

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Huntsville Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 287 Baker Street Huntsville, TN 37756	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534</p> <p>Based on facility policy review, medical record review, facility documentation review, observations, and interviews, the facility failed to prevent 1 resident (Resident #10) from self-administering medications without an assessment for self-administration and without a physician's order for self-administration.</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, Self-Administration of Medication Guidelines, revealed .A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely .The results of the interdisciplinary team assessment will be recorded in the resident's medical record. The attending physician will be notified of the result of the interdisciplinary team assessment .</p> <p>Medical record review revealed Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Psoriatic Arthritis, Chronic Obstructive Pulmonary Disease, Lactose Intolerance, Bipolar Disorder, Peripheral Vascular Disease, Anxiety Disorder, Obsessive-Compulsive Personality Disorder, and Major Depressive Disorder.</p> <p>Medical record review of the Psychiatric Nurse Practitioner (NP) Notes for Resident #10 dated 1/4/2024, revealed .I was asked to see him today regarding he [him] [Resident #10] having medications at bedside. He apparently was trying to 'hoard' medications. When I [NP] asked him why he had done that he tell[s] me that it was a 'dumb idea he had in his head' .</p> <p>Medical record review of the NP Progress Note for Resident #10 dated 1/5/2024, revealed .the nurse reports he [Resident #10] was noted to have several pills in his room. I discussed this with him. He denies suicidal ideation. We discussed the importance of note [not] keeping medications in his room and taking all medications as prescribed. He verbalized understanding and has no concerns at this time .Staff have no other concerns .</p> <p>Medical record review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medical record review of a NP Progress Note for Resident #10 dated 3/20/2024, revealed .I [NP] discussed with him [Resident #10] his recent visit with [Medical Director]. No new recommendations were made Addendum details: I was notified by the DON [Director of Nursing] .multiple medications were found in [Resident #10's] bed when staff was changing his linens. Myself [NP], DON .and Social Services .attempted to discuss this with [Resident #10]. He became agitated. He would never discuss why or how he obtained these medications. The medications included [name of pain medication], [name of muscle relaxant for spasms, cramping], [name of a medication to treat conditions where there is too much acid in the stomach] .</p> <p>Medical record review of the Nursing Notes for Resident #10 dated 3/21/2024 at 11:45 PM, revealed . [Resident #10] approached nurse in hall at 10:50 PM and ask if I could come to his room, he had some medication he needed to give me; I asked if he was okay with me getting another nurse to go witness what he was giving me and he stated 'Only if you trust them' .I asked .RN [Registered Nurse] B to go with me to the resident's room and upon entering room he unzipped duffel bag and handed us a white grocery bag filled with several zip lock [bags] with multiple pills in each one. He [Resident #10] stated he wanted to make a clean start of things and thanked us for listening. The pills were placed in the med [medication] room .</p> <p>During an interview on 4/15/2024 at 10:10 AM, Resident #10 stated .the Nurse Practitioner deliberately decreased my pain medication .they [the facility staff] said I had hoarded meds. The CNA [Certified Nursing Assistant] illegally searched my headphone case .there was a little over the counter vitamins maybe a few prescription meds [medications]. They [the medications] were way inside in this pocket zipped up .Maybe some pain pills [opiod pain medications] they [facility staff] accused me of not taking my medicine .</p> <p>During an interview on 4/17/2024 at 11:15 AM, the DON stated I was notified by the nursing staff they had found medications in his [Resident #10's] room .He said that he wasn't holding on to them [the medications] for self-harm, he had difficulty taking all his medicines at one time, but that was the only explanation, except he had narcolepsy and he would just fall asleep and not take them all .Yes, the nurse is supposed to watch the resident take all medications prior to leaving the room, unless the resident has been assessed and we have a physician's order for self-administration of medication, which he does not have .</p> <p>During an interview on 4/23/2024 at 8:35 AM, Resident #10 was asked how was he able to accumulate so many medications? Resident #10 stated .it was over a long period of time .I don't know .It was never just necessarily a daytime thing, just a few here and there over a period .</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/24/2024 at 10:30 AM, Licensed Practical Nurse (LPN) C stated Resident #10 was very time consuming when administering his multiple medications. I [LPN C] suppose there has been a time that I have taken my eyes off of him [Resident #10] or gone back to the med [medication] cart sitting at his room door .he does order vitamins and minerals on the Internet .I did find some [name of a dietary enzyme to aid in digestion of milk and milk products] and one [name of anti-nausea medication] at bedside in January 2024, but that was all that it was .I spoke with the DON he identified the medicine as [name of a dietary enzyme] .and one [anti-nausea medication] .he got [was prescribed] 3 [name of a dietary enzyme] before each meal, but sometimes he just wants one .he would wait and take them right before the meal .I had given him his [anti-nausea medication] .at his 4:00 PM med pass and I guess he hadn't taken it .yes even though he did not have an order for self-administration of medications I did leave his [anti-nausea medication] and [name of a dietary enzyme medication] in the room with him if he didn't take it during his medication pass . for self-administering.</p> <p>During an interview on 4/24/2024 at 1:40 PM, the Executive DON stated .[LPN C] did bring me the medication she found at [Resident #10's] bedside on 1/3/2024, I [Executive DON] identified the medications as 1 [anti-nausea medication] and 2 [dietary enzyme medications] .</p> <p>During an interview on 4/30/2024 at 9:00 AM, the DON confirmed the facility failed to follow their policy for Self-Administration of Medications Guidelines. Resident #10 had not been assessed for self-administration of medications and the nurses allowed Resident #10 to self-administer medications.</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>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** 36534</p> <p>Based on facility documents, observations, and interviews, the facility failed to maintain a homelike environment, free from odors in 4 resident rooms of 21 resident rooms reviewed for homelike environment.</p> <p>The findings include:</p> <p>Review of a facility document Wheelchair Cleaning dated monthly, revealed wheelchairs of incontinent residents were to be cleaned weekly and the document had no documentation of wheelchair cleaning after 9/1/2023.</p> <p>Observation on 4/16/2024 at 4:05 PM, with the DON, in room [ROOM NUMBER], revealed a strong foul odor. The resident was seated on his bed, and no odor was noted in close proximity to the resident. Upon further investigation, the foul odor was noted to be the resident's wheelchair.</p> <p>During an interview on 4/16/2024 at 4:10 PM, the DON confirmed the foul odor in the room was from urine and the DON indicated it was from the resident's wheelchair.</p> <p>Observation on 4/16/2024 at 4:35 PM, with the DON, in room [ROOM NUMBER], revealed a strong foul odor. The resident was lying in the bed and no odor was observed in close proximity to the resident. Upon further investigation, the foul odor was identified as coming from the resident's personal recliner.</p> <p>During an interview on 4/16/2024 at 4:40 PM, the DON confirmed the foul odor in the room was urine and it was coming from the resident's recliner.</p> <p>Observation on 4/16/2024 at 4:45 PM, with the DON in room [ROOM NUMBER], showed a strong foul odor. The resident was lying in the bed, no odors were observed in close proximity to the resident. Upon further investigation, the foul odor was noted to be coming from the resident's rock-n-go chair wheelchair.</p> <p>During an interview on 4/16/2024 at 4:40 PM, the DON confirmed the foul odor in the room was urine and it was coming from the resident's rock-n-go wheelchair.</p> <p>During an interview on 4/22/2024 at 11:00 AM, the DON confirmed wheelchairs and specialty wheelchairs were to be cleaned weekly for incontinent residents and monthly for continent residents and stated .We had a system in place but the log for documentation of the wheelchairs being cleaned got under the counter and wheelchair cleaning has not been documented since September 1, 2023. Personal recliners are part of the deep cleaning schedule by housekeeping .part of our RAP [Resident Advocate Program] rounds .at the bottom of the sheet there is a specific question related to odors . During this interview, the DON confirmed the facility had failed to maintain a homelike environment in 3 resident rooms.</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534</p> <p>Based on review of facility policy, medical record review, facility documentation, observations, and interviews, the facility failed to develop a comprehensive care plan and implement appropriate interventions for 1 resident (Resident #10), to prevent hoarding of medications, and failed to implement appropriate interventions to alert staff 1 Resident (Resident #10) was ordering and receiving over the counter medications online. The facility's failure to develop a comprehensive care plan and implement appropriate interventions placed Resident #10 and all other residents in the facility in an Immediate Jeopardy situation, (a condition in which facility noncompliance with one or more conditions of participation has resulted in or is likely to result in serious injury, harm, impairment, or death and must be immediately corrected). The facility's failure to develop a comprehensive care plan and implement appropriate interventions had the potential to impact all residents in the facility.</p> <p>The Facility Administrator was notified of the IJ on 4/30/2024 at 1:50 PM, in the conference room.</p> <p>The Immediate began on 1/3/2024, and ended on 5/2/2024.</p> <p>The facility was cited Immediate Jeopardy at F-656 at a scope and severity of J.</p> <p>The IJ began on 1/3/2024, and continued through 4/30/2024. The IJ ended on 5/1/2024, and was removed on site.</p> <p>An acceptable Allegation of Compliance which removed the immediacy was provided by the facility and verified onsite on 5/3/2024, for F-656.</p> <p>The facility is required to submit a Plan of Correction (POC).</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, Comprehensive Care Plans, revealed .it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment</p> <p>Medical record review revealed Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Psoriatic Arthritis, Chronic Obstructive Pulmonary Disease, Lactose Intolerance, Bipolar Disorder, Peripheral Vascular Disease, Anxiety Disorder, Obsessive-Compulsive Personality Disorder, and Major Depressive Disorder.</p> <p>Medical record review of a comprehensive care plan dated 9/26/2022, revealed no revision or updates for manipulative behaviors involving medication including hoarding and/or cheeking medication related to the incident on 1/3/2024, when Resident #10 was found with medications at bedside.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Medical record review of the Psychiatric Nurse Practitioner (NP) Notes for Resident #10 dated 1/4/2024, revealed .I was asked to see him today regarding he [him] having medications at bedside. He apparently was trying to 'hoard' medications. When I asked him why he had done that he tell[s] me that it was a 'dumb idea he had in his head' .He denies any suicidal ideation .</p> <p>Medical record review of the NP Progress Note for Resident #10 dated 1/5/2024, revealed .the nurse reports he was noted to have several pills in his room. I discussed this with him. He denies suicidal ideation. We discussed the importance of note [not] keeping medications in his room and taking all medications as prescribed .</p> <p>Medical record review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.</p> <p>Medical record review of a NP Progress Note for Resident #10 dated 3/20/2024, showed .I discussed with him his recent visit with [Medical Director]. No new recommendations were made Addendum details: I was notified by the DON [Director of Nursing] .That multiple medications were found in [Resident #10's] bed when staff was changing his linens. Myself, DON .and Social Services .attempted to discuss this with [Resident #10]. He became agitated. He would never discuss why or how he obtained these medications. The medications included [name of pain medication], [name of muscle relaxant for spasms, cramping] and [name of a medication to treat conditions where there is too much acid in the stomach] .</p> <p>Medical record review of a comprehensive care plan for Resident #10 revised 3/20/2024, revealed .has potential for impaired behaviors related to manipulative behaviors involving medication including hoarding/cheeking .has potential for impaired or inappropriate behaviors related to accumulation of items in his room .Resident #10 is to take medication crushed per nurse practitioner .</p> <p>Medical record review of the Nursing Notes for Resident #10 dated 3/21/2024 at 11:45 PM, revealed . [Resident #10] approached nurse in hall at 10:50 PM, and ask if I could come to his room, he had some medication he needed to give me; I asked if he was okay with me getting another nurse to go witness what he was giving me and he stated 'Only if you trust them.' I asked .RN [Registered Nurse] B to go with me to resident's room and upon entering room he unzipped [a] duffle bag and handed us a white grocery bag filled with several zip lock [bags] with multiple pills in each one. He stated he wanted to make a clean start of things and thanked us for listening. The pills were placed in the med room .</p> <p>Medical record review of a comprehensive care plan for Resident #10 revised 3/21/2024, revealed at 12:00 AM, (3/22/2024) Resident #10 was placed on 15-minute checks, for increase monitoring. and the checks were discontinued on 3/22/2024 at 9:00 AM.</p> <p>Medical record review of a comprehensive care plan for Resident #10 revised 3/25/2024, revealed all medications to be given crushed in applesauce, (name of medication used to treat seizure disorders and certain psychiatric conditions) may be given whole in applesauce.</p> <p>Medical record review of a comprehensive care plan for Resident #10 revised 3/30/2024, revealed .can take medications whole. He must rinse his mouth and spit after medication administration to ensure medications are swallowed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Medical record review of a Physician's Order for Resident #10 dated 4/5/2024, revealed .take medication at med cart.</p> <p>Medical record review of LPN B's Nursing Notes for Resident #10 dated 4/5/2024, revealed .resident approached nurses' station and ask if we had seen his package from [local store]; I explained that yesterday 4/4 2024, that (activities personnel) had brought me a package from [local store] with his name on it and asked me where to put it d/t [due to] it containing [potassium]. I explained to the resident I turned it into the DON, and he became irate, stating that we violated his rights by taking his mail. I attempted to educate him on how the facility has the right to inspect packages due to safety concerns; and how he could not order medication and expect to be able to keep it as he chooses that even OTC [over the counter] meds have to be Dr. [Doctor] ordered, he began cussing and yelling and stating that we will no longer discuss this issue what done is done and Administration can deal with on Monday .</p> <p>Medical record review of a comprehensive care plan for Resident #10 dated 4/5/2024, revealed Behavior Care Plan .has potential for impaired or inappropriate behaviors related to manipulative behaviors involving medication . The care plan revealed no problem identified or interventions developed related to Resident #10 ordering and receiving over the counter medications and dietary supplements by mail or delivery.</p> <p>During an interview on 4/18/2024 at 9:35 AM, the DON stated .I do not recall any [name of narcotic pain medication] or psych meds [psychoactive medications] in the bag he turned in .in the initial bag there were [name of stomach medication], [name of narcotic pain medication], [name of medication used to treat nerve pain], [name of seizure medication also used for mood disorder], vitamin C, [name of headache pain medication], and several over the counter vitamins and medications .there were probably 20 different medications in the medications found but we did not count the medicines or identify all the meds I will estimate around 200 to 250 pills. I did recognize some of them .he does have several over the counter vitamins, and medications .3/20/2024 was the first time I had knowledge of him not taking all of his medication .I was not the DON in January [2024] and had no knowledge of medications being found at bedside .</p> <p>During an observation on 4/18/2024 at 1:15 PM, with the Executive DON, in [Resident #10's] room, revealed the resident had received a package by mail. The Executive DON ask for permission to open the package. The package contained a bottle of magnesium [dietary supplement]. The Executive DON, explained the dangers in taking medications not prescribed, and explained the resident was not allowed to keep any medications in his room. The resident agreed to the Executive DON removing the magnesium and storing it in the medication room. The Executive DON stated he would speak to the NP to see if she wanted to order labs to see if the supplement was needed. Resident #10 agreed to this resolution .</p> <p>Medical record review of Resident #10's comprehensive care plan on 4/18/2024, after the observation in Resident #10's room revealed the resident had received magnesium by mail, there was no update, revision, or intervention related to Resident #10 receiving dietary supplements he ordered online and received by mail.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/23/2024 at 8:35 AM, Resident #10 was asked how was he able to accumulate so many medications and he stated .it was over a long period of time .I don't know .It was never just necessarily a daytime thing, just a few here and there over a period .I just didn't want to get accused of not taking my meds .</p> <p>During an interview on 4/24/2024 at 9:35 AM, the Medical Director stated .if another resident had found and taken the medications it is always a possibility of that resident having harm if they took them .when we found out he was hoarding these medications we had concerns he would try to trade them for favors from staff or residents .the crushing was to prevent him from pocketing them and spitting them out .could others have had harm? If other residents had wandered into his room and found them that would be a possibility that would stand to reason. I couldn't deny that the medications could have be taken by them is plausible and could have suffered harm that is a possibility .we can't exclude that possibility .I suppose it would have been a possibility he could have taken the medications inappropriately. I suppose there would have been some risks of harm .I wasn't involved in the pill count, but with that amount of medications who's to say what he could have done with them at any point in time .I can't quantify the risk, but there was a risk .</p> <p>During an interview on 4/30/2024 at 9:00 AM, the DON confirmed the facility failed to develop and implement a comprehensive care plan addressing Resident #10 ordering and receiving over the counter medications and supplements and failed to implement appropriate interventions following the discovery on 1/3/2024, of medications left at Resident #10's bedside, which assisted Resident #10 in hoarding medications in his room.</p> <p>The Surveyor verified the Removal Plan by:</p> <p>1 A. On 4/30/2024, the QAPI (quality assurance performance improvement) committee, which includes the DON, Risk Manager, Social Services Director, and Administrator, conducted an Ad-Hoc QAPI meeting and identified the root cause of the alleged deficiency. The root cause identified the medications, which were found at bedside of Resident #10, was indicative of Resident #10's manipulative behavior.</p> <p>Compliance was validated by review of the AD-Hoc QAPI minutes for the 4/30/2024 meeting and confirmed the signatures of attendance.</p> <p>1 B. On 4/30/2024, and 5/1/2024, the IDT (Interdisciplinary team) reviewed Resident #10's behavioral care plan.</p> <p>Compliance was validated by interview with the DON and Administrator and review of Resident #10's care plan.</p> <p>On 5/1/2024, use of a dispenser tray during medication administration was added to the care plan interventions by the IDT.</p> <p>This intervention was validated by reviewing the care plan and observation of Resident #10's medication administration on 5/3/2024 at 12:00 PM.</p> <p>The DON provided training to the nurses on 5/1/2024, for the use of the medication dispenser tray during medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>This training was validated by reviewing education, cross-referencing the sign-in sheet with staff roster, and interviews with facility LPNs and RNs.</p> <p>On 5/1/2024, the IDT updated the 4/23/2024 care plan intervention related to Resident #10's packages to include all packages received.</p> <p>This intervention will have front office staff monitor packages coming in for Resident #10. This intervention applies to all packages addressed to Resident #10. The front desk will notify the DON and/or the Administrator during the week of all packages received for Resident #10. This will be done (Monday-Friday) on week days. During the weekends, the MOD (Manager on duty) and/or nurse supervisor will monitor packages received for Resident #10.</p> <p>This intervention was validated by care plan review and interviews with the front office staff and nurses.</p> <p>On 5/1/2024, the Administrator/DON provided the front desk staff, assigned MODs, nurse supervisors and nurses instructions to notify the Administrator, DON, MOD, nurse supervisor of packages received for Resident #10.</p> <p>This intervention was validated by interviews with the front office staff, nurses and nurse supervisors and review of the education sign-in sheet.</p> <p>On 5/1/2024, the DON and Administrator shared the care planned intervention with Resident #10. Resident #10 expressed understanding and agreed to open packages in the presence of the Administrator, DON, MOD, or nurse supervisor.</p> <p>Compliance was validated by an interview with Resident #10.</p> <p>On 5/1/2024, use of a tongue depressor starting on 5/1/2024, to perform an oral cheek check during medication administration to ensure all medicines are swallowed by resident #10.</p> <p>This was validated through observation of medication administration for Resident #10 and with nursing interviews.</p> <p>Care plan intervention for accurate use of tongue depressor was added on 5/1/2024 by the IDT.</p> <p>This was validated through review of the updated plan of care on 5/2/2024.</p> <p>Tongue depressor use: The nurse will use the tongue depressor to check the oral cavity for cheeking of medications. The nurse will ask Resident #10 to open his mouth. The nurse will observe the tongue's resting position then ask Resident #10 to stick his tongue out. The nurse will place the tongue depressor against the tip of the tongue that is sticking out to check for any medications in both inner area cheeks. The nurse will then gently press the tongue with the tongue depressor to get an unobstructed view of the oral cavity.</p> <p>If a medication is seen during the mouth check using the tongue depressor, Resident #10 will be provided with water to swallow the medication. After that, the nurse will repeat the process.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The nurse will repeat the process until no medication is seen with the mouth check using the tongue depressor.</p> <p>To ensure implementation of this care plan intervention, the DON and Risk Manager provided nurses with training related to use of the tongue depressor during medication administration with Resident #10. The training was completed on 5/1/2024. The nurses not present for training will be notified of the intervention for Resident #10 related to the use of tongue depressor prior to start of their shifts.</p> <p>Compliance was validated by observation of a Medication Pass for Resident #10, review of education sign-in sheets with staff roster and nurses' interviews.</p> <p>On 5/1/2024, the DON also provided Resident #10 with education about the use of the tongue depressor during medication administration. Resident #10 expressed understanding and agreement to the new intervention.</p> <p>Compliance was validated during an interview with resident #10.</p> <p>Modification of medication administration and the number of medications being administered during each medication pass was completed by the DON, Risk Manager, and Executive DON on 5/1/2024.</p> <p>Compliance was validated by review of the worksheet dated 5/1/2024, and interview with the DON on 5/2/2024.</p> <p>The resident was provided education on 5/1/2024, by the DON about changes of the medication administration times and the number of medications planned to be administered with each of the medication pass times as a new care plan intervention.</p> <p>This intervention was validated during an interview with Resident #10 on 5/2/2024. He confirmed the education for the adjusted times for medication administration was given to him on 5/1/2024.</p> <p>The DON informed the nurses on 5/1/2024, of the new medication schedule and the modified number of medications being administered with each medication pass. The nurse will be notified of the intervention for Resident #10 related to the number of medications and new medication schedule prior to start of their shifts.</p> <p>This intervention was validated through review of education attendance sign-in sheets and nurse interviews.</p> <p>It was identified the resident stays awake most of the time until 2:00 AM, so another medication pass time was added at 1:00 AM.</p> <p>This was validated with nurses' interviews and an interview with Resident #10 on 5/2/2024.</p> <p>On 5/1/2024, after the modification of the medication schedule and review of all medications being administered, the total number of medications were divided equally into 10 medication administration times, which allowed 3-5 medications to be administered with each medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>This intervention was validated by reviewing a worksheet completed by the DON and the NP, distributing medications to add an additional medication pass and interviews with nursing staff.</p> <p>C. On 5/1/2024, the Social Service Director scheduled a monthly care plan meeting with Resident #10 to review his plan of care and assess the status of care plan interventions.</p> <p>The Social Service Director met with Resident #10 to discuss a monthly care plan meeting calendar. The care plan meeting will be attended by the IDT which includes the DON, Administrator, Risk Manager, Social Service Director, Director of Rehabilitation, and Nurse Practitioner.</p> <p>A laminated listing of care plan meeting dates was given to resident #10 as a reminder.</p> <p>This intervention was validated during an interview with the Social Service Director and Resident #10.</p> <p>On 5/1/2024 the DON trained the nurses to notify the DON or Administrator if Resident #10 becomes uncooperative during medication administration. Nurses who are not available due to vacation or leave of absence will receive the training before they start their next shift upon return to work.</p> <p>This was validated through nursing interviews and review of the 5/1/2024 education with the attendance sign-in sheet on 5/2/2024.</p> <p>Starting 5/1/2024, medication observations will be done by the DON, Risk Manager, Unit Manager, and MDS Nurse to observe the nurse during medication administration for Resident #10. The DON, Risk Manager, Unit Manager, and MDS Nurse will observe the nurse to verify the care plan interventions are being followed during medication administration. Any identified concern will be addressed immediately. If a nurse does not follow the care plan interventions during the medication administration, the nurse will be provided with additional training before the next medication administration.</p> <p>This intervention was validated through review of completed audits.</p> <p>The document audit titled Observation Pass Observation audit will be used to document the results of the observations to identify concerns and corrective actions. The completed audits will be kept by the DON and will be readily available for review by QAPI committee members.</p> <p>This intervention was validated by review of the Observation Pass Observation audits completed.</p> <p>The audit will be completed for four weeks. After four weeks, the QAPI team will review the results of the medication observation audit to determine if additional interventions or monitoring are necessary.</p> <p>For the next three months a weekly Ad-Hoc QAPI meeting will be held and participated in by the Administrator, the VP of operations, DON, Risk Manager, MDS Nurse, Social Service, and NP to discuss the implementation of resident #10's care plan interventions. If concerns are identified, the QAPI team will determine if additional care plan interventions are needed to sustain compliance.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534</p> <p>Based on medical record review, facility documentation review, observation, and interviews, the facility failed to ensure adequate supervision during medication administration to prevent 1 resident (Resident #10) from hoarding medications and the facility failed to adequately address 1 resident's (Resident #10) ordering and accumulating over the counter medications and supplements from outside sources for self-administration. The facility's failure to ensure adequate supervision during medication administration placed Resident #10 and all other residents in the facility in an Immediate Jeopardy situation, (A condition in which facility noncompliance with one or more conditions of participation has resulted in or is likely to result in serious injury, harm, impairment, or death and must be immediately corrected). The facility's failure to ensure adequate supervision during medication administration had the potential to impact all residents in the facility. On 4/15/2024, the facility census was 70.</p> <p>The Facility Administrator was notified of the IJ on 4/30/2024 at 1:55 PM, in the conference room.</p> <p>The Immediate Jeopardy began on 1/3/2024, and ended on 5/1/2024.</p> <p>The facility was cited Immediate Jeopardy at F-689 at a scope and severity of J.</p> <p>The IJ began on 1/3/2024, and continued through 5/1/2024. The IJ ended on 5/2/2024, and was removed on site.</p> <p>An acceptable Allegation of Compliance which removed the immediacy was provided by the facility and verified onsite by surveyor on 5/3/2024 for F-689.</p> <p>The facility's noncompliance at F-689 continues at a scope and severity of D for monitoring the effectiveness of the corrective action.</p> <p>The facility is required to submit a Plan of Correction (POC).</p> <p>The findings include:</p> <p>Medical record review revealed Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Psoriatic Arthritis, Chronic Obstructive Pulmonary Disease, Lactose Intolerance, Bipolar Disorder, Peripheral Vascular Disease, Anxiety Disorder, Obsessive-Compulsive Personality Disorder, and Major Depressive Disorder.</p> <p>Medical record review of the Licensed Practical Nurse (LPN) C's Nursing Note for Resident #10 dated 1/3/2024 at 6:02 PM, revealed .medication found at bedside 15-minute checks [for] 72 hours in place for safety r/t [related to] hoarding medication. APRN [Advanced Practice Nurse Practitioner] made aware with Psychiatric MD to eval [evaluate] Rt [Resident] made aware of orders .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Medical record review of the Psychiatric Nurse Practitioner (NP) Notes for Resident #10 dated 1/4/2024, revealed . I [NP] was asked to see him today regarding he [him] having medications at bedside. He apparently was trying to 'hoard' medications. When I asked him why he had done that he tell[s] me that it was a 'dumb idea he had in his head.' He denies any suicidal ideation .Review chart for medications, labs, and history. No known triggers to behaviors modifying factors. Risk and severity for complications is moderate .Continue to monitor and offer supportive care. Continue current treatment plan and medications. He denies any suicidal plan, suicidal ideation, or homicidal ideation .</p> <p>Medical record review of the LPN C Nursing Note for Resident #10 dated 1/4/2024 at 12:41 PM, revealed . currently on 15-minute checks for safety r/t [related to] hoarding meds no issues noted this day Rt [resident] behavior is cheerful up in w/c [wheelchair] propelling self in hallways no c/o [complaint of] pain or acute distress noted in view of staff .</p> <p>Medical record review of the NP Progress Note for Resident #10 dated 1/5/2024, revealed .the nurse reports he [Resident #10] was noted to have several pills in his room. I discussed this with him. He denies suicidal ideation. We discussed the importance of note [not] keeping medications in his room and taking all medications as prescribed. He verbalized understanding and has no concerns at this time .Staff have no other concerns .</p> <p>Medical record review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.</p> <p>Medical record review of the Nursing Note by the Director of Nursing (DON) for Resident #10 dated 3/20/2024, revealed .Notified by resident's [Resident #10's] nurse that multiple medications were found in resident's room. [Resident 10] was taking a shower and the CNA [Certified Nursing Assistant] was making the resident's bed. There was a headphone case on the bed that was partially zipped. The CNA picked it up and heard rattling. The CNA opened the case fully and observed multiple medications inside. CNA gave medications to nurse. Provider notified .NP and Social Service Director and DON went to resident's room to discuss the found medications. When asked the resident became furious stating, you all illegally searched my stuff! You violated my civil rights! Explained to the resident that none of his belongings had been searched and the medications had been found while cleaning off his bed. Resident remains furious and continuous to yell and insist that he was 'set up.' Resident continues to state he wasn't hoarding medication and that staff is out to get him. Resident was specifically asked if he had any thoughts of harming himself in any way. Resident denies this. Resident states 'I have no plans to hurt myself or anyone else.' Resident denies hoarding the medication in attempt to hurt himself. Staff explained to resident that we were concerned for his health and safety due to episodes of crying and labile moods and that we had contacted Mobile Crisis and they recommended to go to the ER [emergency room] for further evaluation. Resident adamantly refuses to go to the ER. Resident states 'I don't need to go I'm not going to hurt myself.' NP informed resident that his medicines would have to be crushed from now on for safety. Informed resident that staff could not ensure he was safely taking his medication due to his frequent refusals and excuses when asked to take medication in front of the nurse. Resident verbalized understanding .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Medical record review of a NP Progress Note for Resident #10 dated 3/20/2024, revealed .I discussed with him his recent visit with [Medical Director]. No new recommendations were made .Addendum details: I was notified by the DON . That multiple medications were found in [Resident #10's] bed when staff was changing his linens. Myself, DON .and Social Services .attempted to discuss this with [Resident #10]. He became agitated. He would never discuss why or how he obtained these medications. The medications included [name of narcotic pain medication], [name of a muscle relaxant], [name of a medication to reduce stomach acid]. He currently denies any SI/HI [suicidal ideations/homicidal ideations] .GDRs [gradual dose reduction] of these medications will be initiated, and all medications will be given crushed in applesauce. DON to educate staff .</p> <p>Medical record review of a comprehensive care plan for Resident #10 revised 3/20/2024, revealed .has potential for impaired behaviors related to manipulative behaviors involving medication including hoarding/cheeking .Resident #10 is to take medication crushed per nurse practitioner.</p> <p>Medical record review of LPN B's Nursing Note for Resident #10 dated 3/21/2024 at 11:45 PM, revealed . [Resident #10] approached nurse in hall at 10:50 PM and ask if I could come to his room, he had some medication he needed to give me; I asked if he was okay with me getting another nurse to go witness what he was giving me and he stated 'Only if you trust them.' I asked .RN [Registered Nurse] B to go with me to resident's room and upon entering room he unzipped duffel bag and handed us a white grocery bag filled with several zip lock [bags] with multiple pills in each one. He stated he wanted to make a clean start of things and thanked us for listening. The pills were placed in the med room .</p> <p>Review of a facility document titled, Ad Hoc Quality Assurance and Performance Improving Meeting, for Resident #10 dated 3/22/2024, revealed .Opportunity for Improvement Medication Administration. Data Medication being left at bedside. Minimize the opportunity for obtaining a cache of medications. Root Cause Analysis. Resident #10 tends to delay the process of medication administration. Due to the timeframe, nursing staff may leave medications at bedside or not observe/verify medication being swallowed. Plan Modify the administration methods crushed, mixed, dissolved. Educate for staff regarding manipulative behaviors surrounding medication administration. Responsible Team Members. Nursing .</p> <p>Medical record review of the NP Progress Notes for Resident #10 dated 3/22/2024, revealed . The nurse also reports he turned into her and another nurse voluntarily approximately 500 pills that had been hoarded by the resident. This was discussed with him by myself and DON . I consulted [Medical Director] for assistance with plan of care regarding this issue. It was explained to [Resident #10] that a medication review was done with discontinuation of several medications that were found to be hoarded and not being taken as directed. Also explained that his medications will continue to be crushed in applesauce. Discontinue [name of narcotic pain medication] .</p> <p>Medical record review of a comprehensive care plan for Resident #10 revised 3/25/2024, revealed all medications to be given crushed in applesauce, (name of medication used to treat seizure disorders and certain psychiatric conditions) may be given whole in applesauce.</p> <p>Medical record review of a comprehensive care plan for Resident #10 revised 3/30/2024, revealed .can take medications whole. He must rinse his mouth and spit after medication administration to ensure medications are swallowed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Medical record review of a comprehensive care plan for Resident #10 dated 4/5/2024, revealed Behavior Care Plan .has potential for impaired or inappropriate behaviors related to manipulative behaviors involving medication including hoarding/cheeking .Ensure the safety of Resident and others .Notify provider of new onset finding .can take medications whole. He must rinse his mouth and spit after medication administration to ensure medications are swallowed .is allowed to take medication whole at the nurses' cart per Nurse Practitioner.</p> <p>Medical record review of LPN B's Nursing Note for Resident #10 dated 4/5/2024, revealed .resident approached nurses' station and ask if we had seen his package from [local store]; I explained that yesterday 4/4 2024, that (activities personnel) had brought me a package from [local store] with his name on it and asked me where to put it d/t [due to] it containing (Potassium) .I explained to the resident I turned it into the DON, and he became irate, stating that we violated his right by taking his mail. I attempted to educate him on how the facility has the right to inspect packages due to safety concerns; and how he could not order medication and expect to be able to keep it as he chooses that even OTC [over the counter] meds have to be Dr. ordered, he began cussing and yelling and stating that we will no longer discuss this issue what done is done and administration can deal with on Monday .</p> <p>During an interview on 4/15/2024 at 10:10 AM, Resident #10 stated .I am in serious pain . he then turned his body halfway around took his arm and lifted his shirt to show 2 scars .He stated .I have had two back fusions .[NP] deliberately decreased my pain medication .they said I had hoarded meds. The CNA illegally searched my headphone case .there was a little over the counter vitamins maybe a few prescription meds .Maybe some pain pills. I have narcolepsy and I have been too nauseated to eat .I am being punished if I had meds left over, I just kept them because if I slept over too late to get my meds .they decreased my pain pill to 2 times a day .</p> <p>During an interview on 4/17/2024 at 9:35 AM, RN A stated .when I came in the DON pulled me to the side and showed me the pills she had put them in a baggie and put in the safe .the DON and Administrator had a corporate call for an significant event .I did look at the pills there was [name of medication to treat nerve pain], pain medication [narcotic] .multiple over the counter vitamins. Initially it was small bag with I'm guessing 50 assorted pills .later in the day or the next day, he turned over a bag to a night shift nurse it was a gallon bag about 1/4 full which contained a variety of medications .I am not sure what all was in the bag .he willingly gave those to the nurse .</p> <p>During an interview on 4/17/2024 at 10:15 AM, Certified Nursing Assistant (CNA) A was asked about the medications found in Resident #10's room on 3/20/2024, .on his way to the shower he asked me if I would make his bed. I asked if he had cleaned his bed off because he has a lot of electronics he said 'mostly yes' .I gathered the stuff to make his bed, I started removing items off his bed to his table and I started to pick up what resembled a CD case, it was unzipped, and a pill had fallen out and was laying on the bed. So I opened the container right as my co-worker walked in .there was a bag, medicine cups, and loose pills in the bottom of the case .there was a lot of pills I guesstimate at least over 50 .I told CNA B to call our nurse. Our nurse came down [LPN] A and she pulled out her phone and took pictures, so we had proof of how and what we found, then she gathered all the meds and we all 3 walked them to the nurses' station .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/17/2024 at 11:15 AM, the DON stated . I was notified by the nursing staff they had found medications in his room. I interviewed the nurse and CNA on the hall regarding the situation .she [CNA A] told me that [Resident #10] was going to have a shower .She told him that she was going to clean up his bed and remake his bed [Resident #10] agreed to that .his headphone case was on the bed. She said she picked it up heard a rattle .it was partially zipped .she saw the medications. She immediately took them to the nurse and the nurse gave them to me we notified the nurse practitioner about it. We wanted to make sure why he was hoarding medication. We went down to speak to him about it and specifically asked him if he had any suicidal thoughts, or any feelings of self-harm he said no. He said that he wasn't holding on to them for self-harm, he had difficulty taking all his medicines at one time, but that was the only explanation, except he had narcolepsy and he would just fall asleep and not take them all . I said [Resident #10] if you fell asleep and didn't take them all why did you not tell the nurse so we could dispose of them. He said he felt he would be retaliated against and I told him no not if he explained what had happened .Yes, the nurse is supposed to watch the resident take all medications prior to leaving the room, unless the resident has been assessed and we have a physicians order for self-administration of medication .He is very difficult he will only take one medication at a time and requires several minutes up to 5 minutes between medications .the next day on night shift he asked the nurse to come to his room, per the nurse (LPN B) he unzipped a duffle bag and gave her a grocery bag containing multiple small [bags] of medications. He turned it in to [LPN B] and [RN B] .they immediately called me .he said he turned it in because of the statement I had made to him about letting someone know that is why he turned it in .We did have concerns about that many medications of manipulative behaviors such as cheeking, or taking them out of his mouth .at that point the NP felt it was necessary to crush his medications to ensure they were taken appropriately .his pain medication had been decreased previously with the first medications found on 3/20/2024. After this his pain medication was discontinued .[Resident #10] was very upset about his medications being crushed and he did report that to me. He complained of nausea and vomiting with the crushed medications. I discussed it with the NP and it was decided to try whole medications in applesauce, he continued to report nausea and vomiting and that he could not take it that way. The NP and I had a discussion with him regarding our concerns of him taking his medications properly in a timely manner. He told me he did not have any problems taking his medications consecutively when I discussed the delay in taking medications. He agreed to take them in a timely manner. The NP agreed he could take them whole he is to take a sip of water and spit it out after each medication. He has done very well with that .</p> <p>During an interview on 4/18/2024 at 9:05 AM, with the DON and Executive DON, in Resident #10's room, he stated .the pills the CNA found when she violated my civil rights was in this case [the case was hard shelled approximately 8" X 8 X 2, tattered case] .he said the medicines were in cups by the head phones and other medications were in the small zipper case . He was asked about the medications he turned in, he stated he had them hid it the side pocket of his recliner in the pocket next to the bed in a bag .I had the bag pushed way down so no one could see it .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/18/2024 at 9:35 AM, the DON stated .he is correct I do not recall any [name for pain pill] or psychiatric meds in the bag he turned in .there were about 3 [name of nerve medication] and no [name of pain medication] .in the initial bag there were [names of stomach, pain, nerve medication and the name of a medication to treat seizure disorder and certain psychiatric conditions, including for Bipolar Disorder, vitamin C, over the counter headache medication, and several over the counter vitamins and medications .there were probably 20 different medications in the medications found but we did not count the medicines or identify all the meds. I will estimate around 200 to 250 pills. I did recognize the some of them .In the pills we found I am estimating approximately 30 pills [prescribed medications] . 3/20/2024, was the first time I had knowledge of him not taking all of his medication .I was not the DON in January and had no knowledge of medications being found at bedside .</p> <p>During an interview on 4/18/2024 at 10:00 AM, LPN A stated .I was the nurse on duty when the CNA found the medications on his bed in a headphone case. It was unzipped and when she picked it up, she could see the pills, she didn't touch anything until I was in the room .I went to the room, the case was on the bed I flipped it open, there were some cups stacked on top of each other and some in a plastic baggie .when we removed the headphones there were some loose pills. Mind you that headphone case is never left unattended he was in a hurry to get his shower .normally it was always on his person, in his backpack on his chair, or .in his room .I brought them all up front, got a large zip lock bag and put them in the med room until the DON got here .he had multiple medications [ordered] 4 or 5 eye drops, [medication for constipation], [fiber], [aerosol inhaler] .he would not take med cart water he wanted his own bathroom faucet water. You had to mix the [name of fiber and constipation medication] in the room and get a separate cup to get the water to rinse his mouth out with after the inhaler from his bathroom sink. So we did have to turn our back on him to get water from the sink. It could easily be 45 minutes to an hour to administer his meds. I suspect when we would be getting water from the bathroom that would be when he would remove the medications and hid them .he would not always eat his breakfast tray so I would leave him on occasion with a couple of lactate but all others I would look to make sure nothing was left .he has a diagnosis of narcolepsy so it is not uncommon for him to fall asleep .I didn't see any of his narcolepsy medications .but I never saw any excessive drowsiness or him appearing to be under the influence of excessive medication .since then we tried crushing meds in applesauce but he makes himself vomit .the first day he took it just fine .then the next day when he saw we were still going to crush his meds he would take a bite then he was try to gag and sometimes to the point he would eventually vomit .the next step was whole in applesauce that ended the same .the last thing is he can have them whole at the med cart in front of the camera, or he has to rinse and spit after each medicine .</p> <p>During an observation on 4/18/2024 at 1:15 PM, with the Executive DON, in [Resident #10's] room, revealed the resident had received a package via mail. The Executive DON ask for permission to open the package. The package contained a bottle of magnesium [dietary supplement]. The Executive DON, explained the dangers in taking medications not prescribed, and explained the resident was not allowed to keep any medications in his room. The resident agreed to the Executive DON removing the magnesium and storing it in the medication room. The Executive DON stated he would speak to the NP to see if she wanted to order labs to see if the supplement was needed. Resident #10 agreed to this resolution .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Medical record review the Executive DON's Nursing Note for Resident #10 dated 4/18/2024 at 2:18 PM, revealed .package arrived with suspicion of medication being inside .went to discuss with [Resident #10] .he gave permission .to open in front of him. Magnesium was noted to be in package .educated him that it's against regulation to keep medication in room without MD/NP signing that he can. He agreed to allow us to store medication until we talk with NP .</p> <p>During an interview on 4/22/2024 at 7:00 PM, LPN B stated .I think it was a couple of nights later [3/21/2022 or 3/22/2024], I was at the end of the hall getting ready to do my midnight med pass and he came up the hall in his wheelchair, he asked me to come to his room he wanted to give me something, I asked him what and he said he didn't want to say in the hall I said if it is that serious, I needed a witness so I asked [RN B] the charge nurse to go with me to his room. When we went in, he had a duffle bag zipped setting by the windowsill he pulled out some bubble wrap and unwrapped it and there were a couple bags that had quite a few pills in it, I am guessing approximately 250 pills in it .we told him we had to turn them in he said he understood he wanted to turn over a new leaf .he said he wasn't trying to kill himself or anything like that .he wanted to come clean .I don't know how he did that because since I have been giving him his medicine since last May or April, he took one pill at a time .we talked a lot during the med pass so I know he took them . there aren't any wonderers on his hall but other wonderers from the other halls do go down that hall at times .</p> <p>During an observation of medication administration on 4/23/2024 at 8:09 AM-8:30 AM, with LPN A, in Resident #10's room, revealed the resident had a (inhaler), (muscle relaxant), (anti-depressant), (medication for obsessive-compulsive disorder), (diuretic), (2 medications to treat too much stomach acid), (a numbing patch to relieve nerve pain), (medication to treat symptoms of an enlarged prostate), and 2 eye medications. Resident #10 refused the ordered fiber and constipation medications. The resident requested a PRN (as needed) medication ordered to reduce chest congestion, a PRN medication for headache, and an anti-nausea PRN medication. He used the inhaler first, then the nurse administered the first eye drop, he took the medication cup and poured out the medication on an unoccupied bed. There was a 15 to 20 second delay between each medication. After the medications were all taken the nurse looked at her watch and stated okay lets do the last eye drop .</p> <p>During an interview on 4/23/2024 at 8:35 AM, when Resident #10 was asked about accumulating so many medications, he stated .it was over a long period of time .It was never just necessarily a daytime thing, just a few here and there over a period .I just didn't want to get accused of not taking my meds .Oh no I would never share any of my meds with any other resident, I would never do that in a million years. No, I didn't have any thoughts of harming myself .</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/24/2024 at 9:35 AM, the Medical Director stated .if another resident had found and taken the medications it is always a possibility of that resident having harm if they took them .when we found out he was hoarding these medications we had concerns he would try to trade them for favors from staff or residents .the crushing was to prevent him from pocketing them and spitting them out .could others have had harm if other residents had wandered into his room and found them that would be a possibility that would stand to reason I couldn't deny that the medications could have be taken by them is plausible and could have suffered harm that is a possibility .we can't exclude that possibility .I suppose it would have been a possibility he could have taken the medications inappropriately I suppose there would have been some risks of harm .I wasn't involved in the pill count, but with that amount of medications who's to say what he could have done with them at any point in time .I can't quantify the risk, but there was a risk .I have never had anything like that before .he definitely unique .because he was hoarding all these medications including pain medications we had suspicion he was not being honest about his pain level .I did give my approval to the NP to discontinue pain meds .every time I see him he is in his wheelchair, and I see no evidence of pain .I am very open for him to go to a pain clinic whether he would follow through with that or not .there are some instances that the pain clinic will refuse to see residents .we do use alternatives to narcotics such as [named 2 medications for nerve pain], physical therapy, topical .gels .we do acknowledge residents with pain and we do address pain .with our resources .</p> <p>During an interview on 4/24/2024 at 10:30 AM, LPN C stated .he is very time consuming .I suppose there has been a time that I have taken my eyes off of him, or gone back to the med cart sitting at his room door . but I never just left him with a cup of meds and not be in the room, bathroom, or in the doorway while he had his medications .I did find some [medications] at the bedside in January .I spoke with the DON he identified the medicine .I removed them from the room, they were at the bedside because he said he took them before meals .after that I didn't leave them anymore and that was the only time I had every found any medication in his room .</p> <p>During an interview on 4/24/2024 at 12:30 PM, the NP stated .I did observe both sets of medications, but I did not dig through them .I don't see the medications on a regular basis so I did not identify any of them . there were approximately 30ish pills of a variety of mediations in the bag that the facility found, the second bag there were probably 200 plus of a variety of medications .the facility did inform me that the first bag did contain some pain medication .but no pain medication in the second bag .On 3/22/2024 I noted I had been informed he had turned in a large quantity of various medications .The DON and I discussed with him the medicines that he had and I would be doing a medication review and be discontinuing several of those medications .I gave him a printed list of the medications that were going to be discontinued and those that he would continue to receive .there was a potential there for him to have taken the medications prior to our knowledge of him having them and there would have been a potential for harm if he had taken the medications it would have been a possibility for a resident to dig through his stuff and find the medications . there could have been a potential for harm if another resident had taken the medications he was hoarding .</p> <p>During an interview on 4/24/2024 at 1:40 PM, the Executive DON stated .LPN C did bring me the medication she found at bedside on January 3rd, 2024, I identified the medications .this was the first time this had happened .I did an inservice with the nurses not to leave any medication at bedside .and I did educate the resident that we could not leave any medications in the room .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/2024 at 9:00 AM, the DON confirmed the facility failed to provide adequate supervision for Resident #10 during medication administration to ensure the resident consumed all medications. It is possible however very unlikely a resident would have wandered into his room and found the medication. The medications were hidden very well not easily accessible .it would have taken some time to find .</p> <p>The Surveyor verified the Removal Plan by:</p> <p>1 A. On 4/30/2024, the QAPI [Quality Assurance Performance Improvement] committee, which includes the DON, Risk Manager, Social Services Director, and Administrator, conducted an Ad-Hoc QAPI meeting and identified the root cause of the alleged deficiency. The root cause identified medications which were found at bedside of Resident #10 was indicative of Resident #10's manipulative behavior.</p> <p>Compliance was validated by review on 5/2/2024 of the meeting minutes and attendance sign-in sheet, dated 4/30/2024.</p> <p>The QAPI committee identified the following as the root cause: Resident #10 tends to delay the process of medication administration and because of his manipulative ways of making the process of medication administration that takes a long time, around 45 minutes to one hour, the nurse leave the medications at bed side, or the nurse does not have time to observe or verify the medication is being swallowed by Resident #10.</p> <p>Compliance was validated by review of the QAPI meeting minutes on 5/2/2024.</p> <p>1 B. On 5/1/2024, the QAPI committee which includes the DON, Risk Manager, Executive DON, Administrator, VP of Regulatory Compliance and QAPI Chief Regulatory and Compliance Officer conducted an AD-Hoc meeting and discussed Resident #10's hoarding behavior and identified ways to eliminate any opportunity for Resident #10 to hoard medications during medication administration and prevent medications being delivered to him through his online ordering of medications.</p> <p>This was validated through a 5/2/2024 review of the 5/1/2024 QAPI meeting minutes and attendance signatures.</p> <p>Root cause analysis was also conducted to determine why nurses leave medication at his bedside without ensuring the medications are swallowed by the resident. It was identified that in one medication pass, Resident #10 still required the nurse to pour the medications on his bedspread/linens which is part of his distracting manipulative actions. It was also identified that in one medication pass schedule time, there are 24 medications to be administered. This number of medications as well as medications being poured onto the white linens creates an opportunity for resident #10 to hide and hoard medications. These were the root causes identified.</p> <p>Compliance was validated by interview with the DON and Administrator on 5/2/2024.</p> <p>C. On 4/30/2024, and 5/1/2024, the IDT team reviewed resident #10's behavior care plan.</p> <p>This was validated with interview with the DON and Administrator on 5/2/2024. The updated care plan was also reviewed for new interventions on 5/2/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Behavioral care plan initiated on 3/20/2024, was reviewed by the IDT to address the resident potential for impaired or inappropriate behaviors related to manipulative behaviors involving medication, including medication hoarding by cheeking medications. The care plan was reviewed and updated to reflect the following changes.</p> <p>On 5/1/2024, use of dispenser tray during medication administration was added to the care plan by the IDT on 5/1/2024.</p> <p>Compliance was validated by review of the updated care plan on 5/2/2024.</p> <p>This was reviewed by the DON/Risk Manager/Executive DON with the pharmacy [TRUNCATED]</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534</p> <p>Based on review of facility policy, medical record review, facility documentation, observations, and interviews, the facility failed to provide a complete and accurate record of Resident #10's medication administration. The facility's medication nurses failed to ensure Resident #10 swallowed all medications when administered. This failure resulted in Resident #10's Medication Administration Record (MAR) documenting medications administered that were not taken by Resident #10 and subsequently hoarded by the resident. This failure placed Resident #10 and all other residents in the facility, in an Immediate Jeopardy situation (A condition in which facility noncompliance with one or more conditions of participation has resulted in or is likely to result in serious injury, harm, impairment, or death and must be immediately corrected). The facility's failure to observe and document accurate medication administration had the potential to impact all residents in the facility. On 4/15/2024, the facility census was 70.</p> <p>The Facility Administrator was notified of the IJ on 4/30/2024 at 1:55 PM, in the conference room.</p> <p>The Immediate Jeopardy began on 1/3/2024, and ended on 5/1/2024.</p> <p>The facility was cited Immediate Jeopardy at F-842 at a scope and severity of J.</p> <p>The IJ began on 1/3/2024, and continued through 4/30/2024. The IJ ended on 5/1/2024, and was removed onsite on 5/2/2024.</p> <p>An acceptable Allegation of Compliance, which removed the immediacy was provided by the facility and verified onsite on 5/2/2024, for F-842.</p> <p>The facility is required to submit a Plan of Correction (POC).</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, Medication Administration Procedures, revealed . Observes resident swallow medications .Documents initials [administering nurse] after administration of medication.</p> <p>Medical record review revealed Resident #10 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Psoriatic Arthritis, Chronic Obstructive Pulmonary Disease, Lactose Intolerance, Bipolar Disorder, Peripheral Vascular Disease, Anxiety Disorder, Obsessive-Compulsive Personality Disorder, and Major Depressive Disorder.</p> <p>Medical record review of Medication Administration Records for Resident #10 dated 1/1/2024-3/31/2024, do not accurately document the medications that were administered as evidenced by the undetermined amount of medications Resident #10 had hoarded in his room.</p> <p>Medical record review of the Nursing Notes for Resident #10 dated 1/3/2024 at 6:02 PM, revealed . medication found at bedside .</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Medical record review of the Psychiatric Nurse Practitioner (NP) Note for Resident #10 dated 1/4/2024, revealed .I was asked to see him today regarding he [him] having medications at bedside. He apparently was trying to 'hoard' medications. When I asked him why he had done that he tell[s] me that it was a 'dumb idea he had in his head. He denies any suicidal ideation .</p> <p>Medical record review of the NP Progress Note for Resident #10 dated 1/5/2024, revealed .the nurse reports he was noted to have several pills in his room. I discussed this with him. He denies suicidal ideation. We discussed the importance of note [not] keeping medications in his room and taking all medications as prescribed .</p> <p>Medical record review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact.</p> <p>Medical record review of the Nursing Notes for Resident #10 dated 3/20/2024, revealed .Notified by resident's nurse that multiple medications were found in resident's room. Was taking a shower and the CNA [Certified Nursing Assistant] was making the resident's bed. The CNA stated there was a headphone case on the bed that was partially zipped .picked it up and heard rattling .opened the case fully and observed multiple medications inside .gave the medications to the nurse .NP, Social Service Director, and DON [Director of Nursing] went to the resident's room to discuss the found medications .</p> <p>Medical record review of Licensed Practical Nurse (LPN) B's Nursing Note for Resident #10 dated 3/21/2024 at 11:45 PM, revealed . [Resident #10] approached nurse in hall at 10:50 PM and ask if I could come to his room, he had some medication he needed to give me; I asked if he was okay with me getting another nurse to go witness what he was giving me and he stated 'only if you trust them.' I asked .RN [Registered Nurse] B to go with me to resident's room and upon entering room he unzipped duffel bag and handed us a white grocery bag filled with several zip lock [bags] with multiple pills in each one. He stated he wanted to make a clean start of things and thanked us for listening. The pills were placed in the med room .</p> <p>During an interview on 4/17/2024 at 11:15 AM, the Director of Nursing (DON) stated .I was notified by the nursing staff they had found medications in his room .we notified the nurse practitioner about it. We wanted to make sure why he was hoarding medication .he said he wasn't holding on to them for self-harm, he had difficulty taking all his medicines at one time, but that was the only explanation, except he had narcolepsy and he would just fall asleep and not take them all .I said [resident's name] if you fell asleep and didn't take them all why did you not tell the nurse so we could dispose of them. He said he felt he would be retaliated against, and I told him no not if he explained what had happened .Yes, the nurse is supposed to watch the resident take all medications prior to leaving the room .</p> <p>During an interview on 4/30/2024 at 9:00 AM, the DON confirmed the facility failed to accurately document Resident #10's medication administration.</p> <p>1 A. On 4/30/2024 the QAPI [Quality Assurance Performance Improvement] committee, which includes the DON, Risk Manager, Social Services Director, and Administrator conducted an Ad-Hoc QAPI meeting and identified the root cause of the alleged deficiency.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The QAPI committee identified the following as the root cause. Resident #10 tends to delay the process of medication administration and because of his manipulative ways of making the process of medication administration it takes a long time, around 45 minutes to 1 hour. The nurse leaves the medication at bedside, or the nurse does not spend time to observe or verify the medication is being swallowed by Resident #10. This resulted in resident #10 being able to hoard medication and nurses documenting the medication as administered in error.</p> <p>Compliance was validated through review of the 4/30/2024 meeting minutes and attendance sign-in sheet on 5/2/2024.</p> <p>On 5/1/2024 facility nurses were trained on use of the tongue depressor during medication administration.</p> <p>Compliance was validated through nursing interviews on 5/2/2024 and review of education sign-in sheets dated 5/1/2024.</p> <p>Nurse training was completed to ensure nurses use a tongue depressor to check the oral cavity for cheeking of medication during medication administration. Nurses who were on vacation or leave of absence will receive the training before they start their shift upon returning to work.</p> <p>The training includes the following:</p> <p>Tongue depressor use: the nurse will use the tongue depressor to check the oral cavity for cheeking of medications. The nurse will ask resident #10 to open his mouth. The nurse will observe the tongue's resting position, then ask Resident #10 to stick out his tongue. The nurse will place the tongue depressor against the tip of the tongue to check for any medications in both inner areas of cheeks. The nurse will then gently press the tongue with the tongue depressor to get an unobstructed view of the oral cavity.</p> <p>If a medication is seen during the mouth check using the tongue depressor, Resident #10 will be provided with water to swallow the medication. After that, the nurse will repeat the process of checking the mouth using the tongue depressor.</p> <p>The nurse will repeat the process until no medication is seen with the mouth check, using the tongue depressor.</p> <p>If for any reason, Resident #10 becomes uncooperative, the nurse will notify the DON and/or the Administrator for additional guidance and intervention.</p> <p>Compliance was validated through nursing interviews and review of education signature sheets on 5/1/2024. The process was validated by an observation of a medication administration for Resident #10 on 5/1/2024.</p> <p>On 5/1/2024, the nurses were trained how to document refusal of medications.</p> <p>Compliance was validated through interviews on 5/2/2024 with nursing and review of education attendance signature sheets.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Starting on 5/1/2024, medication observations will be done by the DON, Risk Manager, Unit Manager, and MDS Nurse alternately to observe the nurse during medication administration for Resident #10. The DON, Risk Manager, Unit Manager, or MDS nurse will observe the nurse to verify the care plan interventions are being followed during medication administration. Any identified concern will be addressed immediately. If a nurse does not follow the care plan interventions during the medication administration, the nurse will be provided with additional training before the next medication administration.</p> <p>This intervention was validated through review of completed audits.</p> <p>The document titled, Observation Pass Observation audit will be used to document the results of the observations to identify any concerns and corrective actions. The completed audits will be kept by the DON and will be readily available for review by QAPI committee members.</p> <p>This intervention was validated on 5/2/2024 by review of the Observation Pass Observation audits completed on 5/1/2024.</p> <p>The audit will be completed for four weeks. After four weeks, the QAPI team will review the results of the medication observation audit to determine if additional interventions or monitoring are necessary.</p> <p>For the next three months a weekly Ad-Hoc QAPI meeting will be held and participated in by the Administrator, the VP of operations, DON, Risk Manager, MDS nurse, Social Service, and NP to discuss the implementation of Resident #10's care plan interventions. If concerns are identified the QAPI team will determine additional care plan interventions that may be needed to sustain compliance.</p>		