STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445228	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Greeneville	725 Crum Street Greeneville, TN 37743

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003 Based on facility policies and procedures review, medical record review, and interviews the facility failed to permit 1 resident (Resident #350) to return to the facility after a hospitalization and failed to follow the facility's procedure for discharge for 1 resident (Resident #195) of 7 residents reviewed for Transfers and Discharge. The findings include: Review of the Pharmacy Services and Procedures policy titled, Discharge with Medication [from the facility], dated 1/1/2022, A medication release form should be used to record the inventory released upon discharge . Review of the facility's policy titled, Permitting Residents to Return Policy, reviewed 8/10/2023, revealed .The facility will permit residents to return to the facility after a hospitalization or therapeutic leave . Medical record review revealed Resident #350 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Pneumonia, Alzheimer's Disease, and Atherosclerotic Heart Disease (clogged arteries). Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #350 scored a 00 on the Brief Interview for Mental Status Assessment (BIMS) which indicated the resident had severe cognitive impairment. Review of a Health Status Note dated 12/18/2023 at 8:33 PM, revealed Resident #350 was transferred to the hospital for evaluation and treatment. Review of a Health Status Note dated 12/19/2023 at 2:04 AM, revealed Resident #350 was admitted to the hospital. Review of a discharge MDS assessment dated [DATE], revealed .Discharge-return anticipated . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/2024 at 7:46 AM, the Social Services Director stated the Administrator made decisions as to whether residents were accepted back into the facility after a hospitalization . The Social Services Director confirmed Resident #350 was transferred to the hospital and the facility refused to accept the resident back to the facility. During an interview on 5/1/2024 at 2:11 PM, the Administrator stated Resident #350 went out as a skilled patient and the resident's daughter refused to pay the bed hold. Continued interview revealed no bed hold was initiated for Resident #350. The Administrator stated the facility was very capable of caring for Resident #350, but could not meet the needs and expectations of the resident's daughter. The resident's daughter was informed the facility had filled the resident's bed and she was advised to find an alternative placement for her mother. During a telephone interview on 5/2/2023 at 8:25 AM, the complainant stated the facility initially told her they could hold Resident #350's bed for a couple of days. Continued interview revealed the Administrator told her . We can't take your mom [Resident #350) back .we can't meet your needs . The complainant stated she called the Corporate [NAME] President who told her he had approved the resident not returning to the facility. 35460 Medical record review revealed Resident #195 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Pneumonia, and Emphysema. Review of the admission MDS assessment dated [DATE], revealed Resident #195 scored a 7 on the BIMS assessment which indicated the resident had a severe cognitive impairment. Review of a nurse's note for Resident #195 dated 3/3/2024 at 12:00 PM, revealed .left with her [Resident #195] son at 12pm [12:00 PM] to go home, medication was sent with her . son packed up her belongings, went over discharge paperwork and medication list, let her know that she needed to make an apt [appointment] with her healthcare provider, ask if he [resident's son] had any questions he stated no signed paperwork and left with patient via w/c [wheelchair] . During an interview on 4/28/2024 at 1:05 PM with Resident #195's niece confirmed the resident was discharged home on 3/3/2024 with her son. Continued interview revealed the niece had visited Resident #195 at her home on 3/7/2024 and discovered medication cards in a bag which had been sent home with the resident at discharge. The medications sent home with Resident #195's had her roommate's (Resident #16) name on the cards. Further interview revealed the niece called the DON who requested she return the medication cards to the facility. Continued interview confirmed Resident #195 was not administered any of Resident #16's medications. During a telephone interview on 5/1/2024 at 9:50 AM, Licensed Practical Nurse A confirmed she had been notified by the Director of Nursing (DON) on 3/7/2024 Resident #195 had been discharged home with Resident #16's medication. Review of the Medication Administration Record for Resident #16 dated 3/3/2024, revealed Resident #16 had received her prescribed medications. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/2024 at 10:15 AM, the DON confirmed Resident #195's niece had returned the unused medication with Resident #16's name on them and no medications were missing from the card. Continued interview confirmed there was no adverse outcome for Residents #195. Further interview confirmed Resident #16 had received her ordered medications and there was no interruption in her treatment.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405 Based on review of the Resident Assessment Instrument (RAI) Version 3.0 Manual, medical record review, and interview, the facility failed to transmit a discharge Minimum Data Set (MDS) assessment timely for 1 resident (Resident #1) of 22 residents reviewed. The findings include: Review of the RAI Version 3.0 Manual dated 10/2023, Chapter 2: Assessments for the RAI revealed . Discharge refers to the date a resident leaves the facility . A Discharge assessment is required with all . discharges .Discharge assessment .Must be transmitted .no later than 14 calendar days after the MDS completion date . Medical record review revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Adult Failure to Thrive, Malnutrition, and Pressure Ulcers. The resident was discharged to the hospital on 12/22/2023. Medical record review of the MDS assessments revealed Resident #1 did not have a discharge MDS assessment completed or transmitted and was more than 120 days overdue. During an interview on 4/30/2024 at 1:00 PM, the MDS Coordinator confirmed Resident #25 had been discharged from the facility on 12/22/2023, the discharge assessment had not been completed or transmitted and was more that 120 days overdue.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, review of the Resident Assessment Instrument (RAI) Manual 3.0, medical record review, observations, and interviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 resident (Residents #56) of 22 residents reviewed for MDS assessments. The findings include: Review of the facility's policy titled, Resident Assessment Instrument & Care Plan Development, revised 8/16/2022, revealed .the MDS uses assessment patient observation .to form the foundation of the comprehensive assessment . Review of the RAI Manual 3.0 dated 10/1/2023, revealed . primary purpose as an assessment instrument is to identify resident care problems that are addressed in an individualized care plan .the assessment [MDS] accurately reflects the resident's status .physician-prescribed weight-loss regimen .resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order . Medical record review revealed Resident #56 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Gastro-Esophageal Reflux Disease Review of a quarterly MDS assessment dated [DATE], revealed Resident #56 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment, had weight loss of 5%, and was on a physician prescribed weight-loss regimen. Review of a comprehensive care plan for Resident #56 dated 4/18/2024, revealed .-[minus] 9.2% [weight-loss] x [times] 30 days, -14.8% x 90days, -26.1% x 180 days .regular diet with thin liquids, large protein portions, fortified cereal at breakfast, fortified potatoes at lunch, ice cream at lunch, [protein supplement] x 2 a day, [high calorie supplement] .TID [three times a day] .Observe and report PRN [as needed] any changes .in weight . Medical record review of Resident #56's weights for 180 days, revealed Resident #56's weight on 10/25/2023 was 242 lbs (pounds) and weight on 4/24/2024 was 178 lbs, which was a total loss of 26.45% in 180 days. Medical record review of a Registered Dietitian (RD) Note for Resident #56 dated 4/25/2024, revealed . Weight Note .178# [pounds] weight loss of -9.2% x 30 days, -14.8% x 90 days, and -26.1% x 180 days. Weight loss r/t [related to] decreased PO [oral] intake and medical conditions .[recommendations] Add [high calorie supplement] TID for additional calories/protein to stabilize weight .Will continue to follow up . Review of the Physician's Orders for Resident #56 dated 4/29/2024, revealed .[high calorie supplement] three times a day for weight loss .[protein supplement] two times a day .Regular diet with diet condiments . fortified food to breakfast and ice cream to lunch and dinner . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/2024 at 10:29 AM, the MDS Coordinator stated Resident #56 was not on a physician prescribed weight-loss program and confirmed the entry was marked in error on the MDS assessment dated [DATE]. During an interview on 4/30/2024 at 3:57 PM, the RD stated Resident #56's weight was currently at a desired range for Resident #56's height but the facility wanted to prevent any further weight loss. The RD confirmed Resident #56 was not on a physician prescribed weight-loss program and the MDS assessment dated [DATE] was marked in error.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405 Based on facility policy review, medical record review and interview, the facility failed to refer 2 (Residents #1 and #74) after the resident's were identified with possible serious mental disorders, to the state-designated authority for a Level II Pre-Admission Screening and Resident Review (PASARR) of 10 residents reviewed for PASARR. The findings include: Review of the facility policy titled, Pre-admission Screening and Resident Review (PASARR), revised 10/6/2022, revealed .the facility is required to notify the appropriate state mental health authority or state intellectual disability authority when a resident with a mental disorder .has a significant change in their physical or mental condition. This will ensure .residents with a mental disorder .receive the care .services they need in the most appropriate setting .Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Psychosis (added 12/6/2023), Anxiety Disorder, and Depression (present on admission). Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Psychosis (added 12/6/2023), Anxiety Disorder, and Depression (present on admission). Review of a PASARR for Resident #1 dated 8/23/2023, revealed .Based on the information received, there is no reported history or indicators of major mental illness, intellectual/development disability, or related condition. A level II evaluation is not required and the Level I is approved .Should there be an exacerbation related to mental illness or a discrepancy in the reported information, a status change should be submitted . for further evaluation . Review of a quarterly (MDS) assessment dated [DATE], revealed Resident #1 scored a 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had mild cognitive impairment, and had indicators of hallucinations and delusions. 41291 Medical record review revealed Resident #74 was admitted to the facility on [DATE], with diagnoses including Psychosis (added 10/31/2024), Adjustment Disorder, Anxiety and Depression (present on admission). Review of a PASARR for Resident #74 dated 6/23/2023, revealed .Based on the information received, there is no reported history or indicators of major mental illness, intellectual/developmental disability, or related condition. A Level II evaluation is not required and the Level I is approved .Should there be an exacerbation related to mental illness or a discrepancy in the reported information, a status change should be submitted . for further evaluation . (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #74 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact, had potential indicators of hallucinations, had an active diagnosis of Psychotic Disorder and received an antidepressant. During an interview on 4/30/2024 at 3:53 PM, the Director of Nursing (DON) confirmed a PASARR for Level II screening for Resident #1 and Resident #74 was not submitted after a new diagnosis of Psychosis was added on 10/31/2023 for Resident #74 and 12/6/2023 for Resident #1.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review, observations, and interviews, the facility failed to develop the comprehensive care plan for 2 residents (Resident #68 and #74) of 22 residents reviewed for care plans. The findings include: Review of the facility's policy titled, Comprehensive Care Plans and Revisions, dated 3/2/2022, revealed .the facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care .when these changes occur the facility should review . the plan of care to reflect the changes to care delivery . Medical record review revealed Resident #68 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Need for Assistance with Personal Care, and Urinary Tract Infection. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #68 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #68 required partial/ moderate staff assistance with toileting and was frequently incontinent of urine. Review of a comprehensive care plan for Resident #68 dated 3/21/2024, revealed .Urinary Tract Infection . lab [laboratory specimen] .as ordered . Further review revealed the transmission-based precautions [contact precautions] were not developed on the care plan. Review of the Physician's Orders for Resident #68 dated 4/29/2024, revealed .Contact Precautions Diagnosis: MDRO [multi-drug resistant organism] in urine until 5/06/2024 .Nitrofurantoin [antibiotic medication] .for urinary tract infection . Review of a urine culture and sensitivity report for Resident #68 dated 4/23/2024, revealed .vancomycin resistant enterococci [bacteria] . was present in the urine culture. During an observation on 4/28/2024 at 10:45 AM, revealed Resident #68 had transmission-based precaution signage placed on the entry door to the room and the personal protective equipment was stored on a rack on the entry door for staff use. During an interview on 4/28/2024 at 10:50 AM, the Certified Nursing Assistant (CNA) A stated Resident #68 was in contact precautions due to an infection in her [Resident #68's] urine. During an interview on 4/29/2024 at 1:29 PM, the Director of Nursing (DON) stated when transmission-based precautions are initiated, the care plan should be developed to reflect that status change. The DON confirmed the care plan was not developed to reflect Resident #68's medical need and the physician's order for contact isolation with the transmission based precautions. 41291 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review revealed Resident #74 was admitted to the facility on [DATE], with diagnoses including Psychosis (added 10/31/2024), Adjustment Disorder, Anxiety and Depression (present on admission). Review of a quarterly MDS assessment dated [DATE], revealed Resident #74 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact, had potential indicators of Hallucinations, had an active diagnosis of Psychotic Disorder, and received an antidepressant. Review of a comprehensive care plan for Resident #74 dated 4/24/2024, revealed .obsessive behavior problem with males .uses antidepressant medication r/t [r/t] Depression and hypersexuality . Further review revealed the care plan did not reflect Resident #74 had Psychosis or Hallucinations. During an interview on 4/30/2024 at 3:53 PM, the DON confirmed the comprehensive care plan for Resident #74 had not been updated to reflect the diagnoses of Psychosis and Hallucinations.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure the medical record was complete and accurate for 1 resident (Resident #68) of 22 residents reviewed for medical records. The findings include: Review of the facility's policy titled, Nursing Documentation, dated 8/20/2019, revealed .the medical record must also reflect the resident's condition and the care and services provided .changes in .condition . Medical record review revealed Resident #68 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Need for Assistance with Personal Care, and Urinary Tract Infection. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #68 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #68 required partial/ moderate staff assistance with toileting and was frequently incontinent of urine. Review of a comprehensive care plan for Resident #68 dated 3/21/2024, revealed .Urinary Tract Infection . lab .as ordered . Review of the Physician's Orders for Resident #68 dated 4/29/2024, revealed .UA C&S [urinalysis culture and sensitivity] [urine test to determine presence of bacteria] due to increased confusion .Completed . Review of the Nurse's Notes for Resident #68 dated 4/4/2024 thru 4/29/2024, revealed no nurse entry where the UA C/S specimen was obtained. Review of a urine culture and sensitivity report for Resident #68 dated 4/23/2024, revealed the urine specimen was obtained at the facility on 4/23/2024. During an interview on 5/1/2024 at 2:01 PM, Registered Nurse (RN) A stated she worked on 4/23/2024 and had obtained the ordered urine specimen for Resident #68. RN A stated the urine specimen for Resident #68 was obtained via clean catch method and was sent to the lab (laboratory) for processing. RN A stated she forgot to document the procedure in the medical record. During an interview on 4/29/2024 at 1:29 PM, the Director of Nursing (DON) stated it was the facility's expectation when urine specimens were obtained, those procedures were documented in the medical record for that specific resident. The DON confirmed Resident #68's medical record was not considered complete or accurate when the nurse failed to document the urinalysis specimen obtained on 4/23/2024.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41291 Based on facility policy review, observation, and interview the facility failed to assist or offer 2 (Residents #76 and #10) the opportunity to perform hand hygiene before an evening meal on 1 of 2 units observed for meal service. The findings include: Review of the facility's policy titled, Hand Hygiene, revised 6/13/2023 revealed .The facility must establish . maintain an infection prevention .control program designed to provide a safe, sanitary, and comfortabel environment .to prevent the development and transmission of communicable diseases and infections . During an observation on 4/29/2024 at 5:13 PM on the Cedar Unit, Activities Director (AD) B took the evening meal tray to Resident #76 and did not offer hand hygiene to the resident prior to setting the meal tray up. During an interview on 4/29/2024 at 5:14 PM, AD B confirmed she did not offer hand hygiene to Resident #76 prior to setting up her evening meal tray. During an interview on 4/29/2024 at 5:18 PM, Resident #76 confirmed she was not offered hand hygiene prior to her evening meal. During an observation on 4/29/2024 at 5:24 PM on the Cedar Unit, Certified Nursing Assistant (CNA) B took the evening meal tray to Resident #10 and did not offer hand hygiene to the resident prior to setting the meal tray up. During an interview on 4/29/2024 at 5:25 PM, Resident #10 confirmed she was not offered hand hygiene prior to her evening meal. The resident stated, .sometimes they will give me a wet wipe, but not all the time . During an interview on 4/29/2024 at 5:26 PM, CNA B confirmed he did not offer hand hygiene to Resident #10 prior to setting up her evening meal tray. During an interview on 4/30/2024 at 3:53 PM, the Director of Nursing (DON) stated it was her expectation that staff assisted residents to wash their hands prior to meals. The DON further stated infection control practices were not maintained when AD B and CNA B did not offer the Residents #76 and #10 assistance to wash their hands or hand hygiene prior to the evening meal that was served.