

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER Greystone Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 181 Dunlap Road Blountville, TN 37617	

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 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>27405</p> <p>Based on facility policy review, review of resident council minutes, and interview, the facility failed to ensure the residents' grievances related to adding more fresh fruits to meals and staff yelling and cursing in the hallways were promptly acted upon for 12 of 12 residents who attended the 10/29/2024 resident council meeting.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Quality Assistance Procedure, revised 10/30/2023, revealed .The facility will provide a designated staff person who is approved by the resident or group .responsible for responding to written request .The facility will consider the views of a resident or family group and act upon . recommendations of such groups concerning issues of resident care and life in the facility .</p> <p>Review of Resident Council Minutes dated 8/16/2024, revealed .staff yelling and cursing in the hallways . would like new options on the .menu .tired of tropical fruit .</p> <p>During an interview on 10/29/2024 at 2:00 PM, residents participating in the resident council stated the prior concerns of staff disruptive yelling and cursing in the hallways and menu concerns were not acted upon or corrected.</p> <p>During an interview on 10/30/2024 at 8:05 AM, the Dietary Manager (DM) confirmed she was aware residents had stated during the Resident Council Meeting on 8/16/2024 they would like more fresh fruits served. Continued interview confirmed the DM added a fresh fruit bar 1 time in September with no further action.</p> <p>During an interview on 10/30/2024 at 8:25 AM, the Director of Nursing (DON) confirmed she was aware residents had stated staff was loud and cursed in the hallways. Continued interview revealed the DON stated no staff had admitted to the behavior and confirmed she was not aware there were continued concerns.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786</p> <p>Based on facility document review, medical record review, and interviews, the facility failed to ensure Durable Power of Attorney (POA) documents were entered into the medical record for 2 residents (Residents #23 and #86) and failed to provide education regarding Advance Directives on admission for 6 residents (Residents #7, #8, #18, #37, #342 and #343).</p> <p>The findings include:</p> <p>Medical record review revealed Resident #23 was initially admitted to the facility on [DATE], and was most recently readmitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Seizures, Dementia, Depression, Bipolar Disorder, Anxiety, and Psychosis.</p> <p>Review of Resident #23's admission document dated 10/18/2018, titled, Advanced Directives and Other Legal Documents, revealed the resident had previously formulated a Durable Power of Attorney (POA) prior to admission to the facility and also revealed the POA signed legal documents on the behalf of the resident.</p> <p>Review of the resident's undated document titled ADMISSION RECORD revealed [POA name] .Contact Type .POA .Medical (Not activated) .</p> <p>Review of Resident #23's medical record revealed the durable POA documents had not been entered into the resident's medical record.</p> <p>Review of an annual MDS assessment dated [DATE], revealed Resident #23 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment, indicating severe cognitive impairment.</p> <p>Medical review revealed Resident #86 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Stroke, Paralysis, Depression, Post Traumatic Stress Disorder, and Tracheostomy Care.</p> <p>Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #86 scored a 9 on the BIMS assessment which indicated moderate cognitive impairment.</p> <p>Review of Resident #86's admission document dated 9/18/2024, titled, Advanced Directives and Other Legal Documents, revealed the resident's family chose to execute advance directives.</p> <p>Review of Resident #86's medical record revealed advance directive documents had not been entered into the resident's medical record.</p> <p>Medical record review revealed Resident #7 was admitted to the facility with diagnoses including Dementia, Bipolar Disorder, and Psychosis.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #7 scored a 9 on the BIMS assessment which indicated moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #7's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive.</p> <p>Medical record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Dementia, Type 2 Diabetes, and Unspecified Psychosis.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #8 scored a 9 on the BIMS assessment, which indicated moderate cognitive impairment.</p> <p>Review of Resident #8's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive.</p> <p>Medical record review revealed Resident #18 was admitted to the facility on [DATE] with diagnosis including Hemiplegia, Generalized Anxiety Disorder, and Mood Disorder.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #18 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact.</p> <p>Review of Resident #18's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive.</p> <p>Medical record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including Dementia, Muscle Weakness, and Generalized Anxiety.</p> <p>Review of an annual MDS assessment dated [DATE], revealed Resident #37 scored a 4 on the BIMS assessment, indicating severe cognitive impairment.</p> <p>Review of Resident #37's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive.</p> <p>Medical record review revealed Resident #342 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Mood Disorder, Critical Illness, Anxiety, and Myasthenia Gravis.</p> <p>Review of an admission MDS assessment dated [DATE], revealed Resident #342 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact.</p> <p>Review of Resident #342's undated admission document titled, Advanced Directives and Other Legal Documents, revealed the resident had not received education to formulate an advance directive at admission.</p> <p>Medical record review revealed Resident #343 was admitted to the facility on [DATE], with diagnoses including Stroke, Tracheostomy Status, Depression, Difficulty Speaking, and Anxiety.</p> <p>Review of an admission MDS assessment dated [DATE], revealed Resident #343 scored a 00 on the BIMS assessment, indicating severe cognitive impairment.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #343's undated admission document titled, Advanced Directives and Other Legal Documents, revealed the resident and/or the resident's representative did not receive education to formulate an advance directive at admission.</p> <p>During a record review and interview on 10/30/2024 at 12:40 PM, the Social Services Director (SSD) reviewed the medical records for Resident #23 and Resident #86 and stated Resident #23 had not signed her own documents and stated Resident #86's family had requested to execute an advance directive on admission. The SSD stated she was not knowledgeable of when Resident #23's POA advance directive was activated, confirmed the durable POA document was not entered in the medical record for Resident #23, and confirmed the facility did not obtain or execute advance directives for Resident #86.</p> <p>During a record review and interview on 10/30/2024 at 2:55 PM, the Admissions Director reviewed admission documents for Resident's #7, #8, #18, #37, #342, and #343, and confirmed education to formulate an advance directive was not provided to these residents or their representatives at admission.</p> <p>50480</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to provide 3 of 3 residents (Resident #12, Resident #400, and Resident #401) an Advanced Beneficiary Notice (ABN) after therapy services were discontinued, the resident remained in the facility for long-term care services, or was discharged from the facility. The facility's failure resulted in residents not being informed of the cost of therapy services if continued therapy services were desired which did not allow the residents to have an informed choice.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Advance Beneficiary Notices, revised 10/30/2023, revealed .It is the policy of the facility to provide timely notices regarding Medicare eligibility and coverage .A notice of Medicare Non-Coverage .shall be issued to the resident/ representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility .</p> <p>Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Anxiety Disorder, and Dysphasia.</p> <p>Review of a Physical Therapy Discharge Summary note dated 8/28/2024, revealed Resident #12 was discharged from skilled Medicare services.</p> <p>Review of the medical record for Resident #12 revealed an ABN was not provided to the resident upon discharge of physical therapy services.</p> <p>Medical record review revealed Resident #400 was admitted to the facility on [DATE] with diagnoses including Chronic Diastolic Congestive Heart Failure, Dysphasia, and Abnormalities of Gait.</p> <p>Review of a Physical Therapy Discharge Summary note dated 8/15/2024, revealed Resident #400 was discharged from skilled Medicare services.</p> <p>Review of the medical record for Resident #400 revealed an ABN was not provided to the resident upon discharge from physical therapy services.</p> <p>Medical record review revealed Resident #401 was admitted to the facility on [DATE] with diagnoses including Personal History of Transient Ischemic Attack, Dysphasia, and Other Lack of Coordination.</p> <p>Review of a Physical Therapy Discharge Summary note dated 7/2/2024, revealed Resident #401 was discharged from skilled Medicare services.</p> <p>Review of the medical record for Resident #401 revealed an ABN was not provided to the resident upon discharge from physical therapy services.</p> <p>(continued on next page)</p>		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 8:20 AM, the Administrator confirmed the ABN notices explaining their informed choice were not given to Resident #12, Resident #400, and Resident #401 prior to discharge from skilled Medicare services.		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49792</p> <p>Based on facility policy review, observations, and interviews, the facility failed to provide effective housekeeping and maintenance services to ensure a safe, sanitary homelike environment for 1 resident (Resident #51) of 95 residents reviewed for a safe, sanitary homelike environment.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Safe and Homelike Environment, dated [DATE], revealed .Environment refers to any environment .including .the resident's rooms. Sanitary includes .preventing the spread of disease-causing organisms. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary .environment .reporting lingering odors .to Housekeeping Department.</p> <p>Review of the facility's policy titled, Resident Refrigerators, dated [DATE], revealed .Housekeeping staff shall record .temperatures daily on a temperature log .shall clean the refrigerator daily .discard any foods that are out of compliance leftovers shall be dated .foods with use by dates shall be discarded .</p> <p>Observations on [DATE] at 11:10 AM, [DATE] at 2:47 PM, [DATE] at 3:07 PM, and [DATE] at 9:42 AM, of room [ROOM NUMBER] revealed a strong urine odor in the resident's room. A dark brown substance was noted on walls in several places. A rust-colored substance was noted in various places around the air conditioning unit. Dried food was observed inside the vent area of the air conditioning unit. [NAME] stains were observed on the black window curtains.</p> <p>During an interview on [DATE] at 9:40 AM, the 2nd Floor Unit Manager and Housekeeping Director confirmed the resident rooms were cleaned daily and as necessary. The Housekeeping Director stated curtains were changed when stained or soiled. While in room [ROOM NUMBER], the Housekeeping Director confirmed dried food debris inside the vent area of the air conditioning unit and the curtains were stained. The 2nd floor unit manager confirmed room [ROOM NUMBER] was not in a sanitary condition and did not represent a homelike environment.</p> <p>Observations on [DATE] at 11:30 AM and [DATE] at 3:02 PM of room [ROOM NUMBER] revealed a dark brown dried liquid substance in the resident's personal refrigerator. The personal refrigerator contained a piece of cake covered in plastic wrap that was not dated.</p> <p>Observations on [DATE] at 11:42 AM and [DATE] at 3:21 PM of room [ROOM NUMBER] revealed a dark brown dried liquid substance in the resident's personal refrigerator. The refrigerator contained 3 slices of pepperoni pizza stored in quart bags that did not have a date on it. An unopened pint sized container of milk revealed an expiration date of [DATE].</p> <p>During an interview on [DATE] at 9:33AM, the 2nd Floor Unit Manager stated it was the responsibility of the Certified Nursing Aide's (CNA's) to clean personal refrigerators, to perform daily temperature checks, and obtain the information on the temperature log located on the front door of the refrigerator. The 2nd Floor Unit Manager confirmed the personal refrigerators in rooms [ROOM NUMBERS] had not been cleaned, the food items were not dated, and the milk was expired.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:52 AM, the Administrator stated he did not know who was responsible to clean and maintain the residents' personal refrigerators, but stated .I should know so I am going to find out .</p> <p>During an interview with [DATE] at 11:59AM, the Housekeeping Director stated housekeeping staff cleaned the resident personal refrigerators and the CNAs obtained the temperature checks. She confirmed there was confusion regarding who was responsible for cleaning the refrigerators and performing temperature checks.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to submit a Level 2 Preadmission Screening and Resident Review (PASARR) for 2 residents (Resident #7 and #37).</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, PASARR - Pre-Admission Screen and Resident Review, revealed .resident is admitted with a level diagnosis as indicated .review is required upon change in the residents condition .</p> <p>Medical record review revealed Resident #7 was admitted to the facility with diagnoses including Dementia, Bipolar Disorder, and Psychosis.</p> <p>Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #7 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment, indicating moderate cognitive impairment.</p> <p>Medical record review revealed Resident #7's PASARR dated 9/29/2023, did not include a diagnosis of Post Traumatic Stress Disorder.</p> <p>Medical record review of the Psychiatric Evaluation dated 12/5/2023, revealed Resident #7 had a new diagnosis of Post Traumatic Stress Disorder.</p> <p>Medical record review revealed Resident #7 did not have a new PASARR submitted, after the new diagnosis of Post Traumatic Stress Disorder was added on 12/5/2023.</p> <p>Medical record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including Dementia, Muscle Weakness, and Generalized Anxiety.</p> <p>Review of the annual MDS assessment dated [DATE], revealed Resident #37 scored a 4 on the BIMS assessment, indicating severe cognitive impairment.</p> <p>Medical record review revealed Resident #37's PASARR dated 9/26/2023, did not include a diagnosis of Unspecified Mood Disorder.</p> <p>Medical record review of the Psychiatric Evaluation dated 12/20/2023, revealed Resident #37 had a new diagnosis of Unspecified Mood Disorder.</p> <p>Medical record review revealed Resident #37 did not have a new PASARR submitted to the state designated authority after the new diagnosis of Mood Disorder was added on 12/20/2023.</p> <p>(continued on next page)</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/30/2024 at 3:40 PM, the PASARR Coordinator confirmed it was her expectation Resident #7 should have been referred for a Level 2 PASARR evaluation after a new diagnosis of Post Traumatic Stress Disorder and Resident #37 should have been referred for a Level 2 PASARR evaluation, after a new diagnosis of Unspecified Mood Disorder was added.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480</p> <p>Based on facility policy review, observations, and interviews, the facility failed to maintain resident-care oxygen equipment in a clean and sanitary condition for 2 residents (Resident #23 and Resident #50) of 8 residents observed for oxygen use.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Equipment, revised 10/23/2024, revealed .resident-care equipment will be cleaned .Cleaning .is the removal of visible soil from objects and surfaces .Direct care staff are responsible for cleaning single-resident equipment when visibly soiled .</p> <p>Medical record review revealed Resident #23 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Stroke, Dementia, Weakness, and Obstructive Sleep Apnea.</p> <p>During an observation on 10/28/2024 at 4:10 PM, a blue 5-liter oxygen concentrator was noted beside Resident #23's bed. The blue 5-liter oxygen concentrator was soiled with a tan brown-like substance covering the top and front of the concentrator.</p> <p>During an observation on 10/30/2024 at 9:35 AM, a blue 5-liter oxygen concentrator was noted beside Resident #23's bed. The blue 5-liter oxygen concentrator was soiled with a tan brown-like substance covering the top and front of the concentrator.</p> <p>Medical record review revealed Resident #50 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Heart Failure, COPD, and Dementia.</p> <p>During an observation on 10/28/2024 at 4:00 PM, a black 10-liter oxygen concentrator was noted beside Resident #50's bed. The black 10-liter oxygen concentrator was soiled with a tan brown-like substance covering the top and front of the concentrator.</p> <p>During an observation on 10/30/2024 at 9:37 AM, a black 10-liter oxygen concentrator was noted beside Resident #50's bed. The black 10-liter oxygen concentrator was soiled with a tan brown-like substance covering the top and front of the concentrator.</p> <p>During an interview on 10/30/2024 at 9:28 AM, Respiratory Therapist (RT) stated the nursing staff was responsible for cleaning oxygen concentrators for residents on the 2nd floor (Resident #23's and Resident #50's floor).</p> <p>During interview and observation on 10/30/2024 at 9:35 AM, the 2nd floor Registered Nurse (RN) J stated the respiratory therapy staff were responsible for cleaning oxygen resident-care equipment. The RN observed the blue 5-liter oxygen concentrator and confirmed the concentrator was soiled and available for Resident #23's use, and confirmed the black 10-liter oxygen concentrator was soiled and available for Resident #50's use.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/2024 at 9:50 AM, the Director of Nursing (DON) stated nursing staff were responsible for cleaning resident oxygen concentrators when visibly soiled. The DON confirmed Resident #23's and Resident #50's oxygen concentrators were not maintained in a clean and sanitary condition.</p> <p>During an interview on 10/30/2024 at 10:00 AM, the Respiratory Therapy Manager stated nursing staff were responsible for cleaning oxygen concentrators for residents on the 2nd floor (Resident #23's and Resident #50's floor).</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>50407</p> <p>Based on facility policy review, observations, and interviews, the facility failed to ensure daily staff posting information included the resident census, the facility name, and actual number of hours worked by Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNA) on 3 of 3 days reviewed for staff postings.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Facility Required Postings, revised on 1/1/2022, revealed .The facility will post required postings .staffing information .</p> <p>Review of the Daily Staffing Sheets dated 10/28/2024-10/30/2024 revealed the following:</p> <p>The resident census and facility name was not listed for 3 days on the Daily Posted Staffing Sheets from 10/28/2024-10/30/2024.</p> <p>The RN hours, LPN hours, and CNA hours were not documented on the Daily Posted Staffing Sheets for 3 days from 10/28/2024-10/30/2024.</p> <p>During an interview on 10/30/2024 at 8:45 AM, the Staffing/Central Supply Coordinator confirmed the Daily Posted Staffing Sheets on 10/28/2024-10/30/2024 did not include the resident census, the facility name, or the actual hours worked by RNs, LPNs, and CNAs.</p> <p>During an interview on 10/30/2024 at 9:26 AM, the Director of Nursing (DON) reviewed the Daily Posted Staffing Sheets for 10/28/2024, 10/29/2024, and 10/30/2024. The DON confirmed the resident census, the facility name, and actual hours worked by RNs, LPNs, and CNAs were not included on the staffing sheets.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405</p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure proper administration of an oral inhaler for 1 resident (Resident #52) of 4 residents observed for medication administration.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Medication Administration .Oral Inhalations, dated 1/2023, revealed .To allow for safe, accurate, and effective administration of medication using an oral inhaler .Equipment .prescribed inhaler device .cup of water for rinsing mouth after steroid medication .ask resident to breathe out (do not exhale into the inhaler) .press down of the inhaler once to release medication as resident starts to breathe in slowly .hold breath for 5-10 seconds or as long as possible to allow medication to reach deeply into lungs .</p> <p>Medical record review revealed Resident #52 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis, Morbid Obesity, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #52 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact.</p> <p>Review on 10/29/2024 of the current Physician Recapitulation Orders revealed, .[name brand of inhalation medication] start date 5/18/2024 inhalation [type of inhaler] .2 puffs inhale orally two times a day .Rinse mouth with water and spit back into cup after use .</p> <p>During an observation on 10/29/2024 at 7:00 AM, Licensed Practical Nurse (LPN) C administered the inhaler to Resident #52, and failed to give any instructions prior to use to the resident. Continued observation revealed LPN C also failed to have the resident rinse the mouth and spit back into cup after use.</p> <p>During an interview on 10/29/2024 at 2:05 PM, LPN C confirmed she failed to give any instruction for the prescribed inhaler prior to use and failed to have Resident #52 rinse the mouth and spit back into cup after use.</p> <p>During an interview on 10/30/2024 at 6:04 PM, the Director of Nursing (DON) confirmed the facility policy for administration of oral inhalations for Resident #52 was not followed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>27405</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure medications were properly and securely stored in 1 of 3 medication storage rooms.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Medication Storage, revised 1/30/2024, revealed .It is the policy of this facility to ensure all medications housed on our premises will be stored .to ensure proper .security .Narcotics and Controlled Substances: Schedule II drugs .are stored under double-lock and key .</p> <p>During an observation of the 2nd floor medication room with Registered Nurse (RN) A on 10/29/2024 at 9:45 AM, revealed 27 [name brand pain medication] (Schedule II pain medication) oral tablets stored in the 2nd floor medication room in an unlocked refrigerator.</p> <p>During an interview on 10/29/2024 at 9:47 AM, RN A confirmed the Schedule II pain medication was not stored under 2 locks, 1 lock on medication room door and 1 lock in the medication room refrigerator, and confirmed the refrigerator storing the narcotic pain medication was unlocked.</p> <p>During an interview on 10/30/2024 at 6:04 PM, the Director of Nursing confirmed the facility policy for medication storage for Schedule II medications was not followed.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786</p> <p>Based on facility policy review, observations, and interviews, the facility failed to maintain kitchen equipment in a sanitary condition, ensure spices were properly sealed, and failed to discard expired food which had the potential to affect 92 of 95 residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Environment, revised ,d+[DATE], revealed .Dining Services Director will ensure kitchen is maintained in a clean sanitary manner, including floors, walls .</p> <p>Review of the facility's policy titled, Food Storage: Dry Goods, revised ,d+[DATE], revealed .packaged .foods items will be kept .properly sealed .</p> <p>During an observation of the food preparation area on [DATE] at 10:15 AM, with the Certified Dietary Manager (CDM), revealed the following:</p> <ol style="list-style-type: none"> 1. 12-ounce bottle of salt and pepper seasoning salt was not sealed and available for use. 2. An unopened container of mild wing sauce, with an expiration date of [DATE], available for use. 3. The area behind the deep fryer contained a greasy film with food particles. 4. The pipe under the dirty sink area actively dripping significant amounts of water into a full bucket of cloudy water, and moist food particles on the wall. <p>During an observation and interview on [DATE] at 10:15 AM, the Certified Dietary Manager (CDM) stated equipment and floors were cleaned daily and confirmed the area behind the deep fryer contained a greasy film with food particles and was not maintained in a clean sanitary condition.</p> <p>During an observation and interview on [DATE] at 10:30 AM, the CDM stated the pipe under the dirty sink area had been leaking for a few days and confirmed a bucket of cloudy water and food particles on the wall. The CDM confirmed the kitchen areas had not been maintained in a clean sanitary manner.</p> <p>During an observation and interview on [DATE] 10:40 AM, the CDM confirmed the dry storage area contained an unopened container of mild wing sauce, expiration date [DATE], had not been discarded, and was available for use.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation and interview on [DATE] at 8:20 AM, the CDM confirmed a 12-ounce container of Salt and Pepper Seasoning Salt, .d+[DATE] full, was left open to air and not properly sealed to prevent contamination.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>49786</p> <p>Based on facility policy review, observations, and interviews, the facility failed to ensure garbage and refuse were properly contained in 3 of 3 dumpsters.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Environment, revised 9/2017, revealed .trash will be properly disposed of in external receptacles (dumpsters) and the surrounding area will be free of debris .</p> <p>During an observation and interview on 10/28/2024 at 12:00 PM, the CDM confirmed the outside dumpster area contained three dumpsters for waste disposal and was observed with scattered refuse including used gloves, plastic medicine cups, plastic drinking cups, used wipes, drinking straws, plastic spoons, clear plastic bag filled with trash and was not maintained in a clean sanitary condition.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>50407</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure a device containing electronic health records was secured and not visible to unauthorized persons for 1 medication cart of 6 medication carts observed.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Electronic Protected Health Information (E PHI), revised 1/1/2022, revealed . ePHI is protected health information that is maintained in electronic media .Facility personnel shall ensure the confidentiality .availability of all ePHI that the facility creates .to protect .that data or information is not made available .to unauthorized persons .devices should always be locked when leaving the device so no unauthorized person can view .data .</p> <p>During an observation on 10/28/2024 at 10:55 AM, on the 100 Hallway, resident information was visible on the unattended and unlocked laptop screen attached to the 100 Hallway medication cart.</p> <p>During an interview on 10/28/2024 at 11:00 AM, Registered Nurse (RN) E confirmed resident information was visible to unauthorized persons on the unattended and unlocked laptop screen attached to the 100 Hallway medication cart.</p> <p>During an interview on 10/30/2024 at 9:26 AM, the Director of Nursing (DON) stated the facility's expectation was to lock laptop screens on unattended medication carts. The DON confirmed the facility failed to ensure residents' information was not visible to unauthorized persons when RN E left the unattended medication cart laptop screen unlocked.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49792</p> <p>Based on facility document review, observations, and interviews, the facility failed to offer 8 residents (Residents #33, #8, #34, #1, #63, #70, #292, and #24) with hand hygiene assistance before a lunch and breakfast meal on 2 of 3 hallways observed for meal service.</p> <p>The findings include:</p> <p>Review of the facility's document titled, Validation Checklist Hand Hygiene, undated, revealed .Purpose .to validate staff and residents are following hand hygiene protocols .Residents are offered hand hygiene prior to meals .</p> <p>During an observation on 10/28/2024 at 12:40 PM, on the 300 Hallway, Certified Nursing Assistant (CNA) F delivered the lunch meal tray to Resident #33 and did not offer hand hygiene assistance to the resident, prior to setting up the meal tray.</p> <p>During an interview on 10/28/2024 at 12:44 PM, CNA F confirmed hand hygiene assistance was not offered to Resident #33, prior to setting up the lunch meal tray.</p> <p>During an observation on 10/28/2024 at 12:52 PM, on the 200 Hallway, CNA G delivered the lunch meal tray to Resident #8 and did not offer hand hygiene assistance, prior to setting up the meal tray.</p> <p>During an interview on 10/28/2024 at 12:55 PM, CNA G confirmed hand hygiene assistance was not offered to Resident #8, prior to setting up the lunch meal tray.</p> <p>During an observation on 10/28/2024 at 12:56 PM, on the 200 Hallway, CNA H delivered the lunch meal tray to Resident #34 and did not offer hand hygiene assistance, prior to setting up the meal tray.</p> <p>During an interview on 10/28/2024 at 12:58 PM, CNA H confirmed hand hygiene assistance was not offered to Resident #34, prior to setting up the lunch meal tray.</p> <p>During an observation on 10/28/2024 at 12:59 PM, on the 200 Hallway, Licensed Practical Nurse (LPN) D delivered the lunch meal tray to Resident #1 and did not offer hand hygiene assistance, prior to setting up the meal tray.</p> <p>During an interview on 10/28/2024 at 1:03 PM, LPN D confirmed hand hygiene assistance was not offered to Resident #1, prior to setting up the lunch meal tray.</p> <p>During an observation on 10/28/2024 at 1:34 PM, on the 200 Hallway, CNA H delivered the lunch meal tray to Resident #63 and did not offer hand hygiene assistance, prior to setting up the meal tray.</p> <p>During an observation on 10/28/2024 at 1:38 PM, on the 200 Hallway, CNA H delivered the lunch meal tray to Resident #70 and did not offer hand hygiene assistance, prior to setting up the meal tray.</p> <p>During an interview on 10/28/2024 at 1:48 PM, CNA H confirmed hand hygiene assistance was not offered to Resident #63 and Resident #70 prior to setting up their lunch meal tray.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 10/29/2024 at 8:15 AM, on the 200 Hallway, CNA H delivered the breakfast meal tray to Resident #292 and did not offer hand hygiene assistance to the resident prior to setting up the breakfast meal tray.</p> <p>During an observation on 10/29/2024 at 8:18 AM, on the 200 Hallway, CNA H delivered the breakfast meal tray to Resident #24 and did not offer hand hygiene assistance to the resident, prior to setting up the breakfast meal tray.</p> <p>During an interview on 10/29/2024 at 8:27 AM, CNA H confirmed she did not offer hand hygiene assistance to Residents #292 and #24 prior to setting up their breakfast meal tray.</p> <p>During an interview on 10/30/2024 at 9:26 AM, the Director of Nursing confirmed it was the facility's expectation residents were offered hand hygiene assistance prior to meals.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure 1 resident's (Resident #50) call light was within reach out of 24 residents observed.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Call Lights: Accessibility and Timely Response, revised 12/28/2023, revealed .Staff are educated in the proper use of the resident call system .ensuring resident access to the call light .</p> <p>Medical record review revealed resident #50 was admitted to the facility on [DATE] with diagnoses including Malignant Neoplasm of the Lung, Psychosis, and Diabetes.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #50 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment, indicating moderate cognitive impairment. The MDS revealed the resident was dependent with eating, toileting, and dressing.</p> <p>During an observation on 10/28/2024 at 12:45 PM, Resident #50 was observed asking for her nurse, the call light was in the bedside drawer with the drawer partially closed, out of the resident's reach.</p> <p>During an observation and interview on 10/28/2024 at 12:55 PM, Certified Nursing Assistant (CNA) L entered Resident #50's room and stated she was unsure why the soft call light was in the bedside drawer because it was laying on her belly when she left her bedside around 6:30 AM.</p> <p>During an interview on 10/28/2024 at 12:55 PM, Licensed Practical Nurse (LPN) K confirmed Resident #50's soft call light was in the bedside drawer, with the drawer partially closed and not within the resident's reach.</p>		