

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2024
NAME OF PROVIDER OR SUPPLIER  Heritage Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE  1026 McFarland Street Morristown, TN 37814	

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 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>45837</p> <p>Based on facility policy reviews, observations, and interviews, the facility failed to provide a homelike environment during dining in 2 of 4 dining rooms observed.</p> <p>The findings include:</p> <p>Review of facility policy titled, Resident Dining Services, revised 4/26/23, showed .The facility has an established process to ensure food is served in accordance with professional standard for food service safety and in a safe, clean, homelike environment .</p> <p>During an observation of dining on 2/26/2024 at 12:17 PM, Certified Nursing Assistants (CNA) #2, CNA #3, and the Activities Director (AD) delivered the meal trays to the 10 residents in the main dining room. The dishes of food, beverages, and silverware remained on the brown plastic trays on the table for all 10 residents eating in the dining room.</p> <p>During an interview on 2/26/2024 at 12:26 PM, CNA #3 stated it was typical for meals to be left on the trays.</p> <p>During an interview on 2/26/2024 at 12:29 PM, CNA #2 stated the food had always been left on the trays when it was served.</p> <p>During an interview on 2/26/2024 at 12:32 PM, the AD stated she usually helped in the dining room. The AD stated the food was typically left on the trays and further stated it made it easier for the residents.</p> <p>During an observation in the 100 hall day room on 2/27/2024 at 8:49 AM, a resident ate breakfast independently. The food plate was on a brown tray, and the resident consumed the milk directly out of the carton.</p> <p>During an observation and interview on 2/27/2024 at 8:53 AM, in the 100 hall day room, Registered Nurse (RN) #1 confirmed 4 residents ate the breakfast meal off plates positioned on brown plastic trays, and 2 of the residents consumed milk directly from the cartons.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/28/2024 at 2:55 PM, the Certified Dietary Manager (CDM) stated the meals had always been served on the trays. The CDM stated she did not recall any discussion about home like atmosphere or removing the food from the trays.</p> <p>During an interview 2/28/2024 at 2:57PM, the Administrator stated he would have to check the facility policy on dining and meal service regarding a homelike environment before he could comment about meals being left on food trays on the dining tables when the residents were served.</p> <p>50216</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45837</p> <p>Based on medical record review, observation and interview, the facility failed to revise a comprehensive care plan for enteral feeding for 1 resident (Resident #79) of 32 residents reviewed for care plans.</p> <p>The findings include:</p> <p>Resident #79 was admitted to the facility on [DATE] with diagnoses including Personal History of Malignant Neoplasm of Larynx, Chronic Obstructive Pulmonary Disease and Dysphagia.</p> <p>Review of a care plan dated 4/11/2023 showed, .At risk for weight fluctuation r/t [related to] current health status Abnormal weight loss, Adult failure to thrive, Severe Malnutrition .every shift Jevity 1.5 at 65 ml/hour x 22 hours via pump. Flush with 100 ml water every 4 hours .</p> <p>Review of physician's order dated 11/27/2023 for Resident #79 showed, .Enteral Feed every shift Jevity 1.5 at 60 ml [milliliters]/[per] hour x 22 hours. Flush with 150 ml water every 4 hours .</p> <p>During an observation on 2/26/2024 at 11:02 AM, in Resident #79's room, showed the resident received tube feeding through a percutaneous gastric tube (PEG tube, a tube surgically placed in the stomach that is used for feeding) by a pump which delivered Jevity 1.5 (a concentrated liquid nutrition formula) at a rate of 60 ml/hour with a water flush of 60 ml every 4 hours.</p> <p>During an interview on 2/28/2024 at 8:35 AM, Licensed Practical Nurse (LPN) #5 stated when tube feeding was hung for a resident, she would check the resident's order, check the PEG site for cleanliness, check for placement with her stethoscope and flush with distilled water before starting the feeding.</p> <p>During an interview on 2/28/2024 at 8:58 AM, the Director of Nursing (DON) stated it was her expectation for staff to follow the physician's orders, and the care plan revised to reflect the changes. The DON confirmed the tube feeding flush which had been be running at 150 ml every 4 hours was incorrect and the care plan had not been revised.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837</b></p> <p>Based on review of the facility's policy, medical record review, observation and interview, the facility failed to provide facial hair removal and nail care during activities of daily living for 1 resident (Resident #62) of 32 residents reviewed for activities of daily living care.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Activities of Daily Living (ADLs), dated 2/12/2024, showed .The facility must provide care and services .for the following .bathing, dressing, grooming, and oral care .For Fingernail Care, the following procedure will be followed .Ensure fingernails are clean .to avoid injury and infection .</p> <p>Resident #62 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Dementia, Muscle Weakness, and Generalized Arthritis.</p> <p>Review of an admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #62 had moderate cognitive impairment and required limited assistance of 1 staff member for dressing, toileting and personal hygiene. The resident was always incontinent of urine and bowel.</p> <p>Review of a care plan dated 5/18/2023 showed Resident #62 had an ADL self-care performance deficit related to impaired physical function related to a left arm fracture. The care plan had an intervention of . Personal Hygiene .The resident requires limited assistance .</p> <p>During an observation on 2/26/2024 at 11:10 AM, Resident #62's fingernails had a brown substance caked under them and facial hair was present on the female resident's chin.</p> <p>During an interview on 2/26/2024 at 11:30 AM, Certified Nursing Assistant (CNA) #1 stated she provided incontinence checks and general cleanliness checks on residents at least every 2 hours.</p> <p>During an observation on 2/27/2024 at 9:56 AM, Resident #62 was in her bed, and was eating oatmeal. The resident's fingernails had a brown substance caked under them and facial hair was present on the female resident's chin.</p> <p>During a telephone interview on 2/27/2024 at 11:35 AM, Resident #62's daughter stated the resident sometimes ate with her hands, and she had seen the resident with dirty fingernails during a recent visit.</p> <p>During an observation on 2/27/2024 at 3:37 PM, in room [ROOM NUMBER], Resident #62 had dirty fingernails with a brown substance caked under them and facial hair on her chin.</p> <p>During an interview on 2/28/2024 at 10:32 AM, the Director of Nursing (DON) stated it was her expectation that staff check fingernails and trim them and do whatever was necessary to keep the residents' fingernails clean. The DON stated women residents should have facial hair removed. The DON confirmed the staff was expected to clean a resident's hands and fingernails, especially before dining.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45837</p> <p>Based on review of facility policy, medical record review, observation and interview, the facility failed to follow a physician's order for treatment of edema (swelling) for 1 resident (Resident #21) of 32 residents' physician orders reviewed.</p> <p>The findings include:</p> <p>Resident #21 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia, Chronic Atrial Fibrillation, Hypertension and Muscle Weakness.</p> <p>Review of a physician's order dated 4/9/2023 showed .Keep legs elevated when out of bed every shift .</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #21 had severe cognitive impairment and used a wheelchair for ambulation.</p> <p>During an observation on 2/27/2024 at 9:45 AM, in Resident #21's room, the resident was sitting up straight in a specialized wheelchair with a high back watching TV with her legs hanging down and feet on the floor.</p> <p>During an observation and interview on 2/27/2024 at 9:46 AM, in Resident #21's room, Licensed Practical Nurse (LPN) #6 confirmed the resident was in a specialized wheelchair that had no equipment on it to hold the residents legs elevated, and the resident's feet were on the floor.</p> <p>During an observation on 2/27/2024 at 3:30 PM, Resident #21 was in her room sitting up straight in a specialized wheelchair eating a snack. Her legs were bent and her feet were on the floor with no edema observed.</p> <p>During an observation and interview on 2/28/2024 at 9:18 AM, in the 100 hall day room, the Director of Nursing (DON) observed Resident #21 in her wheelchair and stated the resident did not have her legs elevated nor did she have equipment on her chair to elevate her legs. She also observed the resident's printed orders and stated it was her expectation for staff to follow the physician's orders. The DON confirmed the staff was not following the physician's orders by not elevating the resident's legs when the resident was up out of bed.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45837</p> <p>Based on facility policy review, medical record review, observation and interview, the facility failed to follow a physician's order for enteral feeding for 1 resident (Resident #79) of 3 residents reviewed for enteral feeding.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Administration of Medications, dated 8/24/2023, showed .facility will ensure medications are administered .appropriately per physician order .Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration .Right Dose .Check the MAR [Medication Administration Record] and the doctor's order .</p> <p>Resident #79 was admitted to the facility on [DATE] with diagnoses including Personal History of Malignant Neoplasm of Larynx, Chronic Obstructive Pulmonary Disease and Dysphagia.</p> <p>Review of a care plan dated 4/11/2023 showed, .At risk for weight fluctuation r/t [related to] current health status Abnormal weight loss, Adult failure to thrive, Severe Malnutrition .</p> <p>Medical record review showed Resident #79 had not had any hospitalization s since 10/17/2023.</p> <p>Review of physician's order for Resident #79 dated 11/27/2023 showed, .Enteral Feed every shift Jevity 1.5 at 60 ml/hour x 22 hours. Flush with 150 ml water every 4 hours .,</p> <p>Review of the 2/2024 MAR showed an order of .every shift Jevity 1.5 at 60 ml/hour x 22 hours. Flush with 150 ml water every 4 hours .</p> <p>During an observation on 2/26/2024 at 11:02 AM, in Resident #79's room, the resident received tube feeding through a percutaneous gastric tube (PEG tube, a tube surgically placed in the stomach that is used for feeding) by a pump which delivered Jevity 1.5 at a rate of 60 ml/hour with a water flush of 60 ml every 4 hours.</p> <p>During an observation on 2/27/2024 at 2:59 PM, Resident #79 ambulated, on the 100 hallway, with his tube feeding pump delivering Jevity 1.5 at 60 ml/hour and a water flush of 60 ml every 4 hours.</p> <p>During an observation and interview on 2/28/2024 at 7:58 AM, in Resident #79's room, Registered Nurse (RN) #1 confirmed that the Jevity 1.5 tube feeding for the resident was running at a rate of 60 ml/hr with a flush of 60 ml/every 4 hours (the order was for 150 ml every 4 hours).</p> <p>During an interview on 2/28/2024 at 8:58 AM, the Director of Nursing (DON) stated it was her expectation that when a nurse started a tube feeding, the nurse would check the resident's orders for the correct formula and rate of feeding. The DON confirmed that the tube feeding flush should be running at 150 ml every 4 hours, and the flush was running at 60 ml every 4 hours, and the nursing staff had not followed the physician's orders for tube feeding.</p> <p>(continued on next page)</p>		

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F 0693  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During an interview on 2/28/2024 at 1:12 PM, the Medical Doctor stated Resident #79 was not harmed by the incorrect water flush rate. The resident had not had any dehydration or associated symptoms and the resident was at base line with no hypotensive episodes.		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837</b></p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure necessary emergency equipment was immediately available at the bedside for 1 resident with a tracheostomy (Resident #79) of 1 resident reviewed for tracheostomy care.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Tracheostomy Emergency Supplies/Kits, dated 9/26/2023, showed .The facility will ensure that each resident who presents with a tracheostomy that is actively being used to maintain an airway, will have emergency supplies/kit available at bedside .the following should be stocked at each tracheostomy patient's [resident] bedside .Manual resuscitator and mask [ambu bag] .Suction equipment and supplies .</p> <p>Resident #79 was admitted to the facility on [DATE] with diagnoses including Personal History of Malignant Neoplasm of Larynx, Chronic Obstructive Pulmonary Disease and Dysphagia.</p> <p>Review of a care plan dated 4/6/2023 showed the resident had a tracheostomy with a one-way valve that attaches to a tracheostomy tube with an intervention of .suction as necessary .</p> <p>Review of a physician's order dated 4/14/2023 for Resident #79 showed, .Monitor trach site .every shift for trach care .Trach care every shift and as needed every shift .Suction as needed .</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #79 had moderate cognitive impairment and required a walker and wheelchair for ambulation and required tracheostomy care.</p> <p>During an observation on 2/26/2024 at 11:02 AM, in room [ROOM NUMBER], Resident #79 had a tracheostomy and was breathing normally. Continued observation showed there was a suction machine with no suction tubing or canister and there was no ambu bag, in the resident's room, which was required in the event of an emergency.</p> <p>During an observation and interview on 2/27/2024 at 9:32 AM, Licensed Practical Nurse (LPN) #4 confirmed there was a suction machine in the room but did not have the complete suction tubing or canister, or an ambu bag for emergency use in Resident #79's room.</p> <p>During an interview on 2/28/2024 at 9:30 AM, the Director of Nursing (DON) stated she expected suction equipment, tubing, and an ambu bag be located at the resident's bedside and available for emergency use. The DON confirmed the emergency supplies were not available at the bedside.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>45837</p> <p>Based on facility policy review, observations, and interviews, record review, the facility failed to properly store medication in 1 of 6 medication carts.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Long Term Care (LTC) Facility's Pharmacy Services and Procedure Manual, revised 7/21/2022, showed .external use medications and biologicals are stored separately from internal use medications and biologicals.</p> <p>During an observation and review of a medication storage cart on 2/27/2024 at 7:33 AM, Licensed Practical Nurse (LPN) #1 opened the top large drawer of the Unit 2 Front Hall medication cart. LPN#1 removed an insulin pen belonging to Resident #39. The pen was in a plastic bag with a prescription label on the bag. The insulin pen also had a prescription label to identify the pen belonged to Resident #39. Resident #39's insulin pen had a second label on the pen cap which was noted for Resident #105. LPN #1 removed the insulin pen prescribed for Resident #105 from the drawer. Resident #105's insulin pen did not have a label on it. LPN #1 was asked what the protocol was for this type of situation, she stated, I have to fix it and report it to my supervisor. LPN #1 stated the night nurse gave the insulin injections to the residents at 6:00 AM. LPN #1 also stated she would update her supervisor for direction. Continued observation of the cart showed a Heparin Lock Syringe sealed in plastic wrapping located in an open toothette (oral swab used for mouth care) box in the large bottom drawer of the cart . LPN #1 stated that should not be there. I don't know why it was there. LPN #1 removed the Heparin Lock Syringe from the cart.</p> <p>During a telephone interview on 2/27/2024 at 11:03 AM, LPN #7 stated she administered the insulin to both Resident #39 and #105. LPN #7 stated she checks the insulin pen against the Medication Administration Record (MAR) and the label to make sure they match. LPN #7 stated she checked the dosage, the time, the route, and the expiration date before she administers the insulin.</p> <p>During an interview with on 2/27/2024 at 3:15 PM, the Director of Nursing (DON) stated it was her expectation for the nurse to throw away the insulin pens and order new insulin pens for Resident #39 and #105 to replace them. The DON stated the Heparin Lock syringe should not have been stored in the box of toothettes in the medication cart and orals and topical medications are not supposed to be stored together.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50216</p> <p>Based on facility policy review, medical record review, observation, and interviews, the facility failed to notify the physician in a timely manner regarding abnormal laboratory results for 1 resident (Resident #39) of 24 residents reviewed for labs.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Laboratory Services, dated 9/15/2023, showed .Promptly notify the ordering physician; physician assistant; nurse practitioner; or clinical nurse specialist of laboratory results that fall outside the clinical reference ranges in accordance to the facility policies and procedures for notification of a practitioner or per the physician's order .</p> <p>Resident #39 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Vascular Dementia, Type 2 Diabetes Mellitus, Hypertension, Hemiplegia and Hemiparesis, Repeated Falls, and Adult Failure to Thrive.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident # 39 had a Brief Interview for Mental Status score of 9 which indicated the resident had moderate cognitive impairment.</p> <p>Review of the progress note dated 2/18/2024, showed Licensed Practical Nurse (LPN)#1 collected a urine specimen for Resident #39 and sent the urine to the lab for a urinalysis (UA), culture and sensitivity.</p> <p>Review of the UA culture and sensitivity report dated 2/23/2024, showed Resident #39 had a urinary tract infection. Continued review showed no documentation that a provider had reviewed the report received by the facility on 2/23/2024.</p> <p>Review of a progress note dated 2/26/2024, showed LPN #2 was reviewing laboratory results and found the report on Resident #39's urine had not been sent to the primary care provider (PCP). LPN #2 notified the Nurse Practitioner (NP) and orders for an antibiotic were received.</p> <p>During a telephone interview on 2/28/2024, at 1:00 PM, the Medical Director (MD) stated there was no negative outcome to this resident because of the delay, but he would have expected to be notified of the results the day received.</p> <p>During an interview on 2/28/2024, at 2:13 PM, the Director of Nursing (DON) confirmed the notification of abnormal lab result to the physician or nurse practioner was 3 days delayed.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40606</p> <p>Based on facility policy review, observation, and interview, the facility failed to maintain sanitary kitchen equipment which had the potential to effect 118 of 120 residents in the facility.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Cleaning Schedule, revised 12/17/2021, showed .The Director of Food and Nutrition Services develops a cleaning schedule .to ensure that the Food and Nutrition Services department remains clean and sanitary at all times .A potential cause of foodborne outbreaks is improper cleaning [washing and sanitizing] of equipment and protecting equipment from contamination via splash, dust, grease . The Director of Food and Nutrition Services monitors the cleaning schedule to ensure the tasks are completed timely and appropriately .</p> <p>During the initial kitchen observation on 2/26/2024 at 10:55 AM, with the Certified Dietary Manager (CDM) showed the facility's gas stove had a thin layer of dried brown/black food debris noted on top of both oven doors, and on top of the handle of the oven on the left side. The convection oven was observed with multiple spatters of dried brown food debris was observed on the front of the oven at the control panel.</p> <p>During an interview on 2/26/2024 at 11:18 AM, the CDM confirmed the top of the oven doors and left oven door handle, as well as the control panel of the convection oven, were in an unsanitary condition due to the remnants of dried food debris present on the equipment.</p>		