STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Living Alexian Village Tennessee	671 Alexian Way Signal Mountain, TN 37377

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003 Based on facility policy review, Resident Assessment Instrument (RAI) Manual 3.0 review, medical record review, and interview, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 resident (Resident #6) of 15 residents reviewed. The findings include: Review of the facility's policy titled, MDS Assessment, revised 12/2017, revealed .Residents of our skilled nursing communities will have a MDS Assessment completed in accordance with CMS [Centers for Medicare and Medicaid Services] guidelines as outlined in the RAI Manual .MDS Assessments are based on information from resident, family, physician, caregivers, and/or clinical assessment .MDS Assessments are used by the Interdisciplinary Assessment Team to develop a plan of care .Coding of the MDS item sets will be completed in accordance with the RAI guidelines . Review of the RAI Manual 3.0 dated 10/2023 revealed .Number of Falls Since Admission/Entry or Reentry or Prior Assessment .Review nursing home incident reports and medical record .for falls and level of injury . Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Bipolar Disorder, Weakness, Vascular Dementia, and Adult Failure to Thrive. Review of the comprehensive care plan revised 12/27/2023, for Resident #6 revealed, .[Resident #6] has potential for falls . Intervention added to include .use wedge (pillow, blanket) to provide support . Review of the Nurse's Notes for Resident #6 dated 12/27/2023, revealed Resident #6 was found on the floor beside the bed.CNA [certified nurse assistant] found resident on floor beside bed . The resident was transported to the emergency department for further evaluation and treatment. Review of a quarterly MDS assessment for Resident #6 dated 1/25/2024, revealed no falls documented since the prior assessment. During an interview on 8/7/2024 at 10:25 AM, the Interim MDS Coordinator, confirmed Resident #6 had experienced a fall on 12/27/2023 and confirmed the quarterly MDS assessment dated [DATE] was inaccurate for Resident #6.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on facility policy review, medical record review, facility investigation review, and interviews, the facility failed to ensure discontinued narcotics were removed from the inventory after discontinued for 1 resident (Resident #11) of 4 residents reviewed for narcotic administration. The facilities failure to timely remove discontinued drugs from inventory resulted in discontinued medications documented as withdrawn from stock but not accounted for in the medical record. The findings include: Review of the facility policy titled, Discarding and Destroying Medications, revised 12/2019, revealed .All unused controlled substances should continue to be counted each shift with the active controlled substances until properly disposed of .Unused controlled substance cards and log sheets should be marked with a red X to denote they are no longer to be used .Disposal of controlled substances must take place after discontinuation of use by the resident . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Mood Disorder with Depressive Features, Unspecified Gait Abnormalities, Muscle Weakness and Cognitive Communication Deficit. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 6 on the Brief Interview of Mental Status (BIMS) assessment which indicated severe cognitive impairment. Review of a physician's order for Resident #11 dated 3/15/2024, revealed the resident was prescribed Oxycodone Acetaminophen (Percocet, a narcotic for pain) 5/325 milligram tablets, one tablet by mouth every 4 hours as needed for pain. The medication was filled with 12 tablets supplied by the pharmacy on 3/15/2024. Review of the Individual Controlled Substance Count Sheet, corresponding Medication Administration Record (MAR) and Pain Assessments revealed Resident #11 had not required use of or administered the pain medications between 3/15/2024 and 3/24/2024. Review of the MAR and Physician Order Summary report for 3/2024, revealed Percocet for Resident #11 was discontinued on 3/24/2024. Review of the Individual Controlled Substance Count Sheet revealed 2 doses of Resident #11's Percocet were documented as withdrawn from inventory for administration to Resident #11 on 3/29/2024 at 9:00 PM and on 3/30/2024 at 5:00 AM by Registered Nurse (RN) G (5 days after the medication was discontinued and was to have been disposed of). Review of the MAR revealed no documentation the medications were administered to Resident #11 by RN G. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation and witness statements dated 3/30/2024, revealed on the morning of 3/30/2024, the oncoming nurse, Licensed Practical Nurse (LPN) H, reported to the Director of Nursing (DON) she had concerns related to RN G's statements made to her during shift change report. LPN H noted Resident #11's Percocet supply on the cart had been accessed by RN G the night before, and 2 doses of Percocet were documented as withdrawn for administration to Resident #11. LPN H reported to the DON that she questioned RN G about the matter, and RN G informed LPN H Percocet was withdrawn and given to address Resident #11's complaints of pain due to Migraine Headache. LPN H assessed Resident #11 immediately after shift change, and Resident #11 reported she had not requested pain medications for any reason the night before and did not have any pain. Resident #11 reported she did not recall seeing RN G in her room at all the night before. Further review of the facility investigation showed the facility attempted repeatedly to contact RN G for investigation without success despite several voice messages. The facility notified RN G's employer they needed to speak to her about narcotic count irregularities. RN G nor her employer returned the attempted phone calls. During an interview on 8/6/2024 at 9:50 AM, LPN H reported she had cared for Resident #11 regularly for several years and she became suspicious during shift report on 3/30/2024 after she was informed by RN G Percocet had been given for migraine. LPN H reported she had cared for Resident #11 for over 3 years, knew Resident #11 very well and to her knowledge, Resident #11 had no history of migraine. LPN H also reported Resident #11 refused narcotics prescribed for fracture pain in the past and preferred to use over the counter Tylenol instead. LPN H reported she had cared for Resident #11 daily after recent surgery and Resident #11 had refused any pain medications offered her and had stated the skin cancer removals did not cause her discomfort (This was corroborated by review of the MAR and corresponding nursing notes dated 3/15/2024-3/28/2024). LPN H reported she questioned Resident #11 after shift change report and Resident #11 reported she had not experienced Migraines the night prior, had not asked for any medication and did not recall seeing RN G in her room at all the night before. LPN H stated despite Resident #11's cognitive limitations, Resident #11 was able to make needs known and LPN H considered Resident #11 a reliable informant when it came to expressions of pain or unmet needs. During an interview on 8/6/2024 at 5:12 PM, the Director of Nursing (DON) reported she led the facility investigation. The DON reported the discontinued medication was to have been removed from the medication cart on 3/24/2024, and the medication had not been removed timely per her expectations. The DON reported Percocet was removed from Resident #11's stock on the medication cart on the morning of 3/30/2024 and destroyed. The DON reported RN G documented Percocet as withdrawn from inventory for use but had not documented administration of the medication anywhere in the record. Continued interview revealed the DON reported those findings, when taken into context with Resident #11's statements which indicated she had not requested pain medications or recalled seeing RN G in her room the night before, led the DON to conclude it was likely the Percocet was diverted. The DON stated she made multiple attempts to contact RN G to discuss allegations over several days and neither the employer nor RN G responded to allegations or cooperated with the facility investigation. The DON confirmed based upon its own investigation, the facility determined had discontinued Percocet been removed from stocks and destructed timely, the incident would not have occurred.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837 Based on facility policy review, medical record review, and interviews, the facility failed to ensure the medical record was complete for 1 resident (Resident #4) of 15 residents reviewed for complete medical records. The findings include: Review of the facility policy titled, Change in a Resident's Condition or Status, revised 2/2022, revealed .The nurse will record in the resident's medical record information relative to changes in the resident's medical . condition or status . Review of the facility policy titled, Falls, revised 7/2023, revealed .this procedure .provide guidelines for evaluation of a resident in the event a fall occurred .The Licensed Nurse shall document the fall in the resident's clinical record . Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Dementia and General Anxiety Disorder. The resident was discharged on [DATE]. Review of a comprehensive care plan for Resident #4 dated 10/17/2023, revealed .[Resident #4] has potential for further falls r/t [related to] history of falls prior to admission . Review of a significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 scored an 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. The resident required partial to moderate assistance for activities of daily living (ADLs). Review of Resident #4's medical record revealed no documentation of a fall on 1/25/2024. Review of the facility investigation report for Resident #4 dated 1/27/2024, revealed the resident had an unwitnessed fall on 1/25/2024 that was not documented in the medical record when it occured. The investigation stated .Upon entering the room, [Resident #4] was sitting with his back against his chest [furniture] with his legs spread open. One foot on the floor, and the other foot on his floor mat. He denied hitting his head or another part of his body. His son showed up shortly afterwards .notified .the DON and the Administrator . During a telephone interview on 8/5/2024 at 4:14 PM, Licensed Practical Nurse (LPN) A stated she did a skin check for Resident #4 and found a skin tear on the resident's left forearm. The wound had a dressing on it, but the skin tear had not been documented in the resident's medical record. The LPN stated she was told by a staff member the resident had fallen, and the resident had reported he had a recent fall. The LPN stated she reported the finding to management but could not remember to whom she had reported the incident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/5/2024 at 5:05 PM, the Quality Nurse stated an agency nurse, Registered Nurse (RN) B, failed to report and document a fall for Resident #4. The facility administration was alerted to the fall by an Environmental Services (EVS) employee after a new skin injury was discovered, and an injury of unknown origin investigation was initiated. The facility completed a thorough investigation of the fall, and the agency nurse was terminated. During an interview on 8/6/2024 at 11:21 AM, EVS C stated she did not remember the exact date, but she was in the hall outside Resident #4's room and observed the resident sitting on the side of his bed. She knew he was not supposed to be up without assistance, so she went to get the nurse. The EVS staff member stated .I heard a commotion and peeked back in to see [Resident #4] had stumbled against his clothes closet, but he was still standing . EVS C told Resident #4 to be still; she was getting help. She then went to get the nurse, and when she and RN B returned, the resident was sitting on his buttocks by the clothes closet. During an interview on 8/7/2024 at 8:17 AM, the DON stated it was her expectation nursing staff chart a resident fall in the medical record at the time of occurrence. The DON confirmed that the nurse did not chart Resident #4's fall on 1/25/2024 in the medical record and had not followed the facility's policy.