

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Huntingdon Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 635 High Street Huntingdon, TN 38344	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49311</p> <p>Based on policy review, observation, and interview, the facility failed to ensure that residents were treated with dignity and respect as evidenced by 1 of 63 (Resident #62) residents not receiving their meal tray timely with the other residents seated at the table in the main dining room.</p> <p>The findings included:</p> <p>1. Review of the facility's policy titled, Resident Meal Service dated 1/1/2022, revealed .Each resident shall receive the correct diet .shall receive prompt meal service and appropriate .assistance .Nursing personnel will ensure that residents are served the correct food tray .Nursing personnel will evaluate food .intake in residents with, or at risk for, significant nutritional problems .</p> <p>2. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE], with diagnoses including Severe Protein-Calorie Malnutrition and Neurocognitive Disorder.</p> <p>Review of the Care Plan dated 3/20/2024, revealed .Resident is at risk for altered nutritional status related to low body mass index, dx [diagnosis] of protein calorie malnutrition-present on admission. Therapeutic diet / [and] sandwich lunch and dinner .</p> <p>Review of the Physician's Orders dated 3/20/2024, revealed .Regular texture, Regular fluid, thin consistency, Fortified foods to all meals, send sandwich with lunch and supper trays .</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #62 was moderately cognitively impaired and required set up or clean up assistance with eating.</p> <p>Observation in the Main Dining room on 7/15/2024 at 11:34 AM, revealed the trays arrived in the dining room and were distributed to the residents. Resident #62 was sitting at the dining table with Resident #3 and Resident #16. Residents #3 and #16 received their tray and was eating. Resident #62 was not given a tray. The Lead Dietitian was notified that Resident #62 did not receive a tray. Resident #62 was brought a tray at 11:52 AM.</p> <p>During an interview on 7/15/2024 at 11:53 AM, the Registered Dietician (RD) confirmed that Resident #62 should have been given a tray when the other residents at the table were served.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/17/2024 at 12:22 PM, the Director of Nursing (DON) confirmed that Resident #62 should have received a tray when the other residents at the table were served.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>48285</p> <p>Based on policy review, observation, and interview, the facility failed to provide effective housekeeping to maintain a sanitary and comfortable environment as evidenced by a floor in a resident's room had 2 straws, white powdery substance and torn salt packet on the floor in 1 of 7 (Resident #8) resident rooms, and 3 dried dark brown spots on the floor, dried brown substance on the outside of the toilet, back of the toilet tank and on the door frame in 1 of 4 (Resident #12) observed bathrooms.</p> <p>The findings include:</p> <p>1. Review of the facility's undated policy titled, 7-Step Daily Washroom Cleaning, revealed, .Clean and Sanitize Commode .includes the tank, the seat, the bowl and the base .Spot Clean the Walls .Damp Mop the Floor .</p> <p>Review of the facility's undated policy titled, 5-Step Daily Room Cleaning, revealed .Dust Mop .entire floor . especially behind dressers and beds .All corners and along the baseboards must be dust mopped to prevent buildup .Damp Mop .most important area .to disinfect is the floor .</p> <p>2. Observation and interview on 7/17/2024 at 7:58 AM, Resident #12 asked this surveyor to look at the Resident's room and bathroom. The room had an odor and dried dark brown spots of the floor. The bathroom toilet had dried dark brown substance on the outside of the toilet, back of the toilet tank and on the door frame.</p> <p>Observations in Resident #12 bathroom on 7/17/2024 at 8:30 AM, revealed a dried brown substance on the floor, dried dark brown substance on the outside of the toilet, back of the toilet tank and on the door frame.</p> <p>Observation on 7/17/2024 at 10:05 AM, revealed a Wet Floor sign outside of Resident #12's room. The dried dark brown substance on the outside of the toilet, back of the toilet tank, and on the door frame was still present.</p> <p>Observation and interview on 7/17/2024 at 11:47 AM, the Administrator was asked if she thought the bathroom had been cleaned. She stated it didn't look like it had been cleaned.</p> <p>Observation and interview on 7/17/2024 12:00 PM, the Housekeeping Supervisor was asked if Resident #59's bathroom and room had been cleaned. I asked her if she thought the floor was sticky, the Housekeeping Supervisor confirmed the floor was sticky and dirty. The Housekeeping Supervisor was shown the bathroom and asked if the bathroom had been cleaned. She confirmed the bathroom was not clean and stated it was Unacceptable.</p> <p>3. Observation in Resident #8's room on 7/17/2024 at 8:14 AM, revealed the floor had 1 straw under the bed and another straw in between the bed and the window. There was a white powdery substance on the side of the bed by the window, a torn salt packet in the corner of the room, and crumbs scattered all over Resident's room. Resident #8 is confined to the bed.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation in Resident #8's room on 7/17/2024 at 10:05 AM, revealed the floor was still dirty with the same paper items.</p> <p>Observation and interview on 7/17/2024 at 11:47 AM, the Administrator confirmed the floor in Resident #8's room was not clean.</p> <p>Observation and interview on 7/17/2024 at 11:47 AM, the Housekeeping Supervisor confirmed that Resident #8's floor had not been cleaned recently.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33379</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure Activities of Daily Living (ADL) assistance was provided related to incontinent care, bathing, and grooming for 3 of 3 sampled residents (Resident #8, #47 and #57) reviewed for ADL care.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's policy titled, Activities of Daily Living (ADLs), revised date of 12/28/2023 revealed, . The facility takes measures to minimize the loss of residents functional abilities, including activities of daily living .A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Diabetes, Arthritis, Depression, and Anxiety. <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #8 was cognitively intact and dependent on staff for personal hygiene.</p> <p>Review of the Physician Orders dated 7/7/2024, revealed .Provide diabetic nail care every Sunday or PRN [as needed]</p> <p>Review of the Mediation Administration Record [MAR] dated July 2024, revealed .Provide diabetic nail care every Sunday or PRN one time a day every Sun .</p> <p>Observation and interview on 7/15/2024 at 9:37 AM, revealed Resident #8's fingernails on both hands were approximately 1/4 (quarter) of an inch past the fingertips and had a brown substance under the nails on both hands. Resident #8 stated he would like his nails cut and to be shaved.</p> <p>Observation on 7/16/2024 at 8:07 AM, Resident #8's nails still long and dirty and not shaved.</p> <p>Observation and interview on 7/16/2024 at 4:55 PM, in the Resident's room the Director of Nursing (DON) confirmed Resident #8's nails had not been cleaned or trimmed.</p> <ol style="list-style-type: none"> Review of the medical record revealed Resident #47 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, Seizures, Anxiety and Acute Pulmonary Edema. <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #47 was cognitively intact, and required maximal assist with bathing.</p> <p>Review of Resident #47's Care Plan dated 5/2/2024, revealed .Honor resident's bathing preference. tues [Tuesday] and thurs [Thursday] 2nd shift .</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Bath Reports revealed Resident #47 had no shower or bed bath provided or documented for the following days: 5/3/2024, 6/11/2024, 6/21/2024, 7/5/2024, and 7/12/2024.</p> <p>Observation in the resident's room on 7/15/2024 at 9:09 AM, revealed Resident #47 was sitting in a wheelchair playing cards on her computer.</p> <p>4. Review of the medical record revealed Resident #57 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, Diabetes, Congestive Heart Failure, Depression and Osteoporosis.</p> <p>Review of the Care Plan dated 10/17/2023 revealed, .Resident has an ADL self-care performance deficit related to Alzheimer's Disease, anxiety .generalized weakness .visual impairment .BATHING: 1 person assist .</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #57 was cognitively intact.</p> <p>Review of the Bath Reports revealed Resident #57 had no shower or bed bath provided or documented for the following days: 4/15/2024, 5/2/2024, 5/6/2024, 5/23/2024, 6/3/2024, 6/13/2024, and 7/4/2024.</p> <p>Observation in the resident's room on 7/15/2024 at 2:08 PM, revealed Resident #57 dressed, lying in bed watching television, drinking a diet coke.</p> <p>Interview on 7/17/2024 at 4:00 PM, the Wound Care Nurse provided the shower sheets for Resident #47 and Resident # 57 and confirmed the staff is supposed to fill out the shower sheets on all residents and stated, . I'm not going to fabricate it .if I don't have it, I don't have it .</p> <p>Interview on 7/18/2024 at 11:06 AM, the DON confirmed the facility was unable to provide a document that Resident #47 and Resident #57 received their bath/showers twice a week.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47835</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored and secured when a medication was left in residents rooms for 2 of 2 (Resident #217 and #267) sampled residents, and failed to ensure that all medications were labeled and dated for 2 of 11 (Nurse's Station 1 Medication Room and Nurse's Station 2 Medication Cart) medication storage areas.</p> <p>The findings included:</p> <p>1. Review of the facility's policy titled Medication Administration, dated 1/17/2023, revealed .Medications are administered .as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .Wash hands prior to administering medications .Observe resident consumption of medication .</p> <p>Review of the facility's policy titled Medication Storage, dated 1/30/2024, revealed .During a medication pass, medications must be under the direct observation of the person administering medications .all medication rooms are routinely inspected .for .outdated .medications .and .missing labels .</p> <p>Review of the facility's policy titled Medications and Biologicals-Labeling ., dated 6/20/2024, revealed .Labels for individual drug containers must include .resident's name .physician's name .medication name .prescribed dose .date drug was dispensed .expiration date .</p> <p>Review of the Hospitality Guide, revealed .MEDICATIONS, TREATMENTS AND SELF-ADMINISTRATIONS . We don't allow medication .to be kept in your room .</p> <p>2. Review of the medical record revealed Resident #217 was admitted to the facility on [DATE], with diagnoses including Diabetes, Hypertension, and Hemiplegia.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #217 was cognitively intact.</p> <p>Review of the Medication Administration Record (MAR) dated July 2024, revealed Progesterone Oral Capsule 100 MG (Progesterone) Give 1 capsule by mouth one time a day related to ABNORMAL UTERINE AND VAGINAL BLEEDING .</p> <p>During a random observation and interview in Resident #217's room on 7/15/2024 at 9:30 AM, revealed Resident #217 was sitting up in bed and a pill cup containing 2 pills was on the overbed table. Resident #217 was asked if she takes her own medications, she stated They leave them in here and then I take them when I'm ready. I asked what the medications were, and she stated, progesterone and not sure of the other.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/15/2024 at 9:42 AM, Licensed Practical Nurse (LPN) A was asked if medications should be left in the resident's room unattended. LPN A stated, I usually leave them [medications] for her [Resident #217] to take. LPN A was asked if the Resident was assessed to self administer her medications. He stated, It is alright as far as I know.</p> <p>During an interview on 7/15/2024 at 9:46 AM, the Director of Nursing (DON) was asked if medications should be left with a resident unattended and out of sight for the resident to self administer. She stated, Medications are not to be left unattended with residents.</p> <p>3. Review of medical record revealed Resident #267 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, HIV (Human Immunodeficiency Virus), Diabetes, and Dementia.</p> <p>Review of Care Plan dated 7/11/2024, revealed .Resident has impaired cognitive function .Administer medications as ordered .</p> <p>Review of the Physician's Orders dated 7/12/2024, revealed .Ipratropium Albuterol Solution [treatment of chronic obstructive pulmonary disease] 0.5-2.5 . MG/3ML [milligram/milliliter] 1 vial inhale orally every 8 hours as needed for SOB [Shortness of Breath] or Wheezing via nebulizer .</p> <p>During a random observation in Resident #267's room on 7/15/2024 at 9:20 AM, revealed Resident #267 was sitting up in a wheelchair and self-administering a nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) treatment. There was no staff present.</p> <p>During an interview on 7/15/2024 at 9:25 AM, LPN A was asked if Resident #267 had an assessment or order to self-administer medications. LPN A replied, No. and confirmed that Resident #267 should not have been self-administering medication.</p> <p>Review of the July 2024 Medicine Administration Record/Treatment Administration Record (MAR/TAR) revealed Resident #267's Ipratropium Albuterol Solution nebulizer observed as self-administered on July 15, 2024, was not documented as administered.</p> <p>Review of the admission MDS assessment dated [DATE], still in progress, revealed a BIMS score of 8, which indicated Resident #267 was moderately cognitively impaired.</p> <p>During an interview on 7/17/2024 at 10:53 AM, the Administrator confirmed that if a medication is given it should be signed out on the MAR.</p> <p>During an interview on 7/17/2024 at 10:57 AM, LPN A confirmed that if a medication was administered it should be documented on the MAR.</p> <p>During an interview on 7/17/2024 at 12:22 PM, the DON confirmed that Resident #267 should not have been self-administering medication and if a medication is administered, it should be documented on the MAR.</p> <p>4. Observation on 7/17/2024 at 11:54 AM, revealed an unlabeled insulin pen in a plastic bag with Resident #18's name written in marker on the outside of the bag.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 7/18/2024 at 9:15 AM, at Nurse's Station #1 Medication Room, revealed 6 tubes of normal saline flush (used to clean out an intravenous (IV) catheter) with an expiration date of 7/1/2024, and 25 tubes of Heparin flush (blood thinner used to clean out IV catheters) with an expiration date of 3/1/2024. Registered Nurse (RN) G confirmed that there should be no expired medications in the Medication Room.</p> <p>During an interview on 7/18/2024 at 9:05 AM, RN B confirmed that Resident #18's insulin pen should have been labeled with the Residents name.</p> <p>During an interview on 7/18/2024 at 10:06 AM, the DON confirmed that insulin pens should have a label and that there should be no expired medications in the medication room.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49311</p> <p>Based on facility policy review, observation, and interview, the facility failed to calibrate the thermometer, failed to ensure resident's food was labeled and dated in 2 of 2 resident nourishment refrigerators, and failed to ensure staff beverages were not stored in 1 of 2 resident nourishment refrigerators. The facility had a census of 64 residents with 63 of those residents receiving a meal tray from the kitchen.</p> <p>The findings included:</p> <p>1. Review of the facility's undated policy titled, State Food Safety Resources revealed .A thermometer that is even five degrees off can lead you to .serve food that is not safe to eat .You can only rely on a thermometer if you calibrate it .</p> <p>Review of the facility policy titled Food: Preparation, dated 9/2017, revealed .All foods will be held at appropriate temperatures .Temperatures for TCS [Time/Temperature Control for Safety] foods will be recorded at time of service, and monitored periodically during meal service .</p> <p>Review of the facility's policy titled Use and Storage of Food Brought in by Family or Visitors dated 1/1/2022, revealed .All food items that are .brought in must be labeled .and dated .the facility may refrigerate labeled and dated .items in the nourishment refrigerator .</p> <p>2. Observation and interview on 7/15/2024 at 9:00 AM, with Licensed Practical Nurse (LPN) B, revealed the Nutrition refrigerator located in the Clean Utility Room at Station 1 contained an open unlabeled and undated bag of chips, an unlabeled and undated gallon of tea, and an unlabeled and undated protein shake. LPN B was asked if the protein shake should be labeled with the resident's name. She replied, .It is an employee's shake . LPN B was asked should employee food be stored in the resident's Nutrition refrigerator. She replied, No. LPN B was asked if there should be unlabeled or undated food in the resident's Nutrition refrigerator. LPN B replied No.</p> <p>3. Observation and interview on 7/16/2024 at 9:17 AM, with District Manager B at the Nutrition refrigerator located in the Memory Care Unit Kitchen revealed unlabeled and undated cookies and cream ice cream. District Manager B confirmed that there should not be unlabeled, undated, or employee food in the nutrition refrigerator.</p> <p>During an interview on 7/16/2024 at 9:28 AM, the DM and District Manager A confirmed that there should not be unlabeled, undated, or employee food in the nutrition refrigerator.</p> <p>4. Observation and interview on 7/16/2024 at 11:00 AM, with the Dietary Manager (DM) in the kitchen, revealed that the DM did not calibrate the thermometer prior to checking the final internal cooking temperatures for lunch. The DM was asked if she had been calibrating the thermometers prior to use. The DM replied, Honestly no, I just got them out of the box yesterday. The DM confirmed that the thermometer should be calibrated prior to use.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/16/2024 at 11:48 AM, District Manager A confirmed that thermometers should be calibrated.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30974</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained for 1 of 1 sampled residents (Resident #34) reviewed for transmission- based precautions, failed to provide a clean barrier while administering medications for 4 of 9 residents, (Resident #13, #16, #21 and #32) and used a contaminated alcohol wipe to clean a resident's cheek (Resident #13), and failed to observe Enhanced Barrier Precautions for 1 of 2 (Resident #32) sampled residents.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled Transmission-Based (Isolation) Precautions, dated 12/27/2023, revealed .The facility will have PPE [Personal Protective Equipment] readily available near the entrances of the resident's room. Staff .will don appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions .Contact Precautions .Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment .Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment .</p> <p>Review of the facility's policy titled Enhanced Barrier Precautions, dated 3/26/2024, revealed .infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .Even if the resident is not known to be infected or colonized with a MDRO [Multi Drug Resistant Organism], an order for enhanced barrier precautions will be obtained for residents with .indwelling medical devices (e.g., central lines .feeding tubes . PPE for enhanced barrier precautions is .necessary when performing high-contact care activities .</p> <p>2. Medical record review revealed Resident #34 was admitted to the facility on [DATE], with diagnoses including Dementia, Hypokalemia, Dysphagia, Depression, and Anxiety.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #34 had severe cognitive impairment.</p> <p>Review of the Care Plan dated 3/26/2024, revealed Resident has an infection as evidenced by UTI [urinary tract infection] & [and] is in contact isolation .Contact isolation precautions .</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #34 was severely cognitively impaired.</p> <p>Review of the Physician's Order dated 7/11/2024, revealed CONTACT ISOLATION Place in contact isolation due to ESBL [Extended-spectrum beta-lactamases enzymes that confer resistance to most beta-lactam antibiotics] in the urine .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Huntingdon Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 635 High Street Huntingdon, TN 38344	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Physician's Order dated 7/12/2024, revealed Amoxicillin-Pot [Potassium] Clavulanate [antibiotic] Tablet 875-125 MG [milligram] Give 1 tablet by mouth every 12 hours for urinary tract infection for 7 Days .</p> <p>Observation on 7/18/2024 at 12:48 PM, revealed Certified Nursing Assistant (CNA) B and CNA C were in Resident #34's room, assisted her to the bathroom and back to bed. Neither CNA were dressed out in PPE to assist Resident #34, which was in contact isolation for ESBL in urine.</p> <p>Interview on 7/18/2024 at 3:06 PM, the Registered Nurse (RN) B was asked what PPE should staff wear in a contact isolation room. The RN stated, Gloves and gown .</p> <p>Interview on 7/18/2024 at 3:12 PM, the Infection Control Preventionist (ICP) was asked what PPE is required for Contact Isolation. The ICP stated, Gowns and gloves .</p> <p>3. Observation on 7/17/2024 at 8:29 AM, revealed Licensed Practical Nurse (LPN) A entered Resident #21's room and failed to perform hand hygiene or provide a clean barrier during medication administration.</p> <p>Observation on 7/17/2024 at 8:40 AM, revealed RN G failed to provide a clean barrier while administering Resident #13's eyedrops and insulin. RN G used a contaminated alcohol wipe to clean Resident #13's right cheek, then used a gloved finger to wipe off the left cheek after administering eyedrops.</p> <p>Observation on 7/17/2024 at 8:59 AM, revealed RN G failed to provide a clean barrier while administering Resident #16's ordered oral medications and inhaler.</p> <p>Observation on 7/17/2024 at 10:27 AM, revealed RN G entered Resident #32's room and failed to observe Enhanced Barrier Precautions for a resident with a Percutaneous Endoscopic Gastronomy (a tube that allows nutrition to be received through the stomach) (PEG). RN G also failed to provide a clean barrier while preparing and administering medications.</p> <p>Interview on 7/18/2024 at 10:06 AM, the Director of Nursing (DON) was asked the process when setting up to administer eyedrops. The DON stated, .sanitize your hands .put down a barrier .make sure you take a napkin to wipe their cheek off if the medication runs .use the tissue to wipe their cheek off . The DON was asked if someone should use a contaminated alcohol wipe or finger to wipe off the resident's cheek. The DON stated, No they should not. The DON confirmed that a clean barrier should be provided while administering medications. The DON stated hand hygiene should be performed prior to administering medications.</p> <p>During an interview on 7/18/2024 at 10:32 AM, RN G confirmed that a tissue should have been used to clean resident's cheeks after administering eyedrops. RN G confirmed that Enhanced Barrier Precautions should be followed while performing high contact care for a Resident with a PEG. RN G confirmed that clean barriers should be in place before administering medications.</p>		