

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2024
NAME OF PROVIDER OR SUPPLIER Spring City Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 331 Hinch Street Spring City, TN 37381	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534</p> <p>Based on facility policy, facility investigations police reports, medical record review and interview, the facility failed to protect a resident's right to be free from abuse for 6 of 20 (Resident #23, #24, #7, #8, #10 and #11) residents reviewed for abuse. The facility failed to protect Resident #23, a cognitively impaired female resident, from sexual abuse when Resident #24, a cognitively impaired male resident, made sexual advances toward Resident #23 causing mental distress, which resulted in actual harm to Resident #23 and when the facility failed to protect Resident (#7, #8, #10, #11) from resident-to-resident physical abuse.</p> <p>The findings include:</p> <p>Review of a facility policy titled, Abuse, Neglect and Misappropriation of Property revised 9/15/2023, showed . It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property .Abuse is defined as the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .</p> <p>Resident #23 was admitted to the facility on [DATE], with diagnoses including Dementia Severe with other Behavioral Disturbances, Bipolar Disorder, Depressive Episodes, Cognitive Communication Deficit and Anxiety Disorder.</p> <p>Review of Resident #23's quarterly Minimum Data Set (MDS) assessment dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The resident required extensive assistance of 2-person with bed mobility, transfer, dressing and personal hygiene.</p> <p>Review of the facility investigation dated 7/29/2023 at 6:47 PM, showed Certified Nursing Assistant (CNA) #6, reported to the nurse that she heard someone screaming [Resident #23] and saw Resident #24 in Resident #23's room standing at the side of the bed. His pants and underpants were down on the floor. His left hand was between her legs. She was wearing a brief and a shirt and covered with a sheet.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Police Report dated 7/30/2023, showed .On July 29th at 8:24 PM [police] .dispatched to [facility] in reference to a sexual assault. Police also spoke to [Resident #23] about the incident as well. Upon first questioning [Resident #23] denied memory of any event happening this date. When .was directly asked if she had any recollection of someone touching her without her permission .stated 'Oh yeah, you're talking about that man' .then stated that a man in a wheelchair came into her room and kept wheeling closer to her bedside .stated that the man kept asking her to move her leg and blanket which she refused to do .then stated that the man moved the blanket and was touching her in the groin area, that is when she began screaming for [staff member] .' When I asked [Resident #23] if the man had touched her privates, she stated 'He didn't get that far .</p> <p>Review of a facility obtained interview with Resident #23, dated 7/29/2023 at 9:00 PM, conducted by the DON and UM showed .How are you tonight? 'Nervous' Can you tell me why? 'Cause [because] every time someone comes in here, I don't know if it is that man [Resident #24].' The man that came in here earlier what did he do? 'Rolled his w/c [wheelchair] in beside my bed then he put his hands on my bed and reached for my leg then reached for my blanket like he was trying to pick it up. He tried to put his hand up my gown.' Then what happened? 'He unzipped his britches then tried to grab my hand I didn't let him' Did you see his privates? 'No' Did he touch your privates? 'No, just the outside of my diaper.' Did he hurt you? 'No, he didn't hurt me just made me nervous. I just hollered for [staff] 3 or 4 X [times] .they came and got him out.' Do you feel safe now? 'Yes, just nervous.' Do you want anything? 'Maybe a Tylenol later .</p> <p>Resident#23's record review showed the resident left the nursing facility at 9:10 PM, via ambulance to [hospital] to be evaluated accompanied by staff.</p> <p>Review of Resident #23's Emergency Department Physician Progress Note dated 7/29/2023, showed .Chief Complaint: Sexual Assault (alleged) .Patient states another resident [Resident #24] entered her room and put his hand on her thigh and attempted to slide his hand under her diaper. Patient states she called out mildly and staff removed male resident. Patient states his hand remained above her diaper and there was no sexual intercourse .</p> <p>Review of Resident #23's Nursing Progress Note dated 10:39 PM, showed .Late Entry: Telephone call to family .to advise of abuse and resident being sent out to ED [Emergency Department] for evaluation and treatment if needed. Resident family voiced understanding with no questions. MD notified with no new orders at this time .</p> <p>Review of Resident #23's comprehensive care plan, revised 7/29/2023, showed .Psychosocial Well-Being .at risk for alteration in my mood, behavior, cognition, and level of functioning .at risk to experience adverse psychosocial changes such as an increase in depressive and anxious signs/symptoms that have the potential to negatively affect my wellbeing related to negative encounter with male resident .observe and report to physician any changes in mood, behavior, cognition, and level of functioning caused by situational stressor(s) .observe for psychosocial changes .offer diversional activities if mood changes .Psych [Psychiatric] NP [Nurse Practitioner] to visit with resident on next visit .Sent to ER [emergency room] for evaluation .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #23's Psychiatric Periodic Evaluation NP (Nurse Practitioner) Progress Note dated 8/11/2023, showed .She has been successfully weaned of Seroquel. Staff reports no psych concerns. No problematic behaviors nor distressing delusions/hallucinations. Will attempt GDR [gradual dose reduction] of Depakote at this time. Her appetite is fair. Sleep is good with the use of Melatonin .On exam resident is oriented to person and situation. She only answered a few questions. She would often just stare at me and not answer. She is HOH [hard of hearing] .Decrease Depakote to 250 mg BID [twice daily] then 125 mg midday .</p> <p>Resident #24 was admitted to the facility on [DATE], and passed away at the facility on 8/14/2023, with diagnoses including Disorder of Brain, Hemiplegia and Hemiparesis following Cerebral Infarction and Convulsions.</p> <p>Review of Resident #24's comprehensive behavioral care plan, revised 7/6/2023, showed Resident #24 had socially inappropriate/disruptive behavioral symptoms toward the female staff. Assess whether the behavior endangers the resident and/or others intervene if necessary. Maintain a calm environment and approach to the resident. When available have male staff provide the care for the resident.</p> <p>Review of Resident #24's admission MDS assessment dated [DATE], showed a BIMS score of 9, indicating moderate cognitive impairment.</p> <p>Review of Resident #24's nursing progress note dated 7/29/2023 at 2:30 PM (approximately 4 hours and 15 minutes prior to the incident), showed, .Resident inappropriately touching staff. Staff provided redirection multiple times and resident would continue to grab at staff throughout the day. Redirection successful for a short time period. Resident placed in eye view of staff [for an undetermined and undocumented amount of time] .</p> <p>Review of a facility obtained interview with Resident #24 dated 7/29/2023 at 9:20 PM, by the DON and the the UM showed, .What happened tonight? 'I don't remember.' Did you go in a lady's room? 'I don't know.' Did you touch anyone tonight? 'I don't remember.' Interview stopped with Resident stating He does not remember. He states he has no memory to any portion of the incident when asked .</p> <p>Review of Resident #24's nursing progress note dated 7/29/2023 at 10:25 PM, showed, .Resident was placed on one-on-one monitoring at 6:47 PM [after incident with Resident #23] .spoke with [family member] she did give approval of room change [Resident #24's room had been next door to Resident #23] .</p> <p>Review of Resident #24's comprehensive care plan, revised 7/29/2023, showed, .Behavioral Resident exhibits inappropriate sexual behavior towards female resident administer medication per MD .order, notify appropriate agencies, Notify MD/Responsible party, one on one supervision until evaluated by MD/Psych NP and continue after as needed. Provide diversional activities as needed. Room change to room away from female resident.</p> <p>Review of Resident #24's Medication Administration Record dated 7/29/2023-8/26/2023, showed Resident #24 remained on one-on-one supervision from 7/29/2023 at 7:00 PM - 8/3/2023 at 11:55 PM.</p> <p>Review of a facility document Safety Check Log dated 8/4/2023-8/9/2023, showed Resident #24 remained on 15-minute safety checks.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/1/2024 at 2:00 PM, CNA #6 stated, .I heard a scream, I heard help, help .I was shocked to see that he [Resident #24] was standing at the side of her [Resident #23] bed, his hand was inside her brief at the side, I don't know how deep into the brief he got, the tape was still intact .the sheet was half way off but her brief was on .I yelled hey and I grabbed his hand off of her that is when I noticed his pants and brief were down his legs you could see his privates and his butt .I covered her [Resident #23] back up and pulled him [Resident #24] out of the room .I took him to the nurses' station and reported it to the nurse .the nurse went to [Resident #23] room we kept him at the nurses' station .her facial expression showed she was upset. I think she was .scared but she didn't say that she was .I had heard he could be inappropriate with staff .</p> <p>During an interview on 2/7/2024 at 11:15 AM, CNA #8 stated, .after the incident occurred I did one on one with Resident #24 at the nurses station .he was a little handsy he tried to grab my chest a couple of times .I was with him until the police came .another CNA provided one on one after the police arrived .I was sent to the hospital with [Resident #23] .At the .hospital she was .nervous .I asked her about the incident and she said .he had not raped her .</p> <p>During an interview on 2/13/2023 at 1:00 PM, the Administrator stated, .we did not substantiate this allegation as abuse because first [Resident #23] denied at the hospital [sexual assault] happened to her .the CNA saw what she saw .[Resident #24] had brain cancer and passed away on 8/14/2023, to me that says his cancer in his brain progressed so rapidly he did not know what he was doing .I can't quantify a reasonable person's reactions because that is not the situation .</p> <p>Review of the facility's investigation, police report, ER physician's progress note, medical records review for Resident #23 and #24 and interviews, showed the facility's failure to provide supervision and effective interventions for Resident #24's sexual behaviors resulted in actual harm for Resident #23 when Resident #24 was found in Resident #23's room with his hand inside her brief and she was screaming.</p> <p>Resident #7 was admitted to the facility on [DATE], and discharged on [DATE], with diagnoses including Cerebral Infarction, Schizoaffective Disorder Bipolar Type, Alzheimer's Disease and Dementia with other Behavioral Disturbance.</p> <p>Review of Resident #7's quarterly MDS assessment dated [DATE], showed a BIMS score of 14, indicating the resident was cognitively intact with no behaviors noted during the assessment period.</p> <p>Resident #8 was admitted to the facility on [DATE], with diagnoses including Disorder of Bone Density, Delusional Disorders, Dysphagia, Dementia with other Behavioral Disturbances, Major Depressive Disorder, Anxiety Disorder, and Alzheimer's Disease.</p> <p>Review of Resident #8's quarterly MDS assessment dated [DATE], showed a BIMS score of 3 indicating severe cognitive impairment. Potential Indicators of Psychosis of delusions were noted in the assessment period.</p> <p>Review of a facility investigation dated 8/2/2023, showed Resident #7 stated she and Resident #8 had a verbal altercation when Resident #8 came in her room. Resident #7 stated she told Resident #8 to get out. Resident #8 then slapped at her with no injuries and Resident #7 pulled Resident #8's thumb with no injuries. Resident #8 is delusional and thought Resident #7 was hitting a child. Resident #8's BIMS score is 3. The facility determined that both residents had contact with each other.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Police Department Report dated 8/2/2023 at 4:52 PM, showed, .simple assault .no arrests associated with this incident .police dispatched to [facility] in reference to a delayed assault. When I arrived, I spoke with the Director [Administrator] .stated they had two patients get into a physical altercation today around 3:35 PM .[Administrator] stated [Resident #8] went into [Resident #7]'s room. When [Resident #7] told [Resident #8] to leave [Resident #8] then struck [Resident #7] in the neck/shoulder area with her hand and then [Resident #7] grabbed [Resident #8's] thumb and bent it backwards. [Administrator] stated she was told the incident occurred because [Resident #8] thought [Resident #7] was attacking a small child. [Administrator] then took me to the nurses' station and [Assistant Director of Nursing/ADON] took me to speak to both parties. I spoke to [Resident #8] first and [Resident #8] advised that she did not remember anything about the incident. [Resident #8] has a BIMS score of 3. I then went and spoke to [Resident #7] who has a BIMS score of 14 who stated [Resident #8] came into her room and [Resident #7] asked [Resident #8] to leave the room and then [Resident #8] put her finger in the face of [Resident #7] and they exchanged some words then [Resident #8] struck her in the neck/shoulder area and [Resident #7] stated she then grabbed [Resident #8's] thumb and bent it backward .</p> <p>Review of Resident #7's nursing progress note dated 8/2/2023 at 7:09 PM, showed, .ADON met with [Resident #7] to follow up regarding incident this afternoon, in which the resident was slapped .</p> <p>During an interview on 1/23/2024 at 12:15 PM, the ADON, stated, .[Resident #8] and [Resident #7] were roommates, [Resident #8] was moved .but they were roommates for a while .[Resident #8] has severe dementia and she would continuously go back to her old room with [Resident #7] .[Resident #8] entered [Resident #7]'s room and [Resident #7] reported she had asked her to leave several times .she reported that [Resident #8] had smacked her on the neck .When she smacked her, she [Resident #7] had grabbed [Resident #8's] thumb and bent it back .when I did [Resident #8]'s assessment her thumb was red but she had full range of motion .when I asked her what happened all she said was she was protecting the child, but she had no idea what happened to her thumb .she didn't recall hitting another resident .</p> <p>During an interview on 1/29/2024 at 3:10 PM, LPN #7 stated, .I was at the nursing station and [Resident #7] came up the hall and stated she just hit me .[Resident #7] was a little agitated at first over the fact that [Resident #8] had been in her room .</p> <p>During an interview on 1/30/2024 at 3:15 PM, the DON stated, .[Resident #7] reported that [Resident #8] slapped her on the neck .in turn [Resident #7] bent [Resident #8]'s thumb back trying to protect herself .I do not think her action of slapping [Resident #7] was a willful act related to her cognition score of 3 .</p> <p>During an interview on 2/12/2024 at 12:40 PM, the Administrator stated, .this was an unwitnessed allegation . I don't think [Resident #8] had the presence of mind to hurt somebody .she did not do it to abuse [Resident #7]. [Resident #7] reacted by bending [Resident #8's] thumb back, neither sustained injury .</p> <p>Resident #10 was admitted to the facility on [DATE], discharged to inpatient psych (psychiatric treatment) on 6/29/2023, readmitted on [DATE], discharged to inpatient psych on 9/29/2023, and returned on 10/9/2023, with diagnoses including Cerebral Infarction, Delusional Disorders, Major Depressive Disorder, Dementia Severe with other Behavioral Disturbance, Anxiety Disorder and Cerebrovascular Disease.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/3/2024 at 3:30 PM, RN #1 stated, .I heard [Resident #10] .and saw [Resident #10] in [Resident #11's] room, and [Resident #11] yelled get out and was holding [Resident #10]'s right arm .and [Resident #10] was pulling away from her. I did not see the skin tear occur but I can only assume that is when the skin tear occurred .I took [Resident #10] to the nurses station, cleaned her arm and put steri-strips on her arm. It was a small skin tear .It was actively bleeding .within 10 minutes .got her watching TV she had forgotten all about it .[Resident #11] .calmed down when I took [Resident #10] out of her room .there were no changes in either of the residents emotional behaviors .[Resident #11] didn't like anyone in her room . [Resident #11] was yelling at [Resident #10] to get her out of her room .it was like she was pushing her arm to direct her out .</p> <p>During an interview on 1/30/2024 at 2:10 PM, the DON stated, .we did not substantiate abuse .it was unsubstantiated as abuse due to the cognition of the residents and the definition of willful must have acted deliberately .During the altercation [Resident #10] did receive a skin tear and bruising to her right hand .</p> <p>During an interview on 2/12/2024 at 12:40 PM, the Administrator stated, .I don't think that was abuse it was a response to [Resident #10] being in her [Resident #11's] room .</p>		

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NAME OF PROVIDER OR SUPPLIER Spring City Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 331 Hinch Street Spring City, TN 37381	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534</p> <p>Based on review of a facility policy, facility investigation, medical record review and interviews, the facility failed to report an allegation of sexual abuse within the required 2-hour timeframe for 1 resident (#21) of 8 allegations of abuse reviewed for reporting.</p> <p>The findings include:</p> <p>Review of a facility policy titled, Abuse, Neglect and Misappropriation of Property revised 9/15/2023, showed, .It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property .Sexual abuse is defines as non-consensual sexual contact of any type with a resident .For the purpose of this guidance, Covered individuals include the owner, operator, employee, manager, agent, or contractor of the facility .Staff would also include caregivers who provide care and services on behalf of the facility .Reporting/Response .Every Stakeholder shall immediately report any allegation of abuse .or suspicion of a crime .to the Facility Administrator or designee .Any abuse allegation must be reported to State within 2 hours from the time the allegation was received .</p> <p>Resident #21 was admitted to the facility on [DATE], with diagnoses including Cerebral Palsy, Abnormal Posture, Post-Traumatic Stress Disorder, Nightmare Disorder, Anxiety Disorder and Major Depressive Disorder.</p> <p>Review of Resident #21's quarterly Minimum Data Set (MDS) assessment dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The resident required extensive assistance of two plus person assist for bed mobility and toilet use.</p> <p>Review of a facility obtained interview with Resident #21 on 10/5/2023 showed, .What happened last Tuesday r/t [related to] [Alleged Perpetrator]? 'He came in my room before lunch.' Was your roommate in the room? 'Yes.' He came up to you [your] bed? 'He asked if he could check my brief to see if I need changed. I said yes if you think it needs to be changed.' Then what happened? 'He pulled my pants and brief down he started massaging my hip and behind I was laying on my right side. He pulled his pants down and put his penis in my vagina.' What did you say? 'Nothing.' How long was he in here? 'Probably 5-10 minutes.' Did he ejaculate? 'Not that I could tell.' What did he do when he was done? 'Pulled my brief and pants up then pulled his up. He kissed my hand and walked off.' Did you tell anyone that day? 'No When did you tell someone? 'That Friday [indicated the Behavioral Nurse Practitioner] and then today I told [name of Certified Nursing Assistant (CNA) #9.' Do you want anyone notified? 'No' .</p> <p>During an interview on 1/29/2024 at 3:55 PM, Social Service Director Float, stated, .I did speak with [Resident #21] I went in with the DON [Director of Nursing] and the Unit Manager/Licensed Practical Nurse (LPN) # 5 .she reported that a male CNA [Certified Nursing Assistant] approximately 2 weeks ago had sex with her .She reported that she had told one of the psychologists [Behavioral Health Nurse Practitioner] previously .and she had not said anything to staff.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/30/2024 at 12:45 PM, the FNP (Family Nurse Practitioner/Behavioral Health Nurse Practitioner/NP) stated, .I .provide behavioral health services .she did tell me on the 29th there was new black CNA, through an agency and he had worked her hallway came in to provide peri-care. She was already in the bed when he was changing her brief and that he inserted his penis in her .I asked her how did he manage to do that she said he climbed on the bed and got on top of her and that was how he had intercourse but said I don't think that he finished. She didn't tell me anything after that except she did say her roommate was in the room in bed sleeping and the curtain was closed. She said she was trying to be quite so her roommate didn't hear .I asked her why would you be quite you were getting violated you need to scream she never answered me she just started crying. She said she was afraid she was going to get kicked out of the facility if she told anyone. I reassured her that she would not get kicked out for something brought on her .I asked her if she had told anyone she said no she hadn't reported it. I asked her who did she want to report it to the DON, Social Service Director, or the Administrator. She said no she did not want to talk about it anymore today. I said I am supposed to report it what about the other residents here and their safety we need to protect others, and she kept saying no, no, I am not going to talking about it anymore. Then she said I promise I will go with you the next time you are here to report it .I said you promise when I am here next you will tell someone and she said she would .I did not report it to anyone, the Administrator called me a few days after because the resident had told her she had told me .I felt I should report it but I was trying to protect her privacy and her wishes and to make sure she did in the future .she was adamant she was not going to report it right then .</p> <p>During an interview on 2/5/2024 at 2:30 PM, CNA #9 stated, .it was the second time I had been in [Resident #21's room] that day .she [Resident #21] asked me if she could talk to me. I said yes, she asked me to shut the door. She just started crying she said a male CNA had intercourse with her .then she asked me not to say anything I told her I had to .I promised her everything would be okay and she would get the help she needed .</p> <p>During an interview on 2/12/2024 at 12:40 PM, the Administrator stated, . we did not substantiate sexual abuse .the hall she is on the most traveled hall in the building, there were no witnesses, staff was interviewed, residents were interviewed, and her roommate and there was no witnesses to anything like that . [Resident #21] did report to the Behavioral Health NP on Friday September 29th an allegation, but the Behavioral Health NP did not notify the facility because the resident asked her not to .the Behavioral Health NP was one of our contractors she has not been allowed back into the facility since .based on our abuse policy she should have reported the incident to the facility . During the interview, the Administrator stated she did not follow our abuse policy for reporting and the facility did not report the allegation of sexual abuse within the federally required 2-hour time frame .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534</p> <p>Based on review of facility policy, medical record review and interviews, the facility failed to follow physician orders for medication administration for 1 resident (#18) of 3 residents reviewed for medication administration.</p> <p>The findings include:</p> <p>Review of a facility policy titled, Medication Administration General Guidelines undated showed .Medications are administered as prescribed in accordance with manufacture's specifications, good nursing principles and practices .Medications are administered in accordance with written orders of the prescriber .</p> <p>Resident #18 was admitted to the facility on [DATE] and discharged on [DATE], with diagnoses including Disruption of External Operation Surgical Wound, History of Falling, Parkinson's Disease, and Epilepsy.</p> <p>Review of Resident #18's Discharge Minimum Data Set (MDS) assessment dated [DATE], showed return not anticipated.</p> <p>Review of Resident #18's Physician Admission Orders dated 3/3/2023, showed May administer first dose of medications when received from pharmacy . The orders included:</p> <p>Amantadine HCL (hydrochloride) (a medication used to treat Parkinson's Disease) 100 milligram (mg) twice a day 6:00 AM-10:00 AM, 6:00 PM-10:00 PM;</p> <p>Aspirin 325 mg twice a day 7:00 AM-11:00 AM, 7:00 PM-11:00 PM; Carbidopa-levodopa (medication to treat Parkinson's Disease) tablet 25 mg-250 mg, 1.5 tablet four times a day 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM;</p> <p>Dicyclomine capsule (medication used to treat Irritable Bowel Syndrome) 10 mg three times a day as needed (PRN);</p> <p>Entacapone tablet (medication used to treat Parkinson's Disease in conjunction with other medications) 1.5 mg oral four times a day 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM;</p> <p>Gabapentin capsule (medication used to treat nerve ending pain such as Neuropathy) 400 mg, 2 capsules four times a day 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM;</p> <p>Levetiracetam (medication used to treat Seizure Disorder) 1000 mg three times a day 7:00 AM-11:00 AM, 11:15 AM-3:00 PM, 7:00 PM-11:00 PM;</p> <p>Metoprolol tartrate (medication used to treat Hypertension) 25 mg twice a day 7:00 AM-11:00 AM and 7:00 PM-11:00 PM;</p> <p>Oxcarbazepine (medication used to treat Seizure Disorder) 1200 mg once a day 7:00 PM-11:00 PM;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Oxcarbazepine 900 mg once a day 7:15 AM-11:00 AM;</p> <p>Oxycodone (opioid pain medication) 10 mg-325 mg every 4 hours PRN; Trazodone (medication used to treat Depression and Insomnia) 50 mg once a day 7:00 PM-11:00 PM.</p> <p>During an interview on 1/18/2024 at 1:10 PM, Resident #18's spouse stated .I went first thing in the morning it was before 10:00 AM [3/5/2024] I'm sure, but he hadn't gotten his medication .and he was shaking .</p> <p>During an interview on 2/7/2024 at 1:50 PM, the Director of Nursing (DON) stated .he came in at 3:58 PM, which was too late to make the 2nd pharmacy run on 3/4/2023 [for delivery at approximately 11:00 PM] .he had orders for Amantadine .that is not something we have in our EDK [emergency drug kit] .his dosage [of Carbidopa-Levodopa] was not available and the Entacapone .was not in our EDK .his medications were put in the computer and ordered from pharmacy on 3/5/2023 at 10:01 AM [the morning after the admission] and would have been delivered on the first run at 4:00 PM on 3/5/2023 [24 hours after his admission] .Keppra 1000 mg three times a day, Metoprolol 25 mg twice a day .were available in our EDK and should have been administered as ordered .all .medications .not available in our EDK .would have been covered by our standing order to provide .dose when delivered from pharmacy . The DON confirmed Resident #18 had not been administered the following medications as ordered Levetiracetam [Keppra] 1000 mg on 3/4/2023 at 8:00 PM-11:00 PM dose, Metoprolol Tartrate 25 mg on 3/4/2023 at 9:00 PM-11:00 PM dose, Aspirin 325 mg on 3/4/2023 8:00 PM-11:00 PM dose, and Gabapentin 800 mg on 3/4/2023 at 8:00 PM dose which should have been available in the EDK.</p> <p>During an interview on 2/27/2024 at 10:50 AM, the Medical Director stated due to seizure type medications and Parkinson's medications .staying in the body, Resident #18 .could have been possible to have increased tremors, but missing a couple of doses of either type of medication would not cause harm .</p> <p>During an interview on 2/27/2024 at 11:15 AM, the Pharmacist stated medications ordered by 11:00 AM would be delivered during the first pharmacy delivery between 2:00 PM and 3:00 PM. Medications ordered by 7:00 PM would be delivered during the second pharmacy delivery between 12:00 AM-2:00 AM. Continued interview revealed if the facility needed a medication outside the ordering time parameters, the facility was to call the pharmacy and request the medication be added to the delivery. In the event the delivery was in route, the pharmacy could make a special delivery or the medication would be obtained from the back up pharmacy which would be delivered to the facility prior to the next scheduled delivery.</p>		