| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445123 | A. Building<br>B. Wing | 12/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ascension Living Alexian Village Tennessee | 671 Alexian Way<br>Signal Mountain, TN 37377 |

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) |
|---|---|
| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility investigation review, and interviews, and corrective action plans, the facility failed to prevent significant medication errors for 1 (Resident #99) resident of 4 residents reviewed for medication administration. Registered Nurse (RN) M administered medications intended for another resident to Resident #99 in error. The medication error caused Resident #99 to develop severe hypotension (low blood pressure) resulting in hospitalization. The facility's failure to administer medications according to physician's orders resulted in HARM to Resident #99. The facility was cited at F-760 as Past Non-Compliance. No further corrective actions are required. Non-Compliance began 9/1/2025 and ended on 11/17/2025. The findings include:Review of the facility policy titled, Administering Medications, dated 12/2024, revealed .Medications shall be administered in accordance with orders .per best practice/regulatory guidelines .The individual administering medications verifies the resident's identity before giving medications .The individual administering the medication must check the label 3 times to verify right resident, right medication, right dosage, right time and right .route of administration .before giving the medication . Review of the medical record revealed Resident #99 was admitted to the facility on [DATE] with diagnoses including Hemiplegia, Affecting Right Dominant Side, Atrial Fibrillation, Hypertensive Chronic Kidney Disease, Hypertension, and Anemia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #99 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #99 required supervision by staff with activities of daily living.Review of the facility investigation and witness statements dated 9/1/2025, revealed at approximately 8:25 AM, RN M obtained medications from the medication cart which were prescribed to another resident located next door to Resident #99. RN M failed to check the medication labels for the correct resident, medication, dosage, and time prior to the administration of the medications to Resident #99. RN Mfailed to identify the medication error that had occurred during the documentation of the medication administration to Resident #99. Resident #99 became symptomatic at approximately 10:25 AM (2 hours after administration of the incorrect medications) when he reported dizziness, and lightheadedness, and questioned the nurse as to what medications he had been given. RN M discovered she had administered medications intended for another resident located in the room next door to Resident #99, in error. Resident #99 received incorrect medications of Isosorbide Mononitrate Extended Release Tablet 120 milligrams (mg) (medication used to treat Coronary Artery Disease and lowers blood pressure), Jardiance 10 mg tablet (medication used to treat Diabetes, Heart Failure and Chronic Kidney Disease which lowers blood pressure and blood sugar levels), Losartan 50 mg tablet (medication used to lower blood pressure), Mucinex 600 mg (a decongestant), Pantoprazole 40mg (a medication used to treat gastric reflux) and Vitamin D3. Continued review of the facility investigation and nursing notes dated 9/1/2025, revealed .[Resident #99] was given wrong packet of medications .not his .but the person in neighboring room .Resident's BP [blood pressure] was 90/60 HR [heart rate] 53, BG [blood glucose] 168 .Nurse realized he was given wrong meds[medications] .contacted MD [medical doctor] .told to push fluids .give salty and sugary snack to counter [counteract medications] and recheck in half hour .When BP continued to<br>(continued on next page) |

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 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | drop 59/36 [critical low] MD ordered IV [intravenous fluids].500 ML [milliliter] bolus .Following bolus, BP improved to 76/53 [critical low] and MD ordered second 500 ML bolus .IV was lost [unable to be used] trying to set up second bolus .Resident reported 'seeing black things' and MD ordered him sent out [emergency room )ER)] and skip placing a new IV .911 was called .Resident was sent to [hospital] .Review of the regional hospital emergency department (ED) medical records for Resident #99 dated 9/1/2025, revealed .Chief Complaint . [Resident #99] is an 85 y.o. [year-old] male admitted [to the ED] with .hypotension .Patient [Resident #99] is direct transfer from [satellite hospital] due to medication error at SNF [skilled nursing facility] .Patient was inadvertently administered another patient's medications .received Isosorbide Mononitrate 120mg, Jardiance 10mg, Losartan 50mg .Mucinex 600mg, Pantoprazole 40mg and Vitamin D3 . Continued review revealed .After patient [Resident #99] was mistakenly given wrong medications .about 1.5 hours later he complained about light headedness, his BP rapidly trended down .An IV was started at the SNF .but was quickly sent by EMS to the [satellite hospital] ED where he arrived with a BP of 82/51 [low] He received another 500ml bolus en route to the ED .Received another 1500ML NS [Normal Saline] [bolus] at [satellite hospital] en route to [regional hospital ED] .On arrival.BP was 80/50 [low] and another 500 ML NS bolus was ordered . Continued review revealed .Subsequent BPs have been 99/57, 94/53, and 96/54 .All antihypertensives suspended and no meds prescribed that might adversely impact BP .He is awake, alert, oriented x4 [person, place, time, and circumstances] .denies any complaints .understands situation .Patient [Resident #99] is admitted for observation [to the hospital] overnight .once BP is stabilized . and side effects are resolved .During an interview on 12/9/2025 at 11:37 AM, RN M stated on the morning the error was made (9/1/2025), she was distracted as she spoke to another staff member while preparing medications from the medication cart. RN M stated she had inadvertently pulled the wrong medications (intended for another resident) from the medication cart and administered the medications to Resident #99, in error. RN M confirmed at the time of the medication error, she had not checked the labels or medications according to established clinical standards and facility policy, to verify the correct resident, medication, dosage, time, or route of administration before administering the medications to Resident #99.During an interview on 11/9/2025 at 11:50 AM, the Director of Nursing (DON) confirmed the facility investigation and root cause analysis conducted by the facility in response to the significant medication error of Resident #99 was a result of RN M violating facility policies, and not following the clinical standards of practice related to safe medication administration, which led to the severe hypotension, and hospitalization (HARM) to Resident #99. The facilities corrective action plans were reviewed, verified, and validated on site by the Surveyor from 12/8/2025 - 12/10/2025 as follows:On 9/1/2025, RN M informed facility administration of the error as soon as it was determined on 9/1/2025 and began monitoring and documenting Resident #99's vital signs and clinical status. The nurse and facility supervisor immediately notified the attending Physician and Responsible Party for Resident #99 of the error and impacts on the resident. The Physician ordered supportive treatments. The nurse and supervisory staff completed all required internal documentation of the incident which was reported to facility leadership. On 9/1/2025, an Ad HOC (unplanned meeting for a specific urgent purpose) Quality Assurance (QA) meeting of the incident was performed which included the house supervisor, DON, and the physician by phone, which was verified and validated onsite by the surveyor through review of the QA meeting minutes, sign in sheets, and interviews of administrative staff and physician from 12/8/2025 - 12/10/2025.On 9/1/2025, the facility Quality Director and DON performed a full audit of all medication carts in the facility for all resident medications and no other medication errors were identified. Surveyor verified and validated onsite from 12/8/2025 - 12/10/2025 through review of audits, documentation, and multiple staff interviews with no concerns identified. 0n 9/1/2025, after the facility investigation and root cause analysis was conducted, the facility initiated immediate re-education of all licensed nurses on duty which was conducted by the House Supervisor and the Quality Director related to the 5 rights of medication administration, standards of practice related to<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | medication administration, and facility policy. All staff who were not on duty between 9/1/2025-9/2/2025 were required to complete online re-education prior to start of their next scheduled shift. Staff Education for all licensed nursing personnel was completed by 9/5/2025. Surveyor verified and validated onsite through review of staff education, sign in sheets, and facility documents, and through multiple staff interviews conducted on 12/8/2025 - 12/10/2025. On 9/5/2025, RN M received corrective counseling which was documented in the personnel file. RN M was reassigned to an alternate clinical unit after completion of counseling and re-education related to the five rights of medication administration. Surveyor verified and validated onsite RN M had received corrective counseling and was knowledgeable about the 5 rights of medication administration through employee record review and interview conducted on 12/10/2025. On 9/5/2025, the facility Quality Assurance (QA) Team reviewed the incident findings and ordered additional interventions which included Pharmacy Audits for 4 weeks that included observations of medication administration for accuracy and medication administration competency testing conducted from 9/5/2025 through 9/30/2025. The surveyor verified and validated onsite through review of the completed Pharmacy Audits, nurse competency testing, observations of medication administration, and medical record review of physician orders from 12/8/2025-12/10/2025. The facility QA team re-evaluated findings of the weekly audits and identified no other errors had occurred, and additional education related to medication administration and related facility policies, was completed on 10/20/2025. The QA team elected to continue observations and knowledge checks for two additional periods performed on 10/21/2025 and 10/30/2025 with no additional negative findings. The surveyor verified and validated onsite through facility documentation review from 12/8/2025 - 12/10/2025. The Surveyor verified, the facility continued with observations and knowledge checks with no concerns identified. The QA team conducted additional medical record reviews of randomly selected residents on 10/20/2025 - 11/17/2025. Nursing leadership reviewed findings in daily morning meetings with all the department heads. The facility continued with weekly medication cart audits by the DON and these audits were implemented as a measure to maintain sustained compliance and were ongoing at the time of the State Agency Recertification Survey with no additional medication errors identified. The surveyor verified and validated onsite through facility documentation review, weekly audit reviews, and interviews. The facility continues with ongoing audits with no concerns identified. The State Survey Agency (SA) corroborated the staff had received education and retraining related to the incident, medication errors, medication administration, following standards of practice, and the 5 rights of medication administration. The education was performed as reported/documented and verified through multiple staff interviews, and observations of medication administration passes conducted throughout the onsite recertification survey. No medication errors were observed during surveyor observations. No medication errors were detected during clinical record reviews of sampled residents. Quality Assurance sign-in sheets were also reviewed and corroborated with the corrective actions reported and the corresponding timeline and facility investigation documents. The facility's Medical Director confirmed participation in the QA meeting of the incident during interview on 12/9/2025.Review of the medical record revealed Resident #99 returned to the facility after an overnight hospitalization observation (9/2/2025) and completed his rehabilitation at the SNF without further incidents. Close monitoring of the resident was documented upon his return and continued until his eventual discharge back to an assisted living on 9/5/2025. At the time of the State Agency survey, Resident #99 remained in stable condition as a resident at the adjacent assisted living center on campus where he lived with his spouse. |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation and interviews, the facility failed to ensure staff promoted resident dignity during dining for 1 resident (Resident #26) of 7 residents observed during dining.The findings Include:Review of the facility's undated policy titled, Tennessee Notices .Nursing Home Resident Rights, revealed .you [the resident] have the right to a dignified existence .a facility environment must treat each resident with respect and dignity and care for each resident in a manner .that promotes maintenance or enhancement of his or her quality of life .Review of the medical record revealed Resident #26 was admitted to the facility on [DATE] with diagnoses including History of Stroke with Hemiplegia, Aphasia, and Atrial Fibrillation.Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #26 had severely impaired cognitive skills for daily decision making, and required substantial/maximal assistance with eating. During an observation on 12/8/2025 at 12:20 PM, Licensed Practical Nurse (LPN) O was in the 8th floor dining room, standing up awhile assisting Resident #26 with the lunch meal.During an interview on 12/8/2025 at 12:30 PM, LPN O stated, .I get antsy sitting too long, so I usually stand up if I'm feeding a resident, and we have several feeders [referring to residents who require assistance to eat] so I just kind of bounce around . During an interview on 12/8/2025 at 2:00 PM, the Registered Nurse/Director of Quality Management (RN/DQM) stated standing while assisting the resident to eat and referring to resident's who required assistance with eating as feeders did not maintain resident's dignity. The RN/DQM confirmed staff were expected to maintain resident dignity during meals by sitting at the resident's eye level when assisting residents during dining and should not refer to residents as feeders. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, review of the medical record, observation, and interview, the facility failed to ensure call lights were within reach for 1 resident (Resident #41) of 18 residents reviewed on the 800-west hallway. The findings include:Review of the facility policy titled, Procedure: Answering the Call Light, dated 1/2024, revealed .The purpose of this procedure is to respond to the resident's requests and needs. The community [facility] should be adequately equipped to allow residents to call for assistance .when the resident is in bed .be sure the call light is within reach of the resident .Review of the medical record revealed Resident #41 was admitted to the facility on [DATE] with diagnoses including Anemia, Coronary Artery Disease, Hypertension, Parkinsons, and Depression.Review of the comprehensive care plan for Resident #41 dated 5/19/2025, revealed .[Resident #41] is at risk for impaired communication related to cognitive impairment .[Resident #41] will be able to communicate some of her basic needs effectively .Call light in reach .Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #41 scored a 5 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment, and required substantial/maximal assistance for personal hygiene, bathing, and toileting.During an observation on 12/8/2025 at 11:45 AM, revealed Resident #41 lying in bed with the call light hanging over the headboard of the bed and was not within reach of the resident. Further observation revealed Resident #41 was holding a chicken salad sandwich and some of the contents had fallen onto the resident's clothing. During an observation and interview on 12/8/2025 at 1:50 PM, revealed Resident #41 lying in bed with the call light hanging over the headboard of the bed and was not within reach of the resident. Resident #41 stated when she needed assistance from the staff, she .pushed a button .During an observation on 12/8/2025 at 4:12 PM, revealed Resident #41 lying in bed with the call light hanging over the headboard of the bed and was not within reach of the resident. During an observation and interview on 12/8/2025 at 4:15 PM, with Licensed Practical Nurse (LPN) F, revealed Resident #41 lying in bed with the call light hanging over the headboard of the bed and was not within reach of the resident. LPN F stated Resident #41 was able to activate the call light when she needed staff assistance. LPN F confirmed the call light was out of Resident #41's reach.During an interview on 12/10/2025 at 9:15 AM, Certified Nursing Assistant (CNA) J stated she provided care for Resident #41 routinely and the resident was able to activate the call light when she needed assistance from the staff.During an interview on 12/10/2025 at 9:20 AM, CNA G stated she provided care for Resident #41 and the resident was able to activate the call light when she needed assistance from the staff.During an interview on 12/10/2025 at 11:02 AM, the Director of Nursing stated it was her expectation for Resident #41 to have her call light in reach at all times. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's policy, review of the medical records, observations, and interviews, the facility failed to implement the comprehensive care plan for an orthotic device for 1 resident (Resident #12) and failed to update the care plan for refusal of splint use for 1 resident (Resident #39) of 5 residents reviewed for Activities of Daily Living (ADLs)/Mobility.The findings Include:Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease and Dysphagia.Review of the medical record revealed Resident #12 was transferred to the hospital on 9/11/2025, returned to the facility the same day with a new diagnosis of a fracture of the right distal fibula (bone in the lower leg toward the ankle), and the resident had a new physician's order for a tall walking boot at all times.Review of the comprehensive care plan for Resident #12 dated 9/12/2025, revealed, .resident to wear boot on her right leg at all times, can be removed during showers only . The care plan did not contain documentation of the right ankle fracture.Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #12 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact, and required substantial/maximal assistance with putting on/taking off footwear.During observations on 12/8/2025 at 10:30 AM and 2:30 PM, Resident #12 was lying in bed, and the orthotic foot boot was lying on a chair in the corner of the room.During an interview on 12/8/2025 at 2:30 PM, Resident #12 was asked if staff assists her to wear the boot on her foot, and the resident stated, .they don't put that on . but it's not hurting .During observations on 12/9/2025 at 11:00 AM and 4:00 PM, Resident #12 was lying in bed, and the orthotic foot boot was lying on a chair in the corner of the room.During an interview on 12/9/2025 at 4:00 PM, Resident #12 was asked if she wore the foot boot, and the resident stated, .no . When asked if she is supposed to wear the boot on her foot, the resident stated, .I think so .Review of the medical record revealed Resident #39 was admitted to the facility on [DATE] with diagnoses including History of a Stroke with Hemiplegia, Weakness, and Contractures of Left Arm, Hand, and Wrist. Review of the comprehensive care plan for Resident #39 dated 3/21/2024, revealed, .needs assistance with daily ADL care .left hand contracture .left wrist/hand splint-to be applied early am around 7 am .gentle stretch of left elbow prior to applying .remove around 3 pm .Review of an annual MDS assessment dated [DATE], revealed Resident #39 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact, was dependent on staff for dressing, and did not reject care.During observations on 12/8/2025 at 10:35 AM and 2:35 PM, Resident #39 was lying in bed, without a splint on her left wrist or hand.During observations on 12/9/2025 at 9:45 AM and 2:05 PM, Resident #39 was lying in bed, without a splint on her left wrist or hand.During an interview on 12/9/2025 at 2:05 PM, Resident #39 was asked if staff assists her to wear the splints on her left arm and hand, and the resident stated, .no, I told them I don't wear those because they hurt .I told [named an Occupational Therapist] .Review of the Treatment Administration Record (TAR) dated 12/1/2025 to 12/10/2025, revealed Resident #39 refused the left wrist/hand splint when staff attempted application.Review of the Nurse's notes 12/1/2025 to 12/10/2025 revealed no documentation Resident #39 refused splint application.During an interview on 12/10/2025 at 2:30 PM, the Registered Nurse/Director of Quality Management (RN/DQM) stated staff were expected to follow the care plan for orthotic use, and confirmed Resident #12 should have her foot boot on at all times. The RN/DQM stated the care plan should be updated when a resident refuses an intervention consistently so further evaluation could be conducted, and confirmed Resident #39's refusal of splints was not reflected in the resident's care plan. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and staff interview, the facility failed to ensure accurate documentation of a resident's meal intake which prevented the facility from determining whether the resident met the criteria for administering the ordered nutritional supplement for 1 resident (Resident #2) of 3 residents reviewed for nutrition.The findings Include: Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Specified Nutritional Anemia, Dysphagia, History of Subdural Hematoma, and Chronic Migraines.Review of the comprehensive care plan for Resident #2 dated 11/17/2025, revealed .at risk for unintended weight loss related to inadequate intake and dysphagia .provide nutritional supplements as ordered .Review of a Physician's Order for Resident #2 dated 11/20/2025, revealed .Give one container of Jevity [liquid nutrition supplement] if resident eats 50% or less at meals . to be administered three times daily.Review of a significant change in status Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact, and was able to feed himself with setup or clean-up assistance. Review of the facility's daily meal intake documentation for Resident #2 dated 12/1/2025 to 12/10/2025, revealed there was a total of 28 meals, the resident consumed between 25-50% for 5 out of 28 meals (lunch on 12/2/2025, breakfast on 12/3/2025, lunch on 12/4/2025, breakfast on 12/8/2025, and lunch on 12/9/2025). The documentation was not specific on whether these intakes were 25% to 49%, which would meet the physician's order criteria for the nutritional supplement, or 50%, which would not meet the physician's order criteria. Further review revealed no documentation of meal intake percentage on 8 out of 28 meals (dinner on 12/1/2025, 12/2/2025, and 12/3/2025; all 3 meals on 12/7/2025, dinner on 12/9/2025, and breakfast on 12/10/2025), preventing the facility from determining whether the resident met the criteria for administering the ordered supplement.Review of the Treatment Administration Record (TAR) dated 12/1/2025 to 12/10/2025, revealed .Give one container of Jevity if resident eats 50% or less at meals . and was to be administered three times daily at 9 AM, 1 PM, and 6 PM. There were 28 meals including breakfast on 12/10/2025, and all entries were signed off by the licensed nurses as N-Treatment Not Administered. Further review revealed the TAR contained no documentation of the reason the nutritional supplement was not administered.Review of the Nursing progress notes for Resident #2 dated 12/1/2025 to 12/10/2025, revealed no documentation for a reason the Jevity supplement was not administered. Review of the medical record revealed Resident #2 had not had any significant weight loss.During an interview on 12/10/2025 at 2:30 PM, the Director of Nursing (DON) stated staff were expected to document intake at every meal and to administer Jevity according to physician orders. The DON confirmed Resident #2's documentation 12/1/2025 to 12/10/2025 for meal intake was incomplete, the Jevity supplement was not administered, and there was no documentation related to why the supplement was not administered. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, review of the facility assessment, review of a facility document, review of resident council minutes, review of the medical record, observations, and interviews, the facility failed to ensure sufficient nursing staff as determined by the acuity of the resident population on 1 of 4 hallways observed. The findings include:Review of the facility policy titled, Procedure: Answering the Call Light, dated 1/2024, revealed .The purpose of this procedure is to respond to the resident's requests and needs .Answer the resident's call light as soon as possible .Review of the facility assessment tool dated 6/16/2025, revealed .Staffing Plan .Staffing ratios and needs are based upon resident census, resident need, and facility acuity [the severity of a resident's illness or condition, indicating the intensity of care needed] .Staffing assignments are based on overall patient [resident] acuity per unit [hallway] .Assignments are .modified to reflect resident needs based on acuity .Review of facility documentation dated 12/11/2025, revealed 9 residents of 18 residents on the 800-west hallway required 2-person assistance. Further review revealed out of the 9 residents, 4 required the use of a hoyer (mechanical patient lift used to safely move individuals who are bedridden or have limited mobility) lift.Review of a Resident Council Meeting Agenda/Minutes form dated 5/14/2025, revealed, .8 [NAME] needs a new CNA, wants 3 total .Review of a Resident Council Meeting Agenda/Minutes form dated 6/19/2025, revealed .needs a 3rd CNA on 8 west .request from Council members [Residents #78 and #35] .Review of a Resident Council Meeting Agenda/Minutes form dated 7/9/2025, revealed .ongoing staffing concerns .8th Floor .West .Review of Resident Council Notes dated 8/2025, revealed .8W [800-west hallway] .Council expressed concern about lack of CNA support .to support Hoyer .needs and .transfers .Review of Resident Council Notes dated 9/2025, 10/2025, and 11/2025, revealed staffing on 8-west was not discussed.Review of the medical record revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including Parkinsonism, Left Femur Fracture, and Muscle Wasting and Atrophy.Review of the comprehensive care plan for Resident #23 dated 11/26/2025, revealed .[Resident #23] needs assistance with daily ADL [Activities of Daily Living] care .TRANSFER .need total assistance .BED MOBILITY .need extensive assistance .TOILETING .extensive assistance .incontinent of bladder .bowel .BATHING .extensive assistance .DRESSING .total assistance .Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #23 scored a 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. Further review revealed the resident required partial/moderate assistance for bathing, toileting hygiene, lower body dressing, and was dependent for personal hygiene.Review of the medical record revealed Resident #35 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including Type 2 Diabetes, Morbid Obesity, and Hemiplegia Following Cerebrovascular Disease Affecting Left Nondominant Side.Review of an annual MDS assessment dated [DATE], revealed Resident #35 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident was dependent on staff for bathing, toileting hygiene, lower body dressing, and required substantial/maximal assistance with bathing and upper body dressing.Review of the comprehensive care plan for Resident #35 dated 10/31/2025, revealed, .[Resident #35] needs assistance with daily ADL care .need substantial assistance with upper body dressing and lower body dressing needs .total assist .needs substantial/total assist with toileting hygiene .substantial assist of 2 (total) for turning side to side .total assist with use of Hoyer lift .check and change q [every] 2 h [hours] .Review of the medical record revealed Resident #37 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Functional Quadriplegia, Complete Lesion at C5 Level of Cervical Spinal Cord, Spastic Hemiplegia Affecting Left Nondominant Side, Neuromuscular Dysfunction of Bladder, and Need for Assistance with Personal Care.Review of the comprehensive care plan for<br>(continued on next page) |

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|---|---|---|---|
| | 445123 | A. Building<br>B. Wing | 12/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ascension Living Alexian Village Tennessee | 671 Alexian Way<br>Signal Mountain, TN 37377 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #37 dated 8/24/2023, revealed .[Resident #37] needs assistance with daily ADL care. Functional quadriplegia .C5 injury in accident. Non ambulatory .need total assistance x [times] 2 person staff support with transfer .hoyer lift be used with use of x2 staff support .catheter .incontinent of bowel .total assistance with 2 person staff support to turn side to side in bed .BATHING .total assistance with 2 person staff support .DRESSING .total assistance with 2 person staff support .TOILETING .dependent on 2 staff members with toileting .Review of a quarterly MDS assessment dated [DATE], revealed Resident #37 scored a 15 on the BIMS which indicated the resident was cognitively intact. Further review revealed the resident was dependent on staff for bathing, toileting/personal hygiene, and upper/lower body dressing.Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type 2 Diabetes, Quadriplegia, Morbid Obesity, and Need for Assistance with Personal Care.Review of the comprehensive care plan for Resident #78 dated 4/1/2024, revealed .[Resident #78] needs assistance with daily ADL care .dx [diagnosis] .Quadriplegia .TOILETING .total assistance .incontinent of bladder .bowel .BATHING .extensive assistance .DRESSING .Total assistance .TRANSFER .total assistance .2 person .sit to stand [a medical device that helps people who can stand but need assistance to rise from a seated position] lift .BED MOBILITY .total assistance with 2 person staff support .Review of a quarterly MDS assessment dated [DATE], revealed Resident #78 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident was dependent on staff for toileting hygiene, lower body dressing, and required substantial/maximal assistance with bathing and upper body dressing.During an observation on 12/9/2025 at 9:30 AM, Resident #78's (room [ROOM NUMBER] on the west hallway) call light was activated. Further observation revealed the call light remained unanswered after 20 minutes.During an observation and interview on 12/9/2025 at 9:50 AM, revealed resident #78 was seated in a wheelchair in her room. The resident stated she needed to be assisted to the bathroom for a bowel movement. The resident had activated the call light for assistance, and no one had checked to see what she needed. The resident also stated the staff were slow to respond to her call light frequently at various times of the day. Resident #78 stated she was incontinent of urine most of the time and was incontinent of bowel some of the time.During an observation on 12/9/2025 at 9:59 AM (call light activated for 29 minutes), revealed Licensed Practical Nurse (LPN) A answered Resident #78's call light and assisted the resident to the bathroom with a second employee.During an interview on 12/9/2025 at 10:05 AM, Certified Nursing Assistant (CNA) B stated she worked the 800-west hallway and there were 2 CNA's and a nurse daily on day shift (6:00 AM-6:00 PM). There were multiple residents that were a 2-person transfer/assistance and 3 residents (Residents #35, #37, and #78) who required up to 1 1/2 to 2 hours to provide the resident's care. CNA B also stated when 2 CNA's were in a resident's room who required 1 1/2 to 2 hour care, the CNA's were unable to answer other call lights and meet the needs of the other residents timely.During an interview on 12/9/2025 at 10:08 AM, CNA C stated she worked the 800-west hallway and there were 2 CNA's and a nurse daily on day shift. There were multiple residents that were a 2-person transfer/assistance and 3 residents (Residents #35, #37, and #78) who required up to 1 1/2 to 2 hours to provide the needed care. CNA C also stated when 2 CNA's were in a resident's room who required 1 1/2 to 2 hour care, the CNA's were unable to answer other call lights and meet the needs of the other residents timely.During an interview on 12/9/2025 at 10:12 AM, the Director of Nursing (DON) stated she was aware the 800-west hallway had multiple residents that required 2-person transfer/assistance. There were multiple residents who required up to 1 1/2 to 2 hours for the CNA's to provide personal care. The DON also stated she had asked some of the residents to move to another hallway .to spread out the acuity of the residents . and the residents refused to move.During an interview on 12/9/2025 at 10:45 AM, LPN A stated the hallway had multiple high acuity residents. Multiple residents on the 800-west hallway required 2-person transfer/assistance and some required up to 1 1/2 to 2 hours to provide the needed care. There were 2 CNA's and 1 nurse on shift at all<br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | times during day shift and when the CNA's were in a resident room who required 2-person staff assistance, other resident call lights were not always answered timely. LPN A also stated Resident #78 was incontinent of bladder and was incontinent of bowel 75% of the time.During an interview on 12/9/2025 at 11:30 AM, Resident #78 stated staff had assisted her to the bathroom and she had not been incontinent of her bowel.During an interview on 12/9/2025 at 2:10 PM, CNA D stated she used to work the 800-west hallway, and the hallway had 2 CNA's and 1 nurse scheduled daily on day shift. There were multiple residents who required 2-person transfer/assistance, and it would take a long time to provide care for some of the residents. CNA D also stated call lights were not always answered and care provided timely when 2 CNA's had to provide care for the 2 person assist residents.During an interview on 12/9/2025 at 2:15 PM, CNA E stated he worked the 800-west hallway at times, and the hallway had 2 CNA's and 1 nurse scheduled daily on day shift. There were multiple residents who required 2-person assistance, and it would take a long time to provide care for some of the residents. CNA E also stated call lights were not always answered and care provided timely when 2 CNA's had to provide care for the 2 person assist residents.During an interview on 12/9/2025 at 2:30 PM, Resident #35 stated she resided on the 800-west hallway in room [ROOM NUMBER]. It would take up to 30-45 minutes for her call light to be answered at times. Resident #35 also stated she was incontinent of bladder and bowel, required 2 staff assistance to change her brief, and did not always have care provided timely.During an interview on 12/9/2025 at 2:48 PM, Resident #23 stated there were times when staff did not respond to her call light timely.During an interview on 12/10/2025 at 7:28 AM, the DON confirmed the 800-west hallway had a high acuity level and staffing needed to be adjusted to meet the needs of the residents timely.During an interview on 12/10/2025 at 7:36 AM, LPN F stated she worked day shift on the 800-west hallway routinely and there were 2 CNA's and a nurse daily on the hallway. There were multiple residents that required 2-person transfer/assistance and 3 residents (Residents #35, #37, and #78) who required up to 1 1/2 to 2 hours to provide the needed care. LPN F also stated call lights were not always answered and care provided timely when 2 CNA's had to provide care for the 2 person assist residents.During an interview on 12/10/2025 at 7:45 AM, Resident #78 stated there were 3 CNA's on the hallway today and the facility needed 3 CNA's every day on day shift.During an interview on 12/10/2025 at 7:50 AM, CNA G stated she worked day shift on the 800-west hallway routinely. There were 2 CNA's and 1 nurse scheduled daily on the hallway. Multiple residents on the hallway required 2-person transfer/assistance and 3 residents (Residents #35, #37, and #78) who required up to 1 1/2 to 2 hours to provide the resident's care. CNA G also stated call lights were not always answered and care provided timely when 2 CNA's had to provide care for the 2 person assist residents.During an interview on 12/10/2025 at 7:55 AM, CNA H stated she worked day shift on the 800-west hallway routinely. There were 2 CNA's and 1 nurse scheduled daily on the hallway. Multiple residents on the hallway required 2-person transfer/assistance and 3 residents (Residents #35, #37, and #78) who required up to1 1/2 to 2 hours to provide the resident's care. CNA H also stated call lights were not always answered and care provided timely when 2 CNA's had to provide care for the 2 person assist residents.During an interview on 12/10/2025 at 8:04 AM, Registered Nurse (RN) I stated 8-west hallway typically had 2 CNA's and 1 nurse scheduled on day shift. The hallway had multiple residents who required 2-person transfer/assistance. RN I also stated there had been times when the call lights were not answered timely due to the high acuity of resident needs.During an interview on 12/10/2025 at 8:15 AM, CNA J stated she worked the 800-west hallway routinely on day shift. There were 2 CNA's and 1 nurse scheduled daily on the hallway. Multiple residents on the hallway required 2-person transfer/assistance and there were multiple residents who required up to 1 1/2 to 2 hours to provide the resident's care. CNA J also stated there were times when she was unable to answer call lights and provide care timely to residents on the hallway.During an interview on 12/10/2025 at 8:30 AM, the Administrator stated she was aware there had been multiple resident complaints regarding staffing concerns on the 800-west hallway. The hallway had multiple residents who required 2-person (continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | transfer/assistance and some who required up to 1 1/2 to 2 hours to provide the needed care for the resident. The concerns were discussed (no date given) with corporate administration and there was no resolution. The Administrator confirmed the 800-west hallway had a high acuity and staffing needed to be adjusted.During an interview on 12/10/2025 at 9:50 AM, the Director of Clinical Operations stated she acquired the facility on 11/17/2025. She was made aware by the facility on 12/9/2025 there was a staffing concern on the 800-west hallway. She also stated she talked with corporate administration on 12/9/2025 and was given permission to adjust staffing levels to meet the needs of the high acuity residents. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on review of the facility policy, observation, and interviews, the facility failed to reconcile controlled medications for 3 residents (Residents #86, #13, and #67) of 8 residents reviewed for controlled substance reconciliation. The findings include: Review of the facility's policy titled, Medication Administration, dated 12/2025, revealed .if medication is a controlled substance .sign narcotic book . During an observation and interview beginning on 12/9/2025 at 7:15 AM of the 700 East Medication Cart revealed the following: Registered Nurse (RN) N was asked to review Resident #86's narcotic reconciliation sheet. Review of the Controlled Drug Record (narcotic reconciliation sheet) for Resident #86 revealed .oxyCODONE (opioid used to treat moderate to severe pain) 10/325 MG (Milligram) .Amount Left .8 . Review of Resident #86's narcotic card revealed a count of 7 tablets remaining. RN N was asked about the difference in the number and stated, .she [Resident #86] refused the dose earlier and it needs to be wasted with the supervisor .There are 7 in the package, not 8 .RN N was asked to review Resident #13's narcotic reconciliation sheet. Review of the Controlled Drug Record for Resident #13 revealed .traMADol TAB (Tablet/opioid used to treat moderately severe pain) 50MG .Amount Left .23 .Review of Resident #13's narcotic card revealed a count of 22 tablets remaining. RN N was asked about the difference in the .Amount and stated, .I gave her a dose earlier .I signed them off in the computer but haven't signed them off in the book yet [narcotic reconciliation sheet] . RN N was asked to review Resident #67's narcotic reconciliation sheet. Review of the Controlled Drug Record for Resident #67 revealed .traMADol TAB 50MG .Amount Remaining .6 . Review of Resident #67's narcotic card revealed a count of 5 tablets remaining. RN N was asked about the difference in the number and stated, .I gave her a dose earlier .I haven't written it in the book yet . During an interview on 12/9/2025 at 9:08 AM, the Director of Nursing (DON) confirmed narcotics should be signed out on the narcotic reconciliation sheet as soon as they were administered to a resident |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure proper infection control practices related to hand hygiene were followed during meal service when 1 staff member failed to offer hand hygiene assistance to 1 resident (Resident #24) of #24 residents observed during meal tray distribution on 1 of 4 hallways.The findings include:Review of the facility's policy titled, Hand Hygiene, revised 6/2025, revealed .Encouragement, remainders, and/or assistance with hand hygiene is provided to residents before meals .Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including Hemiplegia, Need for assistance with personal care.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #24 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was severely cognitively impaired. Further review revealed the resident required supervision or touching assistance with eating and partial to moderate assistance with personal hygiene.Review of the comprehensive care plan for Resident #24 revised on 3/10/2025, revealed .need assistance with daily ADL [activities of daily living] care .Hygiene/Oral .need total assistance .Eating .assist resident with [meal] tray set up .During an observation on 10/8/2025 at 12:24 PM, revealed Certified Nursing Assistant (CNA) K carry the meal tray down the 800 hallway. CNA K took the meal tray into Resident #24's room, opened the resident's silverware, picked up Resident #24's drink, opened a straw to place inside the drink, and opened the cover from the plate of food. Resident #24 picked up his fork and began eating his meal. CNA K failed to offer Resident #24 hand hygiene assistance prior to the resident eating the lunch meal.During an interview on 12/8/2025 at 12:57 PM, CNA K stated she failed to offer hand hygiene assistance to Resident #24 prior to the lunch meal service.During an interview on 12/9/2025 at 3:15 PM, the Director of Nursing (DON) stated the staff were to complete hand hygiene before assisting a resident with the meal tray setup and to offer hand hygiene assistance to all residents before serving the meal. The DON confirmed infection prevention and control practices were not maintained during the lunch meal service on 12/8/2025 when CNA K failed to offer Resident #24 hand hygiene assistance prior to the lunch meal service. |