

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 09262</p> <p>Based on document review, record review, interview and policy review, the facility failed to ensure residents were free from misappropriation for one of one resident (Resident (R) 76) reviewed for misappropriation. Specifically, Licensed Practical Nurse (LPN) 1 took Resident (R)76's Zofran (antiemetic) from the facility's drug destruction bin and injected LPN2 with the medication, intramuscularly (IM). The facility's failure to safeguard R76's medication placed all residents at risk for their medications to be misappropriated.</p> <p>Findings include:</p> <p>Review of the TN00064574 intake revealed the allegation, Report of staff taking medication from the destruction box to give each other medication. On Monday, August 7, 2023, a unit manager gave another unit manager an IM injection of both Zofran and Phenergan [antiemetic medication] without an order. The Zofran came from the MDS [Minimum Data Set] nurse who kept the vial in her desk drawer. The unit manager drove home after that .The DON [Director of Nursing] notified Regional about the incident which both unit managers admitted to but said it is a practice they have always been able to do. There was no disciplinary action taken .</p> <p>Review of R76's undated Face Sheet located in the resident's electronic medical record (EMR) under the Face Sheet tab indicated that R76's was admitted to the facility on [DATE] and was discharged on [DATE].</p> <p>During an interview on 09/03/24 at 9:51 AM, LPN3 stated that she heard through the facility's gossip about the incident of two nurses taking medication from the drug destruction box, and the one nurse administered the medication to another nurse. LPN3 stated she did not hear who the nurses were and did not know what happened to the nurses. LPN3 further stated that the Regional office came to the facility and investigated. The Regional office also conducted an inservice.</p> <p>During an interview on 09/03/24 at 10:08 AM, the Minimum Data Set Coordinator (MDSC) stated she heard last year, August 2023, a nurse had administered herself an IM dose of Zofran. The MDSC stated it was facility gossip and she did not hear the name of the nurse and did not know if the nurse was fired, quit, or was still working at the facility. She heard the medication came from the drug destruction bin. The MDSC also stated she was not aware of any staff keeping Zofran in their desk. The MDS Coordinator stated that all the nurses were inserviced.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Interview on 09/03/24 at 12:42 PM, the Consultant Pharmacist stated she heard last year through the facility's gossip that a nurse gave herself an IM injection of Zofran. The Consultant Pharmacist stated she did not hear the name of the nurse and did not know what happened to the nurse. She stated an inservice was conducted for all nurses after this incident. The Consultant Pharmacist stated she had nothing to do with drug destruction at the facility. The Consultant Pharmacist stated she could run a report for 08/2023 to see which residents had an order for Zofran IM.</p> <p>During an interview with the Administrator on 09/04/24 at 8:30 AM, she stated the facility had two unit managers, LPN6 on the west unit and LPN1 on the east unit.</p> <p>Interview on 09/04/24 at 8:39 AM, LPN6 stated that she had worked in the position of unit manager since May 2024. LPN6 stated that she remembered hearing about the incident of two nurses taking medication out of the drug destruction box, but did not know who the nurses were. LPN6 opened the west medication room and inside on the cabinet was a clear plastic bin that LPN6 stated is where the discharged non-narcotic medications were placed until they were destroyed.</p> <p>Interview on 09/04/24 at 9:00 AM, LPN1 stated that she had been the unit manager since 2020. LPN1 stated she took the Zofran medication out of the drug destruction box and administered the medication IM to LPN2. LPN1 stated LPN2 was still employed at the facility. LPN1 stated LPN2 had the stomach flu when she came to work. She stated she removed the Zofran vial from the drug destruction box, and once she gave the injection to LPN2, she threw the vial into the sharps container and did not record the vial on the drug destruction record. LPN1 stated the Regional Office did an investigation and she received a reprimand for it.</p> <p>During an interview on 09/04/24 at 9:46AM, the Administrator stated that she was made aware of the incident yesterday as she had only been employed at the facility for three months. The Administrator stated she had not seen the Regional office's investigation. The Administrator also stated both LPNs had keys to the medication rooms.</p> <p>Interview on 09/04/24 at 10:52 AM, the Director of Nursing (DON) stated the unit managers had keys to the medication rooms but did not have the keys to the medication room's drug narcotic destruction cabinet. The DON was asked if there was any document the nurses sign that they are to not take residents' medications. The DON stated the nurses sign the facility's Abuse policy. The DON stated that she was not aware of the incident of LPN1 giving LPN2 Zofran IM and that the medication was taken from the non-narcotic drug destruction box as she was not employed at the facility during the time of the incident.</p> <p>During an interview on 09/04/24 at 11:35 AM, LPN6 stated she had the key to the medication room but did not have the key to the drug narcotic destruction cabinet. LPN6 stated she would only have the key to the medication cart's locked narcotic box if she was the nurse on the floor for that cart.</p> <p>During an interview on 09/04/24 at 11:41 AM, LPN1 stated she had the key to the medication room; however, she did not have the key to the drug narcotic destruction cabinet. LPN1 stated when if she was a floor nurse, then she would have the key for the medication cart's narcotic lock box. LPN1 stated she had been assigned as the nurse on the unit for the last couple of months.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the Order Report by Drug Class, Gastrointestinal Drugs, Antiemetics dated 08/01/23 to 08/31/23, provided by the Consultant Pharmacist revealed two residents, R124 and R76 had physician orders for Ondansetron [generic brand of Zofran] HCL, solution 4 mg [milligram]/2 ml [milliliter], amount 2 ml intramuscular. R124's order was dated 02/19/21. Per the EMR Face Sheet indicated R124 was discharged [DATE].</p> <p>During an interview on 09/04/24 at 2:10 PM, the Administrator stated there was no formal investigation that could be provided for this incident. The Administrator stated she tried to contact the former DON that was here at the time of the incident; however, the former DON did not return her call. The Administrator stated the Regional office did come to the facility and had a meeting with all the nurses at the time, but there was no documentation of the meeting or in-service education. The Administrator stated there was no documentation in LPN1's or LPN2's personnel file of a reprimand.</p> <p>During an interview on 09/04/24 at 3:44 PM, LPN2 stated the incident where R76's medication was administered to her did occur. LPN2 stated she was sick. LPN2 stated she did not know who went to get the medication or where they got the medication. She presumed it was from the facility's first dose box. LPN2 stated LPN1 gave her the injection and she thought she only received Zofran. LPN2 further stated afterwards the former DON called the corporate office and they did an investigation. LPN2 stated she did not receive a reprimand. LPN2 also stated as a floor nurse, she had access to the medication cart keys, the narcotic box, and the medication room; however, she did not have a key to the narcotic drug destruction cabinet.</p> <p>Review of LPN2's Timesheet, dated 08/01/23 through 08/31/23 and provided by the Administrator indicated on 08/08/23, LPN2 worked 8:25 AM to 10:24 AM. The Administrator stated LPN2 went home sick and was off on 08/09/24. The time sheet confirmed that LPN2 did not work 08/09/23.</p> <p>Review of LPN2's employee file document titled, Patient Protection and Response Policy for Allegations/ Incidents of Abuse, Neglect and Misappropriation of Property dated 09/01/16 revealed that LPN2 signed the document on 07/12/17.</p> <p>Review of LPN1's employee file document titled, Patient Protection and Response Policy for Allegations/ Incidents of Abuse, Neglect and Misappropriation of Property dated 09/01/16 revealed that LPN1 signed the document on 07/02/19.</p> <p>Review of the Licensed Practical Nurse Job Description dated 11/02/21 indicated, .Assume responsibility for assisting with med [medications] and treatment as needed . Review of LPN2's employee file revealed LPN2 signed the LPN Job Description on 07/12/17 and LPN1 signed the document on 07/02/19.</p> <p>Review of the facility's policy titled, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation dated 02/01/23 indicated, .Definitions . Misappropriation of Patient Property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 09262</p> <p>Based on document review, record review, interview and policy review, the facility failed to ensure misappropriation of resident property was reported to the State Survey Agency (SSA) for one of one resident reviewed for misappropriation (Resident (R) 76). The facility had knowledge R76's Zofran (antiemetic) medication was misappropriated; however, the facility did not report the misappropriation to the SSA. This failure placed all residents at the facility at risk of their personal property being misappropriated and the misappropriation going unreported.</p> <p>Findings include:</p> <p>Review of the TN00064574 intake revealed the allegation, Report of staff taking medication from the destruction box to give each other medication. On Monday, August 7, 2023, a unit manager gave another unit manager an IM [intramuscular] injection of both Zofran and Phenergan [antiemetic medications] without an order. The Zofran came from the MDS [Minimum Data Set] nurse who kept the vial in her desk drawer. The unit manager drove home after that .The DON [Director of Nursing] notified Regional about the incident which both unit managers admitted to but said it is a practice they have always been able to do. There was no disciplinary action taken</p> <p>Interview on 09/04/24 at 9:00 AM, LPN1 stated that she had been the unit manager since 2020. LPN6 stated she took R76's Zofran medication out of the drug destruction box and administered the medication IM to LPN2. LPN1 stated the facility's Regional Office did an investigation.</p> <p>Review of the Order Report by Drug Class, Gastrointestinal Drugs, Antiemetics dated 08/01/23 to 08/31/23 provided by the Consultant Pharmacist revealed that two residents, R124 and R76 had physician orders for Ondansetron HCL, solution 4 mg [milligram]/2 ml [milliliter], amount 2 ml intramuscular. R124's order was dated 02/19/21. Per the EMR Face Sheet indicated R124 was discharged [DATE]. Review of R76's EMR Face Sheet indicated that R76's order was dated 02/25/23 and R76 was discharged on [DATE].</p> <p>During an interview on 09/04/24 at 2:10 PM, the Administrator stated she could not find any documentation of the incident and could not provide documented evidence the misappropriation was reported to the SSA.</p> <p>During an interview on 09/04/24 at 3:44 PM, LPN2 stated LPN1 gave her the Zofran injection and she thought that was the only medication she received.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility's policy titled, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation dated 02/01/23 indicated, .Definitions . Misappropriation of Patient Property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent .6. REPORTING POLICY Any partner having either direct or indirect knowledge of any event that might constitute abuse, neglect, misappropriation of patient property or exploitation must report the event immediately, but not later than 2 hours after forming the suspicion if the events that cause the suspicion involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in abuse or serious bodily injury. All allegations of possible abuse .misappropriation of patient property .will be immediately assessed to determine the appropriate direction of the investigation. There will be no reprisal to partners making good faith reports. Disclosure of any information in the report may only be made to persons connected with reporting and response to the report. The identity of the person reporting abuse . misappropriation of personal property .will only be disclosed on a need to know basis. It is the policy of this facility that abuse allegations (abuse .misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse .misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. Procedure .All alleged violations and all substantiated incidents will be reported immediately to the Administrator or her/his designated representative and to other officials in accordance with State and Federal law (including to the State survey and certification agency) .B, REPORTING OF INVESTIGATION POLICY 1. Policy. External reporting to the state survey and certification agency and all other state required agencies will follow Federal, individual State laws, and licensure regulations .</p> <p>(Cross Reference F602)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>09262</p> <p>Based on document review, record review, interview and policy review, the facility failed to ensure allegations of misappropriation of resident property were thoroughly investigated for one of one resident (Resident (R) 76) reviewed for misappropriation. The facility had knowledge R76's medication was misappropriated; however, no action was taken, and the facility did not complete an investigation. This failure placed all residents at risk for allegations of misappropriation to go uninvestigated.</p> <p>Findings include:</p> <p>Review of the TN00064574 intake revealed the allegation, Report of staff taking medication from the destruction box to give each other medication. On Monday, August 7, 2023, a unit manager gave another unit manager an IM injection of both Zofran and Phenergan [antiemetic medication] without an order. The Zofran came from the MDS [Minimum Data Set] nurse who kept the vial in her desk drawer. The unit manager drove home after that .The DON [Director of Nursing] notified Regional about the incident which both unit managers admitted to but said it is a practice they have always been able to do. There was no disciplinary action taken .</p> <p>During an interview on 09/04/24 at 9:00 AM, LPN1 she took R76's Zofran medication out of the drug destruction box and administered the medication IM to LPN2.</p> <p>During an interview on 09/04/24 at 2:10 PM, the Administrator stated that there was no formal investigation that could be provided into this incident.</p> <p>Interview on 09/04/24 at 3:44 PM, LPN2 stated she did receive an IM injection of Zofran; however, she did not know where the medication came from.</p> <p>Review of the facility's policy titled, Patient Protection and Response Policy for Allegations/Incidents of Abuse .Misappropriation of Property . dated 02/01/23 indicated, .Definitions .Misappropriation of Patient Property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent .All allegations of possible abuse .misappropriation of patient property .will be immediately assessed to determine the appropriate direction of the investigation .</p> <p>(cross reference F602)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26190</p> <p>Based on record review, interview, and facility policy review, the facility failed to notify in writing the resident and the resident's representative regarding the resident's emergent transfer to the hospital for nine residents (Resident (R) 10, R17, R37, R47, R7, R62, R275, R72, and R59) of nine residents reviewed for hospitalization in a total sample of 31 residents. This failure had the possibility to affect every resident (current census of 82 Residents) that was transferred to the hospital during their stay at the facility by not being aware of their appeal rights.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Transfer/discharge date d 03/2024 indicated, 2.1. A. A patient may be transferred or discharged to another health care institution . upon the written order of the attending physician . The policy did not indicate the contents of the transfer notice, and that the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.</p> <p>Review of the facility's undated policy titled, Patient Care Policies indicated, .4.1 Policies and Procedures Regarding Change in Patient Status .B. Notification of Patient Representative The charge nurse on duty is notified of any change in a patient's condition. The charge nurse will then assess the patient's condition and notify .the patient's representative. The patient may not be transferred to the hospital without first notifying the patient's representative .If unable to contact the family, the patient will be transferred per doctor's order, and efforts to reach the patient's representative will be continued and documented .</p> <p>1. Review of R10's undated Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE].</p> <p>Review of R10's EMR under the Progress Notes tab, dated 12/11/23 stated, called into pt. [patient] room to check her, pt. cool and clammy, states she is having trouble breathing - using accessory muscles to breathe, O2 (oxygen) sat (saturation) was running 84 to 86%, O2 put on per nasal cannula with very little results, changed to a mask and increased O2 to a tank 15 L/M (liters per minute) on the non-rebreather, HR (heart rate) running in 140's, both lungs sound wet with bronchi, called MD with order to send her to ER (emergency room ), 911called and ambulance sent to take pt. to ER. Ambulance here by 2210pm [10:10 PM] and then they left by 2213pm [10:13 PM].</p> <p>2. Review of R37's undated Face Sheet located under the Profile tab of the EMR revealed R37 was admitted to the facility on [DATE].</p> <p>Review of R37's EMR under the Progress Notes tab, dated 06/30/24 stated, Patient sent to . ED (emergency department) per 911 for complaints of SOB (shortness of breath). V/S (vital signs) as follows: BP 107/65, P 75, R 16, temp 97.9, O2 sat 96% on RA [room air]. Patient is AAO (alert and oriented) x4 and verbalizes numbness in BUEs (bilateral upper extremities) and a feeling that something is terribly wrong.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>3. Review of R17's EMR Census tab revealed the resident was discharged to the hospital on 03/15/24 at 7:37 PM.</p> <p>Review of R17's EMR Event tab and Observation tab revealed no documentation of the Situation, Background, Assessment, and Recommendations (SBAR) or documentation that the SBAR was provided to the resident and their resident representative for the 03/15/24 transfer to the hospital.</p> <p>4. Review of R47's EMR Census tab revealed the resident was discharged to the hospital on 07/02/24 at 4:00 PM.</p> <p>Review of R47's EMR Event tab and Observation tab revealed no documentation of the SBAR or documentation that the SBAR was provided to the resident and their resident representative for the 07/02/24 transfer to the hospital.</p> <p>5. Review of R7's EMR Census revealed the resident was discharged to the hospital on 01/09/24 at 4:47 PM.</p> <p>Review of R7's EMR Event tab and Observation tab revealed no documentation of the SBAR or documentation that the SBAR was provided to the resident and their resident representative for the 01/09/24 transfer to the hospital.</p> <p>6. Review of R62's EMR Census tab and Progress Note tab revealed the resident was sent to the hospital on 02/27/24 at 12:00 PM.</p> <p>Review of R62's EMR Event tab and Observation tab revealed no documentation of the SBAR or documentation that the SBAR was provided to the resident and their resident representative for the 02/27/24 transfer to the hospital.</p> <p>7. Review of R59's EMR Census tab and Progress Notes tab revealed the resident was sent to the psychiatric hospital on 06/06/24 at 8:56 PM.</p> <p>Review of R59's EMR Event tab and Observation tab revealed no documentation of the SBAR or documentation that the SBAR was provided to the resident and their resident representative for the 06/06/24 transfer to the psychiatric hospital.</p> <p>8. Review of R72's undated Face Sheet, and located in the electronic medical record (EMR) under the Face Sheet tab revealed R72 was admitted to the facility on [DATE].</p> <p>Review of R72's Progress Notes, dated 07/18/24 at 6:58 AM, located in the EMR under the Progress Notes tab, revealed around 4:55 AM this nurse was alerted in this resident's room. He was twitching muscles and having a seizure with episodes of hypoxia. Res [resident] is at 2 lp [liters per minute] of O2 [oxygen] via nasal cannula. O2 sat [saturation] @ [at] 88% [percent] when checked. res positioned of left side and oxygen was regulated at 4LPM. O2 sat went up to 93%. BP- [blood pressure] 173/90. PR- [pulse rate] 128, RR-[respirations] 21 this res had a seizure episode 4x [four times] in 20 mins. MD [medical director] was informed and ordered to sent [sic] the res in [sic] the ER [emergency room]. sister was informed. EMS [emergency medical services] came at 5:20 AM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Review of R72's Transfer/Bed Hold Policy, dated 07/18/24, located in the EMR under the Resident Documents tab, revealed This letter is to serve as your Emergency Notice of Transfer from our center . Federal regulation 42 CFR 483.14 (C)(4)(I)(D) states in part the Notice must be made as soon as practicable before transfer or discharge . You can receive more information on the appeal process from the State Long Term Care Ombudsman: . Continued review of the form revealed the appeal rights were not listed on the form.</p> <p>9. Review of R275's Census tab located in the resident's EMR revealed the resident was discharged to the hospital on 08/17/24 and 08/30/24.</p> <p>Review of 275's EMR revealed no documented evidence a written notice of transfer was issued to the resident and the resident's representative for either of the emergent hospital transfers.</p> <p>Interview with the Administrator on 09/05/24 at 3:30 PM revealed she could not produce any documented evidence R275 and R275's representative was provided with written notice of the transfers.</p> <p>Interview with Family Member (F) 3 on 09/05/24 at 4:30 PM revealed she did not receive written notice of R275's transfers to the hospital.</p> <p>Interview with the Director of Nursing (DON) on 09/03/24 at 1:51PM, the DON stated when a resident goes to the hospital, the nurses send with the resident the face sheet, physician orders, the Situation-Background Assessment-Recommendation (SBAR), and advance directive information. The DON stated the SBAR was the transfer form and a copy of the SBAR would be found in the Events tab or the Observation tab of the Electronic Medical Record (EMR). The DON showed a sample SBAR document, and the document contained all of the information required of the transfer form except the SBAR did not indicate the resident's appeal rights. The DON confirmed that the SBAR did not identify the resident's right to appeal the transfer or discharge to the State; the name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests; information on how to obtain an appeal form; and information on obtaining assistance in completing and submitting the appeal hearing request. The DON did not provide documentation that the SBAR was provided to the following residents and their resident representatives.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26190</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure bed hold notifications were provided to residents and residents' responsible party for six residents (Resident (R) 10, R17, R37, R7, R62, and R275) of nine residents reviewed for bed hold notification. Due to this failure the residents and their responsible parties were not informed of the bed hold policy prior to or immediately following the residents' transfer to the hospital. This failure had the possibility to affect every resident (current census of 82 Residents) that was transferred to the hospital during their stay at the facility and placed the residents at risk for losing their bed.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Bed Hold/Bed Reservation Policy revised 11/2016, indicated . In the event of the patient's transfer from the center, the social services department is responsible for contacting the . legal representative to discuss the center's bed hold policy and to ascertain the plans of the patient to reserve the bed. Patient's bed will be held until the call placed to ascertain the plans of the patient/patient representative to reserve the bed .Medicaid .prior to transfer of a patient for hospitalization .a Medicaid participating center must provide written notice to .an immediate family member, surrogate or representative of the duration of any bed hold .</p> <p>Review of the facility's policy titled, Transfer/discharge date d 03/2024 indicated, 2.1. A. A patient may be transferred or discharged to another health care institution . upon the written order of the attending physician . The policy did not indicate the facility must notify the resident and/or the resident's representative(s) of the bed hold policy in writing in a language and manner they understand.</p> <p>Review of the facility's undated policy titled, Resident Rights which indicated, .7. Bed Hold Policy Patients leaving the center for any length of time to a location . The policy did not indicate the facility must provide the resident and/or the resident representative a written notice of the bed hold policy which specified the duration of the bed-hold.</p> <p>1. Review of R10's undated Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE].</p> <p>Review of R10's EMR under the Progress Notes tab, dated 12/11/23 stated, called into pt. [patient] room to check her, pt. cool and clammy, states she is having trouble breathing - using accessory muscles to breathe, O2 (oxygen) sat (saturation) was running 84 to 86%, O2 put on per nasal cannula with very little results, changed to a mask and increased O2 to a tank 15 L/M (liters per minute) on the non-rebreather, HR (heart rate) running in 140's, both lungs sound wet with bronchi, called MD with order to send her to ER (emergency room ), 911called and ambulance sent to take pt. to ER. Ambulance here by 2210pm [10:10 PM] and then they left by 2213pm [10:13 PM].</p> <p>2. Review of R37's undated Face Sheet located under the Profile tab of the EMR revealed R37 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Review of R37's EMR under the Progress Notes tab, dated 06/30/24 stated, Patient sent to . ED (emergency department) per 911 for complaints of SOB (shortness of breath). V/S (vital signs) as follows: BP 107/65, P 75, R 16, temp 97.9, O2 sat 96% on RA [room air]. Patient is AAO (alert and oriented) x4 and verbalizes numbness in BUEs (bilateral upper extremities) and a feeling that something is terribly wrong.</p> <p>3. Review of R17's EMR Census tab revealed the resident was discharged to the hospital on 03/15/24 at 7:37 PM.</p> <p>Review of R17's EMR Event tab and Observation tab revealed no documentation of the Situation, Background, Assessment, and Recommendations (SBAR) or documentation that the SBAR/bed hold policy was provided to the resident and their resident representative for the 03/15/24 transfer to the hospital.</p> <p>4. Review of R7's EMR Census revealed the resident was discharged to the hospital on 01/09/24 at 4:47 PM.</p> <p>Review of R7's EMR Event tab and Observation tab revealed no documentation of the SBAR or documentation that the SBAR/bed hold policy was provided to the resident and their resident representative for the 01/09/24 transfer to the hospital.</p> <p>5. Review of R62's EMR Census tab and Progress Note tab revealed the resident was sent to the hospital on 02/27/24 at 12:00 PM.</p> <p>Review of R62's EMR Event tab and Observation tab revealed no documentation of the SBAR or documentation that the SBAR/bed hold policy was provided to the resident and their resident representative for the 02/27/24 transfer to the hospital.</p> <p>6. Review of R275's Census tab located in the resident's EMR revealed the resident was discharged to the hospital on 08/17/24 and 08/30/24.</p> <p>Review of 275's EMR revealed no documented evidence a written notice of transfer was issued to the resident and the resident's representative for either of the emergent hospital transfers.</p> <p>During an interview on 09/03/24 at 1:51 PM, the Director of Nursing (DON) stated when a resident goes to the hospital, the nurses send with the resident the face sheet, physician orders, the Situation-Background Assessment-Recommendation (SBAR), and advance directive information. The DON stated the SBAR was the transfer form and a copy of the SBAR would be found in the Events tab or the Observation tab of the Electronic Medical Record (EMR). The DON showed a sample SBAR document, and the document contained the bed hold information, however, did not provide documentation that the resident or resident representative received the bed hold policy in writing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 15293</p> <p>Based on medical record review, facility policy review and interview, the facility failed to ensure nursing services followed orders for lab testing, followed facility protocol and considered each resident's diagnosis to determine appropriate treatment for 1 of 3 (Resident (R) #72) closed records reviewed. The facility admitted R72 on [DATE] at 5:00 PM with diagnoses including generalized epileptic syndrome, not intractable, without status epilepticus. R72 was to have a lab tests drawn at 2:00 AM on [DATE] which were not performed. Per physician's orders there was no documentation staff monitored and periodically documented the presence or absence of seizure activity for R72. The staff failed to follow the facility's Seizure and Epilepsy Clinical Protocol and document R72's seizure episode with the onset time, duration, and time in between the seizures and failed to notify the physician immediately when R72 experienced status epilepticus.</p> <p>The findings include:</p> <p>1. Review of the facility's policy Seizure and Epilepsy Clinical Protocol not dated revealed, The physician and staff will help identify individuals who have a history of seizure, or epilepsy .the nurse shall assess and document/report the following .any seizure activity in detail (location, duration, severity, recurrence, ect.) . staff should carefully describe signs and symptoms including the resident's vital signs, current level of consciousness, cognitive ability, speech, physical function, abnormal motor activity, tremors, overall physical condition, and a comparison of the resident's current status to his/her (baseline) level of cognition and function. They should not just document or report that the individual is having a seizure (which is a diagnosis, not a description) .The physician will treat underlying causes and risk factors, where possible, for example, correct sodium .</p> <p>Review of the facility's policy Patient Care Policies not dated revealed, .When a significant change in medical condition has occurred or the patient is assessed to be critically ill the attending physician will be notified immediately. Should the attending physician or physician extender not be available, the alternate physician will be notified .when an acute medical condition is identified and the attending and/or the alternate physician are unavailable, the charge nurse will take the steps necessary to assure the appropriate medical care is provided, including, but not limited to, contacting the center's Medical Director .</p> <p>2. Medical record review revealed R72 was admitted to the facility on [DATE] at 5:00 PM with diagnoses which included other generalized epilepsy and epileptic syndromes, not intractable, without status epilepticus and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R72 was admitted following hospitalization for unresponsiveness, generalized tonic/clonic seizures, and was ultimately diagnosed with post stroke epilepsy with prolonged postictal encephalopathy.</p> <p>Resident Orders dated [DATE] revealed to chart Resident observations and functional assessments twice a day at 7:00 AM and 7:00 PM. There was no documentation in R72's medical record of a Resident observation and functional assessment at 7:00 PM on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Labs Administration History dated [DATE] - [DATE] revealed a Basic Metabolic Profile (BMP) and Complete Blood Count (CBC) were to be obtained on [DATE] at 2:00 AM. There was no documentation the labs were obtained or a reason why the labs were not obtained.</p> <p>Review of R72's Progress Notes, dated [DATE] at 6:58 AM and completed by RN1, located in the EMR under the Progress Notes tab, revealed around 4:55 AM this nurse was alerted in this resident's room. He was twitching muscles and having a seizure with episodes of hypoxia. Res [resident] is at 2 lp [liters per minute] of O2 [oxygen] via nasal cannula. O2 sat [saturation] @ [at] 88% [percent] when checked. res positioned of left side and oxygen was regulated at 4LPM. O2 sat went up to 93%. BP- [blood pressure] , d+[DATE]. PR- [pulse rate] 128, RR-[respirations] 21 this res had a seizure episode 4x [four times] in 20 mins. MD [Medical Director] was informed and ordered to sent [sic] the res in [sic] the ER [emergency room] . sister was informed. EMS [emergency medical services] came at 5:20 AM. There was no documentation in the medical record staff followed the facility policy and documented the seizure activity in detail (location, duration, severity, recurrence) and described signs and symptoms including the resident's vital signs, current level of consciousness, cognitive ability, speech, physical function, abnormal motor activity, tremors, overall physical condition, and a comparison of the resident's current status to his/her (baseline) level of cognition and function.</p> <p>Review of the Observation Detail List Report for R72 dated [DATE] at 7:17 AM for R72 revealed, . Neurological Evaluation seizure .Primary Care Clinician Notified [DATE] 05:20 AM .Name of Family/Health Care Agent Notified [DATE] 05:25 AM . R72's physician was notified 25 minutes after the Resident had started seizure activity. There was no documentation of attempts to contact an alternate physician or the Medical Director per facility policy. R72's family was notified 30 minutes after R72's seizure activity.</p> <p>R72 was admitted to the hospital with status epilepticus. R72's Valproic Acid (Depakote level on admission the to the hospital was 44 (normal being 50 - 120). R72 was transferred to inpatient Hospice on [DATE] with diagnoses including status epilepticus, acute encephalopathy, acute respiratory failure and comatose. R72 expired at Hospice on [DATE].</p> <p>3. During an interview on [DATE] at 7:58 PM, Registered Nurse (RN) 1 stated R72 had four seizures in 20 minutes on [DATE] and the seizures began at 4:55 AM. RN1 also stated she placed R72 on his left side in the bed, monitored his vital signs, and increased his oxygen, but did not check his blood sugar. RN1 stated she attempted to call the physician; however, there was no answer. RN1 also stated she called 911 after R72 had two seizures, and R72 had another seizure while waiting for EMS to arrive, then had a fourth seizure when EMS arrived at the facility. RN1 verified R72 did not have an order for a benzodiazepine, and she needed an order from R72's physician to administer any medications from the first dose pharmacy refrigerator which she did not have time to do. RN1 confirmed she was not trained on the seizure protocol and did not know exactly how long the seizures lasted but thought they lasted three minutes with a couple of minutes in between each seizure. RN1 acknowledged she did not delegate any tasks to other nursing staff during the seizure episodes.</p> <p>During an interview on [DATE] at 9:13 AM, the former Director of Nursing (DON) stated she expected RN1 to notify R72's physician after the first seizure to obtain orders to try to stop the seizure which included an order for Ativan (a benzodiazepine) injection which was available in the first dose pharmacy refrigerator. The former DON also stated RN1 should have documented the time of the call made to the R72's physician (Medical Director) and details of the seizures.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 9:21 AM, the Medical Director, R72's physician, stated she expected the nurse to notify her after the first seizure. The Medical Director also stated had RN1 contacted her after the first seizure, she would have ordered Ativan 1 MG intermuscular (IM) injection which was in the first dose box in the refrigerator, and then she would have ordered R72 to be transferred to the hospital. The Medical Director verified she was contacted by RN1, and she gave the order to send R72 out to the hospital on [DATE] but did not know what time RN1 contacted her. The Medical Director also stated documenting the time of the onset of the seizures, duration, and time in between were important factors in determining the type of seizure and treatment for the seizure. The Medical Director indicated if a seizure was prolonged then it could lead to brain damage or death that is why timely treatment was important. The Medical Director further stated she was the only provider for the facility and there was no other provider for the facility to call if they could not reach her.</p> <p>During an interview on [DATE] at 12:55 PM, the DON stated she completed the quality improvement tool for the rehospitalization of R72 on [DATE]. The DON stated R72 was discharged from the hospital too soon, had a new onset of seizures with a recent change in antiseizure medication, and was not stable when he was admitted to the facility. The DON also stated RN1 should have recorded how long the seizures lasted, the time lapse in between seizures and asked another nurse to keep the resident safe while she notified the Medical Director the resident had the first seizure.</p> <p>During an interview on [DATE] at 6:23 PM, the Administrator confirmed R72 passed away at an inpatient hospice on [DATE]. On [DATE] at 6:20 PM, the Administrator stated RN1 contacted the Medical Director on [DATE] at 4:59 AM but the Medical Director did not answer the call and there were no other providers to contact at the facility.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 09262</p> <p>Based on observation, interview, record review, review of manufacturer's instructions, and review of the facility's policy, the facility failed to ensure residents were provided and received pharmaceutical services to meet the needs of each resident for one of 30 sampled residents (Resident (R) 76) and for three of 15 supplemental residents (R123, R20, and R21). R123's medications were not delivered timely by the pharmacy and the resident was not administered her medications as ordered by her physician. Also, R20's medications were administered via the resident's gastronomy tube (G-Tube); however, the nurse did not check the resident's G-Tube placement prior to the administration of the medications. Additionally, the nurse failed to prime R21's insulin syringe per the manufacturer's instructions prior to administering the resident's insulin. Furthermore, R76's discontinued medication was not disposed of/destroyed per the facility's policy. These failures placed the residents at risk of complications from their medications not being administered per physician's order and manufacturers recommendations; and placed resident's medications that were supposed to be destroyed at risk to be misappropriated.</p> <p>Findings include:</p> <p>1. Review of the facility's policy titled, Medication Ordering and Receiving from Pharmacy, dated [DATE] indicated, Ordering and receiving .Policy, Medications . are received from the provider pharmacy on a timely basis. The facility maintains accurate records of medication orders and receipts. 3. New orders are ordered and scheduled to begin after the next regular pharmacy delivery. Stat and emergency medications are ordered as follows: a. Emergency or STAT [one-time order that is administered without delay due to the urgency of the circumstances] medication should be obtained from the emergency box/kit. If the emergency or STAT medication is not available int he emergency box/kit, then the prescriber should be notified of available alternatives .</p> <p>Review of the Medication Pass Reminds on Medication Carts in-service dated [DATE] provided by the Administrator revealed, 38 .Check the first dose boxes for medication availability. There are 4 first dose boxes available, Box A, Box B, IV Box and a controlled substance emergency kit. For new orders, if medication is unailable in the center, contact the prescriber for further instructions, if medication is needed prior to normal delivery, contact pharmacy immediately .</p> <p>Review of R123's undated Face Sheet located in the resident's electronic medical record (EMR) revealed the resident was admitted on [DATE] at 4:30 PM.</p> <p>During an interview on [DATE] at 9:0AM, Family Member (F) 123 stated R123 was admitted to the facility on [DATE]. F123 stated the resident was a Type 1 diabetic and she took three short acting insulins. F123 stated R123's insulin was not provided until the next day ([DATE]) around 3:00 PM. F123 stated R123's blood sugar ran around 400. F123 further stated the resident did not receive her eye ointment medication she received in the hospital until [DATE]. F123 also stated R123 received pain medication every four hours in the hospital; however, the resident did not receive the pain medications nor a muscle relaxant medication or her eye ointment. F123 stated that last night ([DATE]) was the first time R123 received eye ointment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R123's EMR Progress Notes tab indicated, [DATE] at 4:18 PM, Patient prescription orders have been entered and verified based upon medication information received prior to the patient's admission. Prescription orders have been submitted to pharmacy.</p> <p>Review of R123's Medication Administration Record (MAR) dated [DATE] and located in the resident's EMR under the Reports tab revealed the ordered medications of: oxycodone (narcotic pain medication) 10 mg tablet every four (4) hours as needed (PRN); Erythromycin (an antibiotic medication) eye ointment 5 mg [milligram]/gram QD [every day] at 7:30 PM; Furosemide (a diuretic medication) 40 mg QD at 7:30PM; insulin glargine 100 units/ml QD at 7:30PM; losartan (medication used to treat high blood pressure) 50 mg; and metoprolol tartrate (medication used to treat high blood pressure) 25 mg QD at 7:30PM were not administered to R123 to the resident as ordered by their physician.</p> <p>Review of R123's MAR dated [DATE] revealed the medications insulin lispro 100 units/ml QD at 10:00 AM and Furosemide 40 mg QD at 7:30PM were documented not administered to R123.</p> <p>Review of R123's MAR dated [DATE] revealed Furosemide 40 mg QD at 7:30PM was documented not administered to R123.</p> <p>Review of R123's Care Plan located in the resident's EMR under the Care Plan tab revealed, Problem: I am at risk for pain/discomfort as I am post-hospitalization for generalized weakness, poor appetite, constipation, bladder spasms/dysuria, nausea and increased lower back pain. Comorbidities include Diabetes Mellitus 2, Hypertension, Coronary Artery Disease .Neuropathy, Spinal stenosis, left eye blindness (DM Retinopathy) and Chronic back pain .Impaired mobility and generalized weakness indicated. Requires the use of diuretic, muscle relaxant and narcotic pain medication for SX [symptom] management. I have scheduled spine surgery for [DATE]. The Care Plan goal indicated the resident would state when in pain and/or be free from nonverbal indicators of pain such as tense facial expressions, guarding of body parts, restlessness. Another Care Plan problem indicated, I am at risk for hypo/hyperglycemia as I am a diabetic with the goal of I will not have untreated complications of hypo/hyperglycemia.</p> <p>Review of the First Dose Inventory list provided by the Director of Nursing (DON) revealed the medications Oxycodone 10mg one tablet; Erythromycin eye ointment 5 mg/gram; Furosemide 40 mg; insulin glargine 100 units/ml; losartan 50 mg; and metoprolol tartrate 25 mg were available per the list and could have been administered to the resident.</p> <p>During an interview on [DATE] at 8:38 AM, Licensed Practical Nurse (LPN) 6, unit manager for [NAME] unit, stated prior to a resident being admitted , the medications go to the Network (pharmacy) and remained in pending status. Continued interview revealed once the resident was admitted to the facility, the admitting nurse or unit manager rechecked the medications and then the medications were moved to active status in the facility's EMR system. LPN6 stated once the medications were entered the facility's EMR system (Matrix) the medications should have been sent to the facility on ce the pharmacy received the order. LPN6 also stated if the medications did not arrive on time, the nurse should have gone to the First Dose boxes and refrigerator in the East medication room and obtain the medications after obtaining a onetime order. LPN6 stated if the medications were not in the First Dose boxes or the refrigerator, then the nurse would call the physician and either get the order changed to a drug in the First Dose box or call the medication to the local pharmacy which was the CVS.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 9:59 AM, the Medical Director (who is also the resident's physician) stated she would have expected the medications to be delivered to the facility in a timely manner. She stated something as important as insulin could have come out of the First Dose box, or the nurse should have called the physician and see if another insulin could be used out of the First Dose Box.</p> <p>During an interview on [DATE] at 10:59 AM, the DON reviewed R123's MAR dated [DATE] and [DATE]. The DON confirmed R123 did not receive her insulin at 7:30 PM and her other medications on [DATE]. The DON stated she could not recall any nurse calling her for guidance of what to do since the insulin and the pain medication were not available to be administered timely. The DON stated she found in her pharmacy chat, that LPN3 sent a message to pharmacy asking if anything was needed so the facility could get the resident's oxycodone, and she had already used the two doses in the back up box. The DON confirmed R123 did not receive any narcotic pain medication on [DATE]. The DON reviewed the EMR Vitals tab and stated on [DATE] the pain assessment indicated no assessment for R123's pain level in the vitals section which indicated the pain was not assessed as there was no observation assessment completed. The DON also confirmed there was not anything documented in R123's EMR Progress notes. The DON stated the first progress note about pain assessment was on [DATE] at 8:09 AM and R123's pain level was eight out of 10 with 10 being severe pain.</p> <p>During an interview on [DATE] at 3:33 PM, LPN5 stated the pharmacy delivered the medications around midnight. LPN5 also stated when the medications arrived, he did not administer the medications because he thought it would have been too close to the next time the medications had to be administered. LPN5 stated he did not check the First Dose inventory list because he knew the medications would be delivered around midnight.</p> <p>2. Review of the facility's policy titled, Specific Medication Administration procedures, Enteral Tube Medication Administration .G. Auscultation is no longer recommended for checking placement of the feeding tube .H .check gastric residual volumes .</p> <p>Observation and interview during R20's medication pass on [DATE] at 9:08AM, LPN4 stated that the resident had an order to mix all of the liquid medications and crushed pills. LPN4 added to the cup Multi Vitamin liquid 5 cubic centimeters (cc), then added CertaVite-Antioxidant (vitamin medication) liquid, then added Levetiracetam (medication to treat epilepsy) 100 milligram (mg) 5 cc liquid, then added Potassium Chloride (KCL) (Potassium supplement) 15 cc to the cup, then crushed the following tablets: Lisinopril (blood pressure medication) 5 mg one tab, Metformin (medication for the treatment of Type 2 diabetes) 800 mg one tablet, Acetazolamide (medication to treat seizures) 250 mg one tablet, Amiodarone 100 mg one tablet, and Lasix (diuretic medication) 20 mg one tablet and added the crushed pills to the liquids medications in the cup. LPN4 entered R20's room, applied gloves, placed a barrier on the bedside table, then took the bulb syringe tube and added water to the tube, then the liquid medication mixture, and then flushed the tube with water. LPN4 did not check the Gastrostomy tube (G-Tube for residual prior to administering the water and the liquid medications.</p> <p>Interview on [DATE] at 10:05AM, LPN4 stated that she was supposed to check residual before administering water and the medications.</p> <p>Review of Nursing Inservice Training dated [DATE] revealed LPN4 did not attend the in-service training regarding checking placement of G tube</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Administrator on [DATE] at 10:45AM, she confirmed that LPN4 did not attend the training and that LPN4 had no other training</p> <p>Review of the Medication Pass Reminds on Medication Carts in-service dated [DATE] provided by the Administrator revealed, .Peg tube medication administration .check gastric residual .</p> <p>The Administrator confirmed that LPN4 did not attend the in-service training and that there was no other in-service training that LPN4 attended regarding checking the placement of the G-tube.</p> <p>Review of the facility's policy titled Preparation and General Guidelines dated [DATE] indicated General guidelines for Administering Medication Via Enteral Tube, Procedure, B. Inservice training on .administration . of enteral solutions and medications via the enteral tube is provided by the facility to nursing personnel as needed .</p> <p>3. Review of the Humalog insulin Manufacturer's Instructions provided by the Consulting Pharmacist indicated, Priming your pen, Prime before each injection, priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensure that the pen is working correctly . If you do not prime before each injection, you may get too much or too little insulin .</p> <p>Observation on [DATE] at 12:02 PM, Registered Nurse (RN) 2 checked R21's blood glucose level using the glucometer, and the result was 164. RN2 stated at this time R21 would require two units of Humalog insulin per the sliding scale on the MAR dated [DATE]. Continued observation revealed RN2 removed R21's Humalog insulin pen from the medication cart, dialed two units, entered R21's room and administered the insulin to R21's abdomen. RN2 held the needle in R21's skin for five seconds. RN2 was observed to not prime the Humalog insulin syringe prior to dialing the two units of insulin for a blood sugar of 164.</p> <p>During an interview on [DATE] at 12:15 PM, RN2 stated she thought the insulin pen only had to be primed the first time the pen was used.</p> <p>During an interview on [DATE] at 12:42 PM, the Consulting Pharmacist stated the Humalog insulin pen was to be primed every time the pen was used.</p> <p>Review of the Medication Pass Reminds on Medication Carts in-service dated [DATE] provided by the Administrator revealed, .Medication Administration .43. Insulin pens, Pen must be primed with 2 units prior to each dose . The in-service attendance sheet indicated RN2 did not attend the in-service training.</p> <p>During an interview on [DATE] at 10:54 AM, the Administrator confirmed that RN2 did not attend this in-service training and that there was no documentation of any other in-service training that RN2 attended regarding priming the insulin pen.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of the facility's policy titled, Disposal of Medications and Medication Related Supplies dated [DATE] indicated, Medication Destruction for Non-Controlled Medications, Policy, Discontinued medications, and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy .Procedures. A. Unused .discontinued, expired, and non-returnable medication should be removed from their storage area and secured until destroyed, this medication may be stored in the medication room in a designated area until destroyed. Destruction should be done within 14 days .F. All destroyed medications shall be documented on a medication disposition form .</p> <p>Review of the TN00064574 intake revealed the allegation, Report of staff taking medication from the destruction box to give each other medication. On Monday, [DATE], a unit manager gave another unit manager an IM injection of both Zofran and Phenergan [antiemetic medication] without an order. The Zofran came from the MDS nurse who kept the vial in her desk drawer. The unit manager drove home after that . The DON notified Regional about the incident which both unit managers admitted to but said it is a practice they have always been able to do. There was no disciplinary action taken .</p> <p>Interview on [DATE] at 9:00AM, LPN1 stated that she has been the unit manager since 2020. LPN1 stated that she took the Zofran medication out of the drug destruction box and administered the medication IM to LPN2. LPN1 stated that LPN2 was still employed at the facility. LPN1 stated that LPN2 had stomach flu when she came to work. She stated that she removed the Zofran vial from the drug destruction box, and once she gave the injection to LPN2, she threw the vial into the sharps container and did not record the vial on the drug destruction record.</p> <p>Interview on [DATE] at 3:44PM, LPN2 stated that the incident did occur. LPN2 stated that LPN1 gave her the IM Zofran injection and she thinks she only received Zofran.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>07342</p> <p>Based on observation, interview, and review of the facility's policy, the facility failed to ensure food was stored, prepared, and distributed in accordance with professional standards. The deficient practice has the potential to 80 of 82 residents who receive food by mouth and placed residents at risk for food borne illnesses.</p> <p>Findings include:</p> <p>Observation on 09/02/24 at 9:10 AM revealed bacon bits wrapped in cellophane the size of a football in the first reach in cooler in the main kitchen. The bacon bits were not labeled and dated. The observation also revealed a Styrofoam divided container with spareribs, macaroni and cheese, and potato salad in the first reach in cooler in the main kitchen. The items were not labeled or dated. Continued observation revealed numerous small, dark colored flying insects (too numerous to count) near the reach in coolers, and the three compartment sink, and the floor drain in the main kitchen.</p> <p>Observation on 09/02/24 at 9:15 AM revealed small flying insects near the dishwashing machine. During an interview at the time of each observation, the Food Service Supervisor (FSS) verified the unlabeled and undated food contents in the cooler. The FSS stated the facility had treated the drains for fruit flies; however, she was unable to produce invoices of treatment from a pest control company or the facility maintenance department. The FSS did not recall the last time the drains were treated for fruit flies.</p> <p>Observation on 09/02/24 at 9:15 AM of the dish machine in operation revealed the dish machine was washing dishes, trays, and lids for use at the next meal. The dish machine relied on sanitizing solution to thoroughly rinse the washed items in a low temperature dishwashing machine and to sanitize the washed dishes. The container of sanitizer had less than one inch at the bottom of the one-gallon container and was not dispensing solution through the clear tube leading to the dishwasher in two cycles. Both wash cycles were observed at 40 seconds at 136 degrees Fahrenheit and the rinse cycles were observed at 127 degrees Fahrenheit for 30 seconds. The two racks of dishes were then stored and put back into circulation.</p> <p>During an interview at the time of the observation, the FSS verified the dishwashing solution was not dispensing into the dishwasher. She located a five-gallon container and attached the tubing to the full container now supplying the dishwasher with sanitizing solution.</p> <p>Observation on 09/02/24 at 9:20 AM revealed a large red spill in the walk-in freezer measuring three feet long by one foot wide.</p> <p>Observation and interview on 09/03/24 at 8:45 AM revealed a large red spill in the walk-in freezer which indicated the spill had not been cleaned up from the prior day. The FSS verified the spill and then cleaned the spill up.</p> <p>Observations on 09/02/24 at 9:20 AM of the main kitchen revealed the ceiling had peeled paint hanging from the ceiling above the food preparation area near the stove.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview at the time of the observation, the FSS verified the peeling paint over the food preparation area and indicated maintenance requests had been made; however, nothing had been repaired. The FSS was unable to produce maintenance requests she or her staff had made about the peeling paint noted above.</p> <p>Observations on 09/02/24 at 9:25 AM and on 09/03/24 at 8:50 AM in the main kitchen revealed an electrical outlet on the wall near the stove was coated in food debris.</p> <p>Observations on 09/02/24 9:25 AM and 09/03/24 at 8:50 AM of the wall and ceiling in the main kitchen near the outlet above and stainless-steel shelf container revealed a large amount of food splashes in brown and red in color.</p> <p>Observation of the white exit door to the main dining room from the main kitchen and the locker room door inside the main kitchen to be marred with serve amounts of black stains and dirt with other multi-colored stains over the entire width of each door extending two feet on each side of the door handle vertically.</p> <p>Observation on 09/03/24 from 8:50 AM to 9:40 AM of the handwashing sink in the main kitchen revealed the sink lacked paper towels to dry hands after washing them. Staff were observed at 8:50 AM and 9:30 AM washing their hands and attempting to air dry hands by waving their hands back and forth.</p> <p>During an interview on 09/03/24 at 9:40 AM, the FSS indicated the maintenance department was responsible for changing the paper towels. When asked who changed the paper towels on weekends when maintenance was not available, the FSS shrugged her shoulders and stated, "[I] don't know." She also verified all the splash and food debris on the walls, ceiling and electrical outlets.</p> <p>Observation on 09/03/24 at 10:50 AM revealed the FSS was taking seven mighty shakes to the cooler in the food service area outside of the main kitchen. She was holding stickers in her hand and applying the stickers to each shake. Further observation revealed 21 mighty shakes in the cooler near the steam table without labels. Each carton or mighty shake had a warning label that stated thaw before using. Use within 14 days of thawing."</p> <p>During an interview on 09/03/24 at 1:00 PM, the Regional Dietician indicated she did not have a policy for the distribution and labeling of shakes.</p> <p>During an interview at the time of the observation, the FSS indicated the shakes she was labeling just came off the truck and were now being used. The shakes were thawed. She could not explain the thawing dates for the seven in her possession or the 21 in the refrigerator as to when they were thawed. When asked further questions as to the thawing of the shakes, the FSS acknowledged the shakes were shipped frozen and therefore arrived frozen and had not been thawed prior to her adding stickers. She verified she did not know how long the seven or 21 shakes had been thawed.</p> <p>Interview with the Regional Dietician on 09/04/24 at 4:00 PM revealed that she confirmed and verified all of the above items reviewed and observed earlier in the week. She indicated the facility is waiting for state approval to remodel the entire main kitchen area and expand. She also indicated she has brought in maintenance staff to clean up and paint the main kitchen area.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>07342</p> <p>Based on record review, interview, review of facility policies and procedures, the facility failed to ensure that the binding arbitration agreement signed by residents or legal representatives was understood by the residents for two of three residents (Resident (R) 224 and R226) reviewed for arbitration agreements. This failure placed the residents at risk of entering into an agreement they did not understand.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Arbitration and Financial Agreement Instructions dated 09/2019, under the instructions for ending first stage of the interview indicated in highlighted text .just as important is how the information was explained and the circumstances surrounding that point in time.</p> <p>1. Review of R224's Binding Arbitration Agreement, dated 08/26/24 revealed the agreement was signed by R224.</p> <p>Review R224's Minimum Data Set (MDS) with an assessment reference date (ARD) of 08/29/24 and located under the RAI tab of the EMR revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact.</p> <p>During an interview on 09/05/24 at 11:05 AM, when asked if she understood or signed a binding arbitration agreement, R224 stated no she did not understand and did not remember signing.</p> <p>2. Review R226's Binding Arbitration Agreement, dated 08/26/24 revealed the agreement was signed by R22's friend.</p> <p>Review R226's MDS with an ARD of 09/01/24 and located under the RAI tab of the EMR revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact.</p> <p>During an interview on 09/05/24 at 11:30 AM stated she did not understand what was signed and indicated I signed a lot of papers, not sure what they all meant.</p> <p>During an interview on 09/04/24 at 3:45 PM, the Admissions Director stated she was not aware that a legal representative had to sign if the resident did not understand. She indicated she explained the document to both residents and friends but apparently, they did not understand.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Springfield		STREET ADDRESS, CITY, STATE, ZIP CODE  608 8th Ave East Springfield, TN 37172	
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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>26190</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure Certified Nurse Aides (CNAs) performance evaluations/reviews were completed on a periodic basis, which may be annually for two of three CNAs (CNA1, CNA3) whose personnel files were reviewed. Due to this failure the facility was not able to develop and maintain an in-service training program for certified nurse aides as determined by the nurse aide performance evaluations/reviews.</p> <p>Findings include:</p> <p>Review of CNA1's (date of hire 01/17/17) performance evaluation titled Partner's Incentive for Excellence Customer Satisfaction Evaluation dated 02/27/20 indicated CNA1 had not received an evaluation for a four-year time period.</p> <p>Review of CNA3's (date of hire 08/07/00) performance evaluation titled Partner's Incentive for Excellence Customer Satisfaction Evaluation dated 12/10/08 indicated CNA3 had not received an evaluation for a seven-year time period.</p> <p>During an interview on 09/05/24 at 3:15 PM, the Administrator confirmed the performance evaluations for CNA1 and CNA3 were overdue.</p> <p>Review of the facility's policy titled, Human Resources Policies and Procedures dated 10/06/23 stated, . Frequency of Performance Appraisals .Formal: 1. The supervisor is required to complete a timely performance appraisal for every partner at least annually .3. More frequent performance appraisals may be conducted when supervisors deem necessary .</p>		