility failed to develop an individualized comprehensive care plan for two residents. The first resident's care plan did not contain interventions regarding the amount of assistance the resident needed with ADLs. The second resident had a diagnosis of CVA with hemiparesis and required two staff members for transfer. The resident's care plan did not indicate the resident required two staff members for transfers.

F675 Quality of Life

D The facility failed to ensure choices to receive showers was provided for one resident. The resident was scheduled to have showers three days per week. The resident did not receive showers on multiple days during the four-month period prior to the survey.

F684 Quality of Care

D The facility failed to follow physician's orders for one resident. The resident had a physician's order for a bed alarm. The surveyor observed the resident in their bed without a bed alarm in place.

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers

J The facility failed to provide the necessary treatment and services to promote healing of a pressure ulcer wound for one resident. The resident was the only resident in the facility with a pressure ulcer. The facility failed to provide wound care, failed to notify the resident's physician that the resident was not keeping wound clinic appointments, failed to notify the physician the pressure ulcer wound was declining, and failed to ensure infection control practices were implemented to reduce the potential for infection of the pressure ulcer wound. The failures resulted in Immediate Jeopardy when the resident, who was admitted with a pressure ulcer, did not receive treatment and services to promote healing and prevent worsening of the pressure ulcer wound. The resident missed several wound clinic appointments due to transportation issues, had missing documentation of wound treatments and had measurements indicating the wound had increased in size. Stains were identified on the resident's air mattress indicating drainage from the wound. In an interview with the surveyor, the housekeeper stated they had not cleaned the air mattress. The Medical Director stated they had not been notified of the missed appointments and condition of the wound.

F689 Free of Accident Hazards/Supervision/Devices

J The facility failed to provide adequate supervision for a cognitively impaired resident (#1) at risk for elopement. A cognitively impaired resident exited the facility through the front door after a visitor entered the door code and opened the door allowing the resident into the courtyard. The resident was observed knocking on another door, approximately 174 feet from the door the resident exited through. The temperature outside was 46 degrees. The facility failed to conduct appropriate elopement assessments and elopement drills on all shifts. The facility's failure to prevent the resident with a known history of exit seeking behaviors from eloping from the facility resulted in Immediate Jeopardy. The facility's investigation included an interview with the family member who allowed the resident to exit the facility. The family member stated it was no more than 3-5 minutes afterwards that a staff member asked if they had seen a resident go out the front door. There was documentation of an elopement risk reassessment for the resident that was completed sixteen days after the incident. The Medical Director's note did not contain documentation of an assessment of the resident after the elopement. An elopement drill was conducted nine days after the incident for the day shift only. After interviews with multiple staff members, the surveyor determined the area outside where the resident was found was unsafe for the resident. The facility's failure to prevent and monitor falls resulted in actual harm for Resident #2 when the resident fell and sustained a left hip fracture that required surgical intervention. The facility's incident reports indicated the resident had eight falls with the last fall resulting in a fracture. Prior to the eighth fall, the interventions included safety education for the resident and auto-locking wheelchair brakes. The resident was severely cognitively impaired, and education was not an appropriate intervention. The resident had interventions for auto-locking wheelchair brakes that were ineffective due to having falls related to the wheelchair rolling out from under her. In an interview with the surveyor, the Maintenance Director reported having to make an adjustment on the resident's auto-locking wheelchair brakes but could not produce any documentation of the work order. The resident had an intervention on the fall risk care plan for florescent tape on the resident's call light. The surveyor observed the resident's call light without the tape during the survey.

J The facility failed to provide adequate supervision for one cognitively impaired resident to prevent elopement and failed to prevent an avoidable accident for one resident. A cognitively impaired resident with a history of wandering who resided on the locked unit, was left unsupervised in the main dining room and exited the building through an unlocked, unarmed door. A staff member found the resident wandering in the parking lot and returned the resident to the locked unit. Approximately ten minutes later, the resident exited again through an unlocked, unarmed door on the locked unit. A staff member observed the resident in the parking lot and assisted the resident back to the locked unit. There was no documentation in the progress notes regarding the two elopement events. The Wandering/Elopement risk assessment was completed 18 days after the events. An incident report was not completed. The DON was asked about the incident report and stated it was struck out of the medical record on the request of the Administrator. At the request of the surveyor, the author/LPN was able to retrieve the incident note that was stricken from the record. The Administrator and the DON confirmed the incidents were not investigated, statements from staff were not taken and the incidents were not reported to the SSA. The Maintenance Director confirmed that door alarms on both doors the resident used for exit were not working. The facility failed to prevent the resident from moving unsupervised from a safe environment to an unsafe environment on two occasions. The failure resulted in Immediate Jeopardy. The doors were repaired four days after the event. The residents were at risk for repeated elopements during the four days. The facility also failed to provide adequate supervision and assistance to prevent accidents for another resident that did not rise to the level of Immediate Jeopardy. The resident required two staff members for transfers. The CNA transferred the resident by herself. After the transfer, a skin tear was identified on the resident's leg.

E The facility failed to ensure residents were free of accident hazards when the facility failed to ensure fall risk assessments were complete for one resident, when chemicals were observed unsecured and unattended and when sharps were left unsecured on top of a medication cart. There were no fall risk assessments completed after a resident fell on six occasions and a quarterly fall risk assessment was not completed prior to the resident's last MDS assessment. The facility's fall risk assessment policy required fall risk assessments to be completed upon admission, quarterly and when a resident falls. The storage room was observed with the door ajar with an unsecured and unattended housekeeping cart containing cleaning chemicals and other tools and chemicals on a shelf. There was a wandering resident in the hallway. The surveyor observed two pairs of scissors on top of a medication cart that was unattended.

F690 Bowel/Bladder Incontinence Catheter, UTI

D The facility failed to ensure an indwelling urinary catheter was secured for one resident. The resident's catheter was not secured to their thigh.

F693 Tube Feeding Management/Restore Eating Skills

D The facility failed to ensure staff were following physician orders for automatic flushes for a PEG tube feeding for one resident. The resident had an order for an enteral feeding with automatic flushes with water at 40 ml/hr. The surveyor observed the automatic flushes infusing at 45 ml/hr. on six occasions over two days.

F695 Respiratory/Tracheostomy care and Suctioning

E The facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided with such care, consistent with professional standards of practice, the care plan and the resident's goals and preferences. The resident had a physician's order for tracheostomy care every shift using sterile technique. Review of the treatment record revealed multiple days and shifts without documentation of tracheostomy care. The surveyor observed the resident in bed with a moderate amount of thick secretions visible within the resident's tracheostomy tube. The RT reported the facility runs out of tracheostomy supplies at times. The RT report she had not provided tracheostomy care training to anyone in two years because nurses come and go so frequently at the facility. The RT reported the resident was sent to the hospital to have a tracheostomy tube change two weeks prior to the survey.

F726 Competent Nursing Staff

D The facility failed to have nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and well-being. The nursing staff failed to provide appropriate treatment and services for residents with enteral feedings when they failed to check residuals per policy, failed to provide the appropriate enteral formula and administer the formula per physician's orders for two residents. The nursing/respiratory therapy staff failed to properly care for and perform tracheostomy care for one resident. The nursing staff failed to administer the correct insulin to one resident.

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

E The facility failed to have RN coverage for eight consecutive hours on weekends for a three month period and on two days during the month prior to the survey.

D The facility failed to have RN coverage for eight consecutive hours daily for 23 days over a period covering seven months prior to the survey. The facility failed to provide the posted staffing sheet for five days over the same time frame.

F732 Posted Nurse Staffing Information

A The facility failed to post staffing information in a timely manner. The posted information was dated three days prior to the observation.

F761 Label/Store Drugs & Biologists

K The facility failed to properly label and store multi-dose insulin pens for diabetic residents. The surveyor observed three insulin pens that were expired and 12 of 36 opened insulin pens with no opened or expiration dates. Eighteen days later, the surveyor observed seven of 22 insulin pens with no opened or expiration dates. The facility's failure to properly label multi-dose insulin pens resulted in Immediate Jeopardy. The facility's audits were reviewed that were conducted approximately one and two months prior to the survey by the pharmacy's "med station review" indicated the criteria was not met for dating insulin pens. Observations were made of multiple medication carts. The DON confirmed the insulin pens should be labeled with an open date, an expiration date and should be discarded if expired.

D The facility failed to ensure medications were properly stored when opened and undated medications and expired medications were observed in two medication carts and medication storage areas. There were expired bottles of Prostat liquid protein, and an opened and undated bottle of eye drops and an opened and undated bottle of vitamins.

D The facility failed to ensure medications were properly stored and secured when one nurse failed to remain at the bedside when administering medications to two residents and when one nurse failed to ensure medications were properly secured during PEG site care for one resident. The surveyor observed the nurse at the medication cart in the hall with her back to the resident's room. The resident was observed taking medications that were on his overbed table. The medications were unsecured and out of sight of the nurse. The nurse was observed on another occasion delivering medication to a resident in a cup and leaving the room after instructing the resident to take the medication. Later, the nurse delivered a liquid medication to the resident and left it on the overbed table. The nurse left the room before the resident took the medications on both occasions. Another nurse left wound cleanser and supplies on a resident's over bed table and entered the resident's bathroom for handwashing, leaving the wound cleanser unsecured and unattended at the resident's bedside. The nurse then left the room and entered the hallway leaving the wound cleanser and supplies at the bedside unattended and unsecured for an undetermined amount of time.

F770 Laboratory Services

D The facility failed to ensure laboratory tests were obtained as ordered by the physician for two residents. Over a two-month period, the facility was unable to provide results of several ordered laboratory tests for the two residents.

F791 Routine/Emergency Dental Services in NFs

D The facility failed to secure dental services for one resident. The resident had missing and chipped teeth and was seen by the dentist 2 ½ years prior to the survey. The dentist recommended oral surgery for tooth extractions. No follow-up had been completed for the resident. The resident and the resident's family and resident's nurse all denied the resident had ever complained of pain related to the chipped and broken teeth.

F812 Food Procurement Store/Prepare/Serve - Sanitary

F The facility failed to ensure kitchen equipment was maintained in a sanitary condition. The surveyor made the following observations: multiple pieces broken off of plate warming bases, dried debris on the stove range and the deep fryer and a double welled plate warmer had multiple areas of brown, rust-like substances. The dry storage room had a carton of expired thickened apple juice. The clean dish storage area had one 24-welled muffin pan with dried food debris, one serving spoon had dried debris, and one plastic storage bin had a brown substance in the bottom of the bin.

F814 Dispose Garbage & Refuse Properly

D The facility failed to ensure garbage and refuse were properly contained in the dumpster. There was garbage/debris on the ground around the dumpster.

F835 Administration

D The facility administration failed to administer the facility in a manner that enabled the facility to use its resources effectively and efficiently. The facility administration failed to provide
oversight and supervision to prevent a cognitively impaired resident and a history of wandering, from moving from a safe environment to an unsafe environment. The resident eloped from the facility on two separate occasions within 10 minutes of the other. The facility administration removed the documentation from the EMR regarding the elopements. The administration failed to ensure the nursing staff notified the MD or NP for eight residents with critical blood sugar values resulting in a delay of treatment. The facility administration failed to address
identified noncompliance regarding Insulin Pen labeling for 11 residents reviewed. The facility administration's failure to provide enteral feeding formula as ordered by the MD with no RD on staff to provide input with managing the residents' caloric and protein requirements resulted in significant weight loss for two residents. The facility administration's failed to report and
investigate missing controlled narcotic medications for four residents. During a phone interview the Medical Director stated, "They need to do something about the owner and get someone
with some vision to run the place."

F837 Governing Body

L The facility's Governing Body failed to have an operating system in place to ensure staff provided supervision for a cognitively impaired resident with a history of wandering, who eloped two times on the same day from unlocked, unarmed doors. The Governing Body failed to have an operating system in place to ensure the facility had a sufficient supply of the prescribed enteral feeding formula for two residents that resulted in significant weight loss. The Governing Body failed to employ a RD to manage the caloric and protein needs of the two residents. The Governing Body failed to ensure the facility administration reported, investigated, and addressed allegations of misappropriation for four residents with narcotic medications. The Governing Body failed to address 27 improperly labeled insulin pens for 11 residents. The Governing body failed to have an operating system in place to ensure the physician/provider was notified for eight residents with critical blood sugar values.

F842 Resident Records - Identifiable Information

D The facility failed to maintain an accurate medical record for one resident. The resident had hemodialysis three times per week. The Dialysis Handoff Communication Form was incomplete for several days.

D The facility failed to act in accordance with accepted professional standards when the facility failed to maintain medical records for one resident. The facility also failed to maintain medical records in accordance with accepted professional standards and practice for five residents reviewed for use of controlled substances. The facility reviewed the progress notes of one resident who eloped from the facility twice in the same day. There was no documentation of the two elopements in the resident's progress notes. Five resident's MARs were compared to the Controlled Drug Record sheets. The Controlled Drug Record sheets were missing at least one entry for each of the five residents.
NOTE: Controlled Drug Records/Sign-Out Sheets are not considered a part of a resident's permanent medical record.

F865 QAPI Program/Plan, Disclosure/Good Faith Attempt

F The facility's QAPI Committee failed to implement a systematic approach to maintain resident safety and ensure the highest quality of care for all residents. The Administrator was asked by the surveyor to show documentation of the QAPI committee plan to address identified
deficiencies. No documentation was provided to verify the QAPI committee established and implemented an appropriate plan to address identified deficiencies. No evidence was provided to show the QAPI Committee met after the MD/NP were not notified of critical blood sugar values for eight Residents. No evidence was provided to show the QAPI Committee met following one resident's elopement from the facility. No evidence was provided to show the QAPI Committed met to address the facility's failure to provide the physician-ordered enteral formula for two residents, that resulted in significant weight loss or the facility's failure to employ a RD to manage the resident's nutritional needs. No evidence was provided to show the QAPI Committee met after 27 improperly labeled insulin pens belonging to 11 residents were identified.

F880 Infection Prevention & Control

J The facility failed to maintain an infection prevention program to prevent the development and transmission of infection when one resident with wounds that were infected, draining and had maggots, was noted propelling his wheelchair with the wound drainage leaking onto the facility floor. The resident was observed scratching and touching his wounds with his hands and then touching the towels/linens on the clean linen cart. The failure resulted in Immediate Jeopardy.

The surveyor observed a large brown dried puddle on the floor near the nurses' station. The nurse indicated the resident let his wounds drip all over the facility and maggots were falling from the back of the resident's wheelchair. The resident had a documented history of refusing care and was under the care of hospice. The Social Services notes indicated the resident had refused a condom catheter and was leaving bodily fluids all over the hallway floor and in his room. The resident was observed by the surveyor next to the linen cart, pulling linen onto his lap, scratching himself and leaving a half-dollar sized amount of draining on the floor next to the linen cart and on the floor where the resident was sitting in his wheelchair. The surveyor observed two additional puddles of fluid in the hallway. A nurse reported that other residents were getting the drainage on their hands after rolling through it in their wheelchairs and propelling with their hands. Other residents were interviewed by the surveyor and were asked if they felt the drainage and maggots on the floor were a health hazard. The residents stated they thought it was. The surveyor observed multiple flies in the resident's room. Two staff members were observed while conducting catheter care. One staff member failed to perform hand hygiene between glove changes and the other staff member used the same washcloth for catheter care that was used to clean the resident after an incontinent bowel movement.

E The facility failed to ensure proper infection control practices were followed when three nurses failed to perform proper hand hygiene during medication administration, failed to clean reusable equipment and failed to clean medical supplies after dropping on the floor during PEG site care, and when the facility failed to maintain and monitor for an effective infection prevention and control program for three residents reviewed for Legionella Disease. One nurse failed to perform hand hygiene after removing gloves on two occasions. Another nurse failed to perform hand hygiene after removing gloves on six occasions while the surveyor was observing medication administration and failed to clean a container of wound cleanser after dropping it on the floor. Another nurse failed to clean the stethoscope after checking PEG tube placement and failed to thoroughly dry the feeding tube syringe after cleaning it and placing it back into the bag. The Maintenance Director and the Infection Preventionist were unaware of the required actions for water management and the prevention of Legionella.

D The facility failed to provide hand hygiene assistance for residents prior to their meal. The surveyor observed several meal tray deliveries into resident rooms. The staff did not offer the resident assistance with hand hygiene prior to their meal.

D The facility failed to ensure expired supplies were not available for resident use in one medication cart and failed to ensure staff members performed self-testing for COVID-19 according to current guidance for one self-testing observation. The surveyor observed two staff members performing a self-test for COVID-19 within six feet of other staff members and a resident. The tests were performed at the nurses' station. The nurses' break room was the designated area for COVID-19 testing for staff. There were several expired IV needles within the sterile packaging on the medication cart.

F883 Influenza and Pneumococcal Immunizations

D The facility failed to ensure one resident was assessed for pneumococcal immunization upon admission. There was no documentation that the resident's pneumococcal immunization status was assessed.

F919 Resident Call System

D The facility failed to ensure one resident's call light was within their reach. The resident's call light cord was observed wrapped around the right side rail next to the wall. The call light could not be seen.

F921 Safe/Functional/Sanitary/Comfortable Environment

D The facility failed to ensure a safe, sanitary, and comfortable environment for seven residents. The surveyor observed substances on enteral feeding pumps and at the base of poles. Observations in other residents' rooms included: stains on the walls, dust particles on bed frames, beds, air/heat units and overbed lights, substances on over bed tables, stains on bed rails and substances on headboards.

F925 Maintains Effective Pest Controls Programs

E The facility failed to maintain an effective pest control program. The failure resulted in maggots for one resident with wounds. Flies were observed in six resident's rooms. The facility had pest control services and had installed an ultraviolet fly light trap. Staff interviews indicated they had seen flies over the prior two months.

K222 NFPA 101 Egress Doors

D The facility failed to maintain the egress doors. One delayed egress door was missing the required 15-second delayed egress signage.

K321 Hazardous Areas; Enclosure

D The facility failed to ensure hazardous areas were protected. The door to the soiled linen room was not self-closing. Two wall penetrations were not fire stopped appropriately.

D The facility failed to maintain hazardous areas. A door to a storage room would not close and latch when manually tested.

K324 Cooking Facilities

D The facility failed to ensure commercial cooking equipment suppression system was maintained. The maintenance documentation failed to indicate that the agent distribution piping was not obstructed.

K345 Fire Alarm System; Testing and Maintenance

D The facility failed to maintain the fire alarm system. The facility was unable to provide documentation sensitivity test conducted on the smoke detectors. The last test conducted was in January 2020.

K353 Sprinkler System; Testing and Maintenance

D The facility failed to maintain the sprinkler system. The surveyor observed one sprinkler head in the generator switch/electrical room that was loaded with drywall mud.

D The facility failed to maintain the sprinkler system. The facility was unable to provide documentation of monthly testing for the electric fire pump.

D The facility failed to maintain the fire sprinkler system. The surveyor observed loaded (covered in dust/lint) fire sprinklers in two areas.

K711 Evacuation and Relocation Plan

D The facility failed to ensure staff were familiar with the response in the event of a kitchen fire and were not familiar with the fire plan procedures to extinguish a kitchen fire. Two of three staff were unfamiliar.

K712 Fire Drills

D The facility failed to transmit the fire alarm signal. During the fire drill, the staff did not transmit the fire alarm signal.

K761 Maintenance, Inspection & Testing - Doors

D The facility failed to ensure fire door assemblies were inspected and tested annually. The facility could not provide documentation of an annual inspection and testing of the fire doors.

K918 Electrical Systems - Essential Electric System Maintenance and Testing

D The facility failed to maintain the generator. The facility could not provide documentation of the annual load bank test for the diesel generator.

K920 Electrical Equipment; Power Cords and Extension Cords

D The facility failed to maintain electrical equipment. Extension cords were observed in use in three areas. There were non-PCREE power strips that did not meet the UL 1363 requirements in two resident rooms.

N1102 Records and Reports; Recording of Unusual Incidents

The facility failed to report to the SSA two incidents of elopement within 10 minutes of one another, misappropriation of resident narcotics for three residents and an alleged incident of verbal abuse within the two-hour time frame.

N1207 Resident Rights

The facility failed to provide goods and services to two residents receiving enteral nutrition that resulted in significant weight loss. The two residents went multiple days with no documented enteral feedings. The two residents received different formulas based on the lack of supplies in the facility. No Registered Dietician was employed in the facility for two months and no oversight was provided for significant weight loss or protein caloric needs for the two residents. The facility's failure resulted in Immediate Jeopardy for both residents. One resident had an order for 2 Cal HN, protein dense nutrition to support volume intolerance. Twenty-six days after the order was written, the resident's order was changed to Jevity 1.5. There was no documentation a RD was consulted regarding the change in the enteral formula. There was no RD employed at the time. Documentation indicated the resident had become ill with an elevated temperature and vomiting. The resident's feeding was stopped, and the resident was transferred to the hospital. Upon readmission, the resident had no order for enteral feeding. The resident remained without an order and enteral feedings for 11 days. The resident had a significant weight loss. The second resident had an order for Glucerna 1.5 enteral feeding, and the order was later changed to Jevity 1.5. There was no documentation in the resident's record of an RD consult for the formula change. The resident had four days of no documentation of an enteral feeding and no documentation of why the order had been changed. The resident had a significant weight loss. The supply clerk was interviewed and stated she could not get the orders filled for the feedings due to nonpayment. The Administrator and CEO were made aware on two occasions. In an interview, a staff member reported the facility was out of the correct enteral feedings and the DON told them to "just give what the facility had available".

N1216 Resident Rights

The facility failed to act in accordance with accepted professional standards when the facility failed to maintain medical records for one resident. The facility also failed to maintain medical records in accordance with accepted professional standards and practice for five residents reviewed for use of controlled substances. The facility reviewed the progress notes of one resident who eloped from the facility twice in the same day. There was no documentation of the two elopements in the resident's progress notes. Five resident's MARs were compared to the Controlled Drug Record sheets. The Controlled Drug Record sheets were missing at least one entry for each of the five residents.
NOTE: Controlled Drug Records/Sign-Out Sheets are not considered a part of a resident's permanent medical record.

N1227 Resident Rights; Resident Dignity

The facility failed to inform of or provide written information regarding residents' rights to formulate an advanced directive for two residents. There was no documentation for either resident that the resident or their legal representative was informed of/or provided written information regarding the resident's right to formulate an advanced directive.

The facility failed to promote and protect the rights of three residents by not treating the residents with respect and dignity when the residents who needed assistance and wanted to be out of bed were not assisted out of bed. The surveyor reviewed the facility's "ADL Transfer" documentation for the three residents. Each resident was missing documentation for getting out of bed during the three months prior to the survey. One resident did not get out of the bed for 22 days in one month, the second resident was not out of the bed for a total of 27 days of the month reviewed, and the third resident had no documentation of transferring out of the bed for 31 days of the month prior to the survey and was not out of the bed for 77 days out of the 92 days prior to the survey. All three residents expressed a desire to get out of bed to the surveyor. The Activities Director reported that residents were unable to attend group activities due to not being out of bed.

N1410 Disaster Preparedness; Fire Safety Procedures Plan

The facility failed to conduct all disaster drills annually. The earthquake drill had not been conducted since 2021.

N1411 Disaster Preparedness; Fire Safety Drills

The facility failed to conduct all disaster drills annually. The bomb threat drill had not been conducted since 2021.

N301 Disciplinary Actions

The facility was not in substantial compliance with federal requirements of participation for long-term care facilities.

N301 Disciplinary Procedures

The facility was not in compliance with federal requirements of participation.

The facility failed to maintain substantial compliance with the federal requirements of participation.

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.

N302 Disciplinary Procedures

The facility was not in compliance and deficiencies were cited under Standards for Nursing Homes, Chapter 0720-18.

N424 Administration; Filed Documentation of Abuse Registries

The facility failed to provide adequate supervision for a cognitively impaired resident (#1) at risk for elopement. A cognitively impaired resident exited the facility through the front door after a visitor entered the door code and opened the door allowing the resident into the courtyard. The resident was observed knocking on another door, approximately 174 feet from the door the resident exited through. The temperature outside was 46 degrees. The facility failed to conduct appropriate elopement assessments and elopement drills on all shifts. The facility's failure to prevent the resident with a known history of exit seeking behaviors from eloping from the facility resulted in Immediate Jeopardy. The facility's investigation included an interview with the family member who allowed the resident to exit the facility. The family member stated it was no more than 3-5 minutes afterwards that a staff member asked if they had seen a resident go out the front door. There was documentation of an elopement risk reassessment for the resident that was completed sixteen days after the incident. The Medical Director's note did not contain documentation of an assessment of the resident after the elopement. An elopement drill was conducted nine days after the incident for the day shift only. After interviews with multiple staff members, the surveyor determined the area outside where the resident was found was unsafe for the resident. The facility's failure to prevent and monitor falls resulted in actual harm for Resident #2 when the resident fell and sustained a left hip fracture that required surgical intervention. The facility's incident reports indicated the resident had eight falls with the last fall resulting in a fracture. Prior to the eighth fall, the interventions included safety education for the resident and auto-locking wheelchair brakes. The resident was severely cognitively impaired, and education was not an appropriate intervention. The resident had interventions for auto-locking wheelchair brakes that were ineffective due to having falls related to the wheelchair rolling out from under her. In an interview with the surveyor, the Maintenance Director reported having to make an adjustment on the resident's auto-locking wheelchair brakes but could not produce any documentation of the work order. The resident had an intervention on the fall risk care plan for florescent tape on the resident's call light. The surveyor observed the resident's call light without the tape during the survey.

N620 Infection Control

The facility failed to maintain an infection prevention program to prevent the development and transmission of infection when one resident with wounds that were infected, draining and had maggots, was noted propelling his wheelchair with the wound drainage leaking onto the facility floor. The resident was observed scratching and touching his wounds with his hands and then touching the towels/linens on the clean linen cart. The failure resulted in Immediate Jeopardy.

The surveyor observed a large brown dried puddle on the floor near the nurses' station. The nurse indicated the resident let his wounds drip all over the facility and maggots were falling from the back of the resident's wheelchair. The resident had a documented history of refusing care and was under the care of hospice. The Social Services notes indicated the resident had refused a condom catheter and was leaving bodily fluids all over the hallway floor and in his room. The resident was observed by the surveyor next to the linen cart, pulling linen onto his lap, scratching himself and leaving a half-dollar sized amount of draining on the floor next to the linen cart and on the floor where the resident was sitting in his wheelchair. The surveyor observed two additional puddles of fluid in the hallway. A nurse reported that other residents were getting the drainage on their hands after rolling through it in their wheelchairs and propelling with their hands. Other residents were interviewed by the surveyor and were asked if they felt the drainage and maggots on the floor were a health hazard. The residents stated they thought it was. The surveyor observed multiple flies in the resident's room. Two staff members were observed while conducting catheter care. One staff member failed to perform hand hygiene between glove changes and the other staff member used the same washcloth for catheter care that was used to clean the resident after an incontinent bowel movement.

N621 Infection Control; Pest Control

The facility failed to ensure one resident's call light was within their reach. The resident's call light cord was observed wrapped around the right side rail next to the wall. The call light could not be seen.

N622 Infection Control

The facility failed to maintain an effective pest control program. The failure resulted in maggots for one resident with wounds. Flies were observed in six resident's rooms. The facility had pest control services and had installed an ultraviolet fly light trap. Staff interviews indicated they had seen flies over the prior two months.

N645 Nursing Services

The facility failed to ensure a resident environment that was safe, clean, and sanitary to prevent the spread of disease-causing organisms and infections when one resident who had wounds infected with maggots, was observed handling linens and propelling throughout the facility with the drainage/maggots leaking onto the floor from his wheelchair resulting in Immediate Jeopardy. The surveyor observed a large brown dried puddle on the floor near the nurses' station. The nurse indicated the resident let his wounds drip all over the facility and maggots were falling from the back of the resident's wheelchair. The resident had a documented history of refusing care and was under the care of hospice. The Social Services notes indicated the resident had refused a condom catheter and was leaving bodily fluids all over the hallway floor and in his room. The resident was observed by the surveyor next to the linen cart, pulling linen onto his lap, scratching himself and leaving a half-dollar sized amount of draining on the floor next to the linen cart and on the floor where the resident was sitting in his wheelchair. The surveyor observed two additional puddles of fluid in the hallway. A nurse reported that other residents were getting the drainage on their hands after rolling through it in their wheelchairs and propelling with their hands. Other residents were interviewed by the surveyor and were asked if they felt the drainage and maggots on the floor were a health hazard. The residents stated they thought it was.

N648 Nursing Services

The facility failed to maintain a safe, clean, homelike environment for three residents. The surveyor observed the following: dried white debris on an overbed table, smears of a brown substance on the wall next to a bed and on another resident's siderail.

N657 Nursing Services; Physician Notification

The facility failed to have RN coverage for eight consecutive hours daily for 23 days over a period covering seven months prior to the survey. The facility failed to provide the posted staffing sheet for five days over the same time frame.
NOTE: The requirement for an RN for eight consecutive hours daily and for posting staffing data are federal requirements. The state regulation does not prevent the facility from counting the DON as their RN coverage.

N669 Nursing Services; Physician Notification

The facility failed to notify the physician or NP of hypo/hyperglycemia for eight insulin-dependent residents. Nursing staff failed to notify the MD or NP of blood glucose levels less than 60mg/dl or greater than 400mg/dl as ordered. Failure to report critical blood glucose levels could result in acute/chronic conditions that could lead to organ failure, coma, and/or death, and placed the residents in Immediate Jeopardy. The facility was unable to locate any documentation that the physician or NP were notified of multiple critical blood sugar values that were obtained by fingerstick for the eight residents.

N688 Nursing Services

The facility failed to provide the necessary treatment and services to promote healing of a pressure ulcer wound for one resident. The resident was the only resident in the facility with a pressure ulcer. The facility failed to provide wound care, failed to notify the resident's physician that the resident was not keeping wound clinic appointments, failed to notify the physician the pressure ulcer wound was declining, and failed to ensure infection control practices were implemented to reduce the potential for infection of the pressure ulcer wound. The failures placed the resident in an environment detrimental to their health, safety, and wellbeing. The resident was admitted with a pressure ulcer, did not receive treatment and services to promote healing and prevent worsening of the pressure ulcer wound. The resident missed several wound clinic appointments due to transportation issues, had missing documentation of wound treatments and had measurements indicating the wound had increased in size. Stains were identified on the resident's air mattress indicating drainage from the wound. In an interview with the surveyor, the housekeeper stated they had not cleaned the air mattress. The Medical Director stated they had not been notified of the missed appointments and condition of the wound.

N689 Nursing Services

The facility failed to ensure laboratory tests were obtained as ordered by the physician for two residents. Over a two-month period, the facility was unable to provide results of several ordered laboratory tests for the two residents.

N727 Pharmaceutical Services

The facility failed to ensure medications were properly stored when opened and undated medications and expired medications were observed in two medication carts and medication storage areas. There were expired bottles of Prostat liquid protein, and an opened and undated bottle of eye drops and an opened and undated bottle of vitamins.

N729 Pharmaceutical Services

The facility failed to properly label and store multi-dose insulin pens for diabetic residents. The surveyor observed three insulin pens that were expired and 12 of 36 opened insulin pens with no opened or expiration dates. Eighteen days later, the surveyor observed seven of 22 insulin pens with no opened or expiration dates. The facility's failure to properly label multi-dose insulin pens resulted in Immediate Jeopardy. The facility's audits were reviewed that were conducted approximately one and two months prior to the survey by the pharmacy's "med station review" indicated the criteria was not met for dating insulin pens. Observations were made of multiple medication carts. The DON confirmed the insulin pens should be labeled with an open date, an expiration date and should be discarded if expired.

N766 Food and Dietetic Services; Freezer Temperature

The facility failed to ensure kitchen equipment was maintained in a sanitary condition. The surveyor made the following observations: multiple pieces broken off of plate warming bases, dried debris on the stove range and the deep fryer and a double welled plate warmer had multiple areas of brown, rust-like substances. The dry storage room had a carton of expired thickened apple juice. The clean dish storage area had one 24-welled muffin pan with dried food debris, one serving spoon had dried debris, and one plastic storage bin had a brown substance in the bottom of the bin.

N831 Building Standards

The facility failed to maintain the physical plant. The surveyor observed penetrations in the fire rated ceiling assemblies that were not fire stopped in accordance with approved firestop systems.

The facility failed to maintain the physical plant. A ramp on one hallway had a section of missing flooring on one side of the ramp resulting in difficulties with rolling a wheelchair over the ramp. The flooring on one side of the ramp had been replaced with a black rubber mat. Plans review records indicated the facility failed to get approval from the Tennessee Health Facilities Commission before making alterations to the flooring.

N835 Building Standards; Approval of New Construction

The facility failed to get prior written approval from the Tennessee Health Facilities Commission before making alterations to the nursing home. The facility was operating as a secured facility. Six of seven emergency egress doors were equipped with mag-locks and keypads that kept the facility locked down. The HFC Plans Review had no record of the facility having approval to operate as a secured facility.

The facility failed to get prior approval before making alterations to the facility. One side of the flooring on the ramp of one hallway had been replaced. The facility failed to get approval from the Tennessee Health Facilities Commission before making alterations to the flooring.

N848 Building Standards; Exhaust & Air Pressure

The facility failed to maintain negative air pressure in the required areas. A janitor's closet and the soiled utility room had inoperable exhaust fans.