

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Signature Health of Portland Rehab & Wellness Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Highland Circle Drive Portland, TN 37148	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, hospital documentation review, facility investigation review, and interviews, the facility failed to protect the resident's right to be free from neglect for 1 of 5 sampled residents (Resident #2) reviewed. On 12/13/2023, Resident #2, a vulnerable, bilateral amputee with a diagnosis of paraplegia and neurogenic bladder sustained 3rd degree burns to 4% of his body when urine from a self-catheterization or incontinent episode contacted an energized power strip positioned in the bed with him. During interview staff confirmed episodes of urine leakage after Resident #2 self-catheterized, Resident #2 was not assessed for competency related to self-catheterization and not monitored for risk of electrocution. Staff observed the power strip in bed with Resident #2 on multiple occasions after the Administrator provided the power strip to the resident. The facility's failure to provide the necessary care and services to prevent physical harm for Resident #2 resulted in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) for Resident #2 who sustained Actual Harm.</p> <p>The Director of Nursing and the [NAME] Tennessee [NAME] President of Operations were notified of the Immediate Jeopardy on 4/1/2025 at 6:52 PM in the Administrator's office.</p> <p>The facility was cited at F-600 with a scope and severity of J, which is a substandard quality of care.</p> <p>An acceptable Removal Plan which removed the immediacy of the Jeopardy for F-600 was received on 4/7/2025, and the Removal Plan was validated on-site by the surveyor on 4/7/2025 through 4/10/2025 by medical record review, monitoring log review, observation, review of education records, and staff interviews.</p> <p>F600- The Immediate Jeopardy began on 12/13/2023 through 4/4/2025, the IJ was removed on 04/5/2025.</p> <p>The facility's noncompliance at F-600 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions.</p> <p>A partial extended survey was done 4/1/2025- 4/4/2025.</p> <p>The findings included:</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, revised 9/15/2023, revealed .It is the organization's intention to prevent the occurrence of .Neglect .The organization will include screening, training, prevention .to provide protection for the health, welfare, and rights of each resident residing in the facility .For purposes of this guidance, Covered Individuals include the owner, operator, employee, manager, agent, or contractor of the facility. Staff would also include caregivers who provide care and services to residents on behalf of the facility .Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being .Neglect .Is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .Prevention .Establishing a safe environment that supports, to the extent possible, a resident's safety .Ensuring that residents are free from neglect by having the structures and processes to provide needed care and services to all residents .</p> <p>2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with readmission on [DATE]. Admitting diagnoses included Osteomyelitis, Neuromuscular dysfunction of bladder, Paraplegia, Acquired absence of left leg above knee, and Acquired absence of right leg above knee.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Resident #2 was coded 0 behavior exhibited for Rejection of Care (care necessary to achieve the resident's goals for health and well-being). Resident #2 was coded substantial/maximal assistance for toileting, personal hygiene, partial/moderate assistance with roll left and right in bed and not applicable with transfers resident did not perform. Functional abilities indicate resident's usual ability with everyday activities. Resident #2 was coded for an Indwelling catheter and ostomy appliance.</p> <p>Review of the Point of Care History for Resident #2 dated 11/13/2023-12/13/2023 revealed staff documented incontinent level of bladder control 24 of 61 opportunities/entries.</p> <p>Review of Resident #2's comprehensive care plan revised 11/22/2023, revealed, .Problem Start Date: 8/26/2023 .Resident has potential for altered elimination .Long Term Goal .Resident will have decreased episodes of incontinence .Approach Start Date: 08/26/2023 .Provide incontinent care .Problem Start Date: 11/22/2023 .Resident has impaired decision making R/T [Related/To] depression .</p> <p>There were no care plan categories and interventions related to noncompliance behaviors, refusal of care, and intermittent self-catheterization for Resident #2.</p> <p>Review of the Medication Administration Record for Resident #2 dated 12/13/2023 revealed, . INTERMITTENT CATHETERIZATION, PATIENT DOES [catheterization] HIMMSELF [himself], ENSURE ALL SUPPLIES NEEDED ARE AVAILABLE TO PATIENT . Nursing staff documented urine output each shift. Further review revealed on 12/12/2025 nursing documented administration of the following medications: 6 AM- morphine (opioid pain medication used to treat moderate to severe pain) 15 mg (Milligram) extended release, 7 AM to 11 AM administration of baclofen (muscle relaxant) 10 mg (milligram) , gabapentin (used to treat nerve pain) 600 mg, oxycodone (opioid pain medication used to treat severe pain) 10 mg, All medications listed cause drowsiness.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of a statement signed by Administrator F dated 12/13/2023 revealed on 12/8/2023 Administrator F removed a brown extension cord from Resident #2's room. Administrator F stated Resident #2's phone charger and computer were plugged into the extension cord. Administrator F provided a power strip to the resident, connected it to the outlet then plugged the phone charger and computer into the power strip. Administrator F stated on 12/12/2023 after being called to Resident #2's room, he found Resident #2 had an electrical burn and the power strip was deformed as if it overheated and melted.</p> <p>There was no documentation of an assessment to ensure Resident #2 could use the power strip safely. There was no documentation a care plan was developed for Resident #2 addressing the safe use of a power strip. There was no documentation in the care plan that Resident #2 was educated on the risks of power strip usage, particularly in the bed.</p> <p>Review of an Event Report dated 12/14/2023 revealed on 12/13/2023 Resident #2 sustained a third degree (involves all layers of skin, sometimes fat and muscle tissue) electrical burn measuring 54 x 48 x 0 (centimeters=approximately 21x 19 inches) to right leg and buttocks. Resident #2 was sent to the emergency room for evaluation. The Event Report statement indicated the Interdisciplinary Team (IDT) had met and determined Resident #2 had placed a power strip for electronics in the bed with him and per resident statement, urine may have contacted the power strip. The Event Report stated Resident #2 was given education to not keep the power strip in the bed with him and proper use of electrical devices.</p> <p>The Event Report was closed by the Former Assistant Director of Nursing (FADON). During an interview the FADON could not recall the education noted in the Event Report, or when the education occurred. Resident #2 was transferred to the emergency room on [DATE] and did not return to the facility.</p> <p>Review of Hospital #1's Emergency Provider Report dated 12/13/2023 revealed Resident #2 was seen in the Emergency Department (ED) related to electrical burns sustained when urine leaked from his catheter into a power strip positioned in his bed. Resident #2 alleged he was on the power strip for an unknown amount of time because he was unable to move off of the power supply. The documentation revealed, .On physical exam, about 4% [percentage of total body surface area], third -degree burn noted to right buttock .</p> <p>Review of a Resident Progress Note for Resident #2 dated 12/13/2023, 9:54 AM, revealed, .resident reports having an electric shock to buttocks .evaluation open area with redness surrounding area .the area appears to be gray in coloring with fascia [layer of tissue that covers muscles, bones, and organs] white in coloring . resident states, he had cath [catheterized] himself and was shocked. When asked what was learned from this situation he replied, Never have an electric cord in the bed while you cath . Note was entered by LPN C.</p> <p>During an interview on 3/27/2025 at 2:53 PM, the Occupational Therapist (OT) stated she entered Resident #2's room on 12/13/2023 to perform treatment. Resident #2 was in bed holding a cord and told her to get the nurse. Resident #2 had burns on his buttocks and leg. The OT stated Resident #2 often had many devices and cords in the bed with him. Therapy often had to move the items to complete treatment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 3/31/2025 at 12:40 PM, CNA I stated , I had him [Resident #2] that day [12/13/2023] .I was giving a shower so I didn't know about the accident until after .[Resident #2] kept his computer and phone on the table, they were plugged into a brown extension cord that hung beside the bed . then there was another cord with more places to plug into .it stayed on the end of the bed . CNA I confirmed Resident #2 had episodes of incontinence or spilled urine when he self cathed, which required his bed linens to be changed. CNA I stated she had reported the concerns related to the resident's safety to Administration.</p> <p>During a telephone interview on 3/31/2025 at 1:02 PM, the Former Assistant Director of Nursing (FADON) stated she was called to Resident #2's room on 12/13/2023, to due to an electrical accident. The FADON stated it was difficult to control her emotions due to the severity of Resident #2's injury and the smell of burning flesh. Resident #2 had sustained third degree burns to his buttocks and upper leg. The FADON recalled Resident #2's shirt was wet, and the power strip was melted. The FADON concluded Resident #2 had not had the power strip for a long period of time because she felt as if the accident would have occurred sooner than 12/13/2023. The FADON stated Resident #2 was at risk of injury related to the electrical devices due to occasional incontinent episodes and his habit of keeping energy drinks in bed with him. The FADON was asked if Resident #2 had been observed for competency in the self-catheterization procedure, she replied, I know that he was self-cathing before he came here, I don't know if we actually watched him cath himself. The FADON stated she was unaware of Resident #2 having a power strip, to her knowledge the issue had not been discussed in the clinical meetings before the accident on 12/13/2023. The FADON was asked if staff had provided education related to the use of the power strip supply cord and the risk of using electrical devices while in bed before or after the accident, she replied, Not to my knowledge.</p> <p>During an interview on 3/31/2025 at 5:13 PM, Licensed Practical Nurse (LPN) C confirmed Resident #2 was on her regular assignment in the facility and on 12/13/2023 she was called to Resident #2's room because he had been burned. LPN C stated, .I got to the room, and he was over on his stomach, I could see the burns on his buttocks .the power strip was melted . LPN C confirmed Resident #2 self-cathed and had episodes of incontinence. LPN C was asked if Resident #2 had been observed performing the self-catheterization to determine competency with the procedure, LPN C replied, .I am not sure .he had been doing it a long time before he came here . LPN C stated Resident #2 used a laptop computer and cell phone in the bed and was unsure if the resident had a power strip to supply energy to the devices. The surveyor read the progress note entered by LPN C on 12/13/2023 and asked if she had provided education related to self-catheterization and electrical device safety to Resident #2 prior to the accident, LPN C refused to comment on the progress note which indicated she had asked Resident #2 if he had learned any lessons from the accident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/2/2025 at 9:12 PM, the Former Director of Nursing (FDON) stated Resident #2 liked to keep his electronics in the bed. Resident #2 was encouraged to not keep the electronics in the bed by staff. The FDON stated, "His preference was to keep things close to him. He has a right." The FDON acknowledged Resident #2 self-catheterized due to a neurogenic bladder and had episodes of incontinence. The FDON was asked what interventions were implemented related to Resident #2's safety risk due to noncompliance with recommendations to remove the electronic devices from his bed. The FDON confirmed there were no interventions on Resident #2's care plan, staff continued to encourage him to move the items from his bed and the Administrator provided Resident #2 with an approved power strip. When asked if Resident #2 was observed while performing self-catheterization for competency, the FDON replied, "I don't remember, it would be in his chart." When asked if staff offered to move the power strip and charging cords to a safe location instead of moving Resident #2's electronics, the FDON stated, "I am sure they did and he would not let them."</p> <p>During a telephone interview on 4/4/2025 at 12:09 PM, CNA U stated, "[Named Resident #2] had a habit of keeping electronics, [Named energy drink]s and packs of catheters in the bed with him. I told [Named Administrator F] and he spoke to [Resident #2] then gave him a power strip. [Administrator F] told him not to keep things in bed with him, but [Administrator F] never followed up and it kept happening. There were times when so much junk was in the bed, I couldn't provide care for him. At least 1 time a week [Resident #2] was incontinent or spilled something in his bed and I had to change the linens. I do remember seeing an extension cord on the floor behind the bed before [Resident #2] got the power strip, I remember [Administrator F] plugged it up and put it on the end of the bed."</p> <p>During a telephone interview on 4/4/2025 at 2:29 PM, CNA V stated Resident #2 kept several devices, including charging cords in his bed. CNA V confirmed he could, at times, persuade Resident #2 to allow him to move the computer and phone along with the charging cords. CNA V stated when he was not able to move the electronics, he informed the nurses due to the risk to Resident #2. CNA V stated the nurses were inconsistent with attempts to remove the electronics and would wait and report it to day shift or someone on Monday. CNA V stated it was unsafe for Resident #2 to have electronics and charger cords in bed with him due to medication side effects, incontinent episodes, and accidental spillage of liquids.</p> <p>During a telephone interview on 4/9/2025 at 4:09 PM, Administrator F confirmed he had taken Resident #2's extension cord and replaced the cord with a power strip/multioutlet power cord. Administrator F stated the root cause of the electrocution accident was determined as urine spilled and contacted the energized power strip when Resident #2 self-cathed. The Administrator was asked if the power strip was safe for use by Resident #2 due to risk of incontinence episodes or accidental spillage during the self-cath procedure. Administrator F stated Resident #2 knew what the rules were and he refused to abide by them. When asked if he had discussed different options in placement of the electronics and charger cords with Resident #2, Administrator F stated, "He filed a grievance against me and said he didn't want me in his room, so no more conversation."</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/2025 at 10:47 PM, LPN W stated Resident #2 had been on her assignment before the electrical accident on 12/13/2023. Resident #2 wanted his laptop and phone with him all the time. LPN W recalled the day [Administrator F] gave Resident #2 the power strip, she observed it was on the end of the bed. When asked if she had ever moved the power strip from the bed, or had she been told to keep power strips and electrical cords off of the residents' beds, LPN W confirmed she had not been told to monitor or moved the electrical devices before the accident [12/13/2023]. LPN W stated it isn't safe for electrical cords to be in any resident's bed, particularly residents that are incontinent or impaired. LPN W acknowledged she had not documented Resident #2's refusal to allow staff to remove the electronics from his bed. LPN was not able to recall whether Resident #2 was care planned for noncompliance behaviors. When asked if nursing staff monitored Resident #2 during his self-catheterization procedures, LPN W replied, No, we just made sure he had the supplies to cath and signed it off on the MAR.</p> <p>During a telephone interview on 4/11/2025 at 3:37 PM, the Former Medical Director (FMD) stated Resident #2 performed most of his own care which included intermittent catheterization. The FMD was asked if Resident #2 had episodes of incontinence in addition to the catheterization procedure, she replied, .Most spinal cord injury patients will frequently have overflow incontinence, [Resident #2] consumed large amounts of fluid . The FMD stated she could not recall staff complaints of Resident #2 refusing care.</p> <p>During a telephone interview on 4/11/2025 at 3:06 PM, Resident #2 stated before he was electrocuted (12/13/2023) Administrator F took his extension cord from him and brought him a power strip and placed it on the end of the bed. Resident #2 stated the power strip malfunctioned after water splashed on it during a meal. Resident #2 stated Administrator F told him the power strip was still safe to use. Administrator F replaced the power strip after Resident #2 insisted he did not feel comfortable. Administrator F told Resident #2 the power strip the power strip was hospital grade, and placed it on the end of his bed where it remained until the day of the accident. Resident #2 stated he wasn't sure how urine contacted the power strip. He had a foley (an indwelling catheter) removed a few days before and often had bladder incontinence after having a foley catheter. Resident #2 stated urine could have leaked during a self-catheterization before he went to sleep. Resident #2 was unable to speak without pausing during the interview, often apologizing for his emotions. Resident #2 confirmed he had experienced extreme anxiety and panic after the accident on 12/13/2023.</p> <p>An acceptable Removal Plan which removed the immediacy of the Jeopardy for F-600 was received on 4/7/2025, and the Removal Plan was validated on-site by the surveyor on 4/7/2025 through 4/10/2025 by medical record review, monitoring log review, observation, review of education records, and staff interviews.</p> <p>F600 Abuse/Neglect Immediate Jeopardy Removal Plan</p> <p>1. Corrective Actions for identified resident(s) affected by the deficient practice.</p> <p>The facility failed to ensure resident #2 was free from abuse and neglect and the facility failed to prevent the use of electrical devices and power strips in the bed and was electrocuted.</p> <p>a. Resident #2 discharged to the hospital on [DATE] and did not return.</p> <p>b. On 12/13/2023:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>i.9:38 am- The occupational therapist went into Resident #2's room to work with the resident, upon entering the resident's room, the resident stated he was electrocuted.</p> <p>ii.9:39 am- The therapist immediately got his assigned nurse and the ADON to assess the resident.</p> <p>iii.9:41 am - Upon entering the resident's room, he was noted to be lying on his stomach on the very edge of the left side of his bed. The resident was A&O x4, and no alteration in mentation was noted. The resident reported pain of 10/10 to the area. On the right side of the resident's bed, it was noted that there was a power strip that had two cords plugged into it. The power strip was noted to be melted and deformed and was not plugged into the wall. The resident stated he had pulled the plug out of the wall.</p> <p>iv.The nurse called 911 for EMS transport and the ADON remained with the patient. The right buttock/hip/posterior right thigh area was noted to have an open laceration, surrounding the laceration was a large area of tan/grey skin that had a rough hard texture, and surrounding the entire darkened area was red. Areas of skin were peeling bordering the entire wound. The back lower part of the resident's shirt was noticed to be damp. The resident was not wearing pants.</p> <p>v.The affected area measured in total 54x48x0 cm. The open laceration was measured and was 8x4x2 cm. Vitals signs were obtained: BP 140/88, pulse 94, resp 18, O2 99% on RA, temp 98.2</p> <p>vi.9:47 am - The resident stated that he had just in and out catheterized himself and as he was cleaning himself up, he rolled to his right side and that is when he felt the shock The resident stated that he felt like he was unable to get himself off the power strip for at least 45 seconds but is unsure of the exact time. The resident stated that he was able to get himself off the power strip eventually by grabbing his trapeze bar and he then rolled as far over as he could on the left side of his bed. The patient stated that the occupational therapist walked into the room minutes after it had happened and he immediately reported what had just happened to her and she left to get nursing assistance immediately.</p> <p>vii.10:00 am - EMS and police personnel arrived; the resident was assessed by emergency personnel. EMS left with the resident at 10:12 am. The report was called to Skyline Medical Center.</p> <p>viii.11:47 am- The resident's emergency contact was made aware.</p> <p>ix.12/13/2023 resident #2 was admitted to Skyline Medical Center with a 4% third-degree burn to the right buttock, full thickness electrical burn.</p> <p>x.The Regional Plant Operations Director and Plant Operations Director checked the voltage for the receptacle in resident #2's room and the voltage was verified to be within normal limits. The power strip was UL 1363 approved.</p> <p>2.Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not reoccur.</p> <p>The facility took immediate action to ensure all residents are free from neglect and to ensure the residents receive the services needed to prevent serious harm, serious injury, serious impairment, or death as follows:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. On 4/1/2025 all resident rooms were rounded on by the campus clinical leadership team consisting of the Director of Nursing (DON), Unit Manager (UM), Staff Development Coordinator (SDC), the regional VP of Operations, Regional Nurse Consultants, and Regional Director of Regulatory for electronic items and/or power strips/cords kept in the bed. No items found in resident's beds during rounding. The rounding consisted of entering the room, checking all areas, including the bed, for placement of electrical devices that were not plugged in or stored appropriately to include but not limited to power strips, extension cords, and device chargers.</p> <p>b. On 4/1/2025, all residents with a BIMS 8 or above were educated by the campus clinical leadership team, regional VP of Operations, Regional Nurse Consultants, and Regional Director of Regulatory, on not placing electronics and/or charging devices such as charging cables, power strips, or extension cords in their bed.</p> <p>c. Complete investigation to include rounding and education occurred at the time of the incident in December of 2023.</p> <p>d. Staff or residents voiced no concerns regarding education and verbalized understanding of not placing electronics and/or charging devices such as charging cables, power strips, or extension cords in their bed.</p> <p>3. Measures put in place and systemic changes you will make to ensure that the deficient practice does not reoccur.</p> <p>a. All staff will be re-educated on the Safety and Supervision of Resident Policy, Physical Security Policy, and Abuse, Neglect, and Misappropriation of Property policy by the Administrator and/or Staffing Coordinator beginning 4/1/2025 and will be completed with all staff prior to working their next shift.</p> <p>b. After initial rounding and assurance that no electrical devices are stored in resident beds or areas that could result in electrocution, an audit will be conducted to ensure that electrical devices, power strips, or cords are not placed in resident beds to ensure that compliance is maintained. The audit will be completed by the administrator or designee on 5 residents weekly for 4 weeks, then every other week for 2 months, then monthly for 3 months or until substantial compliance is achieved. If any deficient practice is observed, the resident and staff will be reeducated by the Administrator and the deficiency will be corrected immediately.</p> <p>4. Describe the Quality Assurance & Process Improvement Program that will be put into place.</p> <p>a. An Ad Hoc Quality Assurance meeting was held at the time of occurrence on 12/13/2023 with the Medical Director and the facility QAPI Committee to review the plan of correction and ensure the implementation of the plan.</p> <p>a. A new ad-hoc QAPI meeting will be held on 4/2/25 with the medical provider, Administrator, DON, Maintenance Director, [NAME] President of Operations, Director of Regulatory, and Regional Nurse Consultant regarding the alleged deficient practice, the education given, and the removal plan that was implemented on 4/1/25.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>b.Power strips or extension cords will not be provided to the facility residents. All staff were educated on 4/1/2025.</p> <p>c.As a measure of ongoing compliance, audit results will be submitted to the campus administrator, or designee, for review by the Quality Assurance Performance Improvement Committee until substantial compliance is achieved. The QAPI committee has the right to modify or extend monitoring times according to outcomes of audits.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, facility investigation review, medical record review and interviews, the facility failed to ensure neglect with physical harm was reported to the State Survey Agency (SSA) in accordance with Federal and State law for 1 of 3 sampled residents (Resident #2) reviewed.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, revised 9/15/2023, revealed .It is the organization's intention to prevent the occurrence of abuse, neglect .and to assure that all alleged violations of federal or State laws which involve .neglect .are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law .The Facility Administrator is responsible for reporting all investigations' results to applicable State agencies as required by Federal and State law .Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being .Neglect .Is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress .Prevention .Establishing a safe environment that supports, to the extent possible, a resident's safety .Ensuring that residents are free from neglect by having the structures and processes to provide needed care and services to all residents . 2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Neuromuscular dysfunction of bladder, Paraplegia, Acquired absence of left leg above knee, and Acquired absence of right leg above knee. <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Resident #2 was coded 0 behavior exhibited for Rejection of Care (care necessary to achieve the resident's goals for health and well-being), required substantial/maximal assistance for toileting, personal hygiene, partial/moderate assistance to roll left and right in bed and no transfers occurred during the 7 day look back period. Resident #2 had an Indwelling catheter and ostomy appliance.</p> <p>Review of the Point of Care History for Resident #2 dated 11/13/2023-12/13/2023 revealed staff documented incontinent level of bladder control for 39% of 61 entries.</p> <p>Review of the comprehensive care plan for Resident #2, revised 11/22/2023, revealed, .Problem Start Date: 8/26/2023 .Resident has potential for altered elimination .Long Term Goal .Resident will have decreased episodes of incontinence .Approach Start Date: 08/26/2023 .Provide incontinent care .Problem Start Date: 11/22/2023 .Resident has impaired decision making R/T [Related/To] depression .</p> <p>There was no documentation of interventions in Resident #2's care plan for intermittent Catheterizations and refusal of care.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medication Administration Record for Resident #2 dated 12/13/2023 revealed, . INTERMITTENT CATHETERIZATION, PATIENT DOES [catheterization] HIMMSELF [himself], ENSURE ALL SUPPLIES NEEDED ARE AVAILABLE TO PATIENT . Nursing staff documented urine output each shift. Further review revealed on 12/12/2025 nursing documented administration of the following medications: 6 AM- morphine (opioid pain medication used to treat moderate to severe pain) 15 mg (Milligram) extended release, 7 AM to 11 AM administration of baclofen (muscle relaxant) 10 mg (milligram) , gabapentin (used to treat nerve pain) 600 mg, oxycodone (opioid pain medication used to treat severe pain) 10 mg, All medications listed cause drowsiness.</p> <p>Review of a statement signed by Administrator F dated 12/13/2023 revealed on 12/8/2023 Administrator F confirmed he had removed a brown extension cord with phone and computer charger cords plugged into it from Resident #2's room. Administrator F stated he then provided a power strip to the resident, connected it to the outlet then plugged the phone charger and computer into the power strip. Administrator F stated on 12/13/2023 he was called to Resident #2's room and found Resident #2 had sustained electrical burns and the power strip was deformed as if it overheated and melted.</p> <p>There was no documentation of an assessment to ensure Resident #2 could use the power strip safely. There was no documentation a care plan was developed for Resident #2 addressing the safe use of a power strip. There was no documentation in the care plan that Resident #2 was educated on the risks of power strip usage, particularly in the bed.</p> <p>Review of an Event Report dated 12/14/2023 revealed on 12/13/2023 Resident #2 sustained a third degree (involves all layers of skin, sometimes fat and muscle tissue) electrical burn measuring, . 54 [cm=centimeters] x 48 [cm] x 0 [cm] [approximately 21x 19 inches] . on his right leg and buttocks. Resident #2 was sent to the emergency room for evaluation. The Interdisciplinary Team (IDT) met and determined Resident #2 had placed a power strip for electronics in the bed with him and per resident statement, urine may have contacted the power strip. The documentation revealed as a result of the IDT's findings, Resident #2 was given education to not keep the power strip in the bed with him and proper use of electrical devices.</p> <p>Review of Hospital #1's Emergency Provider Report dated 12/13/2023 revealed Resident #2 was seen in the Emergency Department (ED), treated, and admitted to the hospital, related to electrical burns sustained when urine leaked from his catheter into a power strip in his bed. Resident #2 reported he was on the power strip for an unknown amount of time due to he was unable to move off of the power supply. The documentation revealed, .On physical exam, about 4% [percentage of total body surface area], third -degree burn noted to right buttock .</p> <p>Review of a Resident Progress Note for Resident #2 dated 12/13/2023, 9:54 AM, revealed Resident #2 told (Licensed Practical Nurse-LPN C) he had catheterized himself and was shocked. Further review revealed, . evaluation open area with redness surrounding area .the area appears to be gray in coloring with fascia [layer of tissue that covers muscles, bones, and organs] white in coloring . the progress note was entered by LPN C.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 3/31/2025 at 1:02 PM, the Former Assistant Director of Nursing (FADON) stated on 12/13/2023, Resident #2 sustained electrical burns when urine leaked into an energized power strip that was in bed with him. The FADON admitted it was difficult to control her emotions due to the severity of Resident #2's injury and the smell of burning flesh. The FADON recalled Resident #2's shirt was wet, and the power strip was melted. The FADON stated Resident #2 couldn't have had the power strip for a long period of time because the accident would have occurred sooner considering the risk of incontinence episodes and personal habits of keeping liquids in bed with him. The FADON was asked if Resident #2 had been observed for competency in the self-catheterization procedure, she replied, I know that he was self-cathing before he came here, I don't know if we actually watched him cath himself. The FADON stated she was unaware of Resident #2 having a power strip, to her knowledge the issue had not been discussed in the clinical meetings before the accident on 12/13/2023. The FADON was asked if staff had provided education related to the use of the power strip supply cord and the risk of using electrical devices while in bed before or after the accident, she replied, Not to my knowledge.</p> <p>During a telephone interview on 4/2/2025 at 9:12 PM, the Former Director of Nursing (FDON) stated Resident #2 liked to keep his electronics close to him in bed and was encouraged to not keep the electronics in the bed by staff. The FDON stated, .he has a right . The FDON acknowledged Resident #2 self-catheterized due to a neurogenic bladder and had episodes of incontinence. The FDON was asked what interventions were implemented related to Resident #2's safety risk due to noncompliance with recommendations to remove the electronic devices from his bed. The FDON confirmed there were no interventions on Resident #2's care plan. The FDON acknowledge that the Administrator provided Resident #2 with an approved power strip. When asked if Resident #2 was observed while performing self-catheterization for competency, the FDON replied, I don't remember, it would be in his chart. When asked if staff offered to move the power strip and charging cords to a safe location instead of moving Resident #2's electronics, the FDON stated, I am sure they did and he would not let them. The FDON was asked if the Administrator was the Abuse Coordinator, and if Resident #2's electrocution which resulted in electrical burns had been reported to the SSA. The FDON replied, .I don't think we were required to report the accident .</p> <p>During a telephone interview on 4/9/2025 at 4:09 PM, Administrator F confirmed Resident #2 was electrocuted on 12/13/2023 when urine contacted an energized power cord located in his bed. Administrator F stated he did not report the accident to the SSA as required by State and Federal Regulations.</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, hospital documentation review, and interview, the facility failed to permit 1 of 3 sampled residents (Resident #4) reviewed for discharges to return to the facility after hospitalization.</p> <p>The findings included:</p> <p>1. Review of the facility's policy titled, Transfer/Discharge Notice, revised 2/3/2025, revealed, .The facility is committed to ensuring that all transfers and discharges are conducted in a manner that respects the rights . of residents .while complying with federal and state regulations .The facility must permit each resident to remain in the facility, and not .discharge the resident from the facility unless .The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility .</p> <p>2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included Osteomyelitis of vertebra, sacral and sacrococcygeal region, Hallucinations, Neuromuscular dysfunction of bladder, Paraplegia, Anxiety disorder, and Ileostomy status.</p> <p>Review of the Significant Change MDS assessment dated [DATE], revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. Resident #4 was coded for no potential indicators of Psychosis which included Hallucinations and Delusions and was coded 0 for behaviors. Resident #4 was coded for an Indwelling catheter and an Ostomy.</p> <p>Review of a Progress Note for Resident #4 dated 3/4/2024 revealed, .Assessment/management of mood concerns .Resident experiences agitation .Resident will resist care and refuse care services .Resident has cursed at others .TREATMENT PLAN .Individual Therapy, Psychological Assessment, Psychiatry Consult . The note was signed by Licensed Clinical Social Worker (LCSW) for Behavioral Health Services.</p> <p>Review of a History and Physical for Resident #4 dated 4/4/2024 revealed, .Patient is seen today for initial visit .to assess patient's current psychiatric status .He is referred to [Named Behavioral Health Services] for psychiatric history of depression and anxiety. Historical documents also indicate a personality disorder .Staff report that the patient can be cantankerous [argumentative] and is resistant to care at times .Nursing staff to document any new or worsening moods/behaviors and notify [Behavioral Health Services] . Note signed by Behavioral Health Services APRN [Advanced Practice Registered Nurse].</p> <p>Review of a (Provider) PROGRESS NOTE for Resident #4 dated 5/6/2024, revealed . [Named Resident #4] rolled out of bed and now has a right displaced femur fracture .Staff reports he has had an increase confusion .medications have been adjusted . Note signed by NP ZZ.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident Progress Notes for Resident #4 dated 5/7/2024, revealed, .4:02 [AM] Resident kept ripping colostomy bag off .Resident kept taking it off and threw it. At 0200 [2:00 AM] resident was found in bed with trapeze off of hooks and in hand, swinging and waving it violently. Stated he was going to hurt himself and swung trapeze at this nurse. Resident stated that he would knock this nurse's head off. Resident threw trapeze across the room and grabbed at his tale, rocking it back and forth speaking with confusion . increased confusion and agitation with risk to hurt self or others, non compliant with treatment, and combative .Hospice made aware. [Named Friend VV, Family Member-FM X, and FM UU] were called .None picked up. Resident is being taken to [Named Hospital #2] for examination . Note entered by Licensed Practical Nurse (LPN) L.</p> <p>Review of a Nursing Home Notice of Involuntary Transfer or Discharge form dated 5/7/2024 revealed, . Resident [Named Resident #4] .Place where resident Is going [Hospital #2] .Date Nursing Home Provided Notice and the Proposed Move .5/7/2024 .Reason for discharge .You make the nursing home unsafe for other people .You may endanger the health of other people in the nursing home .no longer able to meet needs r/t safety concern for this resident, facility staff + [and] other residents .I gave these completed pages to the resident: [Named Administrator F] .[Named Former Medical Director-FMD AAA] See Progress Note .I received these pages: [Named Resident #4] unable to sign .</p> <p>Review of Resident Progress Notes for Resident #4 dated 5/7/2024, revealed, .9:58 [AM] Spoke to [Hospital #2] ER [Emergency Room] r/t [related/to] patient .being admitted to hospital . Note entered by Former Director of Nursing (FDON) T.</p> <p>Review of Resident Progress Notes for Resident #4 dated 5/7/2024, revealed, .10:50 [AM] Immediate notice of discharge paperwork completed r/t facility can no longer meet residents needs r/t safety concerns for this resident, all staff members and other residents .MD [Medical Director] states that resident is not appropriate for this facility r/t behaviors .0900 [9:00 AM]- Hospital notified of facility immediate notice of discharge .0910 [9:10 AM] Hospice notified of facility notice of discharge . Note entered by FDON T.</p> <p>Review of Resident Progress Notes for Resident #4 dated 5/7/2024, revealed, .11:30 [AM] Immediate notice of discharge given per phone with [Named FM X and FM UU] . Note entered by FDON T.</p> <p>Review of Resident Progress Notes for Resident #4 dated 5/7/2024, revealed, .15:08 [3:08 PM] Immediate notice of discharge presented to resident at [Named Hospital #2] at this time. All belongings that were left at facility were taken to resident per Administrator at this time . Note entered by FDON T.</p> <p>Review of Resident Progress Notes for Resident #4 dated 5/7/2024, revealed, .17:27 [5:27 PM] Administrator spoke with Ombudsman .Due to an acute mental status change [Named Resident #3] .can not comprehend an Involuntary Discharge notification .Facility is working with State agencies to find the appropriate care for this resident . Note was entered by Administrator F.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Hospital #2's Case Management/Social Services Notes for Resident #4 dated 5/7/2024 revealed, . notified at 0900 [9:00 AM] .[Facility #1] was going to involuntarily discharge the patient from their facility .pt [patient] is confused at this time .called [Named FM X] who was never notified by [Facility #1] that the pt was sent to the hospital .I have spoken with [Named Administrator F] who told bedside staff that he would be coming to the hospital to give the pt the involuntary discharge paperwork .informed [Administrator F] that the pt was altered and was unable to understand or sign any paperwork at this time. [Named Administrator F] asked that I call him back if the patient became A&O [Alert & Oriented] .encouraged [Administrator F] to reach out to the pt's brother with any paperwork he needed to deliver .@ [at] 1600 [4:00 PM] [Administrator F] with [Facility #1] presented to the ER with 5 bags of the patient's belongings and a form he wanted the pt to sign. I informed [Administrator F] again that the pt was in no condition to sign any paperwork or to even understand any paperwork. [Administrator F] went into the pt room, and I accompanied him. Pt was only oriented to self and was talking about nonsensical things. [Administrator F] did agree the pt was inappropriate to deliver any paperwork to .stated that he had started a referral . Note was entered by CM FF.</p> <p>Review of Hospital #2's Case Management/Social Services Notes for Resident #4 dated 5/8/2024 at 12:52 [PM], revealed, .PATIENT IS NOT ALLOWED TO RETURN BACK TO [Named Facility #1] PER THE ADMINISTRATOR . Note was entered by Case Manager (CM) FF.</p> <p>Review of the Hospital #2's Discharge Summary for Resident #4, dated 6/4/2024, revealed, .Reason for admission: Severe Sepsis .urinary tract infection [UTI] .metabolic encephalopathy [brain disorder caused by a chemical imbalance in the blood, usually illness or organ dysfunction] .brought in altered mental status . arrived from LTC [Long Term Care] .found to have UTI and an infected sacral [base of spine] wound .started on antibiotics .suspect encephalopathy combinations of infections, polypharmacy [multiple medications] and hyperammonemia [elevated level of ammonia in the blood, causes confusion] .treated with antibiotics . lactulose .with resolution of encephalopathy. He has been calm and cooperative without any agitation here and is compliant with medications . Signed electronically by Hospital #2 DO [Doctor of Osteopathic].</p> <p>During a telephone interview on 3/31/2025 at 1:02 PM, the Former Assistant Director of Nursing (FADON) stated Resident #4 was argumentative and at times made false allegations against the nursing staff. The FADON stated, .Staff would always go in with 2 people to witness care to make sure [Resident #4] did not accuse them of anything .as far as I know, [Resident #4] was never aggressive towards any of the other residents . [Resident #4] never physically touched staff, that day [5/7/2025] he was more confused, I remember being told he had a bad infections .</p> <p>During a telephone interview on 4/2/2025 at 9:12 PM, F DON T stated, .[Named Resident #4] was discharged to the hospital because he was hitting at nurses with a trapeze bar .he rolled out of bed or threw himself out of bed, which is probably how he broke his leg .[Resident #4] destroyed his room .[Named Administrator F] took his clothes to the hospital .I am not sure if [Administrator F] refused to let him come back .I didn't go to the hospital, I talked to him on the phone and he cursed at me .[Resident #4] told me he was not coming back here . When asked if Resident #4 had ever been aggressive towards other residents, the F DON T replied, .I'm not sure .</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/3/2025 at 12:21 PM, CM CC stated, .[Named Administrator F] told bedside staff in the ER he was coming to bring [Named Resident #4]'s clothes and have him sign Involuntary Discharge papers .I called [Administrator F] and told him [Resident #4] was seriously ill and would not understand the paperwork for discharge, to contact [FM X] .[Administrator F] was told he had to give a notice to [Resident #4], his behaviors were due to illness, [Administrator F] told me 'I don't care if I have to take one from the State, [Named Resident #4] is not coming back to my facility' .</p> <p>During a telephone interview on 4/4/2025 at 2:29 PM, Certified Nursing Assistant (CNA) V stated, .[Named Resident #4] was mad at the world, who could blame him .[Resident #4] cussed a lot, that isn't anything new in my profession .[Resident #4] would get mad about his medicine, and when he was upset, we just had to walk away for a bit .I could usually get him talking and he would calm down .[Resident #4] was not aggressive to other residents .he never hit anyone, he wanted to be left alone .</p> <p>During a telephone interview on 4/8/2025 at 12:07 PM, the Ombudsman stated she went to the hospital to visit Resident #4. The Ombudsman stated, . [Resident #4] told me the only thing he remembered about being sent to the hospital was fighting with someone about his bike .I spoke with [Administrator F] and explained the Involuntary Discharge process to him . [Administrator F] said he was going to help find another place for him because he was not coming back to the facility .</p> <p>During a telephone interview on 4/9/2025 at 4:09 PM, Administrator F stated, .I did not refuse to let [Named Resident #4] come back, he refused to come back, it was a resident choice discharge .I had multiple conversations with the Ombudsman about this, it was [Resident #4]'s choice not to return .</p> <p>During a telephone interview on 4/10/2025 at 10:03 AM, FM X stated the facility did not contact him before discharging Resident #4. FM X stated the case manager at [Hospital #2] called and told him the [Facility #1] was not going to let [Resident #4] come back when he was discharged .</p> <p>During a telephone interview on 4/10/2025 at 10:15 AM, Resident #4 stated, .I don't remember anything that happened before I was sent to the hospital [5/7/2024] .I was told by a nurse that called me from [Facility #1] that I tried to hit people .I was out of my mind .my leg was broke and I don't know how it happened .No one ever offered to let me come back to the facility, the case manager told me the Administrator refused to let me come back .I would have gone back, I was more at home there, the nurses and CNAs were used to me and knew how to help me .</p> <p>During a telephone interview on 4/10/2025 at 3:37 PM,FMD AAA stated, . [Named Resident #4] had lots of conflict, refused treatments, problems with his foley catheter . [Resident #4] wasn't like that to begin with . FMD AAA confirmed Resident #4's acute medical conditions could have contributed to his exacerbation of aggressive behavior on 5/7/2024. When asked if Resident #4 was unsafe to remain in the facility after being treated for multiple infections in the hospital, FMD AAA replied, . [Administrator F] let me know it was going to be an administrative decision to discharge [Resident #4] . [Administrator F] was very upset .wasn't letting the resident come back . When asked if there were other residents in the facility with behavioral concerns, FMD AAA replied, .There are a lot of combative patients at [Named Facility #1] more than most facilities . FMD AAA stated the facility should try to manage a resident's behavioral issues before discharging due to behaviors. Resident #4 was being seen by psych services during his stay in the facility.</p> <p>(continued on next page)</p>

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/11/2025 at 11:17 AM, LPN L stated, "[Named Resident #4] would get irritated with staff and tell them to get out of his room, but he didn't threaten staff .that time [5/7/2024] he was throwing feces from his colostomy bag, kept taking his colostomy bag off when I put it back on .[Resident #4] did throw his trapeze bar, not at me .I sent him out, something was wrong with him . When asked if Resident #4 had ever been aggressive to other residents, LPN L replied, Not to my knowledge.</p>

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility investigation review, and interviews, the facility failed to initiate and provide Basic Life Support (BLS) including Cardiopulmonary Resuscitation (CPR) according to the resident's preference and physician order for 1 of 3 sampled residents (Resident #3) reviewed. On [DATE] Resident #3, a resident designated with full code status, was found unresponsive, without respirations and a palpable pulse. Nursing staff made no attempt to perform BLS/CPR in accordance with the resident's wishes/preferences.</p> <p>The facility's failure to provide BLS/CPR to Resident #3, a resident identified as a full code, resulted in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident).</p> <p>The Administrator and the [NAME] Tennessee [NAME] President of Operations were notified of the Immediate Jeopardy on [DATE] at 5:08 PM in the Administrator's office.</p> <p>The facility was cited at F-678 with a scope and severity of J, which is a substandard quality of care.</p> <p>The IJ existed from [DATE] through [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented a corrective action plan. The corrective actions and monitoring plan were validated onsite by the surveyor on [DATE] - [DATE] through review of education records, interviews with staff, interview with the Director of Nursing (DON), review of audits, and review of the facility QAPI meeting minutes.</p> <p>The facility was cited for past noncompliance (PNC) for F-678 and is not required to submit a Plan of Correction.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's policy titled, Advance Directives, revised [DATE], revealed, .The facility will ensure each resident has the right to .formulate an advance directive . <p>Review of the facility's policy titled, Cardiopulmonary Resuscitation, revised [DATE], revealed, . Cardiopulmonary Resuscitation (CPR)/Basic Life Support (BLS) in victims of sudden cardiac arrest will be initiated by staff .Cardiopulmonary Resuscitation (CPR) will be attempted for any resident who is found to have no palpable pulse and/or no discernible respirations, unless there is a written physician order to the contrary .</p> <ol style="list-style-type: none"> Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included Acute and Chronic Respiratory Failure with hypoxia, Chronic Obstructive Pulmonary Disease (COPD) with (Acute Exacerbation) and Pneumonia. Continued review revealed Resident #3 was a Full Code status with feeding restrictions/no artificial nutrition by tube. <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Care Conference Meeting Minutes dated [DATE] revealed Resident #3 was admitted to the facility with an anticipated discharge home. The plan of care was reviewed with all disciplines, the resident, and the resident's representative (Family Member-FM RR).</p> <p>Review of the Care Conference Meeting Minutes dated [DATE] revealed .Significant Change CP [Care Plan] meeting held with Resident and granddaughter [FM RR]. Code-status reviewed-no changes .therapy discussed progress .Resident is having trouble with energy .Discussed possible palliative [palliative-focus on symptom management for patients with life threatening illnesses along with curative treatments] or hospice care [focus on end-of-life care-when curative care is no longer successful] . Resident #3 anticipated discharge home. The plan of care was reviewed with all disciplines, the resident, and the resident's representative.</p> <p>Review of the Care Plan History report for Resident #3 dated [DATE]-[DATE] revealed, .Problem Start Date: [DATE]-DC [Discontinue] ON: [DATE] .Advanced Directive(s) and/or Code Status .DC Reason: Care Plan Discontinued [Resident in hospital] .Approach Start Date: [DATE] .Honor resident's Advanced Directive and/or Code Status .Problem Start Date: [DATE]-DC [Discontinue] ON: [DATE] .Advanced Directive(s) and/or Code Status .DC Reason: deceased .Approach Start Date: [DATE] .Honor resident's Advanced Directive and/or Code Status . The care plan entry did not reflect Resident's preference for code status.</p> <p>Review of the Physician Order Report for Resident #3 dated [DATE]-[DATE] revealed, .Start Date XXX[DATE] .Code Status: Full Code .Start Date XXX[DATE] .BiPAP [Bilevel Positive Airway Pressure-1 level for inhaling and 1 level for exhaling] .Apply at bedtime .</p> <p>Review of the Tennessee Physician Orders for Scope of Treatment (POST) form for Resident #3 dated [DATE] revealed, . This is a Physician Order Sheet based on the medical conditions and wishes of the person identified .When need occurs, first follow these orders, then contact physician .CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing . Resident #3's wishes/preference was indicated by an X marked in the box next to Resuscitate (CPR). The box indicating the preference was discussed with the resident was marked with an X. The form was signed by Social Services Director (SSD).</p> <p>Review of the Initial History and Physical for Resident #3, dated [DATE], revealed, .Code Status List: Full Code .ADVANCED CARE PLANNING Consent: full code confirmed . The document was signed by the Medical Director (MD G) on [DATE].</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated no cognitive impairment. Resident #3 was coded No for prognosis of condition or chronic disease that may result in a life expectancy of less than 6 months.</p> <p>Review of the Resident Progress Notes for Resident #3 revealed, XXX[DATE] .0:28 [12:28 AM] .Resident is on Avycaz [medication used to treat infection] .Resident is wearing her CPAP [BiPAP] [Continuous Positive Airway Pressure device used for sleep apnea] .Resident took medicine with no problem .Will continue to monitor if the resident will be compliant with her CPAP [BiPAP] .</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Resident Progress Notes for Resident #3 revealed, XXX[DATE] .05:15 H [5:15 AM] .This nurse is about to give the IV [Intravenous administration] Avycaz [Antibiotic] and was trying to start a conversation how compliant is she all through the night with her CPAP on. Resident has no response .no respiratory effort, no response to verbal stimuli or response to light .auscultation [listening-usually performed with a stethoscope-device used to amplify sound from inside the body] of her heart .no beating .no pulse detected. Time of death 0534 [5:34 AM] . The nurse notes Resident #3's time of death 19 minutes after entering the room to administer medication. The note was entered by Registered Nurse (RN) MM.</p> <p>3. Review of the facility's event investigation included statements from staff assigned to provide care for Resident #3 on [DATE]-[DATE]. A statement signed by Registered Nurse (RN) MM revealed RN MM stated during a routine morning ([DATE]) medication administration she and CNA SS entered Resident #3's room to administer medication and found her without a pulse, she then left the room to get her vital sign equipment, returned to Resident #3's room and could not confirm vital signs. RN MM statement was that she did not initiate CPR because Resident #3's fingers were blue, and her lower extremities were turning colors. RN MM confirmed she was aware of Resident #3's full code status and did not attempt CPR. A statement signed by Certified Nursing Assistant (CNA) SS revealed she entered Resident #3's room during routine morning rounds, found Resident #3 without respirations and went to notify RN MM. CNA SS and RN MM tried and were unable to confirm Resident #3's pulse. CNA SS's statement was that CPR was not initiated because RN MM informed her Resident #3 was a Do Not Resuscitate (DNR).</p> <p>4. During a telephone interview on [DATE] at 9:28 AM, FM RR stated, . On [DATE]th [[DATE]] the social worker [SSD] called and asked if I wanted my grandmother's (Resident #3) code status to remain the same, a full code, since it was listed at the hospital [[DATE]-[DATE]] as a DNR [Do not Resuscitate] .I told [SSD] she was really bad sick when she went to the hospital, but when she started to get better and was ready to leave, [Resident #3] said she felt like she had another chance to live and enjoy her grand babies, who were her entire world .I told [SSD] you asked [Resident #3] she is in her right mind, if she says she wants to stay a full code, then she will .Her [Resident #3] death hit us like a ton of brick .we are all still shocked .I haven't told anyone else in my family that the nurse didn't do everything to save her .I think it would torture their mind more if they knew, it [the facility's failure to perform CPR] has [tortured] me .her great grandson who is 6 [age] knows she [Resident #3] is in heaven, but he still cries and crawls in my lap when anyone mentions her name .he misses her so much .</p> <p>During a telephone interview on [DATE] at 11:48 AM, MD G stated she saw Resident #3 for a readmission assessment on [DATE]. MD G confirmed she had a discussion with Resident #3 about her preference for her code status given her chronic illnesses, and Resident #3 indicated she wanted to remain a full code, everything to be done. MD G was asked what her expectations were when staff found a resident with full code status, unresponsive. MD G began to explain Resident #3's multiple comorbidities and prognosis. MD G was asked if she explains the definition of full code status and do not resuscitate to residents during her assessment for advance care planning. MD G she stated that she does explain the choices to the resident. MD G was asked what the resident expected to happen if they chose full code status, MD G confirmed the resident expects life saving efforts which include CPR to be performed.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on [DATE] at 9:30 PM, RN H stated when a resident is found without a pulse and respirations staff were expected to confirm their code status and initiate CPR if the resident was a full code. RN H stated she received report from RN MM the morning of [DATE] and was told Resident #3 was found without a pulse and no respirations. RN H asked RN MM if she had initiated CPR because Resident #3 was a full code, RN MM confirmed she had not initiated CPR, and she did not call 911. RN H stated, . [Named RN MM] told me she went in to give the antibiotic and [Named Resident #3] had already passed, so she did not start CPR .I told her we are supposed to always do CPR and call 911 for residents that are a full code .[RN MM] was upset and said she didn't know why she didn't start CPR .I don't know what she was thinking .</p> <p>During an interview on [DATE] at 3:18 PM, CNA AA confirmed she had worked the night of [DATE]-[DATE], and was completing morning rounds ([DATE]) when CNA SS asked her to help with Resident #3's postmortem care (clean and dress the resident after death). CNA AA was asked to describe Resident #3's physical appearance during the postmortem care. CNA AA stated, .It was 15 till 6 [5:45 AM] when I got to the room to help [Named CNA SS] take care of [Named Resident #3] .she was still warm, but the room was warm too .she was easy to move when we turned her and dressed her .not stiff or anything .she was a white lady, I didn't notice any bad discolored areas on any of her skin .Her feet might have been a little blue . nothing really stands out about her color .her eyes were closed,[eyes] maybe a little crack open after we turned her over to clean her up .she had lines on her face where her mask [BiPAP] was .</p> <p>During a telephone interview on [DATE], the former Director of Nursing (DON QQ) stated RN MM reported she found Resident #3 without a pulse and respirations on [DATE]. RN MM said the resident's lower extremities were discolored and she did not initiate CPR. DON QQ was asked what she expected nursing staff to do if a resident with full code status was found unresponsive, she replied, .If the resident is full code, and without apparent rigor mortis [process that occurs as early as four hours after death, causing muscles to stiffen and become immobile], staff should call a code blue, initiate CPR and call 911 . DON QQ stated she could not determine whether Resident #3 had irreversible signs of death after completing her investigation of the occurrence.</p> <p>Multiple attempts were made during the survey to contact RN MM and CNA SS by phone and email. Messages were left via voicemail with no return communication received and no response to email. RN MM and CNA were assigned to Resident #3 on [DATE] through the morning of [DATE].</p> <p>The facility's corrective actions were validated onsite by the surveyor on [DATE] - [DATE] through policy review, observation, review of education, and staff interviews conducted on all shifts.</p> <p>1. On [DATE] nurse #1 [RN MM] was rounding on resident #2 [Resident #3] at 0515 when nurse noted resident to not be responding. The nurse completed a full assessment assessing respirations, pulse and auscultating heart sound with no response. The nurse noted hands and feet to be purple. At 0534 NP and family were made aware.</p> <p>a. Nurse #1[RN MM] was suspended on [DATE] pending investigation. Verified by employee record review.</p> <p>2. All residents have the potential to be affected.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. On [DATE], State Care Consultant (SCC) audited residents to make sure that all residents had an order for their code status and the code status matched the banner in MatrixCare. Verified by monitoring sheets and record review.</p> <p>b. On [DATE], the Director of Nursing (DON), Unit Manager (UM), Social Services Director (SSD), MDS Coordinator, and campus administrator completed an audit of all POST forms, code status orders, and banner in MatrixCare ensuring accuracy with any concerns immediately corrected. Verified by the surveyor by review of monitoring sheets and record review.</p> <p>c. Beginning [DATE], an audit was started on CPR certifications for all nursing staff by the DON and clinical leadership team, with no concerns noted. Verified by the surveyor by monitoring sheets and licensure review.</p> <p>d. Beginning [DATE], all residents who passed away in the past 90 days were audited to ensure code status preferences were accurately in place per resident preference and will be monitored ongoing for all residents. Verified by surveyor review of the monitoring sheets, staff interviews, and record review for residents who expired in the facility.</p> <p>3. Measures put in place and systemic changes you will make to ensure that the deficient practice does not re-occur.</p> <p>a. The SCC educated the Administration, DON, and UM on CPR policy on [DATE]. Verified by in-service sign in sheets and staff interview.</p> <p>b. Starting [DATE], the Administrator, DON, and UM began in-servicing all nursing staff on the CPR policy. All nursing staff will be in-serviced by [DATE]. All nursing staff who have not completed the in-service will complete the in-service prior to working their next shift. The training was verified by the surveyor through review of all active staff sign-in sheets for in-services and staff interviews on all shifts.</p> <p>c. Starting on [DATE], the DON, UM, or Administrator will complete staff interviews asking the nursing staff about the CPR Policy and Review code status. Interviews will be completed on 5 nursing staff, twice weekly for 4 weeks then weekly for 4 weeks. This was verified by staff interview and monitoring documentation.</p> <p>4. Starting [DATE], the DON and UM, or Process Improvement Program that will be put into place.</p> <p>a. An ad-hoc Quality Assurance meeting was held on [DATE] with the Medical Director and the facility QAPI Committee to review the jeopardy removal plan and ensure the implementation of the plan. Verified by review of the QAPI meeting minutes and sign in sheet.</p> <p>b. Starting [DATE], a Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan. Verified by review of the QAPI meeting minutes and sign in sheet.</p> <p>c. The QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the resident's wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction.</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** Based on facility policy review, medical record review, hospital documentation review, Death Certificate review, facility investigation review, observations, and interviews, the facility failed to provide supervision and ensure the environment remained free of accident hazards to prevent avoidable accidents for 5 of 5 sampled residents (Residents #1, #2, #12, #14, and Resident #15) reviewed for accidents. On [DATE], Resident #2, a vulnerable, bilateral amputee with a diagnosis of paraplegia and neurogenic bladder was electrocuted while lying in bed. Resident #2 sustained 3rd degree burns to 4% of his body when urine contacted an energized power strip (provided by the Administrator) positioned in the Resident's bed with him. Resident #1 was a vulnerable, cognitively impaired, and legally blind resident at high risk for falls. On [DATE] staff assisted Resident #1 to the bathroom and left her unattended. Resident #1 stood up and fell to the floor. Resident #1 sustained a left pubic root fracture [bones making up the front part of the pelvis] resulting in a damaged blood vessel hemorrhage and expired on [DATE]. The cause of death for Resident #1 was documented as BLUNT FORCE INJURY OF THE PELVIS.</p> <p>The facility's failure to provide supervision and a safe environment that was free from accident hazards over which the facility had control and prevent avoidable accidents resulted in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) with actual harm for Resident #1 and Resident #2.</p> <p>The Director of Nursing and the [NAME] Tennessee [NAME] President of Operations were notified of the Immediate Jeopardy on [DATE] at 6:48 PM in the Administrator's office.</p> <p>The Interim Director of Nursing and the [NAME] Tennessee [NAME] President of Operations were notified of the Amended Immediate Jeopardy on [DATE] at 3:44 PM in the Administrator's office.</p> <p>The facility was cited at F-689 with a scope and severity of J, which is substandard quality of care.</p> <p>A partial extended survey was done [DATE]- [DATE].</p> <p>An acceptable Removal Plan which removed the immediacy of the Jeopardy for F-689 was received on [DATE], and the Removal Plan was validated on-site by the surveyor on [DATE] through [DATE] by medical record review, monitoring log review, observation, review of education records, and staff interviews.</p> <p>F689- The Immediate Jeopardy began on [DATE] through [DATE], the IJ was removed on [DATE].</p> <p>The facility's noncompliance at F-689 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions.</p> <p>The facility is required to submit a Plan of Correction.</p> <p>The findings included:</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>1. Review of the facility's policy titled, Accidents and Incidents, revised [DATE], revealed, .The intent is to ensure the facility provides an environment that is free from accidents and incidents that are avoidable . investigates these occurrences with applicable documentation, and appropriate reporting is completed . facility shall investigate, to the best of their ability, the cause of the accident .If indicated, revised interventions shall be implemented .</p> <p>Review of the facility's policy titled, Safety and Supervision of Resident, revised [DATE], revealed, .Resident safety and the supervision that's appropriate based on the individual resident needs are facility-wide priorities .Safety risks and environmental hazards are identified on an ongoing basis .Staff shall use various sources to identify risk factors for residents .Ensure interventions are implemented correctly and consistently .</p> <p>Review of the facility's policy titled, Physical Security (Corporate Security Policy), revised [DATE], revealed, . It is the company's policy to provide a safe workplace that minimizes the risk of fire .Extension cords, surge protectors, power strips, and uninterruptable power supplies must be of the three-wire/three-prong variety . Only electrical equipment that has been approved by Underwriters Laboratories (UL) and bears the UL seal of approval must be used .</p> <p>Review of the facility's policy titled, Falls, revised [DATE], revealed, .The intent of this policy is to ensure the facility provides an environment that is as free from accident hazards, as possible, over which the facility has control to prevent avoidable falls .A Comprehensive Care Plan will be implemented based on the resident's risk for falls .to attempt to reduce the risk of avoidable falls, to the extent possible .care plan will be reviewed following each fall .Care Plan goals and interventions will be revised as applicable, with each review .</p> <p>2. a. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included Osteomyelitis, Neuromuscular dysfunction of bladder, Paraplegia, acquired absence of left leg above knee, and Acquired absence of right leg above knee.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Resident #2 was coded 0 behavior exhibited for Rejection of Care (care necessary to achieve the resident's goals for health and well-being), and Resident #2 was coded substantial/maximal assistance for toileting, personal hygiene, partial/moderate assistance with roll left and right in bed and not applicable with transfers resident did not perform. Functional abilities indicate resident's usual ability with everyday activities. Resident #2 was coded for an Indwelling catheter and ostomy appliance.</p> <p>Review of the Point of Care History for Resident #2 dated [DATE]-[DATE], revealed staff documented incontinent level of bladder control 24 of 61 opportunities/entries.</p> <p>Review of Resident #2's comprehensive care plan revised [DATE], revealed .Problem Start Date: [DATE] . Resident has potential for altered elimination .Long Term Goal .Resident will have decreased episodes of incontinence .Approach Start Date: [DATE] .Provide incontinent care .Problem Start Date: [DATE] .Resident has impaired decision making R/T [Related/To] depression .</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>Review of the Medication Administration Record (MAR) for Resident #2 dated [DATE] revealed . INTERMITTENT CATHETERIZATION, PATIENT DOES [catheterization] HIMMSELF [himself], ENSURE ALL SUPPLIES NEEDED ARE AVAILABLE TO PATIENT . Continued review revealed documentation for administration of the following medications: 6 AM- morphine (opioid pain medication used to treat moderate to severe pain) 15 mg (Milligram) extended release, 7 AM to 11 AM administration of baclofen (muscle relaxant) 10 mg (milligram) , gabapentin (used to treat nerve pain) 600 mg, and oxycodone (opioid pain medication used to treat severe pain) 10 mg, all medications listed cause drowsiness.</p> <p>Review of a statement signed by Administrator F dated [DATE], revealed on [DATE], Administrator F removed a brown extension cord from Resident #2's room. Administrator F stated Resident #2's phone charger and computer were plugged into the extension cord. Administrator F provided a power strip to the resident, connected it to the outlet then plugged the phone charger and computer into the power strip. Administrator F stated on [DATE], after being called to Resident #2's room, he found Resident #2 had an electrical burn and the power strip was deformed as if it overheated and melted.</p> <p>Resident #2 was found in bed with electrical burns at 9:38 AM, after the morning medication administration.</p> <p>Review of an Event Report for [DATE], dated [DATE], revealed Resident #2 sustained a third degree (involves all layers of skin, sometimes fat and muscle tissue) electrical burn measuring 54 cm x 48 cm x 0 cm (cm-centimeters=approximately 21x 19 inches) to right leg and buttocks. Further review revealed Resident #2 was sent to the emergency room for evaluation. An evaluation note included in the Event Report revealed, .IDT [Interdisciplinary Team] met and RCA [Root Cause Analysis] completed. Patient had placed power strip for electronic devices to be plugged in, in the bed with him .resident statement he self catheterizes himself, but has had urgency related to his foley catheter being recently pulled [removed] .stated there was urine in the bed .assumes got on the power strip .Educated of not keeping electrical power strip in the bed with him and proper use of electrical devices .</p> <p>The Event Report was closed by the Former Assistant Director of Nursing (FADON). During an interview the FADON could not recall who provided Resident #2 with the education noted in the Event Report, or when the education occurred. Resident #2 was transferred to the emergency room on [DATE] and did not return to the facility.</p> <p>Review of the Hospital #1's Emergency Provider Report dated [DATE] revealed, .Summation of Visit: Patient [Resident #2] .presents to ED [Emergency Department] complaining of a electrical burn to buttocks .power strip on bed .urine [leaked] from his catheter spelled [spilled] out on to the power strip .rolled over onto the power strip .stated that he was trying to get off of it but stayed there for some time because he is unable to do so .On physical exam, about 4% [percentage of total body surface area], third -degree burn noted to right buttock .</p> <p>Review of a Resident Progress Note for Resident #2 dated [DATE] at 9:54 AM, revealed .Summoned to room by therapy, resident reports having an electric shock to buttocks .evaluation open area with redness surrounding area .the area appears to be gray in coloring with fascia [layer of tissue that covers muscles, bones, and organs] white in coloring .resident states, he had cath [catheterized] himself and was shocked. When asked what was learned from this situation he replied, Never have an electric cord in the bed while you cath . This note was entered by Licensed Practical Nurse (LPN) C.</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 the survey complaint investigation multiple attempts were made to contact the Maintenance Director (Maintenance Director KK) employed at the time of the accident on [DATE]. Multiple voice mail messages were left to request a return phone call. No return communication was received.</p> <p>During an interview on [DATE] at 2:53 PM, the Occupational Therapist (OT) stated, .I went to his [Resident #2] room to do his treatment [[DATE]]. He [Resident #2] was on his back .He held up a cord and said, ' .This thing did something .I need the nurse .' The OT stated, .He seemed calm, like he didn't know what had happened .I asked him if he had unplugged the cord and he told me yes .I went to get the nurse and when I came back to the room, he had turned over and I could see the burns on his backside, it was different than the area I saw before, it was darker, it was horrible, I don't know how he is alive .He [Resident #2] often had a lot of electronics and the extension cord in the bed with him .so many that at times we had to ask him to move them in order to complete his treatments . The OT acknowledged staff were in-serviced on safety and the use of approved cords and power strips. The OT concluded residents, and staff were only allowed to use certain types of cords, and the Maintenance Director would have to approve the device or cord.</p> <p>During an interview on [DATE] at 5:30 PM, Maintenance Director B stated he had been in his position since [DATE]. Maintenance Director B stated, .Residents can have power strips as long as they are UL [Named laboratory that conducts safety testing] approved like the 1363 [Named type of power strip] . When asked if the residents are required to get approval of electrical devices and power cords, and if so, what was the process for approval of the items, Maintenance Director B replied, .I am not sure, I think the nurses have been taught to look at the cords before they are used, and maintenance approves them [electrical cords and devices] . When asked if maintenance kept a log of all electrical devices and cords the residents were using, Maintenance Director B replied, No. When asked if he had a maintenance schedule to check the cords and devices used by the residents to ensure the approved items continued to be safe for use, Maintenance Director B replied, I check them, but I don't have a set schedule. Maintenance Director B concluded he did not document the process of checking the electrical cords used by residents.</p> <p>During a telephone interview on [DATE] at 12:40 PM, CNA I stated she was assigned to Resident #2 on [DATE]. CNA I recalled Resident #2 usually kept his computer and phone on the overbed table with the charging cords plugged in to an extension cord. CNA I stated she had moved the extension cord, which was frequently draped across Resident #2's bed, and then it was replaced by a power strip which rested on the end of the bed. CNA I confirmed Resident #2 had episodes of incontinence or spillage (of urine) related to self-catheterization which required his bed linens to be changed, and she had voiced concerns related to the resident's safety to Administration. CNA I acknowledged it was not safe for any type of electrical device to be in the bed with a resident.</p> <p>During a telephone interview on [DATE] at 1:02 PM, the Former Assistant Director of Nursing (FADON) stated she was called to Resident #2's room on [DATE] related to the resident having burns from the power strip. The FADON stated, .Upon entering the room she had to try and control her emotions as she noticed a smell of burned skin and observed red, gray, and white colored areas over Resident #2's buttocks. The FADON recalled Resident #2's shirt was wet, and the power strip was melted. The FADON stated, .Not sure how long he had the power strip, couldn't have been long or it [the electrical incident] would have happened sooner .He in/out cathed [catheterized to empty urine from the bladder] with urine leaking or spilling, and he kept [Named energy drink]s in the bed with him .If I had seen it [power strip] before, I would have taken it away because it was not safe for him to have it in bed .</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 [DATE] at 5:13 PM, Licensed Practical Nurse (LPN) C stated the OT notified her to come to Resident #2's room because he had been burned. LPN C stated, .I got to the room, and he was over on his stomach, I could see the burns on his buttocks .the power strip was melted .He self-cathed and would be wet at times .He used a laptop and phone in bed . When asked if she had ever seen the power strip in Resident #2's bed and moved it or asked him to move it out of the bed, LPN C responded, .I am not sure . and shrugged her shoulders. When asked if she had asked Resident #2 if he had learned any lessons from the incident, LPN C would not answer.</p> <p>During a telephone interview on [DATE] at 2:29 PM, CNA V stated he worked in the facility as needed through the company's staff pool agency. CNA V stated, .I wasn't working the day it [electrocution accident] happened .I had told the nurses before [Named Resident #2] kept lots of electrical devices and other things, cords, chargers, in bed with him and it wasn't safe .sometimes they would go to his room and tell him to move things, but most of the time it was simply, wait until Monday or next day and report it . CNA V was asked why he felt it wasn't safe for Resident #2 to have electrical devices in his bed. CNA V responded, .He took a lot of pain medication and wasn't really alert at times, out of it .he had a catheter and usually had a large urine output .would be wet at times and need sheets changed from urine or spilling his drink .There was an in-service after that incident .We were told to make sure the residents did not use extension cords and only approved power strips .I don't recall being told to monitor for phones or chargers . When asked how he would determine whether a power strip was approved, CNA V replied, Maintenance had to approve it [power strip].</p> <p>During a telephone interview on [DATE] at 5:09 PM, the Former Staff Development Coordinator (FSDC) confirmed she was hired for the SDC position in [DATE]. When asked if the position of SDC included staff education, the FSDC replied, .Yes, developing staff would include education for staff . The FSDC stated, .I did not any receive any education related to electrical device safety or safe use of power cords .I accepted the position of SDC, and I was asked to train in infection prevention .I did get some training; however, things were extremely unorganized, I just did not feel I was being adequately trained .</p> <p>During a telephone interview on [DATE] at 4:09 PM, Administrator F confirmed he had taken Resident #2's extension cord and replaced the cord with a power strip/multioutlet power cord. Administrator F concluded the power strip was approved for resident use in the facility. Administrator F was asked if the facility had determined the root cause for Resident #2's accident. Administrator F responded, .The root cause was he self-cathed and urine spilled onto the power strip . The Administrator was asked if the power strip was safe for use by Resident #2 due to risk of incontinence episodes or accidental spillage during the self-cath procedure. Administrator F deduced, Resident #2 was a young person who like to have his electronics close by, was rebellious and did not want to be told what to do. Administrator F stated, .He knew what the rules were, and he chose not to comply .</p> <p>During an interview on [DATE] at 10:47 PM, LPN W stated she had been assigned to Resident #2 before the electrical accident on [DATE]. LPN W stated, .He [Resident #2] was in bed most of the time, and he wanted his laptop and phone with him all the time .He had a lot of electronics .The day [Named Administrator F] gave him the power strip, it was on the foot [end] of the bed . When asked if she had ever moved the power strip from the bed, or had she been told to keep power strips and electrical cords off of the residents beds, LPN W replied, .Not before the accident [[DATE]], there were no concerns .I know it isn't safe for electrical cords to be in any resident's bed, in the nursing home, a lot of the residents are incontinent or have dementia .</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 a telephone interview on [DATE] at 7:21 PM, CNA J, requested to remain anonymous. CNA J stated, . I was not in-serviced about electrical cords or power strips when I was hired .I know it isn't safe for residents to have any type of electrical cord in the bed .I have complained to the charge nurse about [Named Resident #15], I would of course move the cords and phone, then find her with the cords in her bed the next time I worked .Now, they are telling everyone to keep the cords out of the beds .</p> <p>During a telephone interview on [DATE] at 3:06 PM, Resident #2 stated prior to [DATE] (accident date), Administrator F had taken his extension cord from him and brought him a metal cased, 2 or 3 outlet, power strip, which the Administrator placed on the end of the bed. Resident #2 stated during a meal, water splashed on the power strip, and it began to crackle and smoke. Resident #2 stated Administrator F checked the power strip and said it was safe to use. Resident #2 insisted he did not feel comfortable with the power strip and Administrator F replaced the power strip with another power strip he (Administrator F) described as hospital grade which was involved in the accident. Resident #2 stated Administrator F placed the power strip on the end of his bed where it remained until the day of the accident. Resident #2 stated prior to the accident, he had an indwelling catheter removed and had episodes of incontinent bladder. Resident #2 recalled on [DATE] he had performed an in/out cath and after that he drifted off to sleep. He was awakened by an unknown smell, rolled back towards the wall and that is when he was electrocuted. Resident #2 stated, .At first, I didn't realize what was happening then I saw smoke .I somehow managed to pull the cord out of the wall .I felt like I was reaching for it [power cord] and I was moving a lot, but it came out of the wall .I screamed for help and a therapy person came in .at first the nurse wouldn't come and then I showed the therapy person my burns .the nurse came then and when I told her what had happened, she wanted to know if I had learned any lesson .I can't believe she said that to me . During the interview Resident #2 frequently paused during conversation, the tone of his voice changed, and he struggled to speak. Resident #2 apologized for the emotion and stated he had experienced a great deal of anxiety and panic after the accident on [DATE]. Resident #2 confirmed he experienced extreme anxiety when talking about the accident.</p> <p>b. Review of the medical records revealed Resident #12 was admitted to the facility on [DATE], with diagnoses which included Pressure ulcer of right buttock, stage 4 (full thickness skin/tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), Paraplegia, and Neuromuscular dysfunction of bladder.</p> <p>Review of the Quarterly MDS assessment dated [DATE], revealed Resident #12 had a BIMS score of 15, which indicated no cognitive impairment. Resident #12 was coded 0 behavior exhibited for Rejection of Care (care necessary to achieve the resident's goals for health and well-being), and Resident #12 was coded dependent to supervision/touching assistance with all functional abilities (indicates resident's usual ability with everyday activities). Resident #12 was coded for an Indwelling catheter and ostomy appliance.</p> <p>Review of Resident #12's comprehensive care plan revised [DATE], revealed .Problem Start Date: [DATE] . Resident requires a suprapubic catheter [urinary catheter inserted into an incision in the pubic area, common problems include urine leaking from opening] R/T [Related/To] neurogenic bladder . Problem Start Date: [DATE] .Behavioral . Resident is noncompliant with electrical devices in bed .Approach Start Date: [DATE] . Educate resident regarding physician orders and risk and benefit of compliance .</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>Observation and interview on [DATE] at 5:30 PM, revealed Resident #12 awake, in bed with computer and phone sitting on an over the bed table in front of her. The electrical devices were connected to charging cables that were plugged in to an 8-port USB (Universal Serial Bus-connector) charging station. The USB charging station was suspended with 5 connecting power cords strapped to the side rail, used for bed mobility on Resident #12's bed. Resident #12 stated the facility had not been concerned about the power cords or charging strip until state was in the building. Resident #12 confirmed staff had attached the charging cords to the side rail and the cords hang beside the bed when not in use.</p> <p>c. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included Hemoperitoneum-intra-abd hemorrhage (internal abdominal bleeding), Fistula of intestine, and Weakness.</p> <p>Review of the Quarterly MDS assessment dated [DATE], revealed Resident #14 had a BIMS score of 13, which indicated no cognitive impairment. Resident #14 was coded 0 behavior exhibited for Rejection of Care (care necessary to achieve the resident's goals for health and well-being), and Resident #14 was coded substantial/maximal assistance to supervision/touching assistance with all functional abilities (indicates resident's usual ability with everyday activities).</p> <p>Review of Resident #14's comprehensive care plan revised [DATE], revealed .Problem Start Date: [DATE] . Resident has a potential for complications associated with urinary incontinence at times . Approach Start Date: [DATE] .Provide assistance with peri care after incontinence as needed .Problem Start Date: [DATE] . Behavioral .refuses to keep cell phone and charger out of bed while charging .Approach Start Date: [DATE] . Educate resident regarding physician orders and risk and benefit of compliance .</p> <p>Observation and interview on [DATE] at 10:00 AM, revealed Resident #14 in bed with a phone charger cord under her back. Resident #14 was asked if she had ever been advised to keep her phone charger cord out of her bed. Resident #14 responded, No.</p> <p>Observation on [DATE] at 4:45 PM, revealed Resident #14 asleep in bed with a phone charger cord laying across her legs.</p> <p>d. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses which included Fracture of unspecified part of neck of left femur (thigh bone), Need for assistance with personal care, and Muscle weakness.</p> <p>Review of the Quarterly MDS assessment dated [DATE], revealed Resident #15 had a BIMS score of 8, which indicated moderate cognitive impairment. Resident #15 was coded 0 behavior exhibited for Rejection of Care (care necessary to achieve the resident's goals for health and well-being), and Resident #15 was coded dependent to setup/clean up assistance with all functional abilities (indicates resident's usual ability with everyday activities). Resident #15 was coded for always incontinent of bowel and bladder.</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>Review of Resident #15's comprehensive care plan revised [DATE], revealed, .Problem Start Date: [DATE] . Resident has a potential for complications associated with urinary incontinence at times . Approach Start Date: [DATE] .Provide assistance with peri care after incontinence as needed .Problem Start Date: [DATE] . Behavioral .removed cast from left arm .Resident is noncompliant with electrical devices in bed .Edited: [DATE] .</p> <p>Observation on [DATE] at 10:05 AM, revealed Resident #15 was awake in bed with a cell phone connected to a charging cord positioned beside her on the bed. Resident #15 spoke to the surveyor upon entering the room and was unable to answer questions appropriately during an attempt to interview.</p> <p>e. Review of facility documents on [DATE] revealed no documentation of policies and procedures related to testing patient care related electrical equipment (PCREE) according to NFPA 99, 10.5.2.1.1 2012 Edition. Review of a facility document titled PCREE testing revealed on [DATE] the facility had thirty-three (33) PCREE devices with deficiencies and no record of repairs was available according to NFPA 99, 10.5.6.3 2012 Edition. The Plant Operations Director verified they were not knowledgeable about facility policies and protocols related to PCREE testing, inspection and maintenance or how to locate the policies.</p> <p>3. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included Chronic diastolic (congestive) heart failure, Need for assistance with personal care, Other specified fracture of right pubis, Difficulty in walking, Orthostatic Hypotension, Syncope and collapse, and Unspecified fall. Resident #1 was previously admitted to the facility 3/2024 and discharged to an Assisted Living Facility 4/2024.</p> <p>Review of the admission Observation document dated [DATE] revealed Resident #1 scored 14 on the fall risk assessment tool and was determined to be a High Fall Risk (scored greater than 13 points).</p> <p>Review of the Resident Progress Notes for Resident #1 revealed, XXX[DATE] .Resident readmitted to facility on 5/31 [2024] .previous resident was discharged back to assisted living .While at the assisted living resident had multiple falls and fractured her ribs and was readmitted to this facility . Note was entered by the Former Director of Nursing [FDON].</p> <p>Review of the admission MDS assessment dated [DATE], revealed Resident #1 was coded for impaired vision (sees large print, but not regular print in newspaper/books). Resident #1 had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #1 uses a walker and a wheelchair, was coded substantial/maximal assistance for toileting hygiene, lower body dressing, putting on/taking off footwear, toilet transfer, sit to stand, chair/bed-to-chair transfer and partial/moderate assistance to walk 10 feet. Bowel and Bladder was coded always continent. Active diagnoses coded included Heart failure, Hypertension, Other Fracture, and Malnutrition. Fall history coded for fall in last month, and fracture related to fall in the 6 months prior to admission.</p> <p>Review of Resident #1's Comprehensive Care Plan created [DATE], revealed .Falls .Resident at risk for falling .Arrange for a clutter free environment .Encourage/assist resident to assume a standing position slowly .Keep call light in reach .Keep personal items and frequently used items within reach .Staff to assist Resident with transfers as needed .therapy eval and treat as needed .</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>Review of the Resident Progress Notes for Resident #1 revealed, XXX[DATE] .0330H [3:30 AM], resident reported to this nurse .lightheadedness and dizziness when she tried [to] go the restroom .BP [Blood Pressure] 72/45 .gave 2 cups of water .repeat vital signs after 30 mins [minutes] BP: 80/50 .0400H [4:00 AM] .called NP [Nurse Practitioner] on call .Give one cup of water and repeat BP after 30 mins .0430H [4:30 AM] . BP 94/58 . Note was entered by RN MM.</p> <p>Review of the Resident Progress Notes for Resident #1 revealed, XXX[DATE] 1807 [6:07 PM] .Resident noted to have come out of room and gotten ice upon return staff heard a loud noise and resident was observed laying in floor .knot on back of head and skin tear to r [right] elbow .NP on call notified .[Note was entered by LPN LL] .21:48 [9:48 PM] RCA [Root Cause Analysis] completed with IDT [Interdisciplinary Team] .Resident was out in hallway getting ice from staff member and went back to room .when attempting to transfer back to bed she fell by tripping over her w/c [wheelchair] foot rest which she forgot to put up when she transferred .intervention is to remove the foot rest from her w/c to prevent further tripping and falls . Therpay [therapy] has also been notified .best intervention and it will also promote independence and allow her to self propel easier with no foot pedals . Note was entered by the FDON.</p> <p>Review of the Physical Therapy Discharge summary dated [DATE] revealed Resident #1 was discharged related to highest practical level achieved independent for transfers (sit to stand, chair/bed to chair), ambulation 10 feet and requires supervision or touching assistance for picking up objects.</p> <p>Review of the Resident Progress Notes for Resident #1 revealed, XXX[DATE] .12:19 [PM] . Resident's daughter called .said that she needed me outside .I was approaching the car resident was unresponsive and drooling .assisted in getting resident to the ground and she became more responsive .BP was 80/40 . transported to [Named Hospital #2] to be assessed .[Note was entered by the MDS Coordinator] 22:57 [10:57 PM] .called [Hospital #2] .Resident has an admitting diagnosis of Syncope [[DATE]-[DATE]] . Note entered by MDS Coordinator.</p> <p><br[TRUNCATED]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Signature Health of Portland Rehab & Wellness Cent		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Highland Circle Drive Portland, TN 37148	
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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>Based on policy review, Quality Assurance and Performance Improvement (QAPI) report, observations, and interview, the QAPI committee failed to ensure systems and processes were in place that implemented and monitored identified interventions for improvement activities to provide a safe environment for residents and failed to provide adequate supervision to ensure staff provided QAPI interventions for a safe environment.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy titled, Quality Assurance/Performance Improvement (QAPI) Program Policy, revised 9/15/2023, revealed, .To provide a process that will enhance the care and experience for all residents .quality of all services provided by the facility .It is the intent of this facility to conduct an on-going Quality Assurance/Performance Improvement (QAPI) program designed to systematically monitor, evaluate and improve the quality and appropriateness of resident care .Documentation of items discussed at the QAPI meeting will be maintained by the facility Administrator . 2. Review of an Event Report dated 12/14/2023 revealed on 12/13/2023, staff found Resident #2 in bed with third degree third degree (involves all layers of skin, sometimes fat and muscle tissue) electrical burns. The Event Report revealed urine had contacted an energized power strip position in the bed with Resident #2. Resident #2 was transferred to the emergency room for evaluation of the electrical burns. 3. Review of the QAPI meeting minutes dated 12/13/2023, revealed the facility removed noncompliant power strips and would replace damaged bed cords. Improvement plans included monitoring care plans for noncompliance interventions and education. Staff interviews revealed on going compliance with education was inconsistent. Observations during the complaint investigation survey found residents with charging cords in bed with them or attached to handrails with no care plan interventions related to noncompliance for those residents. Interview with the Maintenance Director on 3/27/2025 revealed a lack of monitoring consistency for electrical devices and power cords used by residents. Observations during survey with Life Safety surveyor revealed on going noncompliance with electrical cords and bed power cords. 4. During an interview on 4/11/2025 at 5:22 PM, the Administrator confirmed the facility was unable to provide QAPI meeting minutes/details for the first quarter of 2024 and provided evidence of the means to monitor the effectiveness of interventions or evaluate the interventions for performance improvement of safety action plans implemented by the QAPI committee related to the electrocution incident on 12/13/2023. <p>Refer to F-689, F-600, K-0920, and K-0921</p>		