

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 02/11/2025  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
| F 0557<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285</b></p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure the residents' right to retain and use their personal possessions for 1 of 1 (Resident #20) sampled residents.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Quality Assistance Procedure revised 10/30/2023, revealed .Residents, their representatives (sponsors), other interested family members, or resident advocates may file a Quality Assistance Form .concerning treatment, medial care, behavior of other residents, staff members, theft of property, etc., without fear or threat or reprisal in any form .Quality Assistance requests may be submitted orally or in writing. The administrator may delegate the responsibility of Quality Assistance investigation to appropriate department manager .Upon receipt .the department manager will investigate the allegations and submit a written report of such findings to the administrator .The resident .will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems .</p> <p>Review of the undated facility policy titled FEDERAL RIGHTS OF NURSING CENTER RESIDENTS REQUIREMENTS FOR NURSING FACILITIES revealed .The resident has a right to be treated with respect and dignity including .The right to retain and use personal possessions .unless to do so would infringe upon the rights or health and safety of other residents .</p> <p>2. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Need for Assistance with Personal Care and Muscle Weakness.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #20 was cognitively intact.</p> <p>Review of the facility QUALITY ASSISTANCE FORMS (Grievance Log) for August 2024 and September 2024, revealed there was no documentation the facility had completed a form related to Resident #20 missing perfume.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                 |
| F 0557<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>During an interview on 9/24/2024 at 10:13 AM, Resident #20 stated that perfume was missing from a bag she had covered with a towel on her nightstand last week. Resident #20 stated she reported it to Unit Manager S and has not heard anything back.</p> <p>During an interview on 9/26/2024 at 9:21 AM, the Social Services Director was asked if she had replaced Resident #20's perfume. The Social Services Director stated, not yet we are working on it.</p> <p>During an interview on 9/30/2024 at 10:30 AM, the Social Services Director confirmed that missing items should be on the QUALITY ASSISTANCE FORMS when they are reported to staff.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       |                                                 |
| <p>F 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38439</p> <p>Based on policy review, medical record review, observation and interview, the facility failed to ensure food preferences were acknowledged for 1 of 1 (Resident #70) sampled resident reviewed for choices.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Resident Rights revised on 10/30/2023, revealed The facility will ensure that all staff are educated on the rights of residents and the responsibility of the facility to properly care for its residents .</p> <p>Review of the facility policy titled, Resident Food Preferences revealed, Nutritional assessments will include an evaluation of individual food preferences .Upon the resident's admission Dietary Manager or designee will identify a resident's food preferences .The resident's clinical record .will document the resident' likes and dislikes and special dietary instructions or limitations .</p> <p>Review of the medical record revealed Resident #70 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Diabetes, Visual Loss, Stage 5 End Stage Renal Disease, and Quadriplegia.</p> <p>Review of the admission Minimum Data Set, dated dated dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #70 was cognitively intact, required set up for eating, and diagnoses of visual loss and Quadriplegia.</p> <p>During an interview on 9/23/2024 at 10:00 AM, Resident #70 stated, .I am getting pork, and I don't eat pork .</p> <p>Observation in Resident #70's room during dining on 9/23/24 at 12:50 PM, revealed Certified Nursing Assistant (CNA) A removed a tray from the meal cart, knocked and entered Resident #70's room, and placed the tray on the over the bed table. Resident #70 asked, What did they send me. CNA A stated, You have a cut up ham sandwich and then a ham sandwich in a plastic bag, chips, juice, tea, and water. Resident #70 stated, Ma'am I do not eat pork, I have told this to them since I came here, I do not eat pork. CNA A exited the room with the resident's meal ticket and walked down to the kitchen and reported to staff answering the door that Resident #70 said he does not eat pork, and he received ham sandwiches. CNA A walked back down to the Resident's room and told Resident#70 the kitchen was preparing him turkey sandwiches and French fries.</p> <p>Observation in the resident's room on 9/23/2024 at 1:05 PM, revealed CNA A returned to Resident #70's room with 2 turkey sandwiches and French fries.</p> <p>Review of the Resident's meal ticket dated 9/23/2024, confirmed Resident #70 was to be served finger foods only and no pork.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
| F 0561<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Review of the Care plan dated 9/24/2024 revealed Resident #70 was care planned for Activities of Daily Living skills self-care performance deficit, Blindness, and acknowledgement of resident preferences.</p> <p>Observation during dining on 9/24/24 at 8:50 AM, revealed Resident #70 stated, How is this finger food, [looking at] pudding and fruit cocktail in juice, go get the Unit Manager. Unit Manager B entered the room, looked at the tray and stated, I will get this fixed and exited the room.</p> <p>During an interview on 9/24/2024 at 9:02 AM, Unit Manager B confirmed the resident was to have finger food. Unit Manager B confirmed that the pudding and 2 bowls of fruit cocktail in juice was not finger food and Resident #70 should have been served finger foods.</p> <p>During an interview on 9/26/24 at 10:41 AM, the Lead Dietician confirmed that the facility should honor a resident's dietary preferences and allergies.</p> <p>The facility failed to follow dietary preference for Resident #70 when the resident was served pork and did not follow meal ticket preferences for finger foods.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                 |
| <p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38439</p> <p>Based on record review, and interview, the facility failed to provide information to the residents regarding their right to formulate an advance directive for 10 of 32 (Residents #34, #57, #71, #72, #73, #79, #92, #104, #140, and #498) residents reviewed for advance directives.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, End of Life dated 12/29/2023, revealed .the facility .will inform and educate the resident and or the residents' family about decisions for end-of-life .advance directives will be documented in the medical record .</p> <p>2. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Cerebral Infarction, Tracheostomy, 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 13, which indicated Resident #34 was cognitively intact.</p> <p>There was no documentation in the medical record if Resident #34 had an Advance Directive or if the Resident would like to formulate an Advance Directive.</p> <p>3. Review of the medical record revealed Resident #57 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Dementia, Schizophrenia, Dysphagia, and Insomnia.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 12 which indicated Resident #57 was moderately cognitively impaired.</p> <p>There was no documentation in the medical record if Resident #57 had an Advance Directive or if the Resident would like to formulate an Advance Directive.</p> <p>4. Review of the medical record revealed Resident #71 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Anoxic Brain Damage, Intellectual Disabilities, Convulsions, and Tracheostomy.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score that was not assessed indicating Resident #71 was severely cognitively impaired.</p> <p>There was no documentation in the medical record if Resident #71 had an Advance Directive or if the Resident would like to formulate an Advance Directive.</p> <p>5. Review of the medical record revealed Resident #72 was admitted to the facility on [DATE], with diagnoses including Adult Failure to Thrive, Dementia, and Dysphagia.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 3 which indicated Resident #72 was severely cognitively impaired.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
| <p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>There was no documentation in the medical record if Resident #72 had an Advance Directive or if the Resident would like to formulate an Advance Directive.</p> <p>6. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Atrial Flutter, Muscle Weakness, Convulsions, Hypertension, Insomnia, Osteoarthritis, Anxiety, Difficulty Walking and Psychosis.</p> <p>Review of the annual MDS assessment dated [DATE], revealed a BIMS score that was not assessed indicating Resident #73 was severely cognitively impaired.</p> <p>There was no documentation in the medical record if Resident #73 had an Advance Directive or if the Resident would like to formulate and Advance Directive.</p> <p>7. Review of the medical record revealed Resident #79 was admitted to the facility on [DATE], with diagnoses including End Stage Renal disease, Heart Failure, and Hypotension.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 8 which indicated Resident #79 was moderately cognitively impaired.</p> <p>There was no documentation in the medical record if Resident #79 had an Advance Directive or if the Resident would like to formulate an Advance Directive.</p> <p>8. Review of the medical record revealed Resident #92 was admitted to the facility on [DATE] with diagnoses including Venous Insufficiency, Diabetes Mellitus, and Hypertension.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a score of 15 which indicated Resident #92 was cognitively intact.</p> <p>There was no documentation in the medical record if Resident #92 had an Advance Directive or if the Resident would like to formulate an Advance Directive.</p> <p>9. Review of the medical record revealed Resident #104 was admitted to the facility on [DATE] with diagnoses including Acute and Chronic Respiratory Failure, Down's Syndrome, Peripheral Vascular Disease, Muscle Wasting and Atrophy.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS was not conducted since the patient was rarely or never understood.</p> <p>There was no documentation in the medical record if Resident #104 had an Advance Directive or if the Resident would like to formulate an Advance Directive.</p> <p>10. Review of the medical record revealed Resident #140 was admitted to the facility on [DATE], with diagnoses including Nontraumatic Intracerebral Hemorrhage, Hemiplegia, Hemiparesis, Diabetes, and Epilepsy.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score that was not assessed indicating Resident #140 was severely cognitively impaired.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
| <p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>There was no documentation in the medical record if Resident #140 had an Advance Directive or if the Resident would like to formulate an Advance Directive.</p> <p>11. Review of the medical record revealed Resident #498 was admitted to the facility on [DATE], with diagnoses including Non-Traumatic Intracerebral Hemorrhage, Diabetes, Pulmonary Embolism, Sepsis, Dysphagia, and Disorder of Bladder.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a score of 14, which indicated that Resident #498 was cognitively intact.</p> <p>There was no documentation in the medical record if Resident #498 had an Advance Directive or if the Resident would like to formulate and Advance Directive.</p> <p>12. During an interview on 9/26/2024 at 9:01 AM, the Admissions and Marketing Director confirmed that if the resident has a Living Will or Power of Attorney, a copy is made on admission, and Social Services should follow up regarding Advance Directive.</p> <p>During an interview on 10/01/2024 at 9:45 AM, Social Services Director confirmed that information should be given to residents to formulate an Advance Directive.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
| F 0580<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48285</p> <p>Based on policy review, medical record review and interview, the facility failed to notify the resident representative in advance of a change in room for 1 of 1 (Resident #305) sampled residents reviewed.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Change of Room or Roommate dated 10/30/2023, revealed .Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible .The Social Service designee or Licensed Nurse should inform the resident's sponsor/family in advance of a change in the resident's room or roommate .</p> <p>2. Review of the medical record revealed Resident #305 was admitted to the facility on [DATE], with a readmitted [DATE], with diagnoses including Ventricular Tachycardia, Myoclonus, Cognitive Communication, Seizures, Severe Protein- Calorie Malnutrition, and Severe Hypoxic Ischemic Encephalopathy.</p> <p>Review of the census in the medical record revealed Resident #305 was moved from one room number to a different room number on 3/5/2024.</p> <p>Review of Progress Notes dated 3/6/2024 at 6:49 AM, revealed Son notified of room change. Son is in agreement with room change. Resident transferred from [one room number] to [another room number] with all personal belongings.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed the Brief Interview for Mental Status (BIMS) score was not assessed, indicating severely impaired cognition.</p> <p>During a phone interview on 10/15/2024 at 5:05 PM, Unit Manager N confirmed that she did not notify the family until the resident was in new room.</p> <p>The facility failed to notify the resident representative in advance of a room change.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49269</p> <p>Based on policy review, medical record review, Facility Reported Incident (FRI) review, and interview the facility failed to report allegations of abuse and neglect related to injury of unknown origin within 2 hours for 1 of 3 (Resident #248) sampled residents.</p> <p>The Findings include:</p> <p>1. Review of the facility policy titled Abuse, Neglect and Exploitation revised 1/10/2024, revealed .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .establish policies and procedures to investigate any such allegations: and include training for new and existing staff on activities that constitute abuse, neglect .reporting procedures .and resident abuse prevention .the facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law .reporting process for abuse, neglect . including injuries of unknown sources .physical injury of a resident, of unknown source .psychological abuse of a resident observed .failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning &amp; positioning .an immediate investigation is warranted when suspicion .reporting alleged violations to the administrator, state agency, adult protective service and to all other required agencies within specified timeframes as required by state and federal regulations .immediately but not later than 2 hours after the allegation is made if the allegation involve abuse or result in serious bodily injury .not later than 24 hours if the events do not involve abuse and do not result in serious bodily injury .the administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the result of the investigation when final within 5 working days of the incident, as required by state agencies .</p> <p>2. Review of the medical record revealed Resident #248 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Hypertension, Diabetes, Anxiety, and Psychotic Disorder.</p> <p>Review of the quarterly Minimum Data Set, dated dated dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 2 indicating that Resident #248 was severely cognitively impaired, was dependent on staff for activities of daily living activities and required assistance with toileting, bathing, dressing, and bed mobility.</p> <p>Review of the Radiology Interpretation report dated 5/26/2023, revealed .Left Scapula X-Ray complete . Findings .Left scapula .Fontal and scapular Y views [xray taken at an angle] .Anterior gleno-humeral [ball and socket allows for range of motion] dislocation .Impression . Anterior dislocation .Left shoulder X-Ray complete .Findings .Left Shoulder .Frontal and scapular Y views .Anterior gleno-humeral dislocation .Anterior dislocation .</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
| F 0609<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Review of the Nurse Note dated 5/26/2023, revealed 15:30 [3:30 PM] Abnormal Xray results received on left scapula and shoulder. Results forwarded to DON [Director of Nursing] .and [named provider] Dr .Orders received to send to [named facility emergency room ] for further evaluation. 16:18 [4:18 PM] writer called POA [Power of Attorney] .and informed her of results and that she would be transferred to [Named facility emergency room ] for further eval. POA agreed with transfer. Lifecare ambulance service called with estimated ETA [Estimated time of Arrival] of 2 hours. [Named facility emergency room (ER)] called and report given to nurse .to inform of arrival in approximately 2 hours .</p> <p>Review of the Facility's Reported Incident dated 5/27/2023 at 1:14 AM, revealed .Resident frequently yells out due to cognitive deficit. The resident began to yell out more frequently the past 24 hours. NP [Nurse Practitioner] was notified. Labs and x-ray ordered due to c/o [complaints of] left arm [pain]. Resident has c/o left arm pain at times with mobility since admission .5 day follow up added 6/5/2023 .Resident remains in the hospital .</p> <p>There was no documentation the injury of unknown origin was reported per facility policy.</p> <p>During an interview on 10/10/2024 at 10:04 AM, the DON confirmed that an injury of unknown origin should be reported within 2 hours.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047</b></p> <p>Based on policy review, medical record review, facility investigation review and interview, the facility failed to thoroughly investigate an allegation of abuse and failed to report to the government agency the results of the facility investigation within 5 working days for 4 of 13 residents (Resident #58, #248, #298, #300) reviewed for abuse incidents.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Abuse, Neglect and Exploitation, revised 1/10/2024, revealed .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation .the facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law . Possible indicators of abuse include .resident, staff or family report of abuse . Physical marks such as bruises or patterned appearances .on resident's body .physical injury of a resident, of unknown source .written procedures for investigations include: identifying staff responsible for the investigation .investigating different types of alleged violations .identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred providing complete and thorough documentation of the investigation .protection of resident .reporting alleged violations to the administrator, state agency, adult protective service and to all other required agencies within specified timeframes as required by state and federal regulations .the administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the result of the investigation when final .</p> <p>2. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE], with diagnoses including Alzheimer's, Dementia, Anxiety, Psychotic Disorder, Insomnia, Hypertension, and Depression.</p> <p>Review of the Other Skin note dated 10/28/2023, revealed .called to Resident #58's room, by CNA (Certified Nursing Assistant) at approximately 06:00 AM, to look at resident's left hand .noted left hand and digits to be bruised and swollen .Upon assessment, resident noted moaning, when touched .</p> <p>Review of Nurses Note dated 10/28/2023, revealed writer called to resident's room, by CNA, at approximately 06:00 AM, to look at resident's left hand .Upon entry, writer noted left hand and digits to be bruised and swollen .Upon assessment, resident noted moaning when area is touched .Writer notified supervisor on duty .NP [Nurse Practitioner] notified .X-ray ordered . DON [Director of Nursing] notified. Resident's guardian notified .</p> <p>Review of the hospital's History and Physical report revealed .ER [emergency room ] 10/28/2023, with some left hand pain swelling-mechanism of injury not known .found to have proximal fourth and fifth digit fractures on her left hand .</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(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>Review of Progress Note dated 10/30/2023 at 10:58 AM, revealed .SW [Social Worker] contact MPD [Memphis Police Department] non-emergency police number to report allegation of abuse related to resident with bruises all over her body and 2 broken fingers; spoke with .dispatcher . APS [Adult Protective Service] contacted .someone will be out to investigate incident .</p> <p>Review of Nurses Note dated 10/30/2023, revealed bruises noted to left chin, left cheek, left shoulder, left wrist along with a red-looking rash to right buttocks .Wound care nurse notified of rash along with NP notified of all new bruises and new rash to right buttocks. New order from NP for aptt [activated partial thromboplastin time], pt [prothrombin time], inr. [INR - international normalized ratio] .Wound care nurse to evaluate rash on right buttocks .</p> <p>Review of Pertinent Charting-Skin note dated 10/30/2023, revealed Event Date: 10/30/2023 Location of skin area being documented: Bruises noted to left cheek, left chin, left shoulder and left wrist .Rash to right buttocks Description: Rash to right buttocks red raised. No drainage or foul odor noted from rash site. Interventions: Wound care to evaluate area .Physician notification: DR [Doctor], Responsible Party notification .conservator .Referrals: New orders: PT WITH INR APPT.</p> <p>Review of Nurses Note dated 10/30/2023 at 2:28, revealed This residents' conservator here to see resident R/T [related to] bruising noted on resident which was reported to her .conservator spoke to Adon [Assistant Director of Nursing] and DON before leaving facility .New orders for entire left side of upper body plus skull series R/T bruising of unknown origin .</p> <p>Review of the Nurse's Note dated 10/30/2024, revealed Resident #58 resting quietly in bed at this time. NAD [No apparent distress] noted. Lt.[left] hand with splint intact. Will continue to monitor .</p> <p>Review of Pertinent Charting-Skin on 10/31/2023, revealed Location of skin area being documented: bruises to left upper extremity .Brace to left hand r/t finger fractures and broken left wrist . Resident currently sleeping, call light within reach bed in lowest position and locked .</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score was not coded. Resident #58 had short-term memory and long-term memory problems and was dependent upon staff for activities of daily living including bed mobility and transfers.</p> <p>Review of quarterly MDS assessment dated [DATE], revealed a BIMS score was not coded. Resident #58 had short-term memory and long-term memory problems and was dependent upon staff for activities of daily living including transfers.</p> <p>The facility reported the incident on 10/28/2023 but failed to submit the 5 day follow up report of the facility investigation within 5 working days of the incident.</p> <p>3. Review of the medical record revealed Resident #248 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Hypertension, Diabetes, Anxiety, and Psychotic Disorder.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(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>Review of the Radiology Report dated 3/11/2020, revealed WRIST .Results: Scaphoid [bone in the wrist] irregularity .Scapholunate widening suggests ligamentous injury. Degenerative changes. Possible scaphoid fracture, recommend scaphoid views or CT [computed tomography] .HUMERUS [bone in the arm] MINIMUM 2V [view], LEFT .Results. No acute fracture or dislocation. The osseous [bone] structures appear intact. Joint spaces are narrowed. Soft tissues are unremarkable. Conclusion . No acute osseous abnormality. Degenerative changes .</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 2, indicating that Resident #248 was severely cognitively impaired, was dependent on staff for activities of daily living such as toileting, bathing, dressing, and bed mobility, and was always incontinent for bowel and bladder.</p> <p>Review of the Nursing Evaluation Summary dated 3/10/2023, revealed RESIDENT REQUIRE TOTAL CARE WITH ALL ADLS [Activities of Daily Living] X [Times] 1, INCONTINENT OF B/B [Bowel and Bladder], WEAR ADULT DIAPERS, ALERT AND ORIENTED X 1, DISORIENTED TO TIME AND PLACE. APPETITE GOOD PER FEEDING SELF .HAS LEFT SIDED WEAKNESS .</p> <p>Review of the Nurse Note dated 5/26/2023, revealed 15:30 [3:30 PM] Abnormal Xray results received on left scapula and shoulder. Results forwarded to DON [Director of Nursing] . and [named provider] .Orders received to send to [named hospital emergency room (ER)] for further evaluation. 16:18 [4:18 PM] writer called POA [Power of Attorney] .and informed her of results and that she [Resident #248] would be transferred to [Named hospital emergency room ] for further eval. [evaluation] POA agreed with transfer . ambulance service called with estimated ETA [Estimated time of Arrival] of 2 hours. [Named hospital ER] called and report given to nurse .to inform of arrival in approximately 2 hours .</p> <p>Review of nurse's note dated 5/26/2023 revealed .RESIDENT YELLING OUT AGAIN, NOTED TWITCHING TO RT [Right] SIDE OF FACE AND RT. ARM, MENTAL STATUS CHANGE, FNP [Family Nurse Practitioner] NOTIFIED, RECIEVED FOR CBC [Complete blood count], CMP [Complete metabolic panel], MAGNESIUM, NARCO 7.5MG, [used to treat pain], 1 EVERY 6HRS [Hours] PRN [As needed] PAIN, X-RAY LT [Left] SHOULDER AND ARM. RADIOGRAPHICS NOTIFIED .</p> <p>Review of the hospital triage note dated 5/26/2023 at 5:48 PM, revealed .Chief Complaint: left shoulder dislocation .Additional assessment note - triage: pt [patient-Resident #246] is from [named long-term care facility]. Pt is bed bound and nursing home staff states that they think she was possibly turned wrong, and the shoulder was dislocated .</p> <p>Review of the hospital Emergency Department (ED) nurse's note dated 5/26/2023 at 6:44 PM, revealed .Pt [Resident #248] brought by EMS [Emergency Medical Service] and placed in RM [room] .Pt yelling and screaming. RN [Registered Nurse] attempted to reorient pt with no success. EMS reports pt from [named nursing home] and they [nursing home staff] moved her [Resident #248] the wrong way. Deformity noted to left shoulder .Pt taken to xray with RN. call light and personal items within reach. pending scans for further eval .</p> <p>Review of the Radiology Interpretation dated 5/26/2023, revealed .Left Scapula X-Ray complete .Findings . Left scapula . Frontal and scapular Y views .Anterior gleno-humeral [shoulder joint] dislocation . Impression . Anterior dislocation .Left shoulder X-Ray complete .Findings .Left Shoulder .Frontal and scapular Y views . Anterior gleno-humeral dislocation .Anterior dislocation .</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(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>Review of the facility's investigation dated 5/27/2023, revealed . Resident frequently yells out due to cognitive deficit. The resident began to yell out more frequently the past 24 hours. NP [Nurse Practitioner] was notified. Labs and x-ray ordered due to c/o [complaints of] left arm [pain]. Resident has c/o left arm pain at times with mobility since admission .Resident c/o left arm pain. X-ray obtained that indicated a dislocated shoulder. Resident had a previous injury to this shoulder with a fracture [Resident #248 actually had a previous scaphoid or wrist fracture/injury]. There is no outward s/s [signs or symptoms] of trauma to the left shoulder. Resident is alert and oriented to person. She can make her needs known. She does yell out frequently due to cognitively impairment. Resident yelled out more frequently. No c/o [complaints] anyone hurting her. No change in baseline other than more frequently yelling out. Resident has an old injury to her left shoulder [actually an old injury to the scaphoid/wrist] and does c/o pain at times. Pain relieved with Tylenol. Due to her yelling out more frequently today, NP notified for x-ray. MD notified for follow up treatment and diagnostics at the ER .5/27/2023 at 1:38 AM Resident was yelling out more frequently today. She does yell out due to cognitive deficit. NP notified for x-ray. X-ray indicates a dislocation of the shoulder. Investigation in progress. Resident sent to the hospital for follow up. 5 day follow up dated 6/5/2023 Resident remains in the hospital. Diagnosis unknown. The dislocated left shoulder was an old injury. X-ray comparison and CT scans at the hospital verified the injury with an old fx [fracture] has been present previously [refers to an old scaphoid/wrist injury]. Multiple attempts to reduce the left shoulder dislocation have been unsuccessful. Employees that provide care report no falls or injuries. Resident refuses to get OOB [Out of Bed] Resident is alert and oriented to self. Cognitively impaired r/t [related to] hemorrhagic cva [cerebrovascular accident] . Requires one person for bed mobility. The unknown origin injury is not substantiated. The injury is chronic [the scaphoid/wrist injury] .</p> <p>Review of 3 witness statements provided with the facility investigation revealed one statement was undated and staff reported that she did not work with Resident #248. One statement was dated 5/5/2023 (prior to the incident). One statement was dated 6/5/2023 and staff stated that she did not work with Resident #248.</p> <p>During a telephone interview on 10/15/2024 at 10:49AM, the former DON was asked about the facility's investigation for Resident #248's injury of unknown origin and if she was aware of the difference between a scapular and a scaphoid fracture. The former DON stated that she thought the scapular and scaphoid were the same thing. The former DON stated since the scapular and scaphoid are two different areas of the body then the injuries should not have been related. The former DON confirmed a thorough investigation should include witness statements from staff who were assigned care of Resident #248 and statements should be dated and signed by staff.</p> <p>During an interview on 10/16/2024 at 2:13 PM, the Administrator confirmed a thorough investigation included interviewing and obtaining complete and accurate witness statements of staff who were assigned care of Resident #248 over the last 72 hours. The Administrator verified the witness statements should be signed and dated by staff, and the facility 5 day follow up should be submitted within 5 days of the facility reported incident.</p> <p>4. Review of the medical record revealed Resident #298 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Anxiety, Chronic Obstructive Pulmonary Disease, Aphonia and Tracheostomy.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(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>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 9 which indicated Resident #298 was moderately cognitively impaired.</p> <p>Review of the progress notes dated 3/5/2023 at 2:16 PM, revealed .Pt [Resident #298] has new skin issues on both breast r/t holding hands tightly up against chest. Interventions include placing a soft barrier between the Pt arm and breast to relieve the pressure. As well as monitoring the skin condition every day .</p> <p>Review of the nurses note dated 3/13/2023 at 8:20 PM, revealed CNA [Certified Nursing Assistant] discovered 2 bruises, one to each breast this evening during HS [bedtime] care and was reported to her nurse and then shown to me [RN E]. I then informed the DON, the RP and the MD . Resident was also medicated for pain .</p> <p>Review of the Incident Report dated 3/13/2023, revealed .Incident Description .CNA brought to [Named Nurse] attention two new bruises one on each breast her [Resident #298] arms held tightly to her chest .</p> <p>Review of the Skin assessment dated [DATE], revealed .Skin Evaluation .Are there any new abnormal skin areas .yes .site .Chest .2 discolored areas with slight excoriation noted to bilateral breasts. Resident noted holding her hand very tightly at her chest area .Area is caused from resident holding her hands so tight right at chest area causing discoloration .</p> <p>Review of the care plan revised 3/13/2023, revealed .Discoloration to bilateral breasts due to resident holding hands/arms tightly to her chest Date initiated .3/13/2023 .pad area between chest area and hands as allowed .Avoid scratching and keep hands and body parts from excessive moisture .educate .causative factors .to prevent skin injury .</p> <p>Review of the facility investigation revealed 3 witness statements dated 3/17/2023. Review of the witness statements revealed 2 statements verifying Resident #298 keeps her hands close to her chest and keeps her arms and fists balled up close to her chest. There was no documentation of further investigation or statements.</p> <p>During an interview on 10/16/2024 at 2:13 PM, the Administrator stated a thorough investigation would include talking with those who found it, looking at the shower schedules and talk with staff that worked with the resident in the last 72 hours.</p> <p>5. Review of the medical record revealed Resident #300 was admitted to the facility on [DATE], with diagnoses including Malignant Neoplasm of Ovary, Anxiety, and Depression.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 5, which indicated Resident #300 was severely cognitively impaired.</p> <p>Review of Nurses' Notes dated 3/18/2023 at 4:40 AM, revealed .Residents daughter escorted out due to her arguing with resident and threatening to hit her [Resident #300] and at residents request, nurse explained to daughter that she could wait in family room for a ride but could not return to residents room causing a disturbance to her mother and the other residents .</p> <p>(continued on next page)</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
| F 0610<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>A facility investigation for family to resident abuse began on 3/18/2023. Review of the facility investigation revealed Resident #300's daughter visited the Resident and had asked for money from the Resident. Resident #300 refused to give the daughter money, and the daughter was heard threatening to hit Resident #300 and was yelling loudly. The staff removed the daughter from the Resident's room and the Police took the daughter away in the police car. A picture of the alleged perpetrator was shared with staff as a safeguard to keep the daughter from returning to her mother's room. There was no documentation the facility obtained witness statements and/or other residents for the investigation.</p> <p>During an interview on 10/16/2024 at 3:48 PM, the DON confirmed a thorough investigation was not done if there were no witness statements.</p> <p>47835</p> <p>48285</p> <p>49269</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38439</p> <p>Based on medical record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were complete and accurate for 4 of 47 (Resident #6, #41, #84, and #105) MDSs reviewed.</p> <p>The findings include:</p> <p>1. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Osteoarthritis, Acute Upper Respiratory Disease, and Muscle Weakness.</p> <p>Review of the quarterly MDS dated [DATE], revealed the Brief Interview for Mental Status (BIMS) score was completed with a dash, indicating the BIMS score was not assessed.</p> <p>The facility failed to ensure the BIMS was assessed and completed for the quarterly MDS dated [DATE].</p> <p>2. Review of the medical record revealed Resident # 41 was admitted to the facility on [DATE], with diagnoses including Dementia, Cerebral Infarction, Hemiplegia and Hemiparesis, and Muscle Weakness.</p> <p>Review of the annual MDS dated [DATE] revealed the BIMS was completed with a dash, indicating the BIMS score was not assessed.</p> <p>The facility failed to ensure the BIMS score was assessed and completed for the quarterly MDS dated [DATE].</p> <p>3. Review of the medical record revealed Resident #84 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Contracture of Left Hand, Asthma, Absolute Glaucoma of Left Eye, Shortness of Breath, and Lack of Coordination.</p> <p>Review of the quarterly MDS dated [DATE], revealed the BIMS was completed with a dash, indicating the BIMS score was not assessed.</p> <p>The facility failed to ensure the BIMS score was assessed and completed for the quarterly MDS dated [DATE].</p> <p>4. Review of the medical record revealed Resident #105 was admitted to the facility on [DATE], with diagnoses including Transient Cerebral Ischemic Attack, Chronic Obstructive Pulmonary Disease, Dementia, and Cognitive Impairment.</p> <p>Review of the quarterly MDS dated [DATE], revealed the BIMS score was completed with a dash, indicating the BIMS score was not assessed.</p> <p>The facility failed to ensure the BIMS score was assessed and completed for the quarterly MDS dated [DATE].</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 02/11/2025  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
| F 0641<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | 5. During an interview on 10/15/24 at 4:12 PM, the Social Services Director (SSD) confirmed the BIMS score was completed by social services and that she and her assistant split the building to ensure all residents were assessed. The SSD stated the BIMS score should be completed by the Assessment Reference Date (ARD) and when it is not completed by that date then dashes are placed in the blanks in order for the MDS Coordinator to complete the assessment timely. The SSD stated both she and the Social Service Assistant had access to all MDS assessments and when they were due. The SSD confirmed that the BIMS should be completed with no dashes. |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
| F 0645<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285</b></p> <p>Based on the Level 1 Pre-Admission Screening and Resident Review (PASRR) form, policy review, medical record review, and interview, the facility failed to resubmit a PASRR after the resident had the addition of a new mental health diagnosis for 1 of 6 sampled residents (Resident #56) reviewed for PASRRs.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled PASARR-Pre-Admission Screen and Resident Review dated 10/30/2023, revealed .All residents are required to have a level I PASRR screen prior to or upon admission to the facility. When indicated on the level I screen that a level II screen is required, the facility will complete notification to the State's PASRR program notice for the level II screen .if a resident is admitted with a level diagnosis . review is required upon change in the resident's condition .</p> <p>2.Review of the medical record revealed Resident #56 was admitted to the facility on [DATE], with diagnoses including Multiple Sclerosis, Respiratory Failure, Paraplegia, and Cognitive Communication Deficit.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #56 was cognitively intact and diagnoses including Psychotic Disorder and Depression.</p> <p>Review of the Medication Administration Record (MAR) dated May 2024, revealed Resident #56 received Seroquel (used to treat schizophrenia) for Psychosis.</p> <p>Review of the PASSR dated 5/5/2024 did not have Seroquel listed as a Psychoactive (mental health) medication that Resident was taking now or within the last 6 months.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, indicating Resident #56 was cognitively intact and diagnoses including Psychotic Disorder and Depression.</p> <p>3.During a phone interview on 10/3/2024 at 10:37 AM, the pre-Admission Evaluation ([NAME]) /PASRR Nurse was asked if a new PASSR should have been done when the Resident received a new order for Seroquel on 5/6/2024. The [NAME]/PASRR Nurse stated, .I didn't know about the new .order for medication . yes it should have been done prior to 9/24/2024.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                 |
| <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> 48285</p> <p>Based on policy review, medical record review and interview, the facility failed to conduct quarterly care conference meetings for 1 of 1 (Resident #20) sampled resident reviewed.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled Comprehensive Care Plans revised 6/30/2022, revealed .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . Person-centered care means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives .The comprehensive care plan will be prepared by an interdisciplinary team, that includes but is not limited to .the resident and the residents representative .Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family .</p> <p>2. Review of medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Fracture of Right Femur, Dysphagia, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #20 was cognitively intact.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #20 was cognitively intact.</p> <p>When requested, the facility was unable to provide documentation that a quarterly Care Conference was conducted with the Resident or Responsible Party (RP).</p> <p>3. During an interview on 9/24/2024 at 10:17 AM, Resident #20 stated she had not been invited to or attended any care plan meetings.</p> <p>During an interview on 9/30/2024 at 11:44 AM, the Social Services Worker confirmed residents should be invited to participate in quarterly care plan meetings and the facility had not conducted a meeting with Resident #20 since January 2024.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                   |                                                 |
| <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** 47835</b></p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure residents were assisted with Activities of Daily Living (ADLs) for personal grooming for 1 of 4 residents (Resident #80) reviewed for ADLs.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Activities of Daily Living (ADLs), revised 12/28/2022, revealed .The facility takes measures to minimize the loss of residents functional abilities, including activities of daily living . including the ability to bathe, dress, and groom .resident who is unable to carry out activities of daily living receives the necessary services to maintain . grooming and personal and oral hygiene .the facility maintains individual objectives of the care plan through periodic review and evaluation .</p> <p>2. Review of the medical record revealed Resident #80 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, Cerebral Infarction, Muscle Weakness, and Tracheostomy.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #80 was cognitively intact and was dependent on staff for all ADL care.</p> <p>Review of the comprehensive Care Plan revised 9/4/2024, revealed .Resident has an ADL self-care performance deficit .personal hygiene .1 person assists .ventilator dependent .</p> <p>Review of the Documentation Survey Report dated September 2024, revealed .personal hygiene .ability to maintain personal hygiene, including combing hair .Dependent-Helper does ALL of the effort. Resident does none of the effort to complete the activity .</p> <p>Observation in the Resident's room on 9/23/2024 at 10:06 AM, and 9/26/2024 at 7:59 AM, revealed matted and knotted up thin gray hair on the left side of the back of her head.</p> <p>Observation and interview in the Resident's room on 9/30/2024 at 2:49 PM, revealed Resident #80's hair remained matted and knotted. Resident #80 was asked how often you receive a shower. Resident #80 stated, Once or twice a week. Resident #80 was asked has anyone had tried to comb your hair out. Resident #80 confirmed one girl kinda tried to brush it.</p> <p>During an interview on 9/30/24 at 2:45 PM, Certified Nursing Assistant (CNA) L was asked who takes care of making sure residents' hair has been washed and combed. CNA L stated that it should be done every time residents have a shower.</p> <p>Observation and interview in the Resident room on 10/01/24 at 9:59 AM, revealed CNA L was shown Resident #80's hair. CNA L confirmed Resident #80's hair should not be matted and knotted up. CNA L stated, I just told her (Resident #80) that I was going to get a brush and comb .</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
| <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> 38439</p> <p>Based on policy review, medical record review, observations, and interview, the facility failed to follow Physician orders related to blood glucose monitoring, missed medication doses, physician orders for parameters for the use of an anti-hypertensive medication (a medication given for high blood pressure) and failed to obtain vital signs before administering anti-hypertensive medication for 3 of 3 sampled residents (Resident #12, #68, and #73) reviewed for medication administration.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Physician/Practitioner Orders-Consulting revised 3/20/2024, revealed . The attending physician shall authenticate orders for the care and treatment of assigned residents .</p> <p>2. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Hypertension, Diabetes, End Stage Renal Disease, Hyperkalemia and Atrial Fibrillation.</p> <p>Review of the Physician Orders dated 4/23/2024, revealed .May obtain blood glucose as needed if symptoms of hypo/hyperglycemia &amp; [and] notify MD [medical doctor] .</p> <p>Review of the Physician Orders dated 5/10/2024, revealed .blood glucose checks weekly one time a day every Mon [Monday] related to TYPE 2 DIABETES .</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #12 was severely cognitively impaired.</p> <p>Review of the Medication Administration Record (MAR) dated 8/2024, revealed . [blood glucose monitoring] - Every Monday one time a day every Mon related to TYPE 2 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS -Start Date 8/12/2024 0600 [6:00 AM] .</p> <p>Review of the Medication Administration Record (MAR) dated 8/2024, revealed blood glucose monitoring was not performed on 8/5/2024.</p> <p>During an interview on 10/09/2024 at 2:11 PM, Unit Manager B confirmed blood glucose monitoring was not performed on 8/5/2024.</p> <p>3. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE], with diagnoses including Diabetes, Heart Failure, Hypertension, and Stage 4 Pressure Ulcer. Resident #68 was cognitively impaired.</p> <p>Review of Physician's Orders dated 7/2/2024, revealed the following medication orders:</p> <p>a. Atorvastatin 20 milligram (mg), (used to treat cholesterol) give by mouth at bedtime.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       |                                                 |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>b. Metoprolol Tartrate 25mg, (used to treat blood pressure), .hold for SBP [Systolic blood pressure less than 120, diastolic blood pressure less than 60 or Heart rate less than 60.</p> <p>c. Pantoprazole Sodium 40mg, (used to treat acid reflux), .give by mouth two times a day.</p> <p>d. Hydralazine 100mg, (used to treat blood pressure), . give 1 tab two times a day. Systolic blood pressure greater than 160 or less than 100, Diastolic blood pressure greater than 100 or less than 60, pulse less than 60.</p> <p>e. Lamotrigine 25mg, (used to treat mood disorder), give 1.5 tablet by mouth in the morning.</p> <p>f. Losartan Potassium 50mg, (used to treat blood pressure), give 2 tablets by mouth one time a day .Systolic blood pressure greater than 160 or less than 100, Diastolic blood pressure greater than 100 or less than 60, pulse less than 60.</p> <p>g. Albuterol Sulfate Inhalation Nebulization Solution, (used for shortness of breath), (2.5mg/(per)3ML [milliliters] .0.083% (percent) 1 application via mask one time a day.</p> <p>h. Humalog Solution, (used to treat blood glucose), 100unit/ml . Inject 8 unit subcutaneously one time a day.</p> <p>i. Multiple vitamins, (used as supplement), give 1 tablet by mouth one time a day.</p> <p>j. Oyster Shell Calcium 500 +D, (used as a supplement), give 1 tablet by mouth one time a day.</p> <p>k. Juven, (used as a nutritional supplement), two times a day.</p> <p>Review of Resident #68's Medication Administration Record (MAR) dated 7/2024, revealed the following medications were not administered as ordered on 7/25/2024.</p> <p>a. Hydralazine 100mg was not administered for the evening scheduled dose.</p> <p>b. Metoprolol 25mg was not administered for the evening scheduled dose.</p> <p>Review of the MAR dated 8/2024 for Resident #68 revealed the following medications were not administered as ordered on 8/24/2024:</p> <p>a. Albuterol Sulfate 0.083% 1 application via mask one time a day.</p> <p>b. Humalog Solution - 8 units subcutaneously one time a day.</p> <p>c. Lamotrigine 25mg - 1.5 tablet by mouth in the morning.</p> <p>d. Losartan 50mg - 2 tablets by mouth one time a day.</p> <p>e. Oyster Shell Calcium 500 +D - 1 tablet by mouth one time a day.</p> <p>f. Multiple vitamin - 1 tablet by mouth one time a day.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                 |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>g. Hydralazine 100mg was not administered for morning scheduled dose.</p> <p>h. Juven was not administered for morning scheduled dose.</p> <p>i. Metoprolol 25mg was not administered for morning scheduled dose.</p> <p>j. Pantoprazole 40mg was not administered for morning scheduled dose.</p> <p>Review of Resident #68's MAR dated 10/2024 revealed Metoprolol 25mg was administered outside of ordered parameters of hold for systolic blood pressure less than 120 and/or diastolic blood pressure less than 60 for the following dates:</p> <p>a. 10/2/2024 at 9:00 AM with blood pressure 111/82.</p> <p>b. 10/3/2024 at 9:00 AM with blood pressure 112/68.</p> <p>c. 10/4/2024 at 9:00 AM with blood pressure 116/53.</p> <p>d. 10/12/2024 at 9:00 AM with blood pressure 110/52.</p> <p>During an interview on 10/9/2024 at 9:53 AM, the Director of Nursing (DON) confirmed that staff should follow physician orders.</p> <p>4. Review of the medical record revealed Resident #70 was admitted to the facility on [DATE], with diagnoses including Atrial Flutter, Alcohol Use, Muscle Weakness, Convulsions, Hypertension, Anxiety, and Psychosis. Resident #70 was severely cognitively impaired.</p> <p>Review of the Order Review History Report dated 8/25/2024 to 9/25/2024, revealed, .Metoprolol [medication used for high blood pressure] .Tablet Give 12.5 mg [milligrams] .one time a day .HYPERTENSION [medical term for high blood pressure] .hold for HR [heart rate] &lt; [symbol for less than] 60 SBP [systolic blood pressure] &lt;120 DBP [diastolic blood pressure] &lt;60 .</p> <p>Review of the Care Plan dated 9/24/2024, revealed Resident #73 was care planned for impaired cardiovascular status related to hypertension.</p> <p>Review of the June 2024, July 2024, August 2024, and September 2024 MAR revealed the facility failed to document the Resident's blood pressure and heart rate for the use of daily administration of an antihypertensive medication.</p> <p>During an interview on 9/30/2024 at 9:53 AM, Licensed Practical Nurse (LPN) D was asked if a resident had parameters for the use of an antihypertensive medication, where was that information recorded prior to administering the antihypertensive medication. LPN D stated it should on the MAR. LPN D stated she would record the resident's blood pressure when she administered the medication under the vital sign tab on the electronic medical record. LPN D was asked to show where the blood pressure was recorded. LPN D stated she had not recorded any blood pressures for the use of the antihypertensive medication.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                     |                                                                                       |                                                 |
| F 0684<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | During an interview on 9/30/24 at 9:40 AM, the DON confirmed nursing staff should follow physician orders<br>for the use of an antihypertensive medications to include obtaining and recording the resident's blood<br>pressure.<br><br>49269 |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38909</p> <p>Based on facility policy review, facility fall investigation review, medical record review, observation, and interview, the facility failed to ensure the resident environment remained free of accident hazards for 1 of 3 (Resident #77) sampled residents reviewed for accidents. On 8/9/2024, Resident #77, a vulnerable cognitively impaired resident, rolled out of the bed onto the floor and sustained a fracture to the right humerus, resulting in Actual Harm. Certified Nursing Assistant (CNA) W admitted to returning the resident to the bed without notifying the nurse. CNA W was assisted by CNA X, to get Resident #77 back in the bed.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Falls- Clinical Protocol, dated 11/2/2023, revealed .the staff will help identify individuals with a history of falls and risk factors for subsequent falling .Admission Evaluation Data Form, which includes the fall risk evaluation .this form is completed upon admission, quarterly, and with significant change in status .Based on the assessment an initial care plan will be developed and implemented to address identified risk .Goals of the plan of care may include interdisciplinary team, physician, resident and responsible party when possible .Goals may include, but not limited to reduction of falls, minimize injury from falls, and/or prevent falls while maintaining .or improving resident abilities and quality of life .Interventions should be developed and implemented per the assessed needs .Resident's abilities and deficits .Balance .Adaptive equipment needs .Proper use of mechanical lifts and transfer devices .interventions for direct care givers should be placed on the CNA [certified nursing assistant] Kardex [CNA care plan] .For an individual who has fallen, staff should attempt to define possible causes within 24 hours of the fall .Causes refer to factors that are associated with or that directly result in a fall .Once a fall occurs it is important to gather as much information as possible .Provide emergency care and assessments as indicated .The Physician and Responsible party should be notified as soon as the resident is stabilized .Document findings in the resident's medical record .Complete the Fall Re-evaluation .to determine if there are additional risk factors .Document falls on the 24-hour shift report .An accident/[or]incident report will be completed .</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                 |
| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>                                                   | <p>Review of the facility policy titled, Incidents and Accidents Reporting, dated 8/11/2022, revealed .It is the policy of this facility for staff .to report, investigate, and review any accident or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident .'Accident' refers to any unexpected or unintentional incident, which result or may result in injury or illness to a resident .An 'Incident' is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization .The purpose of incident reporting is: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care .Conducting root cause analysis to ascertain .contributing factors . Meet regulatory requirements for analysis and reporting of incidents and accidents .The following incidents/accidents require an incident/accident report .Falls .Unobserved injuries .In the event of an incident or accident, immediate assistance will be provided .Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so .The supervisor or other designee will be notified of the incident/accident .The nurse will notify the resident's practitioner to inform them of the incident/accident .The resident's family or representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital .The nurse/designee will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information .Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions .and orders obtained or follow-up interventions .If an incident/accident was witnessed by other people, the supervisor or designee will obtain the witnesses' account .In the event that an incident must be recorded .the following should occur .Complete the paper form for the incident .Complete all other assessments .paper incident report should be entered electronically .</p> <p>Review of the facility policy titled, Safe Lifting and Movement of Residents, dated 1/1/2022, revealed .Each resident is assessed .to determine lifting and movement assistance needs .Mechanical lifting devices shall be used for heavy lifting .Except during emergency situations or unavoidable circumstances, manual lifting is not permitted .</p> <p>2. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure with Hypoxia, Cerebral Infarction, Gastrostomy Status, Tracheostomy Status, and Atrial Fibrillation.</p> <p>Review of Resident #77's Care Plan date initiated on 8/30/2023, revealed .Resident has an ADL [Activities of Daily Living] self-care performance deficit related to CVA .BED MOBILITY: 2 person assist .</p> <p>Review of Resident #77's Physician orders dated 6/3/2024, revealed .Hydrocodone-Acetaminophen Tablet 5-325 mg [milligrams] Give 1 tablet by mouth every 8 hours for pain .</p> <p>There was no documentation in the medical record on 8/9/2024, when the incident occurred.</p> <p>Review of the Incident/Accident Report for Resident #77 dated 8/13/2024, revealed .Resident's CNA [CNA V] notified nurse of abnormal discoloration to resident's right upper arm .This nurse observed resident flinched and showed signs of discomfort upon her arm being touched/moved .</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>                                                   | <p>Review of the Physician Progress Note dated 8/13/2024, revealed .RUE [right upper extremity] swelling .79 y/o [year old] BF [black female] with hx [history of] multiple CVA, [Cerebrovascular Accident], Chronic Respiratory Failure with Hypoxia, Osteoarthritis .is seen today for RUE swelling .RUE upper arm to hand swelling noted, warm to touch with 2 dime size contusions to inner upper arm noted. Will xray due to hx of arthritis and eval for possible pathogenic fx [fracture] .</p> <p>Review of Resident #77's Care Plan dated 8/13/2024, revealed .Resident is at risk for falls/injury related to Cerebral Vascular Accident (CVA) needs assistance with ADL's [activities of daily living] .Reduce the risk of injury .8/13/2024 X-Ray doppler [test used to detect blood flow] .8/13/2024 ER [emergency room ] evaluation and tx [treatment] .8/13/2024 pain meds as ordered .8/13/2024 immobilizer .monitor resident's position to reduce the risk of sliding/falling .</p> <p>Review of the Physician Progress Note dated 8/16/2024, revealed .FU [follow up] readmission .seen today s/p [status post] ER [emergency room ] with RUE [right upper extremity] commuted [comminuted] displaced fracture through the right humeral neck, humeral shaft is displaced medially with respect to the humeral head, soft tissue of density surrounds the humeral head and proximal humerus suggestive of a component of hematoma seen on CT [computed tomography] scan. She was readmitted with dx [diagnosis] of arm reduction deformity. RUE remains swollen with RUE sling in place .stable .FU with [NAME] [orthopedics] .</p> <p>Resident #77 was evaluated in the ER and returned to the facility with an immobilizer to her right upper extremity and an order for an orthopedic consult.</p> <p>Review of the Incident Investigation Witness Statement from terminated CNA W dated 8/16/2024, for Resident #77 revealed .This incident happened on 8/9/2024 around 2 [2:00] PM .I went in to change [Named Resident] Resident #77 .I left her on her side to change her. I turned her facing the window. She had a large bowel movement. I went out of the room to get more linen .I was gone a couple of minutes. When I returned she was in the floor .I tried to get her up by myself with a sheet. The tubing to her trach was still hooked to her. I left her in the room to get some help .[Named staff] CNA X came in to help me get her back in bed .I never told [Named CNA X] that the [Named Resident] Resident #77 had fallen .we got her up from the floor using the sheet that was under her .I did not tell the nurse or anyone about this incident .I never thought she was hurt .I didn't try to hurt her .</p> <p>Review of Resident #77's Care Plan revised on 8/19/2024, revealed .Resident has an ADL self-care performance deficit related to CVA .BED MOBILITY: 2 person assist .TOILETING: 2 person assist . TRANSFERS: with 2 person assist AND use of mechanical lift .</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #77 was rarely/never understood. Brief Interview for Mental Status (BIMS) wasn't conducted due to Resident #77 was rarely/ never understood. Functional status was coded as dependent on staff for all activities of daily living (ADL's) care.</p> <p>Observation and interview in Resident #77's room on 10/2/2024 at 10:15 AM, revealed CNA V turned and repositioned Resident #77 by herself without using 2 staff assistance. CNA V was asked should Resident #77 have 2 person assistance with turning and repositioning. CNA V stated, .yes, but I don't have time to try to find someone .we are all so busy .</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>                                                   | <p>Attempted to call terminated CNA W on 10/2/2024 at 2:00 PM, to verify statement. CNA W did not return phone call.</p> <p>During an interview on 10/15/2024 at 1:40 PM, CNA V was asked if she witnessed a bruise on Resident #77. CNA V stated, .when I worked on Saturday 8/10/2024 I did not see a bruise and she didn't act like she was hurting .when I gave her a bath on Tuesday 8/13/2024 is when I seen the bruise on her upper right arm .I immediately went to get the nurse so she can see what I was talking about . CNA V was asked if she (Resident #77) can turn herself without assistance. CNA V stated, .she is total dependent on staff, she suppose [supposed] to have 2 people for turning, but I turn her by myself if I can't find someone to help me .</p> <p>During an interview on 10/15/2024 at 1:54 PM, CNA X was asked if she assisted Resident #77 off the floor. CNA X stated, .yes, [Named CNA W] asked me to help clean [Named Resident #77] .the resident was sitting up in the floor, her back against the bed .she had sheets under her .we lifted her up and put [her] back in the bed. I left out of the room. I didn't notify anyone she had fallen .I asked [Named CNA W] how she got on the floor, and she stated she didn't know .I was suspended pending the investigation and was re-educated .I thought the nurse had already been in the room .</p> <p>During an interview on 10/15/2024 at 3:10 PM, the Director of Nursing (DON) was asked how many staff should turn [Named] Resident #77, and how long until the fall was discovered. The DON stated, .[Named Resident #77] is a 2 person staff assist for turning, repositioning, and bed mobility .the occurrence was completed when we were made aware of the bruise, and after investigating and interviewing all staff we determined, and was told what exactly happened .I did not report because we realized soon with a matter of hours what had happened . The DON was asked during her investigation if Resident #77 appeared to be in pain. The DON stated, .No one stated she was in pain until the day the bruise was recognized, however the resident does receive pain medication every 8 hours, and has for several months related to her sacral wound .the physician initially thought it could have been a DVT [Deep Vein Thrombosis] due to her previous history . but also ordered an x-ray of her right humerus and it showed fracture of the lower end of the right humerus . we then sent her to the ER she was there for a few hours and she returned with an immobilizer to her right upper extremity and an order for orthopedic consult. The DON was asked what prompted the termed (terminated) CNA (CNA W) to leave the resident in the bed on her side and then after the fall out of the bed, not tell the nurse and then transfer her from the floor to the bed. The DON stated, .she [CNA W] stated to me it was just a bad judgement call. Both CNA's were suspended but [Named] CNA W was terminated for failure to follow company policy .[Named] CNA X returned to work and [was] given a written warning . The DON stated, The staff know they should report each incident including falls .they should never move the resident who has fallen, before the resident is assessed by the nurse .[Named Resident #77] is a 2 person assist for all bed mobility .with all falls, the CNA should get the nurse so she can assess the resident and then give further instruction to the CNA at that time .</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                 |
| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46047</p> <p>Based on policy review, medical record review, observation and interview, the facility failed to provide appropriate care and services for residents with an indwelling catheter (a tube in the bladder that drains urine) for 2 of 3 residents (Resident #30 and #304) reviewed for indwelling catheters. The facility's failure to implement interventions to prevent pressure and/or secure catheter tubing resulted in Actual Harm when Resident #30 developed a pressure ulcer related to the catheter tubing.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Catheter Care Procedure-Urinary, dated 12/28/2023, revealed .It is the policy of this facility to provide catheter care to all residents that have an indwelling catheter .will provide appropriate catheter care in accordance with current clinical standards .Catheters should be secured to prevent pulling and damage .</p> <p>2. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE], with diagnoses including Paraplegia and Pressure Ulcer at Left Gluteus</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #30 Brief Interview for Mental Status (BIMS) score was unable to be obtained due to severe cognitive impairment, was dependent upon staff for toileting, bed mobility, and transfers, had an indwelling urinary catheter, and was always incontinent of bowel.</p> <p>Review of the signed Physician Orders dated 6/27/2024, revealed . secure anchor [device to stabilize urinary catheter tubing to minimize movement and promote patient comfort] d/t [due to] foley [indwelling urinary] catheter every shift .catheter care every shift .</p> <p>Review of the Progress Note dated 8/30/2024, revealed .When resident's [#30] covers pulled back to perform wound care writer noted resident laying on top of catheter. Skin assessed, deep purple area of trauma noted to left labia [fold of skin around the vaginal opening] .</p> <p>Review of a Pertinent Charting-Skin note dated 8/30/2024, revealed .Location of skin area being documented: Left Labia .Deep purple area of trauma noted to left labia r/t [related to] catheter .</p> <p>(continued on next page)</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
| <p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>                                                   | <p>During an interview on 10/7/2024 at 10:51 AM, Licensed Practical Nurse (LPN O) confirmed she wrote the progress notes dated 8/30/2024 which indicated trauma to Resident #30's left labia. LPN O confirmed she entered Resident #30's room on 8/30/2024 to provide wound care, removed Resident #30's incontinent brief and discovered Resident #30 laying on her foley catheter tubing and confirmed as a result of Resident #30 laying on her foley catheter tubing, at that time, the left labia was deep purple in color and had slough [type of dead tissue that is moist and stringy]. LPN O was asked what caused Resident #30 to be laying on her foley catheter tubing. LPN O stated, .poor positioning, the catheter tubing was not placed correctly, it was placed coming back, toward her bottom and should have been placed with a sticker with clip that holds the foley catheter tubing in place on top of [the] leg. LPN O confirmed that on 8/30/2024 Resident #30 did not have the clip to hold the catheter tubing. LPN was asked the proper positioning of a urinary foley catheter. LPN O stated, .properly clipped [into the clip that holds the catheter tubing], on top of leg, free from any obstruction and clear of pressing up against any part of her body .</p> <p>During an interview on 10/7/2024 at 11:03 AM, LPN O was asked to describe Resident #30's position in bed when she found the resident laying on top of her (indwelling) catheter tubing and the left labia to be purple in color with slough. LPN O stated, .the resident's leg is contracted, she was sitting upright on her bottom with the [indwelling] catheter tubing on that area and the [indwelling] catheter tubing positioned toward the back of the resident, looked like when someone repositioned the resident the catheter tubing got pulled back .the staff should have made sure the catheter was in proper position, appropriately placed, and not under her .</p> <p>During an interview on 10/07/24 at 3:57 PM, the Director of Nursing (DON) confirmed staff should ensure the indwelling catheter tubing was securely anchored to the resident with a clip or any other device. The DON was asked where the indwelling catheter tubing should be anchored. The DON stated, . preferably the thigh area .</p> <p>During an interview on 10/7/2024 at 4:45 PM, the DON was asked if the indwelling catheter tubing was not secured, could it cause injury to the resident. The DON stated, .Yes . The DON was asked could the indwelling catheter tubing cause injury to a resident if the resident was laying on it. The DON stated, .Yes .</p> <p>During an interview on 10/8/2024 at 2:58 PM, the Nurse Practitioner (NP) confirmed Resident #30 should not have been laying on the indwelling catheter tubing. The NP was asked the correct placement of indwelling catheter tubing. The NP stated, .over the thigh .not under the resident .</p> <p>Observation in Resident #30's room on 10/09/2024 at 11:16 AM, revealed the wound to the left labia open, red in color with slight slough around the lower edge of the wound with no drainage.</p> <p>Failure of the facility to ensure the indwelling catheter was properly secured resulted in actual harm to Resident #30.</p> <p>3. Review of the medical record revealed Resident #304 was admitted to the facility on [DATE] with diagnoses including Respiratory Failure, Hypoxia and Acute Kidney Failure.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 14 indicating Resident #304 was cognitively intact.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few                                                          | <p>Review of the Order Review History Report dated 8/26/2024-9/26/2024, revealed .Catheter-Anchor Secured in Place every shift .</p> <p>Observation in the resident's room on 10/10/2024 at 9:32 AM, revealed a catheter anchor clip attached to the indwelling catheter tubing and not secured to Resident #304's leg.</p> <p>During an interview on 10/10/2024 at 9:32 AM, the Infection Control Nurse confirmed that the catheter anchor clip should be attached to the Resident's leg.</p> <p>48285</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       |                                                 |
| <p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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> 38439</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services for residents with percutaneous endoscopic gastrostomy (PEG) tubes (plastic tube inserted into the stomach to administer medications, supplements and liquid food) when staff failed to ensure the enteral feedings and the flush solutions were properly labeled for 3 of 4 sampled residents (Resident #58, #72, and #304) reviewed for enteral feedings and failed to administer site care for 1 of 4 residents (Resident #498) reviewed for PEG tubes.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Feeding Tubes revised 6/30/2022, revealed .Feeding tubes will be used only as necessary to address malnutrition and dehydration, or when the resident's clinical condition deems this intervention medically necessary to maintain acceptable parameters of nutrition and hydration. Feeding tubes will be maintained in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .Feeding tubes will be utilized according to physician orders . The plan of care will reflect the use of a feeding tube and potential complications .</p> <p>2. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE], with diagnoses including Alzheimer's, Nutritional Deficiency, and Dementia.</p> <p>Review of the care plan revised on 10/5/2023, revealed .Administer enteral nutrition per orders. (nocturnal) .</p> <p>Review of Physician's Order dated 11/6/2023, revealed .Change feeding syringe and /or container daily on night shift (label with resident name and date) .</p> <p>Review of the Minimum Data Sets (MDS) dated [DATE], revealed Resident #58's Brief Interview for Mental Status (BIMS) score was not coded, which indicated the resident was severely cognitively impaired, and was assessed as receiving enteral feedings.</p> <p>Review of the Physician's Order dated 8/23/2024, revealed .Two Cal 2.0 [nutritional supplement administered through a PEG tube] @ [at] 45 cc [cubic centimeters] /hr [per hour] x [times] 12 hours 6p [PM]-6a [AM] .</p> <p>Observation in the Resident's room on 9/24/2024 at 7:33 AM, revealed Resident #58's water bottle used for the PEG was not labeled with a date, rate for delivery via PEG, or initials.</p> <p>Observation in the Resident's room on 9/26/2024 at 8:47 AM, revealed Resident #58's enteral feeding was not labeled with a rate of delivery, and the water bottle for the PEG was not labeled with a delivery rate or time.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                   |                                                 |
| F 0693<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Some                        | <p>During an observation and interview on 10/7/2024 at 10:40 AM, in Resident #58's room the Assistant Director of Nursing (ADON) was asked what should be on the enteral feeding and water bottle labels. The ADON stated, It should be labeled with the resident's name, rate [of delivery], room number, date, amount and nurse initial. The ADON confirmed there was no rate or nurse initials on the enteral feeding.</p> <p>3. Review of the medical record revealed Resident #72 was admitted on [DATE], with diagnoses including Adult Failure to Thrive, Dementia, and Dysphagia.</p> <p>Review of Physician's Order dated 5/23/2022, . [for the PEG] Change feeding syringe and/ or container daily on night shift (label with resident name and date) .</p> <p>Review of Physician's Order dated 6/26/2024, .enteral feed every shift Jevity 1.5 [nutritional supplement administered through a PEG tube] @ 60ml [milliliters] /hr x 22 hours .</p> <p>Review of the MDS dated [DATE], revealed Resident #72's BIMS score was not coded, which indicated the resident was severely cognitively impaired.</p> <p>Review of care plan dated 9/16/2024, revealed .Administer enteral nutrition per orders .</p> <p>Observation in the Resident's room on 9/23/2024 at 10:08 AM, revealed no date and rate of delivery on the water bottle for the PEG.</p> <p>Observation in the Resident's room on 9/24/2024 at 7:24 AM, revealed no start date, rate of delivery, or nurse's initials on the enteral feeding, and no date or rate of delivery on the water bottle.</p> <p>During an interview on 9/25/2024 at 10:35 AM, Licensed Practical Nurse (LPN) B confirmed enteral feedings should be labeled with a name, date, and time hung.</p> <p>Observation in the resident's room on 9/26/2024 at 8:27 AM, revealed no nurse initial, rate of delivery, or time on the enteral feeding and no nurse initial on the water bottle.</p> <p>Observation in resident's room on 9/30/2024 at 3:13 PM, revealed no nurse initials on enteral feeding.</p> <p>Observation in resident's room on 10/1/2024 at 9:37 AM, revealed no nurse initials on enteral feeding.</p> <p>Observations in resident's room on 10/2/2024 at 8:56 AM, revealed no date on the enteral feeding.</p> <p>4. Review of the medical record revealed Resident #304 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Hypoxia and Acute Kidney Failure.</p> <p>Review of the Medication Administration Record (MAR) dated September 2024, revealed .Enteral Feed Order every shift for Gastrostomy Flush tube with (150) ML's H2O [water] every (4) hours .Enteral Feed Order every shift for Gastrostomy Jevity 1.5 @65 ml/hr X 22 hours .</p> <p>(continued on next page)</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                 |
| <p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of the admission MDS assessment dated [DATE] revealed a BIMS score of 14 indicating Resident #304 was cognitively intact.</p> <p>Observation in the resident's room on 9/25/2024 at 11:35 AM, revealed Resident #304's enteral feeding was not labeled with a date or time.</p> <p>During an interview on 9/25/2024 at 11:39 AM, LPN B confirmed feedings and water should be labeled.</p> <p>5. Review of the medical record revealed Resident #498 was admitted to the facility on [DATE] with diagnoses including Non-Traumatic Intracerebral Hemorrhage, Diabetes, Dysphagia, and Gastrostomy.</p> <p>Review of a Physician's Order dated 9/6/2024 revealed, .Two Cal HNT [high calorie formula] 1 can 5 times a day .via [by way of] gravity administration .start date 9/6/2024 .End date .9/11/2024.</p> <p>Review of a Physician's Order dated 9/11/2024 revealed, .Jevity 1.5 .1 can/carton bolus every 4 hours .via gravity .</p> <p>Review of the admission MDS assessment dated [DATE], revealed Resident #498 with a BIMS score of 14, indicating the resident was cognitively intact, and used a feeding tube.</p> <p>Review of the Care Plan dated 9/24/2024, revealed Resident #498 was care planned for impaired gastrointestinal status related to the use of a feeding tube.</p> <p>Review of the MAR dated September 2024 revealed no documentation the facility administered PEG site care for the use of a PEG tube.</p> <p>Review of the Treatment Administration Record (TAR) dated September 2024, revealed no documentation the facility administered PEG site care for the use of a PEG tube.</p> <p>Review of the Physician's Orders for September 2024 revealed the facility failed to obtain an order for PEG site care for the use of a PEG tube.</p> <p>Observation in the Resident's room on 9/25/2024 at 9:50 AM, the Resident confirmed he received his feedings through a PEG tube and raised his shirt to show the PEG tube site. The PEG site had no dressing.</p> <p>The facility failed to provide PEG tube site care for the use of a PEG tube to mitigate the risk of infection.</p> <p>During an interview on 10/2/2024 at 11:50 AM, the Director of Nursing (DON) confirmed that the facility failed to obtain a Physician Order for the care of the PEG tube site when the resident was admitted on [DATE] and one had been written with an effective date 10/2/2024. The DON confirmed that PEG tube site care should have been written and administered when the resident was admitted to the facility.</p> <p>46047</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 02/11/2025  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                           |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |                                                                                       |                                                 |
| F 0693<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Some                        | 48285                                                                                                                     |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   |                                                 |
| F 0695<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <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**</b> 49269</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to follow its policy for changing oxygen tubing and failed to follow the prescribed physician order for oxygen administration for 1 of 1 (Resident #68) sampled residents reviewed for respiratory care.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Oxygen Administration revised 10/26/2023, revealed .Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences . Oxygen is administered under orders of a physician . Change oxygen tubing and mask/ cannula weekly and as needed if it becomes soiled or contaminated .</p> <p>2. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE], with diagnoses including Diabetes, Heart Failure, Hypertension, and Stage 4 Pressure Ulcer.</p> <p>Review of the Physician's Order dated 7/12/2024, revealed .Oxygen: RUN @ [at] 1L [liter] /MIN [per minute] VIA [by way of] N/C [nasal cannula] for comfort as needed for shortness of breath .</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated Resident #68 was moderately cognitively impaired.</p> <p>Observations in the Resident's room on 9/23/2024 at 10:58 AM, 9/24/2024 at 9:47 AM and at 1:39 PM, 9/25/2024 at 9:56 AM and at 4:00 PM, and on 9/26/2024 at 7:52 AM, revealed Resident #68 was in bed with oxygen per nasal cannula at 2.5 L per minute and the oxygen tubing was dated 8/6/2024.</p> <p>During observation and interview on 9/25/2024 at 4:39 PM, Licensed Practical Nurse LPN) H was shown Resident #68's oxygen. LPN H verified the Resident's oxygen was not set at 1 L per minute as ordered and the tubing had not been changed weekly per facility policy.</p> <p>During an interview on 9/26/2024 at 8:00 AM, LPN I confirmed the Resident's oxygen was not set at 1 L per minute per facility policy.</p> <p>During an interview on 10/9/2024 at 9:53 AM, the Director of Nursing verified the oxygen tubing should be changed every Thursday and staff should follow Physician's Orders for oxygen therapy.</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                   |                                                 |
| F 0712<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Some                        | <p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285</b></p> <p>Based on facility policy review, medical record review and interview, the facility failed to ensure physician visits were conducted according to facility policy for 9 of 11 residents (#8, #38, #56, #57, #67, #71, #73, #104, #305) reviewed for Physician visits.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility policy titled, Physician Visits and Physician Delegation dated 9/26/2024, revealed .It is the policy of this facility to ensure the physician takes an active role in supervising the care of the residents .The Physician should .see the resident within 30 days of initial admission to the facility .The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by the physician or physician delegate as appropriate by State law .after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist that is acting within scope of practice .</li> <li>Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Hepatic Failure, Acute Hepatitis, Hemiplegia and Hemiparesis.</li> </ol> <p>Review of the MD Progress Notes revealed the Physician visited Resident #8 on 11/3/2023 and 4/24/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy.</p> <ol style="list-style-type: none"> <li>Review of the medical record revealed Resident #38 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Dementia, and Alzheimer's.</li> </ol> <p>Review of the MD Progress Notes revealed Resident #38 had Physician visits on 10/21/2022, 11/3/2023, 5/24/2024, and 9/27/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy.</p> <ol style="list-style-type: none"> <li>Review of the medical record revealed Resident #56 was admitted to the facility on [DATE], with diagnoses including Multiple Sclerosis, Respiratory Failure, Paraplegia, and Cognitive Communication Deficit.</li> </ol> <p>Review of the MD Progress notes revealed Resident #56 had Physician visits on 11/10/2023 and 4/5/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy.</p> <ol style="list-style-type: none"> <li>Review of the medical record revealed Resident #57 was admitted to the facility on [DATE], with diagnoses including of Parkinson's Disease, Dementia, Schizophrenia, Dysphagia, and Insomnia.</li> </ol> <p>Review of the MD Progress notes revealed Resident #57 had Physician visits on 10/27/2023, and 4/5/2023. There was no documentation Physician visits were conducted every other 60 days per facility policy.</p> <p>(continued on next page)</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                 |
| <p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>6. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE], with diagnoses including Dementia, Kidney Failure, Diabetes, and Schizophrenia.</p> <p>Review of the MD Progress notes revealed Resident #67 had Physician visits on 10/27/2023, and 4/5/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy.</p> <p>7. Review of the medical record revealed Resident #71 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Anoxic Brain Damage, Intellectual Disabilities, Convulsions, and Tracheostomy.</p> <p>Review of the MD Progress notes revealed Resident #71 had Physician visits on 11/17/2023, 4/24/2024, and 8/24/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy.</p> <p>8. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Atrial Flutter, Convulsions, Hypertension, and Psychosis.</p> <p>Review of the MD Progress notes revealed Resident #73 had Physician visits on 10/23/2023 and 4/24/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy.</p> <p>9. Review of medical record revealed Resident #104 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Down's Syndrome, and Peripheral Vascular Disease.</p> <p>Review of the MD Progress notes revealed Resident #104 had Physician visits on 6/16/2023, 11/17/2023, and 8/3/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy.</p> <p>10. Review of medical record revealed Resident #305 was admitted to the facility on [DATE], and the most recent readmitted [DATE], with diagnoses including Ventricular Tachycardia, Myoclonus, Cognitive Communication, and Seizures.</p> <p>Review of the MD Progress notes revealed Resident #305 had Physician visits on 11/17/2023 and 4/12/2024. There was no documentation Physician visits were conducted every other 60 days per facility policy.</p> <p>11. During an interview on 10/16/2024 at 2:14 PM, the Administrator was asked how often the Physician should make visits to residents. The Administrator replied, The regulations say after admission within 90 days .and every 60 days after that. The Administrator was asked if it was appropriate to not have MD visit for 5 months. The Administrator replied, .they should follow the federal guidelines .</p> <p>The facility failed to ensure Physician Visits were alternated with Nurse Practitioner visits therefore failing to ensure Physician visits were conducted every other 60 days per facility policy.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
| <p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Post nurse staffing information every day.</p> <p>49311</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure posted staffing information was accurate and current for 5 of 15 days (9/23/2024, 9/25/2024, 10/1/2024, 10/15/2024 and 10/16/2024) during the survey.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Nurse Staffing Posting Information dated 3/4/2024, revealed .The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information .The current date .The facility will post/update the Nurse Staffing Sheet at the beginning of each shift .</p> <p>2. Observations in the front lobby on 9/23/2024 at 3:21 PM, revealed the posted Direct Care Staffing Hours was dated 9/20/2024.</p> <p>Observations in the front lobby on 9/23/2024 at 5:25 PM, revealed the posted Direct Care Staffing Hours was dated 9/24/2024.</p> <p>Observations in the front lobby on 9/25/2024 at 7:36 AM, revealed the posted Direct Care Staffing Hours was dated 9/24/2024.</p> <p>Observations in the front lobby on 10/1/2024 at 2:42 PM, revealed the posted Direct Care Staffing Hours was dated 9/30/2024.</p> <p>Observations in the front lobby on 10/15/2024 at 10:00 AM, revealed the posted Direct Care Staffing Hours was dated 10/14/2024.</p> <p>Observations in the front lobby on 10/16/2024 at 9:22 AM, revealed the posted Direct Care Staffing Hours was dated 10/14/2024.</p> <p>3. During an interview on 10/16/2024 at 10:38 AM, the Staffing Coordinator was asked, who was responsible for posting the daily Direct Care Staffing Hours. The Staffing Coordinator replied, I complete it and leave it for the night nurse to post in the morning. Then I check to make sure its accurate when I get here in the mornings. The Staffing Coordinator confirmed that the daily staffing schedule should be updated and posted daily with the current date.</p> <p>During an interview on 10/16/2024 at 12:02 PM, the Director of Nursing confirmed that the posted daily staffing schedule should be updated daily and posted with the current date.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                 |
| <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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38439</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored and secured for 2 of 2 sampled residents (Residents #49 and #70) when medications were found unattended and unsecured in the resident rooms, and when opened and undated medications were stored in 2 of 13 medication storage areas (100 Hall Medication Room).</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Medication Storage reviewed and revised on 1/30/2024, revealed .It is the policy of this facility to ensure all medications housed on our premises will be stored according to manufacturer's recommendations and sufficient to ensure proper .segregation and security .all drugs and biologicals are stored in locked compartments .medication carts, cabinets, drawers .medication rooms . During a medication pass, medications must be under direct observation of the person administering medications or locked in the medication storage area/cart .</p> <p>2. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE], with diagnoses including Respiratory failure, Chronic Obstructive Pulmonary Disease, Diabetes, Tracheostomy and Chronic Kidney Disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #49 with a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #49 was cognitively intact.</p> <p>Observations in Resident #49's room on 9/23/2024 at 10:57 AM, revealed a medication cup with 3 pills in it on the over the overbed table.</p> <p>During observation and interview on 9/23/2024 at 10:58 AM, Licensed Practical Nurse (LPN) C was asked what was in the medication cup. The LPN stated, Vitamin D (supplement), AZO (used for urinary tract infections) and [NAME] [Benzonatate] for cough.</p> <p>3. Review of the medical record revealed Resident #70 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Diabetes, Visual Loss, Stage 5 End Stage Renal Disease, and Quadriplegia.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicted Resident #70 was cognitively intact, required set up for eating, dependent on staff Activities of Daily Living, Visual Loss and Quadriplegia.</p> <p>Observation in Resident #70's room on 9/23/24 at 10:53 AM, revealed 1 large yellow oblong gel capsule, 1 small yellow capsule, 2 brownish yellowish tablets, and 2 small white tablets, in a plastic medication cup on top of the over the bed table, unsecured and unattended.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
| F 0761<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>During observation and interview in Resident #70's room on 9/23/24 at 11:12 AM, LPN D was shown the plastic medication cup on the over the bed table containing medications. LPN D stated the medications were a Vitamin D, a Renal Vitamin (a supplement used for dialysis patients), Amlodipine (medication used for blood pressure), a Baby Aspirin, Carvedilol (medication used for blood pressure), and Vitamin B Complex (vitamin supplement). LPN D confirmed the medications should not have been left at the bedside unattended and unsecured.</p> <p>4. During an observation on the 100 Hall Medication Storage Room on 10/8/2024 at 3:40 PM, revealed an opened and undated vial of Tubersol (used to perform Tuberculosis skin test) in the medication refrigerator.</p> <p>During an interview on 10/2/2024 at 2:33 PM, the Director of Nursing (DON) verified the medications should not be left at resident's bedside unattended and unsecured and should be locked in the medication cart until they are to be administered.</p> <p>During an interview on 10/9/2024 at 9:53 AM, the DON verified the Tubersol should be dated when opened.</p> <p>48285</p> <p>49269</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                 |
| <p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47835</b></p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure dental services were provided for 1 of 1 sampled resident (Resident #39) reviewed for dental services.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Dental Services Policy dated 11/28/2017, revealed .Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care .Social Services personnel will be responsible for assisting the resident .family in making dental appointments .</p> <p>Review of the medical record revealed Resident #40 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Dependence on Ventilator, Diabetes, and Congestive Heart Failure.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #40 with a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #40 was cognitively intact and had no dental problems present at the time of the assessment.</p> <p>During an observation and interview on 9/24/2024 at 1:52 PM, Resident #40 stated she had broken a tooth a few months ago and ever since she has had trouble eating and drinking anything hot or cold because it would cause her tooth to hurt. Resident #40 could not remember when it happened or who she told but stated she had told more than one person that it had been bothering her.</p> <p>During an interview on 09/26/2024 at 8:35 AM, Certified Nursing Assistant (CNA) P was asked to explain how oral/dental services, interventions, or treatments should be carried out, such as if someone tells you they are having trouble eating or drinking because of a broken tooth or toothache. CNA P replied, I go tell the nurse .for sure let the nurse know.</p> <p>During an interview on 9/26/2024 at 3:35 PM, the Social Services Director was asked on how follow-up visits or recommendations from a dentist are provided to the facility. The Social Services Director stated, We have a provider that comes in . if emergent we can refer them [residents] out .they [Dentists] come once a month . they [Dentist] were here Monday. Usually, the Unit Manager will report it to me .I haven't heard anything about [Resident #40] .No one has said anything about that.</p> <p>During an interview on 09/30/2024 at 10:30 AM, the Social Services Worker provided a list of Residents who were on the Dental list and confirmed Resident #40 was not on the list of those to be seen.</p> <p>During an interview on 10/07/24 at 11:20 AM, the Social Services Worker confirmed Resident #40 had not been added to the dental list on the sign-up board in the Social Services office.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 02/11/2025  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                                                 |
| F 0791<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | During an interview on 10/16/2024 at 12:08 PM, the Director of Nursing (DON) was asked if Social Services were made aware on 9/26/2024 that a resident was having dental pain which caused a resident to not be able to eat or drink hot or cold foods, should the resident have been added to the consult list by 10/7/2024. The DON replied, Depends .there are things that we could do .give them [residents] soft diet .Sometimes it takes a while for them [residents] to get it taken care of |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                 |
| <p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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>49269</p> <p>Based on policy review, facility documentation review, job description review, observation, and interview, the facility failed to ensure food was stored, prepared, and served under sanitary conditions. The facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illnesses. Observations during the survey revealed the kitchen floors were dirty with standing water from leaking pipes, ice machines were broken and/or contained mold. There were no sanitation logs for the 3 compartment sinks. Observations revealed staff didn't know how to use the sanitizer during the survey, and pots and pans were caked with a carbon build-up, dried food particles were observed on the clean utensils, dust was observed on the drying rack for dishes, the warming oven and flat grill were observed with carbon build-up and with food particles, the 2 and 3 compartment sink pipes leaked, and the metal storage carts were dirty. These serious operational processes had the likelihood to result in foodborne illness outbreaks. All nursing home residents who received food from the kitchen were at risk for serious complications from foodborne illnesses as a result of their compromised health status. Unsafe food handling practices were observed when the preparation kitchen staff prepared the macaroni and cheese on the dirty 2 compartment sink, and when the Certified Dietary Manager (CDM) failed to perform hand hygiene during tray line service. The facility's failure to ensure sanitary conditions represented a potential source of pathogen exposure for 109 of 138 residents in the facility which resulted in Immediate Jeopardy.</p> <p>Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident.</p> <p>The Administrator and Director of Nursing were notified of the Immediate Jeopardy for F812 on 10/2/2024 at 5:34 PM in the family room.</p> <p>The facility was cited Immediate Jeopardy at F812 at a scope and severity K.</p> <p>The Immediate Jeopardy began on 10/2/2024 through 10/3/2024, the IJ was removed on 10/4/2024.</p> <p>An acceptable removal plan, which removed the immediacy of the jeopardy, was received on 10/4/2024 at 1:37 PM, and the corrective actions were validated on-site by the surveyors on 10/10/2024.</p> <p>The facility's noncompliance at F-812 continues at a scope and severity of E for monitoring of the effectiveness of the corrective actions.</p> <p>The facility is required to submit a Plan of Correction.</p> <p>The findings include:</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
| <p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>1. Review of the facility policy titled, Kitchen Sanitation, revised 1/1/2022, revealed .The food service area shall be maintained in a clean and sanitary manner .Kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects .Utensils, counters, shelves and equipment shall be kept clean, maintained in good repair .Seals, hinges and fasteners will be kept in good repair .equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions .Sanitizing of environmental surfaces must be performed with one of the following solutions: 50-100 ppm [parts per million] chlorine solution .150-200 ppm quaternary ammonium compound .or 12/5 ppm iodine solution .For fixed equipment or utensils that do not fit in the dishwashing machine, washing shall consist of the following steps: equipment will be disassembled as necessary to allow access of the detergent/solution to all parts; Removable components will be scraped to remove food particle accumulation and washed and sanitized .Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy .damaged or broken equipment that cannot be repaired shall be discarded .If a sink is used for washing utensils, cooking equipment or dishes, and also used to wash produce or thaw food, it will be cleaned between uses with an approved cleaning and sanitizing agent .Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime .The food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas .Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment .</p> <p>Review of the facility policy titled, Food Receiving and Storage, revised 1/1/2022, revealed Foods shall be received and stored in a manner that complies with safe food handling practices, as outlined in the FDA [Federal Drug Administration] Food Code .Food items and snacks kept on the nursing units should be maintained as indicated below: .Food items to be .placed in the refrigerator located at the nurses' station and labeled with an opened on and use by date, sealed or covered and labeled .Foods belonging to residents should be labeled with resident's name, the item and the opened on and use by date .Partially eaten food may not be kept in the refrigerator .Medications .may not be stored in the same refrigerator with food .</p> <p>Review of the facility policy titled, Emergency Food Storage, revised 1/1/2022, revealed .It is the policy of this facility to establish procedures to ensure that food is available for residents, staff, and volunteers in the case of emergency .The Dietary Manager shall maintain a 3 day supply of nonperishable foods and supplies of disposable dishes/utensils .The food and supplies are stored in an area which is less likely to be affected by disaster .The emergency food is rotated/replenished as needed .The amount of food needed is estimated based on the facility assessment, and considers census, total staff, and average number of volunteers/visitors .</p> <p>Review of the facility policy titled, Use and Storage of Food Brought in by Family or Visitors, revised 1/1/2022, revealed .It is the right of the residents of the facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident .All food items that are already prepared by the family or visitor brought in must be labeled with content and dated .If not consumed within days, food will be thrown away by facility staff .</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                 |
| <p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>2. Review of the Lead Registered Dietitian's job description dated 2/20/2023, revealed .Provides clinical nutrition services that are full compliance with all regulatory statutes, company policies and procedures, and performance .Works effectively with others to ensure that quality nutritional services are being provided on a daily basis, and acts as a resource to the Director of Dining Services so that the dining services department is maintained in a clean safe, and sanitary manner. Provides oversight and guidance to the Dining Services Director regarding dining services operations. Inspects food storage room .Recommends to the Director of Dining Services the equipment and supply needs of the department .Assists the Director of Dining Services in placing orders for the equipment and supplies as necessary or as may be required .Makes periodic rounds to inspect equipment and to ensure that equipment is available and working properly .Evaluates inventory levels of food, supplies, equipment, is maintained according to state guidelines .</p> <p>Review of the Dining Services Director's job description dated 7/1/2024, revealed .Manages the dining services program in a single site according to Healthcare Services Group (HCSG) policies and procedures, and federal/state requirements. Provides leadership, support and guidance to ensure that food quality standards, inventory levels, food safety guidelines and customer service expectations are met .Must be able to perform the essential job functions of dietary aide, cook, and dishwasher positions for purposes of training and assisting when there are call-outs .Supervises, coordinates and evaluates work of all dining services employees in preparing and serving food, and cleaning facilities and utensils in a production kitchen . Maintains required records including food production, inventory .Ensures that established sanitation and safety standards are maintained, Oversees and participates in the preparation and serving of food .</p> <p>Review of the Administrator's job description signed and dated 2/13/2023, revealed .Responsible for the efficient and profitable operation of the facility, facility compliance with [Corporate name] policies and State and Federal rules and regulations, and providing the highest quality of care possible .Manages the day-to-day operations of the facility .Implements control systems to ensure accountability of all departments . Monitors performance for achievement of goals and for improvement, and takes corrective action when necessary .</p> <p>3. During observations on the initial tour of the kitchen with the Certified Dietary Manager (CDM) on 9/23/2024 at 9:33 AM, revealed the following:</p> <p>a. The kitchen floor was observed to be wet with water build up throughout the kitchen. The pipes under the 2 compartment sink were leaking water.</p> <p>b. The 2nd shelf of the drying rack contained four baking trays with dried food particles on all four of them, a large muffin pan with dried food particles on it, a large cooking pot and frying pan with black carbon build up noted on the bottom and inside of pans.</p> <p>c. On the drying rack beside the 3 compartment sink was a large pan with dried food particles on it, that had been processed/washed through the 3 compartment sink</p> <p>d. The 3 compartment sink had a cooking pot soaking in the water. The CDM performed a sanitation test of the 3 compartment sink with result of 10 PPM (sanitizing range 50 - 100 ppm). The CDM confirmed sanitation solution was not added prior to testing, and that staff should have added sanitation solution to the water prior to utilizing the 3 compartment sink for sanitation.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                 |
| <p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>e. The ice machine was observed with an out of order sign. The CDM stated the ice machine had not been working for one month with kitchen staff having to utilize an ice machine outside of the kitchen.</p> <p>f. The coffee maker was observed with coffee grounds on top of the coffee pot.</p> <p>g. The tea maker containing brewed tea was observed without a top on it to prevent contaminants from entering the tea maker.</p> <p>h. The stove was observed with a black carbon build up around the stove eyes. The stove only had one knob working for turning the stove eyes on. The staff were observed turning on the stove eyes using the metal stem. The warming oven was missing a handle.</p> <p>i. The flat top grill was observed with dried food particles and dried spilled substance on the top.</p> <p>j. The fryer baskets were observed with old fries and moderate amount of food crumbs and black particles in the baskets.</p> <p>k. The oven was observed with a black build up on the inside and on the oven door. Dietary [NAME] J confirmed that the oven was supposed to be cleaned daily but appeared that it had not been cleaned.</p> <p>l. The three tier metal serving cart storing clean dishes was observed with a moderate amount of dried tan splattered substances and food particles on the shelves, and dirt build up on the wheels of the cart.</p> <p>m. There was 1/2 cut Watermelon dated 9/16/2024, located in the walk-in refrigerator.</p> <p>n. There was one container of cake icing opened and dated 2/10/2024, located on the top shelf in the dry storage area.</p> <p>4. During observations of the kitchen with the Regional CDM on 9/24/2024 at 10:14 AM, revealed the following:</p> <p>a. The pipe was leaking under the 2 compartment sink. A moderate amount of water was observed on the kitchen floor. There was standing water in areas on the kitchen floor which required the use of a mop. The Regional CDM confirmed that the pipe leak under the 2 compartment sink was related to an ongoing water issue with the pipe.</p> <p>b. The tea maker containing brewed tea was uncovered without a top to prevent contaminants from entering the tea maker. The tea maker was beside the dirty coffee maker with coffee grounds on it</p> <p>c. The three tier metal serving cart continued storing clean dishes with a moderate amount of tan dried splattered substances and food particles on the shelves, and dirt build up on the wheels of the cart.</p> <p>d. There was one bag of frozen french fries opened and undated located in the walk-in freezer.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                 |
| <p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>5. During observations of the kitchen with the CDM on 9/25/2024 from 11:29 AM to 1:00 PM, revealed the CDM assisted on the tray line of the steam table. The CDM was observed leaving the tray line to gather items from the walk-in refrigerator and returning to the tray line on multiple occasions. The CDM was observed removing gloves and placing soiled gloves in her pocket, and then donning gloves on multiple occasions and failing to perform hand hygiene prior to returning to serving.</p> <p>6. During observations of the kitchen with the CDM on 9/26/2024 at 1:22 PM, revealed the following:</p> <p>a. A water leak under the 3 compartment sink.</p> <p>b. The freestanding metal drying rack, parked between the 2 compartment sink and the 3 compartment sink, contained clean pots and pans and had a thick dust build up on it.</p> <p>c. The tea maker containing brewed tea was observed uncovered without a top to prevent contaminants from entering the tea maker.</p> <p>d. There continued to be missing knobs on the stove and a broken warming oven handle.</p> <p>The CDM stated during the observations that Maintenance had ordered parts and items were on backorder. When requested on multiple occasions for copies of the purchase orders the facility only provided service calls with estimates for the broken ice machine and steamtable.</p> <p>7. During observations of the 400/500 Hall Nourishment Refrigerator on 9/30/2024 at 10:08 AM, revealed 11 (eleven) Normal Saline vials labeled Respiratory in a zip lock bag. Registered Nurse (RN) K confirmed medications should not be stored in the nourishment refrigerator.</p> <p>8. During observations of the 200 Hall Nourishment Refrigerator on 9/30/2024 at 9:58 AM, revealed a plastic bag labeled with a resident room number dated 9/21/2024 with 2 plastic containers of food.</p> <p>9. During observations on 9/30/2024 at 2:31 PM, revealed the ice machine located outside the kitchen contained black mold-like substance on the inside of the ice machine and a black build up on the inside rim of the ice machine. There was a white substance build up on the exterior of the ice machine. The floor under the ice machine was black and dirty. The kitchen utilizes this ice machine for ice.</p> <p>10. During observations and interview on 9/30/2024 at 4:11 PM, the Administrator was asked to identify the black substance on the inside of the ice machine. The Administrator stated that he did not feel comfortable stating what he thought it looked like but confirmed that it needed to be cleaned.</p> <p>11. During observations of the kitchen with the CDM on 9/30/2024 at 2:36 PM, revealed the following:</p> <p>a. The kitchen staff were preparing macaroni and cheese on the dirty 3 compartment sink.</p> <p>b. There was a small frying pan with black build up on the bottom of the pan, stored on the drying rack.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
| <p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>c. The drying rack was observed with dust on the shelves.</p> <p>d. There was a one ounce (oz) metal serving ladle hanging on the side of the drying rack with dried white food particles on it.</p> <p>e. There was a twelve oz metal ladle hanging on the side of the drying rack with white dried substance on it.</p> <p>f. There was a gray handle serving scoop with food particles observed on the drying rack beside the 3 compartment sink.</p> <p>g. The three tier metal serving cart contained a moderate amount of tan dried substance on the 2nd and 3rd shelves with clean dishes stored on the shelves.</p> <p>12. During observations of the kitchen with the CDM on 10/02/2024 at 10:28 AM, revealed the following:</p> <p>a. A water leak remained under the 3 compartment sink.</p> <p>b. The build-up of dust remained on the freestanding drying rack.</p> <p>c. There was a medium frying pan and a large cooking pot with thick carbon build up on the drying rack.</p> <p>d. The dishwasher staff placed a tray container of dirty dishes on top of another tray container of dirty dishes and ran them through the hot water sanitizing dishwasher.</p> <p>13. During an observation and interview on 10/2/2024 at 10:48 AM, the CDM was asked for a copy of the Daily Cleaning Schedules for the current week of 9/29/2024 - 10/5/2024. The CDM stated she had not put out a new schedule and provided a blank Daily Cleaning Schedule dated 9/29-10/5/2024. The prior week's Daily Cleaning Schedule was still on the kitchen door. The CDM provided a total of 7 weeks of Daily Cleaning Schedules dated 7/28/2024 - 10/5/2024.</p> <p>Review of the Daily Cleaning Schedule for the kitchen revealed missing dates on the Daily Cleaning Schedules and multiple blank areas without initials for the schedules provided. The Daily Cleaning Schedules revealed the following:</p> <p>a. Week of 7/28/2024 - 8/3/2024:</p> <p>Sunday AM the kitchen was not mopped and swept.</p> <p>Sunday PM the coffee maker and nozzle was not cleaned, the tea maker and nozzle was not cleaned, the utility carts were not cleaned, the cooler and freezer seals were not cleaned, the beverage carts were not cleaned, the ice machine was not cleaned, the microwave was not cleaned, the three bay sink was not cleaned, the dish window was not cleaned, the dish tray carts were not cleaned, the coffee and tea urns were not cleaned, the oven top was not cleaned, the floor under the dish machine was not cleaned, and the cooler was not swept or mopped.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       |                                                 |
| <p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Monday AM the can opener was not cleaned, the drip pans were not cleaned, the stove top/grill/backsplash were not cleaned, the cook's tables and shelves were not cleaned, the plate warmer was not cleaned, the beverage station was not cleaned, the food carts were not cleaned, the utility carts were not cleaned, the shelf under the coffee pot was not cleaned, the pantry was not swept or mopped, the tables and shelves were not cleaned, the coffee urns were not cleaned, the lower shelves were not cleaned, the top and sides of the dishwasher were not cleaned, the trash cans were not cleaned, the dish room was not swept or mopped, and the juice area was not cleaned.</p> <p>Monday PM the coffee maker and nozzle was not cleaned, the tea maker and nozzle was not cleaned, the utility carts were not cleaned, the cooler and freezer seals were not cleaned, the beverage carts were not cleaned, the ice machine was not cleaned, the microwave was not cleaned, the three bay sink was not cleaned, the dish window was not cleaned, the dish tray carts were not cleaned, the coffee and tea urns were not cleaned.</p> <p>Monday weekly cleaning of the cook's shelves, the bottom of the oven and the hood vents was not performed.</p> <p>Tuesday AM the hand sink was not cleaned, the beverage station was not cleaned, the inside and outside of the food carts were not cleaned, the utility carts were not cleaned, the shelf under the coffee pot was not cleaned, the pantry was not swept or mopped, the tables and shelves were not cleaned, the coffee urns were not cleaned, the lower shelves were not cleaned, the top and sides of the dishwasher were not cleaned, the dish room was not swept or mopped, and the juice area was not cleaned.</p> <p>Tuesday PM the kitchen was not swept or mopped, the coffee maker and nozzle was not cleaned, the tea maker and nozzle was not cleaned, the utility carts were not cleaned, the cooler and freezer seals were not cleaned, the beverage carts were not cleaned, the ice machine was not cleaned, the microwave was not cleaned, the three bay sink was not cleaned, the dish window was not cleaned, the dish tray carts were not cleaned, and the coffee and tea urns were not cleaned.</p> <p>Tuesday weekly cleaning of the utensil drawer and the rack carts was not performed.</p> <p>Wednesday AM the beverage station was not cleaned, the inside and outside of the food carts were not cleaned, the utility carts were not cleaned, the shelf under the coffee pot was not cleaned, the pantry was not swept or mopped, the tables and shelves were not cleaned, the coffee urns were not cleaned, the lower shelves were not cleaned, the top and sides of the dish machine were not cleaned, the trash cans were not cleaned, and the dish room was not swept or mopped.</p> <p>Wednesday PM the steam table was not cleaned, the can opener was not cleaned, the plate warmer was not cleaned, the steam table wells was not cleaned, the drip pans were not cleaned, the kitchen was not swept or mopped, the prep sink was not cleaned, the three bay sink was not cleaned, the stove top/grill/backsplash was not cleaned, the coffee maker and nozzle was not cleaned, the tea maker and nozzle was not cleaned, the utility carts were not cleaned, the cooler and freezer seals were not cleaned, the beverage carts were not cleaned, the ice machine was not cleaned, the microwave was not cleaned, the dish window was not cleaned, the dish tray carts were not cleaned, and the coffee and tea urns were not cleaned.</p> <p>Wednesday weekly cleaning of the griddle, the rack carts, and sweeping and mopping of the storeroom was not performed.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       |                                                 |
| <p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Thursday AM the hand sink was not cleaned, the beverage station was not cleaned, the inside and outside of the food carts were not cleaned, the utility carts were not cleaned, the shelf under the coffee pot was not cleaned, the pantry was not swept or mopped, the tables and shelves were not cleaned, the coffee urns were not cleaned, the lower shelves were not cleaned, the top and sides of the dish machine were not cleaned, the dish room was not swept or mopped, and the juice area was not cleaned.</p> <p>Thursday PM the coffee maker and nozzle was not cleaned, the tea maker and nozzle was not cleaned, the utility carts were not cleaned, the cooler and freezer seals were not cleaned, the beverage carts were not cleaned, the ice machine was not cleaned, the microwave was not cleaned, the three bay sink was not cleaned, the dish machine filters were not cleaned, the top and sides of the dish machine were not cleaned, the dish room was not swept or mopped, the dish window was not cleaned, the dish tray carts were not cleaned, and the coffee and tea urns were not cleaned.</p> <p>Thursday weekly cleaning of the fryer was not performed.</p> <p>Friday AM the three bay sink was not cleaned, the top and sides of the steam table were not cleaned, the can opener was not cleaned, the prep sink was not cleaned, the drip pans were not cleaned, the stove top/grill/backsplash were not cleaned, the cook's tables and shelves were not cleaned, the kitchen was not swept or mopped, the plate warmer was not cleaned, the hand sink was not cleaned, the beverage station was not cleaned, the food carts were not cleaned, the utility carts were not cleaned, the shelf under the coffee pot was not cleaned, the dish room walls were not cleaned, the tops and sides of the dish machine were not cleaned, the dish room was not swept or mopped, the juice area was not cleaned.</p> <p>Friday PM the steam table was not cleaned, the can opener was not cleaned, the plate warmer was not cleaned, the steam table wells were not cleaned, the drip pans were not cleaned, the kitchen was not swept or mopped, the prep sink was not cleaned, the three bay sink was not cleaned, the stove top/grill/backsplash was not cleaned, the coffee maker and nozzle was not cleaned, the tea maker and nozzle was not cleaned, the food carts were not cleaned, the utility carts were not cleaned, the pantry was not swept or mopped, the cooler and freezer seals were not cleaned, the beverage carts were not cleaned, the exterior of the ice machine was not cleaned, the microwave was not cleaned, the dish bay filters were not cleaned, the top and sides of the dish machine were not cleaned, the dish room walls were not cleaned, the dish room window was not cleaned, the dish tray carts were not cleaned, and the coffee and tea urns were not cleaned.</p> <p>Friday weekly cleaning of the fryer and the delime dish machine was not performed.</p> <p>Saturday AM the three bay sink was not cleaned, the top and sides of the steam table were not cleaned, the can opener was not cleaned, the prep sink was not cleaned, the drip pans were not cleaned, the stove top/grill/backsplash were not cleaned, the cooks tables and shelves were not cleaned, the kitchen was not swept or mopped, the plate warmer was not cleaned, the hand sink was not cleaned, the beverage station was not cleaned, the inside and outside of the food carts was not cleaned, the utility carts were not cleaned, the shelf under the coffee pot was not cleaned, the dish room walls were not cleaned, the tops and sides of the dish machine were not cleaned, the dish room was not swept or mopped, and the juice area was not cleaned.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
| <p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Saturday PM the steam table was not cleaned, the can opener was not cleaned, the plate warmer was not cleaned, the steam table wells were not cleaned, the drip pans were not cleaned, the kitchen was not swept or mopped, the prep sink was not cleaned, the three bay sink was not cleaned, the stove top/grill/backsplash was not cleaned, the coffee maker and nozzle was not cleaned, the tea maker and nozzle was not cleaned, the food carts were not cleaned, the utility carts were not cleaned, the pantry was not swept or mopped, the cooler and freezer seals were not cleaned, the beverage carts were not cleaned, the exterior of the ice machine was not cleaned, the microwave was not cleaned, the three bay sink was not cleaned, the dish window was not cleaned, the dish tray carts were not cleaned, and the coffee and tea urns were not cleaned.</p> <p>Saturday weekly cleaning under the steam table was not performed.</p> <p>b. Week of 8/4/2024-8/10/2024:</p> <p>Sunday AM the hand sink was not cleaned, the beverage station was not cleaned, the inside and outside of the food carts was not cleaned, the utility carts was not cleaned, the shelf under coffee pot was not cleaned, the pantry was not swept or mopped, the tables/shelves were not cleaned, the coffee urns were not cleaned, the lower shelves in dish room were not cleaned, the dish room walls were not cleaned, the top and sides of the dish machine were not cleaned, the dish room was not swept or mopped and the clean juice area was not completed.</p> <p>Sunday PM the steam table was not cleaned, the can opener was not cleaned, the plate warmer was not cleaned, the steam table wells were not cleaned, the drip pans were not cleaned, the kitchen was not swept or mopped, the prep sink was not cleaned, the three bay sink was not cleaned, the stove top/grill and back splash was not cleaned, the coffee maker and nozzle was not cleaned, the tea maker and nozzle was not cleaned, the food carts were not cleaned, the utility carts were not cleaned, the pantry was not swept or mopped, the seals on the cooler and freezer was not cleaned, the beverage carts were not cleaned, the ice machine exterior was not cleaned, the microwave was not cleaned, the three bay sink was not cleaned, the dish window was not cleaned, the dish tray carts were not cleaned and the coffee/tea urns were not cleaned.</p> <p>Sunday weekly cleaning of the top oven, floor under the dish machine, and the cooler was not performed. The cooler was not swept and mopped.</p> <p>Monday AM the hand sink was not cleaned, the beverage station was not cleaned, the inside and outside of the food carts were not cleaned, the utility carts were not cleaned, the shelf under the coffee pot was not cleaned, the pantry was not swept and mopped, the tables/shelves were not cleaned, the coffee urns were not cleaned, the lower shelves in dish room were not cleaned, the dish room walls were not cleaned, the top and sides of the dish machine were not cleaned, the inside and outside of the trash cans were not cleaned, the dish room was not swept and mopped and the juice area was not cleaned.</p> <p>Monday PM the steam table was not cleaned, the can opener was not cleaned, the plate warmer was not cleaned, the steam table wells were not cleaned, the drip pans were not cleaned, the kitchen was not swept or mopped, the prep sink was not cleaned, the three bay sink was not cleaned, the stove top/grill and back splash were not cleaned, the pantry was not swept or mopped, the dish window was not cleaned, the dish tray carts were not cleaned and the coffee/tea urns were not cleaned.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                                                 |
| <p>F 0812</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Monday weekly cleaning of the cook's shelves, the bottom oven, and hood vents were not performed.</p> <p>Tuesday AM the hand sink was not cleaned, the beverage station was not cleaned, the inside and outside of the food carts were not cleaned, the utility carts were not cleaned, the shelf under the coffee pot was not cleaned, the pantry was not swept and mopped, the tables/shelves were not cleaned, the coffee urns were not cleaned, the lower shelves in dish room were not cleaned, the dish room walls were not cleaned, the top and sides of the dish machine were not cleaned, the dish room was not swept and mopped, and the juice area was not cleaned.</p> <p>Tuesday PM the kitchen was not swept and mopped, the three bay sink was not cleaned, the coffee maker and nozzle was not cleaned, the tea maker and nozzle was not cleaned, the utility carts were not cleaned, the pantry was not swept or mopped, the seals on the cooler and freezer were not cleaned, the ice machine exterior was not cleaned, the microwave was not cleaned, the dish room walls were not cleaned, the dish window was not cleaned, the dish tray carts were not cleaned and the coffee/tea urns were not cleaned.</p> <p>Tuesday weekly cleaning of the utensil drawer, and the rack carts was not performed.</p> <p>Wednesday AM the utility carts were not cleaned, the shelf under coffee pot was not cleaned, the pantry was not swept and mopped, the lower shelves in dish room were not cleaned, the dish room walls were not cleaned, the top and sides of the dish machine were not cleaned, inside and outside of trash cans were not cleaned, the dish room was not swept and mopped and the juice area was not cleaned.</p> <p>Wednesday PM the steam table was not cleaned, the can opener was not cleaned, the plate warmer was not cleaned, the steam table wells were not cleaned, the drip pans were not cleaned, the kitchen was not swept or mopped, the prep sink was not cleaned, the three bay sink was not cleaned, the stove top/grill and back splash were not cleaned, the coffee maker and nozzle were not cleaned, the tea maker and nozzle were not cleaned, the inside and outside of the food carts were not cleaned, the utility carts were not cleaned, the pantry was not swept or mopped, the seals on the cooler and freezer were not cleaned, the beverage carts were not cleaned, the ice machine exterior was not cleaned, the microwave was not cleaned, the dish machine filters were not cleaned, the top and sides of the dish machine were not cleaned, the dish window was not cleaned, the dish room was not swept or mopped, the dish tray carts were not cleaned and the coffee/tea urns were not cleaned.</p> <p>Wednesday weekly cleaning of the griddle, delime dish machine, legs and casters was not performed.</p> <p>Thursday AM the hand sink was not cleaned, the beverage station was not cleaned, the inside and outside of the food carts were not cleaned, the utility carts were not cleaned, the shelf under coffee pot was not cleaned , the pantry was not swept and mopped, the tables/shelves were not cleaned, the coffee urns were not cleaned, the lower shelves in dish room were not cleane [TRUNCATED]</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                   |                                                 |
| <p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285</b></p> <p>Based on facility policy review, medical record review, and interview, the facility failed to ensure that the binding arbitration agreement signed by residents or resident's legal representative was understood for 1 of 3 residents (Resident #140) reviewed for arbitration agreement.</p> <p>The findings include:</p> <p>1.Review of the facility policy titled Binding Arbitration Agreements revised on 11/1/2022, revealed .The facility asks all residents to enter into an agreement for binding arbitration. We do not require binding arbitration as a condition of admission .Arbitration is a private process where disputing parties agree that one or several other individuals can make a decision about the dispute after receiving evidence and hearing arguments .Policy Explanation and Compliance Guidelines: .When explaining the arbitration agreement, the facility shall: .explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, this facility . Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands .Ensure the resident or his or her representative acknowledges that he or she understands the agreement .</p> <p>2.Review of medical record revealed Resident #140 was admitted on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Diabetes, and Epilepsy.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was not assessed, indicating severely impaired cognition.</p> <p>During an interview on 10/3/2024 at 10:51 AM, Resident #140's Power of Attorney stated the facility emailed the admission paperwork to her to sign and email back, the staff did not go over the paperwork with her, she had no recollection of signing an arbitration agreement, and it was not explained to her.</p> <p>During an interview on 10/7/2024 at 10:05 AM, the Admissions Director (AD) was asked about the process of explaining the arbitration process. The AD stated, .Do a lot electronically and send via email or come into the office and do it with them electronically .I go over brief things .like visiting hours .If in person, offer a video to watch on it and talk to them, if sent I only go over it if they call with questions .I would say a lay person would not understand . The AD was asked if that was sufficient explanation of the arbitration agreement. The AD replied, .that is a problem. I see it could be beneficial to go over the papers .</p> <p>During an interview on 10/16/2024 at 2:13 PM, the Administrator was asked if the arbitration agreement should be explained to families prior to them signing. The Administrator replied, Yes they need to be explained .</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       |                                                 |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30974</p> <p>Based on review of the Quality Safety Organization (QSO) - 20 -30 - Nursing Home (NH), review of NursingHomeAbuse.org, policy review, medical record review, observation, and interview, the facility failed to maintain an infection prevention and control program which provided a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections for 24 of 38 residents (Residents #22, #28, #34, #49, #62, #63, #71, #75, #77, #80, #83, #90, #116, #117, #120, #123, #129, #131, #133, #139, #144, #304, #348, and #349) reviewed for infection control. The facility failed to provide a sanitary environment to prevent the potential development and transmission of infection for 4 of 4 Halls; 4 residents (Residents #22, #75, #83, and #123) on the 100 and 200 Halls; and 20 residents (Residents #28, #34, #49, #62, #63, #71, #77, #80, #90, #116, #117, #120, #129, #131, #133, #139, #144, #304, #348, and #349) on the 400 and 500 Halls. The 400 and 500 Halls was the tracheostomy/ventilator units with vulnerable, high risk, and compromised residents who were exposed to unsanitary conditions. Observations made from 9/23/2024 through 10/2/2024 revealed there were observations of dried dark brown and tan hardened substances on the residents' bed frames and side rails, enteral feeding pumps, poles, walls, window blinds, and floors. The residents' oxygen concentrators were dirty, had dirty filters, and heavy dust build up. The Heating Ventilation Air Conditioning (HVAC) units were dirty and dusty. The housekeeping department failed to have cleaning disinfectant at all times and/or had to use the disinfectant sparingly per interview. There was a hole observed in the wall in a resident's room, and a gap around the HVAC unit at the end of the 100 Hall by the exit door exposing the facility to the outside. During the 9/23/2024 initial tour of the facility and resident's rooms the Administrator, DON, Housekeeping Supervisor and Maintenance Supervisor accompanied the surveyors and were shown the environment and lack of cleanliness in the rooms. The facility also failed to ensure practices to prevent the potential spread of infection were maintained when 2 of 4 nurses (Registered Nurse (RN) A and Licensed Practical Nurse (LPN) D) failed to clean or disinfect reusable equipment before and after use on residents.</p> <p>The facility's failure to maintain an infection prevention and control program which ensured a safe, clean and sanitary environment to prevent the development and transmission of infection, had the likelihood to cause serious injury, harm, impairment, or death resident resulting in Immediate Jeopardy.</p> <p>Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident.</p> <p>The Administrator and Director of Nursing were notified of the Immediate Jeopardy for F880 on 10/2/2024 at 5:34 PM, in the Family Room.</p> <p>The facility was cited Immediate Jeopardy at F880 at a scope and severity of K.</p> <p>The Immediate Jeopardy began on 10/02/2024 through 10/11/2024, the IJ was removed on 10/12/2024.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>An acceptable removal plan, which removed the immediacy of the Jeopardy, was received on 10/4/2024 at 1:37 PM, and the surveyors were unable to validate the removal plan. The facility submitted an acceptable revised removal plan on 10/11/2024 at 2:59 PM, and it was validated by the surveyors on 10/14/2024.</p> <p>The facility's noncompliance at F-880 continues at a scope and severity of E for monitoring of the effectiveness of the corrective actions.</p> <p>The facility is required to submit a Plan of Correction.</p> <p>The findings include:</p> <p>1. Review of QSO-20-30-NH Updates and Initiatives to Ensure Safety and Quality in Nursing Homes - Actions to Improve Infection Prevention and Control, .Environmental cleaning and disinfection. Clean and disinfect the resident's care environment and shared equipment with agents effective against the identified organism or products on an EPA-registered antimicrobial list recommended by public health authorities. It is important to follow all manufacturer's directions for use for a surface disinfectant including applying the product for the correct contact time. Facilities need to ensure adequate access to supplies and proper instruction for staff (nursing or housekeeping/environmental services) responsible for cleaning pieces of equipment .</p> <p>2. Based on review of NursingHomeAbuse.org, .Many residents in nursing homes have serious health conditions requiring a clean environment. Failing to provide a sanitary space for seniors may lead to infections and the rapid spread of contagious diseases. Therefore, the right hygiene is essential. If your loved one is injured because a nursing home did not maintain a clean facility, then you may be able to pursue a claim for nursing home abuse or neglect .</p> <p>3. Review of the facility policy titled, Routine Cleaning and Disinfection, dated 2/1/2022, revealed .ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible .Cleaning .refers to the removal of visible soil from objects and surfaces .manually or mechanically using water and detergents or enzymatic products .Consistent surface cleaning and disinfection will be conducted with a detailed focus on high touch areas to include .bed rails .tray tables .Sinks and faucets .Staff will ensure cleaning carts are .stocked with necessary supplies at the beginning of each shift .Horizontal surfaces .window sills and hard surface flooring . should be cleaned .on a regular basis .when soiling and spills occur .when a resident is discharged from the facility Cleaning of walls, blinds, and window curtains will be conducted when visibly soiled .Privacy curtains in resident rooms will be changed when visibly dirty .</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                 |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Review of the undated facility policy titled, Daily Cleaning Procedures, revealed .High Dust .work your way clockwise around the room (starting at the door and finishing at the door) and dust all high surfaces .this includes but not limited to pictures/prints, televisions, over the bed lights, blinds, vents and all corners . Disinfect .clockwise around the room disinfect flat surfaces .high touch items .bed siderails, bed frame, foot board and headboard, bedside tables, window sills .heating unit, and any flat surfaces .if resident has a fan in his/her room, check and clean routinely to avoid buildup of dust .Spot Clean Walls and Inspect Privacy Curtains .work your way clockwise around the room .spot cleaning walls and vertical surfaces that are visibly soiled .inspect all privacy curtains in room .if dirty notify your supervisor which curtains need to be changed . Clean Restroom .restock all supplies .empty trash .high dust lights, vents .disinfect sink area .disinfect toilet area-including handrails, call lights and tub/shower .Damp Mop .damp mop the perimeter of the room .then start at the back of the room and use a figure 8 motion to damp mop the entire floor while working your way back to the door .</p> <p>Review of the undated facility policy titled, Deep Cleaning Procedures, revealed .check the posted deep clean schedule in the morning .Clean the scheduled deep clean room .room should be emptied .in a clockwise rotation from .door, clean, polish, scrub, scrape, dust, disinfect, sweep, wipe and mop everything in the room including .sweep and damp mop floor and baseboard making sure to remove all build-up from these areas .floor and edges around the closet floor, and spot check walls and shelf .report any soiled or damaged curtains to your supervisor .Heating Unit .wipe top and all sides, check top vents for any accumulation of dust or other debris .remove build-up from floor under heating unit, sweep and damp mop . Bed .pull bed at least three feet away from wall .spot scrub the wall, remove build-up from floor and baseboards .sweep and damp mop floor and baseboards .thoroughly clean and disinfect all parts of the resident's bed .remove mattress (pay special attention to the bed frame, headboard, footboard, legs and side rails) .disinfect all areas of the mattress and return it to the frame .Bed Side Tables .scrub all areas of table . polish if necessary .Privacy Curtains .check and report any soiled or damaged curtains to supervisor .clean lights above bed and all call lights and cords .Check all corners, ceiling and floor for cobwebs .Spot scrub all walls .Entrance of room .scrub both sides of door and door knob .Remove build-up on floor between room and hallway .Dust mop and damp mop entire room .Sink .disinfect all porcelain on sink, both top and bottom . scrub all fixtures and drains .be sure to scrub wall under sink .Mirror .clean edges of mirror and shelf .clean mirror and use paper towel to dry .</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Review of the facility policy titled, Cleaning and Disinfection of Resident-Care Equipment, dated 1/2/2024, revealed .Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC [Centers for Disease Control and Prevention] recommendations in order to break the chain of infection .'Cleaning' is the removal of visible soil from objects and surfaces and normally is accomplished manually or mechanically using water with detergents or enzymatic products .'Reusable multiple-resident items' are items that may be used multiple times for multiple residents. Examples include stethoscopes, blood pressure cuffs, feeding tube pumps, and oxygen concentrators .non-critical items come in contact with intact skin, but not mucous membranes. These items require cleaning followed by low intermediate level disinfection .(use of EPA [Environmental Protection Agency]-registered disinfectants) following manufacturer's instructions .Staff shall follow established infection control principles for cleaning and disinfecting reusable, noncritical equipment . Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident .Multiple-resident use equipment shall be cleaned and disinfected before being used on another resident .Wear gloves when cleaning/disinfecting equipment .Use only EPA-registered disinfectants with kill claims for the common organisms found in the facility .</p> <p>4. Review of the medical records revealed Resident #22 and Resident #90 shared a room.</p> <p>Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, Anoxic Brain Damage, Persistent Vegetative State, Muscle Weakness, Anxiety, and unspecified Convulsions. Resident #22 had a Percutaneous Endoscopic Gastrostomy (PEG) tube.</p> <p>Review of Resident #22's annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score that was unable to be completed, staff assessed the resident as severely cognitively impaired for daily decision making, and totally dependent on staff for activities of daily living (ADLs).</p> <p>Review of Resident #22's care plan dated 5/3/2024, revealed .Resident has impaired pulmonary/respiratory status related to respiratory failure, tracheostomy, ventilator use .Resident will have reduced complications related to their altered pulmonary/respiratory status .</p> <p>Review of Resident #22's [Named] Hospital History and Physical Examination dated 9/3/2024, revealed . DATE OF ADMISSION: 8/31/2024 .CHIEF PRESENTING COMPLAINT: Fever with lethargy .The patient was evaluated in the emergency room and subsequently was admitted for severe sepsis with acute respiratory failure. The resident was admitted to the intensive care unit .</p> <p>Review of the facility Progress Note for Resident #22 dated 9/6/2024, revealed .Chronic General Debility, Deterioration .malaise .chronic respiratory failure s/p [status post] tracheostomy, Seizure do [disorder], Myasthenia Gravis [autoimmune disease caused by a breakdown in communication between nerves and muscles] quadriplegia .presented to the hospital with persistent fever .found to be septic [serious condition in which the body responds improperly to an infection] due to pneumonia .finished her course of antibiotics in the hospital .</p> <p>Review of the medical record revealed Resident #90 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, Gastrostomy tube, and Seizures.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                 |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Review of Resident #90's quarterly MDS assessment dated [DATE], revealed a BIMS score that was unable to be completed, staff assessed the resident as rarely/never understood for daily decision making, and was dependent on staff for all ADLs.</p> <p>Review of Resident #90's [Named] Hospital History and Physical Examination dated 7/30/2024, revealed . DATE OF ADMISSION: 7/30/2024 .CHIEF PRESENTING COMPLAINT: Wound infection with bleeding from sacral wound .The patient was brought to the emergency room from the nursing home because they stated that she was having fever and also was bleeding from her sacral wound .to be evaluated for possible sepsis . she was subsequently admitted after intravenous antibiotic therapy initiation .</p> <p>Observations in Resident #22 and #90's shared room on 9/23/2024 at 10:30 AM, 9/25/2024 at 11:00 AM, 10/1/2024 at 2:20 PM, and 10/2/2024 at 3:00 PM, revealed dark brown marks on the floor at the doorway of room, tan and brown spots under the base of Resident #90's enteral feeding pump pole, and right side of Resident #90's bed frame contained a thin, brown substance smeared from the head of the bed to the foot of the bed.</p> <p>During an interview on 9/25/2024 at 11:15 AM, LPN U was asked what was on Resident #90's feeding pump pole and what was on Resident #22's bedframe. LPN U stated, .could be dried feeding on the pole and feces on the bed . LPN U was asked who should clean the pump pole and the bedframe. LPN U stated, .whoever makes the mess . LPN U was asked if that (the feeding pole and bedframe) was supposed to be cleaned. LPN U stated, Yes.</p> <p>5. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Tracheostomy, and Gastrostomy tube and received feedings.</p> <p>Review of Resident #28's admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the resident was cognitively intact and needed partial/moderate assist with ADLs.</p> <p>Observations in Resident #28's room on 9/30/2024 at 10:47 AM and 10/2/2024 at 8:50 AM, revealed dark drips and splatters on the wall by the resident's bed and yellowish tan drip stains on the wall by the unoccupied bed in Resident #28's room.</p> <p>6. Review of the medical records revealed Resident #34 and Resident #116 shared a room.</p> <p>Review of the medical record revealed Resident #34 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Cerebral Infarction, Tracheostomy Status, Hemiplegia, and Gastrostomy tube.</p> <p>Review of Resident #34's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated the resident was cognitively intact, and dependent on staff for all ADL's.</p> <p>Review of the medical record revealed Resident #116 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Subdural Hemorrhage, Muscle Weakness, Diabetes, Congestive Heart Failure, and Gastrostomy tube.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                 |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Review of Resident #116's Significant Change MDS assessment dated [DATE], revealed a BIMS score was unable to be completed due to Resident #116 was rarely/never understood. Resident #116 was assessed by staff to be severely cognitively impaired.</p> <p>Observations in Resident #34 and Resident #116's shared room on 9/23/2024 at 9:47 AM and 3:45 PM, 9/25/2024 at 10:30 AM, and 10/2/2024 at 2:30 PM, revealed the vanity mirror was cracked and had brown smears under it, the base of both bed frames had brown smears. Resident #34's right quarter side rail had brown scattered smears on the top and on the side of the side rail. Resident #116's suction cannister contained brown slimy mucus and was not covered, a layer of dust was observed on top of the chest in the corner of the room to the left of Resident #116's bed. Resident #116's feeding pole displayed smears of a tan substance, and the base of the feeding pole was rusted with orange residue and a dried tan substance on it. The floor under the base of the pole revealed a dried brown substance on the floor. The privacy curtain between the 2 residents had splattered brown spots on each side of the curtain. The garbage can under the sink was overflowing with trash and incontinent pads. A thick, dark brown smear appeared on the corner of the bathroom door. The top, right, front edge of Resident #116's nightstand was chipped with sharp edges and jagged wood pieces. The HVAC unit's front vent cover displayed a thick layer of white fuzzy substance, a fuzz ball of dirt, grime and hair. The baseboard behind the base of the rusted brown enteral pump pole contained a smeared brown substance. A dried, thick, dark brown substance was observed on the right side of Resident #116's bed frame.</p> <p>During an interview on 9/25/2024 at 10:36 AM, Certified Nursing Assistant (CNA) P was asked what was on Resident #116's bedframe and Resident #34's side rail and what was the black smear on the corner of the wall beside the bathroom. CNA P stated, .looks like stool . CNA P was asked who was responsible for cleaning that. CNA P stated, .if I do it, I clean it .if I don't do it, I don't clean it . CNA P was asked who was responsible for cleaning the resident rooms. CNA P stated, .doesn't look like no one . CNA P was asked should the resident rooms be clean. CNA P stated, Yes.</p> <p>During an interview on 9/25/2024 at 11:05 AM, LPN C was asked who cleans the rooms. LPN C stated, .we [nursing staff] clean the resident equipment, housekeeping cleans the rooms . LPN C was asked if Resident #34 and Resident #116's room was clean. LPN C stated, No. LPN C was asked should the resident rooms be clean. LPN C stated, Yes.</p> <p>The shared room was not cleaned until 10/3/2024, for the IJ Removal Plan.</p> <p>7. Review of the medical records revealed Resident #49 and Resident #71 shared a room.</p> <p>Review of the medical record revealed Resident #49 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Tracheostomy, and Chronic Kidney Disease.</p> <p>Review of the facility infection tracking report dated June 2024, revealed Resident #49 was diagnosed with a Respiratory Infection on 6/4/2024.</p> <p>Review of Resident #49's quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the Resident was cognitively intact.</p> <p>Review of the Progress Note dated 10/1/2024, revealed Resident #49 was started on antibiotic therapy due to pneumonia.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                 |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Review of the medical record revealed Resident #71 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Anoxic Brain Damage, Intellectual Disabilities, Convulsions, Tracheostomy, and Gastrostomy tube.</p> <p>Review of the facility infection tracking reports dated April 2024 revealed Resident #71 was diagnosed with a Respiratory Infection on 4/17/2024.</p> <p>Review of the facility infection tracking reports dated June 2024 revealed Resident #71 was diagnosed with a Respiratory Infection on 6/14/2024.</p> <p>Review of Resident #71's quarterly MDS assessment dated [DATE], revealed the Resident was not assessed for a BIMS score and had a stage 4 pressure ulcer on the sacrum.</p> <p>Observations in Resident #49 and Resident #71's shared room on 9/23/2204 at 10:57 AM and 4:13 PM, and 9/24/2024 at 7:00 AM, revealed the following:</p> <p>A large area on the floor by Resident #71's bed with dried tan liquid, spots of dried tan liquid and dust build up on the enteral feeding pole, dried tan liquid on the right grab bar of the bed and bed frame, a fan on a stand blowing toward Resident #49 with thick dust on the back side of the fan.</p> <p>Observation in Resident #49 and #71's shared room on 10/2/2024 at 8:57 AM, revealed the filter of Resident #71's oxygen concentrator covered with thick whitish dust and a missing wheel.</p> <p>8. Review of the medical records revealed Resident #62 and Resident #123 shared a room.</p> <p>Review of the medical record revealed Resident #62 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Dependence on Respirator, Tracheostomy, and Gastrostomy tube.</p> <p>Review of Resident #62's quarterly MDS assessment dated [DATE], revealed Resident #62 was not assessed for a BIMS score and was severely cognitively impaired, and dependent on staff for all care.</p> <p>Review of the Tracking and Trending worksheet revealed Resident #62 was started on antibiotic therapy on 7/10/2024 for a Respiratory Infection.</p> <p>Review if the medical record revealed Resident #123 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Tracheostomy, and a Peg tube.</p> <p>Review of Resident #123's quarterly MDS assessment dated [DATE], revealed Resident #123 was not assessed for a BIMS score and was dependent on staff for all care.</p> <p>Observations in Resident #62 and Resident #123's shared room on 9/23/2204 at 10:42 AM and 3:36 PM, 9/24/2024 at 7:34 AM, 9/25/24 at 4:07 PM, and 10/2/2024 at 9:16 AM, revealed splatters and drips on the bottom of Resident #62 and Resident #123's enteral feeding pump poles and a dried pool of yellowish tan substance on the ground under each resident's feeding pole.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                   |                                                 |
| F 0880<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Some               | <p>9. Review of the medical record revealed Resident #63 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Severe Persistent Asthma.</p> <p>Review of Resident #63's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated the Resident was cognitively intact.</p> <p>Observation in Resident #63's room on 9/23/2024 at 11:08 AM and 10/01/2024 at 8:18 AM, revealed dried tan liquid on the floor and the HVAC unit vents contained a thick build up of dust.</p> <p>10. Review of the medical records revealed Resident #75 and Resident #83 shared a room.</p> <p>Review of the medical record revealed Resident #75 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Muscle Weakness, and Gastrostomy tube.</p> <p>Review of Resident #75's quarterly MDS assessment dated [DATE], revealed a BIMS score was unable to be completed, staff assessed the resident as rarely/never understood for daily decision making.</p> <p>Review of the medical record revealed Resident #83 was admitted to the facility on [DATE], with diagnoses including Dysphagia, Cerebral Infarction, Hemiparesis, and Gastrostomy tube.</p> <p>Review of Resident #83's admission MDS assessment dated [DATE], revealed a BIMS score that was unable to be completed, staff assessed the resident as rarely/never understood for daily decision making.</p> <p>Observation in Resident #83's room on 9/23/2024 at 10:00 AM, revealed tan liquid running down the enteral feeding pump pole.</p> <p>Observation in Resident #83's room on 9/30/2024 at 10:29 AM, revealed tan liquid ran down the feeding pump pole and collected at the base of the pole, and tan liquid ran down onto the nightstand and pooled in the floor.</p> <p>Observation in Resident #75 and Resident #83's shared room on 10/1/2024 at 8:13 AM and 3:18 PM, revealed a tan liquid ran down Resident #75 and Resident #83's enteral feeding poles, pooled in the floor and dried on the floor.</p> <p>11. Review of the medical records revealed Resident #77 and Resident #117 shared a room.</p> <p>Review of the medical record revealed Resident #77 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure with Hypoxia, Cerebral Infarction, Tracheostomy Status, Atrial Fibrillation, and Gastrostomy tube.</p> <p>Review of Resident #77's quarterly MDS assessment dated [DATE], revealed a BIMS score was unable to be completed, staff assessed the resident as moderately impaired for daily decision making, dependent on staff for all ADLs, and was coded for a feeding tube, oxygen therapy, suctioning, and tracheostomy.</p> <p>(continued on next page)</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       |                                                 |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Review of the medical record revealed Resident #117 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Cerebrovascular Accident, Hemiplegia/Hemiparesis, Chronic Kidney Disease, Tracheostomy, Pressure Ulcer Sacrum Stage 4, Diabetes, and Gastrostomy tube.</p> <p>Review of Resident #117's quarterly MDS assessment dated [DATE], revealed a BIMS assessment was unable to be completed, staff assessed the resident as rarely/never understood for daily decision making. Resident #117 was dependent on staff for all ADLs, and was coded for an indwelling catheter, feeding tube, oxygen therapy, suction, and tracheostomy.</p> <p>Observations in Resident #77 and Resident #177's shared room on 9/23/2024 at 9:53 AM, revealed the vanity sink contained a dried, brown, chunky substance with the appearance of gastric contents.</p> <p>Observations in Resident #77's and #177's room on 9/25/2024 at 10:10 AM and 10/2/2024 at 2:15PM, revealed Resident #77's oxygen concentrator with white dust like residue blowing off the side of the front of the grill between the vents, the HVAC unit front cover with thick, white, fluffy residue on the vent. The base of Resident #77's enteral pump pole contained a thick, dried, tan substance, a black substance was on the floor in the corner beside the window, Resident #77's bed frame contained thick, black smears with a foul odor, and the floor tile at the head of the bed revealed a black, sticky substance. Resident #177's bed frame contained a thick, black smear with a foul odor on the side and the bottom of the bed frame. The floor under Resident #177's bed was covered with a layer of white dust, black tile grout, and debris. The residents' sink contained rust stains and standing water from a clogged sink, and chipped paint with black smears was observed in the right corner of the vanity with black sticky debris observed under the mirror.</p> <p>During an interview on 9/25/2024 at 10:20 AM, CNA P was asked when Resident #77 and Resident #117's sink was reported clogged. CNA P stated, .I'm not sure, it's been that way for a while . CNA P was asked what was under Resident #177's bed and bedframe. CNA P stated, .looks like dirt and feces .someone needs to clean that .</p> <p>During an interview on 9/25/2024 at 10:24 AM, LPN C was asked who was responsible for reporting clogged sinks. LPN C stated, .we tell maintenance .they will get to it . LPN C was asked who was responsible for cleaning the feeding pumps and poles. LPN C stated, .I would say the nurses . LPN C was asked what was on Resident #77's feeding pump. LPN C stated, .dried enteral feedings and dust . LPN C was asked what was on Resident #77's and #117's bedframe. LPN C stated, .could be dried stool .</p> <p>12. Review of the medical record revealed Resident #80 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Tracheostomy, and Gastrostomy tube.</p> <p>Review of Resident #80's 5-day MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated the Resident was cognitively intact, and dependent on staff for all ADLs.</p> <p>Observations in Resident #80 's room on 9/23/2024 at 10:06 AM and 9/24/2024 at 9:30 AM, revealed a thick, dried, yellowish-tan stain on the floor next to the bed.</p> <p>13. Review of the medical records revealed Resident #120 and Resident #129 shared a room.</p> <p>Review of the medical record revealed Resident #120 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, Diabetes, and Gastrostomy tube.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       |                                                 |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>              | <p>Review of Resident #120's quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated the resident was cognitively intact.</p> <p>Review of the medical record revealed Resident #129 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure and Tracheostomy.</p> <p>Review of Resident #129's quarterly MDS assessment dated [DATE], revealed Resident had no BIMS score, staff assessed the resident as severely cognitively impaired for daily decision making, and the resident was dependent on staff for all ADLs.</p> <p>Review of the Tracking and Trending, report dated August 2024, revealed Resident #129 was treated with antibiotics for Respiratory Infections on 8/6/2024 and 8/25/2024.</p> <p>Review of the Admission/Discharge Report dated 9/1/2024-10/2/2024, revealed Resident #129 was discharged to the hospital on 8/28/2024 after unsuccessful treatment of antibiotics for a respiratory Infection.</p> <p>Review of the Progress Notes dated 10/10/2024, revealed Resident #129 was readmitted to the facility (on 10/10/2024) after being discharged to the hospital on 10/5/2024 for acute respiratory distress.</p> <p>Observation in Resident #120 and Resident #129's shared room on 9/23/2024 at 11:08 AM and 10/01/2024 at 8:18 AM, revealed the HVAC vents contained a thick build up of dust and a dried tan liquid was observed on Resident #129's enteral feeding pump pole and the floor.</p> <p>14. Review of the medical records revealed Resident #131 and Resident #144 shared a room.</p> <p>Review of the medical record revealed Resident #131 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Dependence on Ventilator, and Tracheostomy.</p> <p>Review of Resident #131's quarterly MDS assessment dated [DATE], revealed Resident #131 BIMS score was unable to be completed due to Resident #131 was rarely/never understood. Resident #131 was assessed by staff to be severely cognitively impaired and dependent on staff for all care.</p> <p>Review of the medical record revealed Resident #144 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Dependence on Ventilator, Tracheostomy, and Gastrostomy tube.</p> <p>Review of Resident #144's admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the resident was cognitively intact, and dependent on staff for all care.</p> <p>Review of the Admission/Discharge Report dated 8/1/2024-8/31/2024, revealed Resident #144 was discharged to the hospital 8/15/2024 with a Respiratory Infection.</p> <p>Review of the Tracking and Trending report dated September 2024, revealed Resident #144 was treated with antibiotics for a respiratory infection on 9/5/2024 and 9/6/2024.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                 |
| F 0880<br><br>Level of Harm - Immediate<br>jeopardy to resident health or<br>safety<br><br>Residents Affected - Some               | <p>Observations in Resident #131 and Resident #144's shared room on 9/23/2024 at 10:50 AM and 3:48 PM, on 9/24/2024 at 7:34 AM, on 9/25/2024 at 4:10 PM, and on 10/1/24 at 8:10 AM, revealed a pool of a yellowish tan substance dried on the floor under the enteral feeding pole next to Residents #131's bed and yellowish tan dried drip spots on the floor leading toward the door.</p> <p>15. Review of the medical record revealed Resident #133 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, Chronic Kidney Disease, and Gastrostomy tube.</p> <p>Review of Resident #133's admission MDS assessment dated [DATE], revealed a BIMS score was not completed and staff assessed the resident as cognitively impaired for daily decision making, received oxygen, required suctioning, and received tracheostomy care.</p> <p>Observations in Resident #133's room on 9/23/2024 at 11: [TRUNCATED]</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30974</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure a safe, sanitary, and comfortable environment for 32 of 88 (Resident #6, #8, #15, #17, #27, #28, #32, #33, #36, #38, #39, #41, #48, #55, #57, #58, #61, #66, #68, #69 #70, #74, #79, #83, #84, #87, #88, #93, #97, #99, #105, and #113) sampled resident rooms observed and for 2 of 2 100 hallways (100 short hallway and 100 long hallway) observed.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Routine Cleaning and Disinfection dated 2/1/2022, revealed, .It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible . Cleaning refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products .Consistent surface cleaning and disinfection will be with a detailed focus on high touch areas to include, but not limited to .bed rails, tray tables, call buttons . resident chairs .IV [intravenous] poles .Cleaning of walls, blinds, and window curtains will be conducted when visibly soiled .Privacy curtains in resident rooms will be changed when visibly dirty .</p> <p>Review of the undated facility policy titled, Daily Cleaning Procedures revealed .empty trash .disinfect the waste basket and insert a can liner .High Dust .work your way clockwise around the room (starting at the door and finishing at the door) and dust all high surfaces .this includes but not limited to pictures/prints, televisions, over the bed lights, blinds, vents and all corners .Disinfect .work your way clockwise around the room .disinfect flat surfaces .high touch items .door knobs, light switches, call lights, TV [television] remotes, bed siderails, bed frame, foot board and headboard, bedside tables, closet handles, window sills, chairs, heating unit, and any flat surfaces .if resident has a fan in his/her room, check and clean routinely to avoid buildup of dust .Spot Clean Walls and Inspect Privacy Curtains .work your way clockwise around the room . spot cleaning walls and vertical surfaces that are visibly soiled .inspect all privacy curtains in room .if dirty notify your supervisor which curtains need to be changed .Clean Restroom .restock all supplies .empty trash . high dust lights, vents .disinfect sink area .disinfect toilet area-including handrails, call lights and tub/shower . Dust Mop .dust mop the perimeter of the room first .then start at back of room and use a figure 8 motion to dust mop entire floor working your way back to the door .don't forget the restroom .Damp Mop .damp mop the perimeter of the room .then start at the back of the room and use a figure 8 motion to damp mop the entire floor while working your way back to the door .don't forget the restroom .</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of the undated facility policy titled, Deep Cleaning Procedures revealed Check the posted deep clean schedule in the morning and inform the Nursing Supervisor of the appropriate room number that will be deep cleaned today Clean the scheduled deep clean room .room should be emptied .if it is not, contact the nursing Supervisor to assist the situation .in a clockwise rotation from .door, clean, polish, scrub, scrape, dust, disinfect, sweep, wipe and mop everything in the room including: waste baskets .remove liner, wipe down can with disinfectant and remove all excess build-up .insert new can liner .Dressers-pull dresser completely away from the wall so that you can mop the floor where the dresser was sitting .spot scrub wall behind dresser and wipe down the rear of the dresser .sweep and damp mop floor and baseboard making sure to remove all build-up from these areas .clean all sides with disinfectant cleaner, including drawers and tracks, and remove bottom drawers to clean interior shelf .Chairs .remove cushions and scrub with brush or pad .scrub and polish frame .Closet .floor and edges around the closet floor, and spot check walls and shelf .Windows .clean window tracks and clean blinds .report any soiled or damaged curtains to your supervisor .Heating Unit .wipe top and all sides, check top vents for any accumulation of dust or other debris .remove build-up from floor under heating unit, sweep and damp mop .Nightstand .follow same procedure as Dressers .Bed .pull bed at least three feet away from wall .spot scrub the wall, remove build-up from floor and baseboards .sweep and damp mop floor and baseboards .thoroughly clean and disinfect all parts of the resident's bed .remove mattress (pay special attention to the bed frame, headboard, footboard, legs and side rails) .disinfect all areas of the mattress and return it to the frame .place bed in original position against the wall .Bed Side Tables .scrub all areas of table .polish if necessary .Privacy Curtains .check and report any soiled or damaged curtains to supervisor .clean lights above bed and all call lights and cords .Check all corners, ceiling and floor for cobwebs .Spot scrub all walls .Entrance of room .scrub both sides of door and door knob .Remove build-up on floor between room and hallway .Dust mop and damp mop entire room .Clean restroom by moving in a clockwise rotation from the restroom door .restock all supplies .Vents .use high duster to clean vents .Light cover .dust and disinfect .Walls .spot scrub all walls .Clean the light switch and cover plate .Sink .disinfect all porcelain on sink, both top and bottom .scrub all fixtures and drains .be sure to scrub wall under sink .Plumbing .clean spray hose and all pipes under sink .Toilet .scrub and disinfect toilet bowl .remove all stains and build-up .Safety bar and toilet paper holder .clean and polish .Call light and plate .clean and polish .Mirror .clean edges of mirror and shelf .clean mirror and use paper towel to dry .Check all corners for cobwebs .high and low .spot scrub door, frame and knob .Remove all build-up from floor around bowl, door frame, corners and edges .Dust mop the entire floor .Damp mop the entire floor .</p> <p>Review of the facility policy titled, Preventive Maintenance Program dated 3/12/2022, revealed A Preventive Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public .The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner .The Maintenance Director shall assess all aspects of the physical plant to determine if Preventative Maintenance (PM) is required .</p> <p>2. Review of the Housekeeping Vendor undated checklist titled DEEP CLEAN CHECKOFF LIST, revealed . Inform the resident you are deep cleaning their room. Let resident (s) know you will be in their room for 30 minutes .you must move the bed, dresser, and any large objects so you can clean behind it. This room must be sanitized, dusted, and dirt-free when you are done .CHECK OFF THE FOLLOWING AREAS AS WHEN COMPLETED:</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                       |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>a. Pull out bed (s) and sweep, vacuum under, wipe down bed frames and springs as well</p> <p>b. Pull out dresser (s) and sweep, vacuum under, do not forget to wipe down sides as well</p> <p>c. Dust and wipe down T.V. [television] and underneath</p> <p>d. Clean and dust bed frame, pillows, and springs</p> <p>e. Clean ceilings, vents, and light fixtures</p> <p>f. Clean windowsills and inside of window</p> <p>g. Clean and wipe down heater/radiator units, remove trash from inside of units</p> <p>h. Clean and wipe down pictures / prints on walls</p> <p>i. Clean and wipe down garbage can inside and out</p> <p>j. Clean and wipe down all walls (PAY SPECIAL ATTENTION TO WALLS NEXT TO TRASH CANS AND UNDER SOAP DISPENSERS)</p> <p>k. Check bed linens for rips and tears</p> <p>l. Check skid strips for damage and alert management so they can be replaced</p> <p>m. Clean and wipe down doors, door jams, and door frames</p> <p>n. Clean and wipe down closets and shelves inside and outside</p> <p>o. Clean and wipe down all tables, nightstands, and rolling tables</p> <p>p. Clean and wipe down all chairs</p> <p>q. Clean and wipe down baseboards/edges (Use scraper to remove dirt in corners)</p> <p>r. Clean and disinfect floors</p> <p>s. Clean and disinfect toilet</p> <p>t. Clean and disinfect sink</p> <p>u. Disinfect and wipe down bathroom pull cords</p> <p>v. Clean and disinfect shower stall/tub</p> <p>w. Clean and wipe down vents</p> <p>x. Clean and wipe down ANY wheelchairs in the room</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                   |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>y. Inspect curtains for spills or damage and alert management so they get replaced</p> <p>z. Clean and disinfect refrigerators</p> <p>aa. CLEAN AND DISINFECT ANY PHONES, REMOTES, CALL LIGHTS AND ANYTHING ELSE THAT MAY BELONG TO THE ROOM .</p> <p>3. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE], with diagnoses including Encephalopathy, Dementia, Bipolar Disorder, Muscle Weakness, and Depression.</p> <p>Review of the Resident #27's quarterly MDS assessment dated [DATE], revealed Resident #27 was severely cognitively impaired and was dependent on staff for ADLs.</p> <p>Observation in Resident #27's room on 9/23/2024 at 10:47 AM, and on 10/1/2024 at 7:27 AM, revealed dirty black build-up on the flooring at the threshold entrance of the Resident's room.</p> <p>4. Review of the medical record revealed Resident # 36 was admitted to the facility on [DATE] with diagnoses including Senile Degeneration of the Brain, Dementia, Muscle Weakness, and Alzheimer's Disease.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #36 had a BIMS score of 3, indicating the resident was severely cognitive impaired and dependent on staff for ADLs.</p> <p>c. Observation in the shared bathroom on 9/23/2024 revealed,</p> <p>(1). Black build-up on the floor at the entrance to the room and around the base board of the entrance to the room leading to the bathroom</p> <p>(2). Black build-up on base boards and around bathroom door and the base board and entrance to the close</p> <p>(3). Missing tile around the base of the bathroom vanity exposing cracked tiles and ground, and brown and gray build up</p> <p>(4). Black build-up around the closet door and behind the entrance door, with black build up on the bottom of the closet door</p> <p>(5). Cracked tile behind the entrance door</p> <p>5. Review of the medical records revealed Resident #39 and Resident #41 shared a room.</p> <p>a. Resident #39 was admitted to the facility on [DATE], with diagnoses including Muscle Weakness, Dementia, Acute Respiratory Infection, Hemiplegia and Hemiparesis, Difficulty Walking, Absolute Glaucoma Right Eye, and Legal Blindness.</p> <p>Review of Resident #39's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the Resident was cognitively intact and required moderate assistance with Activities of Daily Living (ADLs).</p> <p>(continued on next page)</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>b. Record review revealed Resident #41 was admitted to the facility on [DATE], with diagnoses including Dementia, Hemiplegia and Hemiparesis, Muscle Weakness, Acquired Absence of Left Leg and Right Leg Below Knee, and Obesity.</p> <p>Review of the annual MDS assessment dated [DATE] revealed Resident #41 was severely cognitively impaired and was dependent on staff for ADL care.</p> <p>c. Observation in Resident #39 and #41's shared room on 9/23/2024 at 9:45 AM, and on 9/30/2024 at 4:27 PM, revealed the following:</p> <p>(1). dark black build-up in the corner of the closet door leading round the base board leading into the resident's room.</p> <p>(2). missing base board on the corner of the closet door, and the floor in front of the closet door with black substance build-up going up the wall near closet door.</p> <p>(3). black build-up in the corners of the entrance door leading from the room to the hallway.</p> <p>(4). dark black build-up in the grout of the bathroom tile floor and around the base board of the bathroom vanity.</p> <p>6. Review of the medical records revealed Resident #6 and Resident #15 shared a room.</p> <p>a. Resident #6 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Acute Upper Respiratory Disease, and Muscle Weakness.</p> <p>Review of Resident #6's quarterly MDS assessment dated [DATE], revealed a BIMS score was not assessed, and the Resident was dependent on staff for ADLs.</p> <p>b. Record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Weakness, Contracture Left Hand, Muscle Weakness, Arthritis, and Lack of Coordination.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 10, indicting Resident #15 was moderately cognitively impaired and required dependence for ADL care.</p> <p>c. Observation in Resident #6 and #15's shared room on 9/23/2024 at 9:45 AM and 9/30/2024 at 4:27 PM, revealed the following:</p> <p>(1). dark black build-up around base board of closet door on the floor and in the corner of the door facing of the closet.</p> <p>(2). dark black build-up behind the entrance door in the corners leading up the wall and leading to the facing of the closet door.</p> <p>(3). dark black build-up leading out of the room into the hallway.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>(4). dark black build-up around the base board of the bathroom entrance and in the corners of the facing of the bathroom door.</p> <p>(5). missing floor tile around base of the bathroom vanity and dark black build-up around in the tile flooring on the bathroom floor.</p> <p>7. Review of the medical records revealed Resident #84 and #105 shared a room.</p> <p>(a). Resident #84 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Asthma, Absolute Glaucoma of Left Eye, and Shortness of Breath.</p> <p>Review of Resident #84's quarterly MDS assessment dated [DATE] revealed Resident was not assessed for a BIMS score, and the Resident was dependent on staff for ADLs.</p> <p>(b). Record revealed Resident #105 was admitted to the facility on [DATE], with diagnoses including Transient Cerebral Ischemic Attack, Chronic Obstructive Pulmonary Disease, Difficulty Walking, and Dementia.</p> <p>Review of the quarterly MDS assessment dated [DATE] revealed Resident #105 was not assessed for a BIMS score and required supervision with ADLs.</p> <p>c. Observation in Resident #84 and #105's shared room on 9/23/2024 at 9:45 AM, and on 9/30/2024 at 4:27 PM, revealed the following:</p> <p>(1). dark black build-up around the base board of the room from the entrance of the room leading into the bathroom and around the corners of the facing of the resident shared closet.</p> <p>(2). missing floor tile at the entrance of the door of the Resident's room.</p> <p>(3). metal transition strip raised and dislodged from the floor that separate the entrance of the resident's room to the hallway.</p> <p>8. Review of the medical record revealed Resident #48 and Resident #57 shared a room.</p> <p>a. Resident #48 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Dementia, Cognitive Communication Deficit, and Muscle Weakness.</p> <p>Review Resident #48's quarterly MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated the Resident was severely cognitively impaired, and was dependent on staff for ADLs.</p> <p>b. Record revealed Resident #57 was admitted to the facility on [DATE], with diagnoses including of Parkinson's Disease, Dementia, Schizophrenia, Dysphagia, and Insomnia.</p> <p>Review of Resident #57's quarterly MDS assessment dated [DATE], revealed a BIMS score of 12, which indicated the Resident was moderately cognitively impaired and was dependent on staff for ADLs.</p> <p>c. Observation in Resident #48 and Resident #57's shared room on 9/23/2024 at 9:45 AM, and on 9/30/2024 at 4:27 PM, revealed the following:</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>(1). dark black build-up around in the corners of the entrance door leading into the Residents' room and in the corner behind the entrance door.</p> <p>(2). dark black build-up around the base board of the closet doors and in the corners of the closet doors going up the wall in the corners.</p> <p>(3). dark black build-up in the grout of the tile floor in the room and in the bathroom around the base of the bathroom vanity.</p> <p>9. Review of the medical record revealed Resident #70 and #97 shared a room.</p> <p>a. Resident #70 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, Muscle Weakness, Visual Loss, and Quadriplegia.</p> <p>Review of Resident #70's admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated the Resident was cognitively intact, had impaired vision, and required maximal assistance with ADLs.</p> <p>b. Record revealed Resident #97 was admitted to the facility on [DATE], with diagnoses including Dementia, Muscle Weakness, Difficulty Walking, and Altered Mental Status.</p> <p>Review Resident #97's admission MDS assessment dated [DATE], revealed a BIMS score of 9, which indicated the Resident was moderately impaired, impaired vision, and dependent on staff for ADLs.</p> <p>c. Observation in Resident #70 and #97's shared room on 9/23/2024 at 9:45 AM, and on 9/30/2024 at 4:27 PM, revealed the following:</p> <p>(1). dark black build-up around corner of the entrance of the door leading into the Residents' room, in the corners going up the wall.</p> <p>(2). dark black build-up behind the entrance of the room door leading around the corner of the closet door entrance going up the wall.</p> <p>(3). chipped and hollowed out wall around base of the entrance of the closet facing leading into the resident room on the A side.</p> <p>(4). dark brown and black build-up around the base of the toilet.</p> <p>(5). dark brown and black build-up in the grout of the bathroom floor tile.</p> <p>(6). missing floor tile and base board around the bathroom vanity with dark black and brown build-up on the grout in the tile floor.</p> <p>(7). plastic white cover hanging off of the bathroom vanity light.</p> <p>10. Record revealed Resident #55 was admitted to the facility on [DATE], with diagnoses including Atrial Fibrillation, Depression, Hypertension, and Muscle Weakness.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #55 was cognitively intact and was dependent on staff to perform ADLs.</p> <p>Observation in Resident #55's room on 9/23/2024 at 10:50 AM and on 10/1/2024 at 7:27 AM, revealed dirty black build-up on the flooring at the threshold entrance of the resident's room.</p> <p>11. Review of the medical record revealed Resident #68 was admitted to the facility on [DATE], with diagnoses including Diabetes, Heart Failure, Hypertension, and Stage 4 Pressure Ulcer.</p> <p>Review of the quarterly MDS dated [DATE], revealed BIMS score of 11 which indicated Resident #68 was moderately cognitively impaired.</p> <p>Observation in Resident #68's room on 9/24/2024 at 9:10 AM and on 10/1/2024 at 7:27 AM, revealed a dirty black build-up on the floor at the threshold entrance of the Resident's room.</p> <p>12. Review of the medial record revealed Resident #74 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Chronic Kidney Disease, Aphasia, Depression, and Hypertension.</p> <p>Review of Resident #74's quarterly MDS assessment dated [DATE], revealed the Resident was not assessed for mental status. Resident was dependent on staff to perform ADLs.</p> <p>Observation in Resident #74's room on 9/23/2024 at 3:25PM and on 10/1/2024 at 7:27 AM, revealed dirty black build-up on the floor at the threshold entrance of the Resident's room.</p> <p>13. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE], with diagnoses of Chronic Respiratory Failure, Tracheostomy.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated she had no cognitive impairment. Resident needed partial/moderate assist with Activities of Daily Living.</p> <p>Observation in Resident's room on 9/23/24 at 3:33 PM, revealed the head of the Resident's bed was semi-reclined, and the foot of bed also elevated. Resident #28 was lying almost sideways, with the right leg hanging off bed with the right foot on floor.</p> <p>Observation in the Resident's room on 9/24/24 at 7:37 AM, revealed the head of the bed was elevated, and the foot of the bed was elevated. The Resident was lying on their back in the bend of the bed with the right leg hanging off the bed towards the floor.</p> <p>During an interview on 9/24/2024 at 2:14 PM, Registered Nurse (RN) E was asked about Resident #28's bed and if there was an order to have it fixed. RN E stated, I did that yesterday .hopefully they will fix that today.</p> <p>During an interview on 10/1/24 at 4:00 PM, the Maintenance Supervisor was asked if a resident's bed should go un-serviced for 2 days when it is stuck in a position to where neither the head nor the foot of bed would not go down. The Maintenance Supervisor confirmed it should not have taken 2 days to get the bed fixed for Resident #28.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>14. Random observations reveal the following:</p> <p>a. Observations in Resident #6's room on 9/24/2024 at 9:01 AM and 3:24 PM and on 9/26/2024 at 1:31 PM, revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview on 9/30/2024 at 4:25 PM, the Maintenance Director confirmed Resident #6's privacy curtain had 3 hooks missing and a hole and it should not be.</p> <p>b. Observations in Resident #8's room on 9/25/2024 at 10:07 AM and 10:53 AM and on 9/26/2024 at 1:14 PM, revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview in Resident #8's room on 9/30/2024 at 3:56 PM, the Maintenance Director confirmed the privacy curtain needed to be replaced due to 1 hook missing and 2 holes.</p> <p>c. Observations in Resident #17's room on 9/24/2024 at 8:46 AM and 3:17 PM, and on 9/25/2024 at 10:49 AM, and on 9/26/2024 at 8:37 AM revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview in Resident #17's room on 9/30/2024 at 3:45 PM, the Maintenance Director confirmed the privacy curtain had 12 hooks missing and should not have any missing hooks.</p> <p>d. Observations in Resident #32's room on 9/24/2024 at 8:43 AM and 3:19 PM, 9/25/2024 at 10:52 AM, and 9/26/2024 at 8:38 AM, revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview in Resident #32's room on 9/30/2024 at 3:51 PM, the Maintenance Director confirmed the privacy curtain had 14 hooks missing and it should not have any missing hooks.</p> <p>e. Observations in Resident #33's room on 9/24/2024 at 8:41 AM and 3:20 PM, and 9/25/2024 at 10:52 AM, and 9/26/2024 at 8:51 AM, revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview in Resident #33's room on 9/30/2024 at 3:52 PM, the Maintenance Director confirmed the privacy curtain needed to be replaced due to 3 hooks missing and 1 hole.</p> <p>f. Observations in Resident #38's room on 9/24/2024 at 8:39 AM and 3:21 PM, 9/25/2024 at 10:53 AM, and 9/26/2024 at 1:14 PM, revealed there were several hooks missing from the privacy curtain.</p> <p>During an observation and interview in Resident #38's room on 9/30/2024 at 4:02 PM, the Maintenance Director confirmed the privacy curtain had 3 hooks missing and it should have any missing.</p> <p>e. Observations in Resident #39's room on 9/24/2024 at 8:32 AM and 3:24 PM 9/25/2024 at 10:58 AM, 9/26/2024 at 1:31 PM, 9/26/2024 at 1:31 PM, and on 9/26/2024 at 1:31 PM, revealed there were several hooks missing from the privacy curtain</p> <p>During an observation and interview in Resident #39's room on 9/30/2024 at 4:28 AM, the Maintenance Director confirmed the privacy curtain needed to be replaced due to black zip ties where the hooks should be, 3 hooks missing and 2 holes.</p> <p>(continued on next page)</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>f. Observation in Resident #58's room on 9/23/2024 at 10:16 AM and on 9/26/2024 at 8:47 AM, revealed the enteral feeding pole had splatters of a tan substance on it and the enteral feeding machine was smeared with an unknown substance.</p> <p>Observations in Resident #69 and Resident #61's shared room on 9/24/2024 at 8:38 AM and 3:22 PM, and 9/25/2024 at 10:54 AM, revealed there were several hooks missing from the privacy curtain.</p> <p>g. During an observation and interview in Resident #61 and Resident #69's shared room on 9/30/2024 at 4:10 PM, the Maintenance Director confirmed that Resident #61's privacy curtain had 8 hooks missing and Resident #69's curtain had 13 hooks missing and should not have missing hooks.</p> <p>h. During observation and interview in Resident #66's room on 9/30/2024 at 4:11 PM, the Maintenance Director confirmed the privacy curtain needed to be replaced due to 3 holes.</p> <p>i. Observations in Resident #79's room on 9/24/2024 at 8:47 AM and 3:13 PM, 9/25/2024 at 10:47 AM, and on 9/26/2024 at 8:37 AM, revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview in Resident #79's room on 9/30/2024 at 3:44 PM, the Maintenance Director confirmed the privacy curtain was missing 9 hooks and should not be missing any hooks.</p> <p>j. Observations in Resident #83's room on 9/24/2024 at 8:41 AM and 3:21 PM, 9/25/2024 at 10:52 AM, and 9/26/2024 at 1:15 PM, revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview in Resident # 83's room on 9/30/2024 at 3:53 PM, the Maintenance Director confirmed the privacy curtain needed to be replaced due to 5 hooks missing and 4 holes.</p> <p>k. Observations in Resident #84's room on 9/24/2024 at 8:34 AM and 3:23 PM, 9/25/2024 at 10:57 AM, and on 9/26/2024 at 1:31 PM, revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview in Resident #84's room on 9/30/2024 at 4:17 PM, the Maintenance Director confirmed the privacy curtain needed to be replaced due to 9 hooks missing, a hole and an orange stain and brown spots.</p> <p>l. Observations in Resident #87's room on 9/24/2024 at 8:37 AM and 3:22 PM, and on 9/25/2024 at 10:56 AM, revealed hooks missing from the privacy curtain.</p> <p>m. Observations in Resident #88's room on 9/25/2024 at 10:56 AM, revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview on 9/30/2024 at 4:16 PM, the Maintenance Director confirmed Resident #88's privacy curtain had 3 hooks missing and should not have missing hooks.</p> <p>n. Observations in Resident #93 and Resident #99's shared room on 9/25/2024 at 10:53 AM and 9/26/2024 at 1:14 PM, revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview in Resident #93's room on 9/30/2024 at 4:03 PM, the Maintenance Director confirmed the privacy curtain needed to be replaced due to 4 hooks missing and 1 hole.</p> <p>(continued on next page)</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445220                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>10/16/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Spring Gate Rehab & Healthcare Center                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3909 Covington Pike<br>Memphis, TN 38135 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During and observation and interview in Resident #99's room on 9/30/2024 at 4:04 PM, the Maintenance Director confirmed the privacy curtain needed to be replaced due to 2 hooks missing and 8 holes.</p> <p>o. Observations in Resident #113's room on 9/25/2024 at 10:54 AM and on 9/26/2024 at 1:13 PM, revealed hooks missing from the privacy curtain.</p> <p>During an observation and interview in Resident #113's room on 9/30/2024 at 4:06 PM, the Maintenance Director confirmed the privacy curtain needed to be replaced due to 3 hooks missing and 5 holes.</p> <p>p. Observation on the 100 Long Hallway on 10/2/2024 at 9:06 AM, revealed one loose handrail on each side of the hallway.</p> <p>q. Observation in the 100 Short Hallway on 10/2/2024 at 9:17 AM, revealed a wall air conditioner unit at the end of the hall with a visible opening to the outside around the unit.</p> <p>38439</p> |                                                                                       |                                                 |