

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER The Waters of Gallatin, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 555 East Bledsoe Street Gallatin, TN 37066	

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>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44447</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to initiate an investigation related to allegations of sexual abuse for 1 (Resident #6) of 3 sampled residents.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, ABUSE PREVENTION PROGRAM, dated 10/22/2022, revealed, .It is the policy of this facility to prevent resident abuse .The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect or a resident by a 3rd [third] party [a party not primarily involved in a situation] .Any incident or allegation involving abuse or mistreatment will result in an abuse investigation .All personnel must promptly report any incident or suspected incident of resident abuse .Any alleged violations involving mistreatment, abuse .MUST be reported to the Administrator .</p> <p>2. Review of the medical records revealed Resident #6 was admitted to the facility on [DATE], with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infarction, Major Depressive Disorder, and Need for Assistance with Personal Care.</p> <p>Review of the Progress Notes for Resident #6 dated 12/2/2024 revealed, .Reported by two staff members suicidal ideation expressed .order from facility provider to send to ER [emergency room] for psych [mental health] eval [evaluation] .</p> <p>Review of the Hospital Transfer Form dated 12/2/2024 revealed Resident #6 was transferred to Hospital #1 on 12/2/2024 at 6:00 PM for suicidal ideations/statements.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #6 required maximal assistance with Self-Care for toileting hygiene, bathing, and Personal hygiene. Behavior was coded for no Hallucinations, Delusions, Physical, Verbal and Other behavioral symptoms.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/8/2025 at 12:37 PM, Adult Protective Services (APS) Q stated the Hospital #1 had reported Resident #6 was admitted to the geriatric psychiatric unit for evaluation on 12/2/2024 and had alleged an incident of sexual abuse by staff at the facility where she resided. APS Q stated, .On 12/4/2024 at 12:30 PM, I spoke with [Named Social Services Director-SSD] about the allegations [Named Resident #6] had made when she was admitted to [Named Hospital #1] .[SSD] said they were looking into it and that [Named Resident #6] was on the memory care unit, could be hallucinating . When asked if she had told the SSD about the specific allegations of sexual abuse, APS Q replied, Yes, she understood [Named Resident #6] had reported the allegations to staff at [Named Hospital #1] .</p> <p>During an interview on 1/14/2025 at 12:26 PM, the SSD stated she had been employed by Facility #1 for 3 years and had received abuse training multiple times. The SSD defined sexual abuse as any type of sexual contact without consent. When asked if APS Q had notified the facility regarding allegations of sexual abuse made by Resident #6, the SSD replied, .Yes, [Named Resident #6] was not cognitively intact, she was on the memory care unit .she was only here for a couple of days . I spoke with [Named Administrator] after [Named APS Q] left .he [Administrator] told me he was already looking into it [Resident #6's allegations] . When asked, if she participated in the facility abuse investigations, the SSD stated she conducts interviews with residents. When asked if she had a role in the investigation related to Resident #6's allegations of sexual abuse, the SSD replied, I am sure that I did.</p> <p>During an interview on 1/14/2025 at 1:10 PM, The Administrator was asked for copies of the investigation related to allegations of sexual abuse reported by Resident #6 on 12/2/2024. The Administrator stated he was not aware of any allegations of sexual abuse made by Resident #6. The Administrator was asked if the SSD had notified him related to the allegations of sexual abuse made by Resident #6 when she had been transferred to Hospital #1 for evaluation. The Administrator stated no one had reported the allegations of sexual abuse made by Resident #6 to him and confirmed the facility had not investigated the alleged sexual abuse. The Administrator affirmed he expected all staff to report allegations of abuse immediately to him, the Abuse Coordinator. The Administrator confirmed all allegations of sexual abuse should be reported and investigated thoroughly.</p> <p>During a telephone interview on 1/15/2025 at 9:45 AM, the Social Worker at Hospital #1 stated Resident #6 was admitted to the facility on [DATE] for psychiatric evaluation following suicidal ideations reported by staff at Facility #1. The Social Worker stated the hospital physician documented bruising on Resident #6's arms and under her chin. The Social Worker stated, .The M.D. [Medical Doctor] reported that [Named Resident #6] had made allegations of sexual assault by two white women, nurses who had both put their fingers in her vagina .[Named Resident #6] alleged she had told the women to stop and they would not .[Named Resident #6] stated she did not really have suicidal thoughts, she just wanted to get out of the facility because she was scared . The Social Worker stated she had reported the allegation to Adult Protective Services (APS) and to the local police department.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44447</p> <p>Based on facility policy review, video footage review, medical record review, facility document review, and interview, the facility failed to provide an environment that is free from accident hazards over which the facility has control for 1 of 3 (Resident #10) sampled residents reviewed for falls.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility policy titled, GUIDELINES FOR INCIDENTS/ACCIDENTS/FALLS, dated 6/30/2023, revealed, .If a resident is involved in an incident/accident an immediate assessment of the resident will be completed by a nurse .Whether or not the resident can be moved or repositioned will be determined by the assessing nurse . Review of video footage dated 1/3/2025 at 11:34 AM, revealed Resident #10 telling staff she was sliding out of the chair. Certified Nursing Assistant (CNA) K then told CNA L to go get the mechanical lift and the bigger chair. CNA K was standing in front of Resident #10 and CNA M was standing behind the resident. Resident #10 was in the transport chair facing the 600 Hall entrance. CNA K attempted to adjust the sling under Resident #10's legs. Resident #10 was leaning over the right chair arm with her feet on the floor. Resident #10 stated, .I am falling out of this thing [transport chair]. CNA M told Resident #10 to lean back, twice, then Resident #10 stated, .I can only lean back so far . CNA K attempted to adjust Resident #10's legs and Resident #10 stated, .I feel like my leg is falling .I am going to be on the floor in a minute . CNA M called Resident #10 by her first name in a loud voice and proceeded to pull the resident backwards with Resident #10's feet both on the floor. Resident #10 yelled out and stated, .I'm not kidding .I am just on the edge of this chair . CNA M stopped pulling the chair, looked at CNA K and stated, .I am losing my patience .I didn't want to get her up in the first place . Resident #10 stated, .I can't I am going to hit the floor in a second . CNA K disagreed with Resident #10 and Resident #10 screams, .Yes I am . as CNA M pulls the chair again. Resident #10 slid out of the chair on to the foot rest and stated, .I tried to tell you . CNA L attempted to support Resident #10 and CNA K covered Resident #10's exposed lower body with a sheet/blanket. CNA M turned her head to the side, raised her hand in the air and states, .I am just to the point of like, so I'm going to get arrested . and myself at risk, no . CNA K states, .This chair don't need to go in her room no more . CNA L states, .We can lift her up with the lift .we can go get the chair she is supposed to have . CNA L and CNA K attempted to move Resident #10 off of the foot rest. CNA M continued to stand behind the transport chair and raises both hands in the air and declares, .I'm going to go get help . Further review of the video footage revealed Licensed Practical Nurse (LPN) E arrived to the area and assured Resident #10 staff would help lift her. Physical Therapy (PT) arrived shortly after LPN E, and assisted with positioning the sling under Resident #10. Staff raised Resident #10 off of the floor on both sides and raised both legs in order to place the sling. Resident #10 cried out during movement. The video footage revealed no one physically touched the resident to assess for injury. Registered Nurse (RN) C was not in the video footage at any time. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Generalized Anxiety Disorder, and history of Age-Related Osteoporosis with Current Pathological Fracture. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Resident #10 was coded for total dependence with all mobility and locomotion in wheelchair.</p> <p>Review of the care plan for Resident #10 dated 7/3/2024 revealed, .7/3/2024 .Pain/Comfort .ROM [Range of Motion] .7/19/2024 .[Named Resident #10] has a 'Self Care Deficit' .Ensure proper positioning while in bed and/or chair .Fall: [Named Resident #10] has the potential for serious injury/fall .1/3/25 [2025] Bariatric Wheelchair .Remind resident of safety awareness .OSTEOPOROSIS: [Named Resident #10] is at risk for Fracture R/T [Related/To] dx: [diagnosis] osteoporosis .Avoid exercises that may increase risk for fractures .</p> <p>Review of the facility incident report dated 1/3/2025 revealed, .[Resident #10] slid from wheelchair on to floor in hallway .Predisposing Physiological Factors . Agitated/Anxious .Decreased safety awareness .</p> <p>Review of the Incident Report Checklist for Resident #10 dated 1/3/2025 revealed a statement from CNA K indicating Resident #10 slowly slid out of her chair and was easily guided to the floor. A statement from CNA L indicated Resident #10 had to be pulled backwards in the chair because her feet would not fit on the foot rest of the transport chair. CNA L's statement revealed Resident #10 was slipping out of an inappropriate chair which required the CNAs to ease her to the floor onto blankets and pillows. A statement from CNA M alleged Resident #10 began to slide out of her wheelchair and CNA grabbed the sling that was underneath the resident and gently slid her to the ground.</p> <p>Review of the Multidisciplinary Incident Report Meeting Minutes dated 1/3/2025 at 11:35 AM, revealed a signature page which included a signature of the Administrator, the Medical Director, the Assistant Director of Nursing (ADON), the Wound Care Nurse, the MDS Coordinator, the Social Services Director, and the Therapy staff. The immediate interventions included (Named non-slip material), and replace Resident #10's transport chair with a Bariatric chair.</p> <p>During an interview on 1/16/2025 at 11:11 AM, Resident #10 stated on 1/3/2025 a Certified Nursing Assistant (CNA-M) transferred her to the transport chair (a narrow mobility chair) using a mechanical lift. Resident #10 stated, .I told [CNA M] I wasn't sitting in the chair right and needed to be pulled .she was in a hurry and seemed agitated .[CNA M] said you shouldn't be going anyway .coming back from activities I kept telling [CNA M] I was about to slip out of the chair, then I did .No one took my blood pressure .When therapy puts me in the wheelchair, I do not ever have a problem sliding out, the techs just rush .</p> <p>During an interview on 1/16/2025 at 12:45 PM, Family Member (FM) P stated, .[Named Resident #10] told staff multiple times during activities and going back to her room that she needed to be pulled up because she was sliding off of her chair .[CNA M] appeared agitated, and a couple of times [CNA M] said she didn't want to get her up .her feet were dragging the floor and she lost her shoe .[staff] stopped once when [Named Resident #10] yelled out .one tech said we need to get a lift, the dark haired tech [CNA M] said no we don't and told [Named Resident #10] she wasn't sliding out, then pulled [Resident #10] again and she slid out onto the floor .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/16/2025 at 6:15 PM, the Activities Assistant stated on 1/3/2025 he walked behind staff pulling Resident #10 backwards with her feet dragging the floor when leaving activities. The Activities Assistant affirmed Resident #10 did tell staff she was sliding out of the chair and then [Resident #10] slid from the chair.</p> <p>During an interview on 1/17/2025 at 11:00 AM, CNA M stated on 1/3/2025 stated, .I was paged to activities because [Resident #10] was sliding out of her chair .she had slid down in the chair and the sling [hammock-like support used to cradle a person's body during a transfer] was dislodged, there was no way to pull her back up .[Resident #10]'s feet were past the foot pedals, on the floor, and I had to pull her backwards .[Named CNA L] and another CNA [CNA K] walked with us down the hall .[Resident #10] said she was sliding out of the chair .no way to use [mechanical lift] in the hall .I was aggravated with the situation .when I got her up in the chair before activities, she complained about being wrong in the chair, I asked her then if she even wanted to go .it isn't safe for her to be in that chair [transfer chair] . When asked why she placed Resident #10 in the transfer chair instead of a wheelchair, CNA M responded, It's her chair, I guess she wants to use it. CNA M stated Resident #10 was sliding out of the chair and staff eased her to the floor then used a mechanical lift to place her in a Bariatric wheelchair (extra wide wheelchair). CNA M stated a nurse assessed the resident and checked vital signs.</p> <p>During an interview on 1/17/2025 at 12:14 PM, CNA K stated, .[Named Resident #10] was not sitting right in her chair .[Resident #10] had slid down and her feet were on the floor .[Named CNA M] came to get her and the resident was yelling because we couldn't get her feet on the foot pedal .[Named CNA M] pulled her backwards out of 600 Hall .[Named Resident #10] kept saying she was sliding out of the chair .I told [Named CNA M] [Resident #10] was sliding out .[Named CNA M] started pulling her backwards again and [Resident #10] slid out into the floor landing on the wheelchair foot pedal . CNA K affirmed she did not recall anyone actually assessing Resident #10 before staff lifted her with the mechanical lift. CNA K concluded the transport chair was not large enough for Resident #10 which caused her to slide out of the chair during transport.</p> <p>During an interview on 1/17/2025 at 12:55 PM, LPN N stated on 1/3/2025 Registered Nurse (RN) C told him to assist the CNAs with Resident #10 after a fall on 200 Hall. LPN N stated RN C was sitting at the nurse station charting when she requested his assistance. LPN N confirmed he did not assess Resident #10 after the fall and did not assist with lifting her from the floor. LPN N conceded the facility protocol required a nurse to perform a head to toe assessment after a fall before moving the resident.</p> <p>During a telephone interview on 1/17/2025 at 4:37 PM, the Physical Therapist (PT) stated on 1/3/2025 he was asked to assist with lifting Resident #10 from the floor after she slid out of her transport chair. The PT stated, .[Named Resident #10] was awake, alert and said nothing was hurting her .I assessed [Resident #10] by applying pressure to her shoulder and both hips .[Resident #10] only complained about the sling bothering her neck .no one has voiced concerns with [Named Resident #10]'s transport chair being too small .no chair ordered because the facility had Bariatric wheelchairs .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 1/17/2025 at 5:05 PM, RN C stated on 1/3/2025 she did not witness Resident #10 slide out of the wheelchair. RN C stated, .I went to the hall and assessed the resident .I did not obtain vital signs until she was back in bed .I felt of her hips, applied pressure to both hips and lifted her pants leg to look for injuries to her legs .I asked [Named Resident #10] if she was in pain and she denied pain . RN C conceded the facility protocol requires the nurse to perform an assessment prior to moving a resident post fall which includes obtaining vital signs.</p> <p>During an interview on 1/17/2025 at 5:15 PM, CNA L stated on 1/3/2025 the 600 Hall nurse (LPN O) told her Resident #10 was sliding out of her chair and to get a mechanical lift to assist Resident #10 back into a sitting position. CNA L stated CNA M came to take Resident #10 back to her room and pulled her backwards in the transport chair because Resident #10's feet were dragging the floor. CNA L stated, .[Named CNA K] and I tried to help hold her in the chair going down the hall .[Resident #10] yelled a couple of times saying she was sliding out of the chair and then she did .I think [Named LPN N] assessed her but I don't know about vital signs .I think they did [obtain vital signs] . When asked if CNA M was agitated, CNA L replied, .Yes, she was huffy, short with answers, and making remarks, I am not sure exactly what she said .</p> <p>During a telephone interview on 1/17/2025 at 5:52 PM, LPN E stated, .The day [Named Resident #10] slid out of her chair I went to help get her up from the floor .several of us put the sling under her and lifted her up to a wheelchair .I went back to the nurses station and told [Named RN C] she could get vital signs now, the resident was back to her room . When asked if RN C had assessed Resident #10 prior to her being moved from the floor, LPN E replied, .I do not recall seeing [RN C] assess the resident, she stayed at the desk charting .</p> <p>During an interview on 1/17/2025 at 6:00 PM, the Director of Nursing (DON) stated she was not present in the facility on 1/3/2025, the day Resident #10 slid from her chair while being pulled backwards in the transport chair. The DON affirmed pulling a resident backwards in a wheelchair was not safe and conceded dragging a resident's feet during transport created a skin injury risk in addition to a fall risk. The DON stated she expected nursing staff to complete an assessment after a fall to prevent any potential additional injury to a resident.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44447</p> <p>Based on the Facility Assessment Tool review, facility policy review, medical record review, and interview, the facility failed to ensure all nursing staff possessed the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being for 1 of 3 (Resident #5) sampled residents.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the Facility Assessment Tool dated 8/7/2024, revealed, .Diseases/conditions, physical and cognitive disabilities that the facility can accommodate .Respiratory System .Chronic Obstructive Pulmonary Disease (COPD) .Decisions regarding caring for residents with conditions not listed .In the event that a referral for admission is received or a current patient develops a new or unfamiliar diagnosis the clinical chart is reviewed .When considering the patient the IDT [Interdisciplinary Team] shall take into account the clinical capabilities of the staff .Specialized education shall be given to staff as necessary to manage new or less common diagnoses .prior to admission .Special Treatments and Conditions .Suctioning Tracheostomy [surgically created opening and placement of a tube/catheter/cannula in the windpipe/trachea, to help a person breathe] Care . 2. Review of the undated facility policy titled, Tracheostomy Care, revealed, .Tracheostomy care is the process of aseptically cleaning the tracheostomy tube and soma [stoma] site .Review physician's order . Gather the necessary equipment .Suction equipment .Trach care kit .Follow relevant infection control procedures .Suction the trach as necessary-following sterile suction technique .Precautions/Hazards . Accidental decannulation .Infection from poor aseptic technique . 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses which included COPD, Tracheostomy Status, and Acquired Absence of Larynx. <p>Review of the physician's orders for Resident #5 revealed, .Trach: site care every shift and as needed as needed AND every shift .Start Date .10/22/2024 .End Date .12/24/2024 .Trach: suction as needed as needed .Start Date .10/22/2024 .End Date .12/24/2024 .</p> <p>Review of the Medication Administration Records dated 10/22/2024- 12-12-2024, for Resident #5 revealed trach site care was documented each shift by nursing staff. Continued review revealed documentation of as needed suctioning provided twice during his stay in the facility.</p> <p>Review of the Admission Minimum Data Set (MDS) dated [DATE], revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Continued review revealed Resident #5's primary medical condition category coded as Debility, Cardiorespiratory Conditions. Resident #5 was coded for Special Treatments, Procedures, and Programs which included Tracheostomy care.</p> <p>Review of the comprehensive care plan dated 10/23/2024, for Resident #5 revealed, .at risk for complications R/T [Related/To] tracheostomy .Trach care per MD [Medical Doctor] order .Trach change .</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Staff alleged Resident #5 provided his own trach care. There was no physician's order for self-care.</p> <p>During an interview on 1/9/2025 at 2:21 PM, Licensed Practical Nurse (LPN) E stated, .I talked to [Named Assistant Director of nursing-ADON and Interim Director of Nursing-DON] the day of [Resident #5's] admission .I told them that I did not have the experience or training to provide care for a trach patient .I never saw a replacement trach tube at [Resident #5's] bedside or in supply .I didn't feel confident to be responsible for a trach patient then and I don't know .We didn't have suction at the bedside and no trach care kits .I was told the admission could not be stopped and [Named Interim DON] called the nurses into the office and provided a quick true/false quiz on trachs .A respiratory consultant came in to set up oxygen for [Resident #5] and I asked him what could I do if the patient lost his airway, he said to call 911 [emergency assistance] and bag [mask bag device used to force air into the lungs] at the trach . LPN E affirmed the brief in-service true/false quiz was the only education on tracheostomy care and precautions provided by the facility. LPN E stated he had minimum training during his LPN course and did not feel it was adequate for hands on care of a tracheostomy.</p> <p>During an interview on 1/13/2025 at 1:55 PM, LPN F stated, .I had [Named Resident #5] on my assignment while he was here .[Resident #5] took care of his trach himself .was not compliant with care, sometimes he would take his trach tube out and leave it open .I don't believe I could put a trach tube back in if I needed to . [Named Interim DON] called us into the office and gave a test on trach care and I googled a video to watch about it [providing care of a tracheostomy] .I believe they handed out a packet of information too .I know there was a care kit at his bedside, not sure if there was a replacement tube in the kit . When asked if she felt the training provided by the facility was adequate to prepare her for Resident #5's care, LPN F replied, No.</p> <p>During a telephone interview on 1/14/2025 at 10:32 PM, LPN G stated, .I received a real quick in-service on trach care .a few questions on a test .I provided suction when [Resident #5] needed it .used a catheter suction .I don't think it [suctioning the trach] is a sterile procedure, I did use clean procedure .[Resident #5] provided his own trach care .I am not really familiar with an emergency kit for trachs . LPN G stated she did not receive an in-service video education related to tracheostomy care and wasn't aware of any type of packet with education provided by the facility.</p> <p>During an interview on 1/15/2025 at 2:53 PM, the ADON stated, .We only had one resident with a trach, [Named Resident #5] .a couple of the nurses were anxious about taking care of his trach .[Named Interim DON] provided some training, I think a video and a post test . When asked if the training was provided to all nursing staff, the ADON replied, I really don't remember. When asked if the video was provided by the DON during the in-service on 10/22/2024, the ADON replied, I'm not sure. The ADON stated there wasn't a specific Staff Development person and affirmed she provided most nursing education. When asked if she had received sufficient training related to tracheostomy care, the ADON replied, I'm not sure.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER The Waters of Gallatin, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 555 East Bledsoe Street Gallatin, TN 37066	
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/16/2025 at 11:43 AM, the Nurse Practitioner (NP) stated, „[Named Resident #5] should not have provided his own trach care .I didn't feel confident that the nurses providing [Resident #5's] care were adequately trained for any type of acute airway compromise. I asked the nurses questions related to an acute airway emergency and trach care, the nurses could not answer correctly .I asked the Wound Care Nurse [LPN H] to assist the nurses with [Resident #5] care . The NP stated she voiced concerns related to staff competency in tracheostomy care to the ADON and the interim DON on the day of Resident #5's admission. When asked about Nursing Administration's response, the NP replied, The Interim DON called the nurses on duty into her office and provided a little 5 question quiz on trach care, which was not adequate.</p> <p>During an interview on 1/17/2025 at 5:25 PM, the Wound Care Nurse (LPN H) stated, .The DON talked to some of the nurses in the office when [Resident #5] was admitted .gave a quick questionnaire, watched a video, and I believe there was a packet .we had not had a trach patient here before [Resident #5] .I have never provided trach care to anyone, here or anywhere else .a couple of the nurses voiced concerns about caring for [Resident #5] .I was never present during trach care for [Resident #5] . When asked if she felt confident to provide care for a tracheostomy patient during an acute airway compromise, LPN H did not reply.</p> <p>During an interview on 1/17/2025 at 6:00 PM, the DON was asked if the competency check-off sheet provided for nursing staff was sufficient to ensure staff had the skill set to provide tracheostomy care. The DON stated, .The check off sheet provided during orientation of nursing staff simply determines a basic knowledge of skills .When a resident is admitted with special care needs, such as a tracheostomy, staff need to have a comprehensive in-service to ensure competency in care .nursing staff should be confident when providing care of all residents and be encouraged to request additional training in order to reach competency for resident safety . The DON reviewed the in-service 5-question true/false quiz and confirmed it was not adequate training.</p> <p>The facility provided an in-service record titled, Trach Care, dated 10/22/2024. The documents provided included a sign in sheet for 8 staff nurses and 1 MDS nurse (which did not include all nursing staff assigned to care for Resident #5) and a Tracheostomy Care Quiz. Review of the 5-question true/false quiz revealed, .</p> <p>1. It is not necessary to have a spare tracheostomy cannula at hand, if cannula is dislodged placing cannula back is permitted .2. After tracheostomy decannulation [removal of the tracheostomy tube] oxygenation is of high priority .3. If resident is dependent on tracheostomy cannulation and tracheostomy becomes decannulated, it becomes an emergency .4. If a resident is observed struggling to oxygenate with tracheostomy cannula in place, immediately notify nurse .5. Always have oxygen and suctioning machine available at resident's bedside .</p>		