

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445501	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER West Hills Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 6801 Middlebrook Pike Knoxville, TN 37919	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35460</p> <p>Based on review of facility policy, medical record review and interviews, the facility failed to provide post dialysis interventions for 1 resident (Resident #151) of 1 residents reviewed for dialysis.</p> <p>The findings include:</p> <p>Review of the facility policy, Dialysis, Residents, Coordination of Care and Post-Care, dated 3/13/2015, revealed All nursing personnel will be responsible for providing safe, accurate, appropriate dialysis care with a general coordination between outside agencies that provide dialysis, post care assessment and interventions to improve resident outcomes .A. General Guidelines 1. Review and ensure orders upon admission are received for follow-up dialysis center appointments, shunt care, diet, and fluid restrictions .</p> <p>Review of the medical record revealed Resident #151 was admitted to the facility on [DATE], with diagnoses including Cirrhosis, Hepatitis C, Osteomyelitis, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, and End Stage Renal Disease.</p> <p>Review of the comprehensive care plan dated 11/13/2024, revealed The resident needs hemodialysis r/t [related to] renal failure s/p [status post] permanent dialysis catheter placement 10-11-2024 right upper chest .Monitor/document/report PRN [as needed] for s/sx [signs and symptoms] of the following: Bleeding, Hemorrhage, Bacteremia, septic shock .</p> <p>Review of the Medication Administration Record (MAR) dated 11/8/2024, did not indicate the location of Resident #151's dialysis catheter or documentation and monitoring of the catheter post dialysis.</p> <p>Review of a nurse progress note dated 11/13/2024, revealed post dialysis the nurse failed to document an assessment of Resident #151's dialysis catheter.</p> <p>During an observation and interview on 11/15/2024 at 8:45 AM, with Resident #151's nurse revealed he left the facility to go to dialysis prior to her coming on shift. Continued interview revealed she did not know the location of his dialysis catheter because it was her first day to provide care for the resident. Observation of the resident's MAR and further interview confirmed there was no record of the location of the dialysis catheter or documentation of post dialysis care.</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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/2024 at 9:00 AM, with the Director of Nursing confirmed the documentation for post dialysis care was not documented on 11/13/2024.		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40606</p> <p>Based on medical record review and interview, the facility failed to resubmit a timely Level I (one) Preadmission Screening and Resident Review (PASRR) for 3 residents (Resident #29, #47 and #54) of 5 residents reviewed for PASRR.</p> <p>The findings include:</p> <p>Review of the medical record revealed Resident #29 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Metabolic Encephalopathy, COVID-19, Major Depressive Disorder, Anxiety Disorder, and Adult Failure to Thrive.</p> <p>Review of Resident # 29's comprehensive care plan dated 7/25/2024, revealed .The resident uses Antianxiety Medication .The resident has a mood problem .The resident has depression . Interventions were in place and implemented.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #29 scored a 14 on the Brief Interview of Mental Status (BIMS) assessment , which indicated the resident was cognitively intact and required extensive assistance of 1 staff member for bed mobility, transfers, toileting, and Activities of Daily Living (ADL) care.</p> <p>Review of a psychiatric progress note for Resident #29 dated 10/28/2024, revealed .Necessity of follow-up visits related to multiple psychiatric diagnoses, will encourage nursing interventions, including socialization, self-care, sleep hygiene .</p> <p>Review of the electronic physician's recapitulation orders for Resident #29 for 11/2024, revealed .Psych [psychiatric] .services may be obtained for the resident as indicated .</p> <p>Review of the medical record revealed Resident #29 had a Level I PASARR completed 7/17/2024, prior to admission to the facility. The screening concluded no mental health diagnosis is known or suspected. On admission to the facility, the resident had mental health diagnoses documented. No further screening was submitted by the facility to the state-designated authority.</p> <p>Review of the medical record revealed Resident #47 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Type 2 Diabetes Mellitus, Adjustment Disorder with Mixed Anxiety and Depressed Mood, and Unspecified Psychosis.</p> <p>Review of an annual MDS assessment dated [DATE], revealed the Resident #47 scored 15 on the BIMS, which indicated the resident was cognitively intact. Further review revealed the resident required extensive assistance of 1 staff member for bed mobility, toileting, dressing, and transfers.</p> <p>Review of the comprehensive care plan dated 6/19/2023, revealed .is on antipsychotic medication r/t [related to] hallucinations .at risk for decreased psychosocial well-being r/t [related to] the sudden, unexpected death of a loved one,,a life-threatening illness/injury . Interventions were initiated.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record revealed Resident #47 had a level I PASARR screening completed on 1/8/2021 with Anxiety Disorder and Depression captured for mental health diagnoses.</p> <p>Review of the medical record revealed the diagnosis of psychosis was added on 8/16/2022, and the facility failed to submit to the state-designated authority for a level II screening.</p> <p>Review of the medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, Schizophrenia, Anxiety, and Depression.</p> <p>Medical record review of a PASRR for Resident #54 dated 2/8/2024, revealed .Your level I screen shows you have evidence of serious mental illness .you are approved for admission for or up to 180 days in a nursing facility .If you or your care provider thinks you need to stay longer than 180 days, a nursing facility staff member must submit a new Level 1 screen .This must be done by or before the 180th day (August 8th 2024)</p> <p>.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact.</p> <p>Review of the medical record for Resident #54 from 2/8/2024 - 11/12/2024, revealed no additional PASRR had been completed or submitted by August 8th, 2024 (180th day).</p> <p>During an interview on 11/14/2024 at 2:20 PM, with the Director of Nursing (DON) and the PASARR Coordinator on speaker phone, the Coordinator confirmed the facility failed to resubmit a timely level 1 PASARR for Resident #54.</p> <p>During an interview on 11/15/2024 at 2:32 PM, the DON confirmed a submission for a level II PASARR was not submitted to the state designated authority after a new mental health diagnosis was added for Residents #29 and #47.</p> <p>49786</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786</p> <p>Based on medical record review, observation and interview, the facility failed to obtain physician orders for oxygen for 1 resident (Resident #301) of 3 residents reviewed for oxygen therapy.</p> <p>The findings include:</p> <p>Review of the medical record revealed Resident #301 was admitted to the facility on [DATE] with diagnoses including Dementia, Age Related Physical Disability and COVID-19.</p> <p>Review of Nursing Skilled Evaluation documentation for Resident #301 dated, 11/9/2024, 11/10/2024, 11/11/2024, 11/12/2024 and 11/14/2024, indicated the resident was utilizing oxygen at 2 liters [per minute] via nasal cannula [NC-an oxygen delivery device placed in the nose].</p> <p>During an observation on 11/12/2024 at 11:00 AM, Resident #301 was resting quietly in bed alert and pleasant. Resident #301 was receiving humidified oxygen at 2 liters via NC.</p> <p>During an observation on 11/13/2024 at 9:30 AM, Resident #301 was sitting up in bed eating breakfast. Resident #301 was receiving humidified oxygen at 2 liters via NC.</p> <p>During an observation on 11/14/2024 at 2:00 AM, Resident #301 was resting quietly in bed alert and pleasant. Resident #301 was receiving humidified oxygen at 2 liters via NC.</p> <p>During an observation on 11/15/2024 at 10:00 AM, resident resting quietly in bed with eyes closed. Resident #301 was receiving humidified oxygen at 2 liters via NC.</p> <p>During an interview on 11/15/2024 at 10:36 AM, the Director of Nursing (DON) stated Resident #301 was hospitalized for COVID and came to the facility on oxygen. The DON onfirmed there was not an order for oxygen and Resident #301's medical provider had been notified. The DON stated the medical provider ordered to discontinue the oxygen administration and monitor the resident to see if she needs to continue the oxygen therapy.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003</p> <p>Based on review of facility policy, medical record review, pharmacy delivery reports, observation and interviews, the facility failed to accurately transcribe a physician's order for 1 resident (Resident #51) of 7 residents reviewed for medication administration.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Medication and Treatment Orders, revised 7/2016, revealed .Drug and biological orders must be recorded in the medical record .</p> <p>Review of the medical record revealed Resident #51 was admitted to the facility on [DATE], with diagnoses including Dysphagia (difficulty swallowing) following Cerebral Infarction (Stroke), Atrial Fibrillation, Hypertension, Heart Failure, and Depression.</p> <p>Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #51 scored 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact.</p> <p>Review of a pharmacy delivery report for Resident #51 revealed Sertraline (Zoloft-antidepressant) 25 mg tablets were delivered to the facility from 9/20/2023-8/1/2024.</p> <p>Review of the Medication Administration Record (MAR) for Resident #51 for 11/2024 revealed .Zoloft [Sertraline] oral [by mouth] Tablet 25 MG [milligrams] .Give 1 tablet by mouth one time a day for DEPRESSION .</p> <p>Review of an electronically transmitted prescription, dated 8/1/2024, revealed the hospice agency sent an electronic order for Resident #51 for Sertraline 50 mg tablet to be administered by mouth once a day to a pharmacy contracted by the facility.</p> <p>Observation of a medication administration pass for Resident #51 on 11/13/2024 at 9:20 AM, revealed Sertraline 50 mg tablet was administered to the resident.</p> <p>During an interview and review of Resident #51's MAR and Sertraline medication package on 11/13/2024 at 10:20 AM, with Licensed Practical Nurse (LPN) A, revealed Sertraline 25 mg by mouth once a day was listed on the MAR. Further review of the medication package revealed Sertraline 50 mg. LPN A confirmed Resident #51 received Sertraline 50 mg.</p> <p>During a telephone interview on 11/15/2024 at 2:40 PM, the hospice Registered Nurse (RN) confirmed Resident #51's Sertraline dosage was increased from 25 mg once a day to 50 mg once a day on 8/1/2024. The hospice RN stated the process for new medication orders was the new order was sent electronically to the pharmacy. The hospice agency then faxed the new order to the facility's 2nd floor nurse's station.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/15/2024 at 3:15 PM, the Director of Nursing confirmed Resident #51's MAR and physician orders were not transcribed correctly.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003</p> <p>Based on review of facility policy, medical record review, observation and interviews, the facility failed to ensure infection control practices were observed during medication administration for 1 resident (Resident #1) of 7 residents observed for medication administration and failed to ensure enhanced barrier precautions (EBP) were implemented for 1 resident (Resident # 45) of 17 residents reviewed for EBP.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Administering Medications, revised 4/2019, revealed .Staff follows established facility infection control procedures (.handwashing .) for the administration of medications .</p> <p>Review of the facility policy titled, Enhanced Barrier Precautions, revised 8/2022, revealed .Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do no otherwise apply .Gloves and gown are applied prior to performing the high contact resident care activity .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .dressing .bathing/showering .transferring .providing hygiene .changing linens .changing briefs or assisting with toileting .device care or use .wound care .EBPs are indicated .for residents with wounds and/or indwelling medical devices regardless of MDRO colonization .Signs are posted indicating the type of precautions and PPE required .PPE [personal protective equipment] .is available either in the resident room or outside of the resident rooms .</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Chronic Kidney Disease, Anxiety, and Depression.</p> <p>Review of the medical record revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including Dysphagia (difficulty swallowing) following Cerebral Infarction (Stroke), Atrial Fibrillation, Hypertension, and Heart Failure.</p> <p>During observation of medication administration for Resident #51 on 11/13/2024 at 9:20 AM, Licensed Practical Nurse (LPN) A failed to perform hand hygiene after administering Resident #51's medication and prior to preparing and administering Resident #1's medication.</p> <p>During an interview on 11/13/2024 at 9:28 AM, LPN A confirmed she failed to perform hand hygiene after administering Resident #51's medication and prior to preparing and administering Resident #1's medication.</p> <p>During an interview on 11/13/2024 at 10:30 AM, the Director Of Nursing (DON) confirmed staff were expected to perform hand hygiene between each resident's medication administration.</p> <p>Review of the medical record revealed Resident #45 was admitted to the facility on [DATE] with diagnoses including Encounter for Orthopedic Aftercare and Fracture of Right Lower Leg.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of Resident #45 on 11/12/2024 at 11:00 AM, revealed Resident #45 had an external fixator (A device to hold broken bones in place. Metal pins or screws are placed into the bone through small incisions into the skin and muscle. The pins and screws are attached to a bar outside the skin) on the right lower leg. There was no signage posted to indicate the resident was on EBP. Personal protective equipment (PPE) was not available inside or outside of the resident's room.</p> <p>Observation of Resident #45 on 11/13/2024 at 1:04 PM, revealed no signage was posted to indicate the resident was on EBP. PPE was not available inside or outside of the resident's room.</p> <p>Observation of Resident #45 on 11/14/2024 at 1:04 PM, revealed no signage was posted to indicate the resident was on EBP. PPE was not available inside or outside of the resident's room.</p> <p>During an interview on 11/14/2024 at 2:40 PM, the Infection Preventionist (IP) confirmed an external fixator was considered an indwelling medical device, requiring EBP and confirmed Resident #45 was not on EBP.</p>