

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Greeneville		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Crum Street Greeneville, TN 37743	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to revise the comprehensive care plan for 1 resident (Resident #94) of 20 residents reviewed for care plans.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Comprehensive Care Plans and Revisions, dated 9/11/2024, revealed . The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised .when these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery .</p> <p>Review of the medical record revealed Resident #94 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Management of Vascular Access Device, Bacteremia (bacteria present in the blood), and Urinary Tract Infection.</p> <p>Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #94 scored a 5 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment. Further review revealed the resident required substantial or maximal assistance with toileting hygiene and had an indwelling urinary catheter.</p> <p>Review of a Nurse Practitioner (NP) Visit Note dated 6/6/2025, revealed Resident #94 had a high fever, altered mental status, decreased urinary output, and a urinary catheter not draining properly. The NP ordered the resident to go to the emergency room for an evaluation.</p> <p>Review of the Hospital Discharge summary dated [DATE], revealed Resident #94 had a peripherally inserted central catheter (PICC) (tube inserted into a vein to deliver medications) placed to the right upper extremity for intravenous (IV) antibiotic therapy and was discharged back to the facility.</p> <p>Review of a readmission Data Collection Tool dated 6/13/2025, revealed Resident #94 readmitted to the facility with a vascular access device.</p> <p>Review of a Physician's Order for Resident #94 dated 6/13/2025, revealed .observe PICC line insertion site every shift .Zosyn (IV antibiotic) administer 3.375 gram IV every 6 hours for bacteremia .</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the comprehensive care plan revised 6/17/2025 (4 days after readmission from the hospital), revealed Resident #94 .has an Activities of Daily Living deficit related to musculoskeletal impairment . weakness .resident is at risk for infection with actual infection present of Urinary Tract Infection (UTI) with antibiotic use . Further review revealed no documentation regarding Resident #94's PICC line.</p> <p>During an observation on 6/23/2025 at 12:10 PM (10 days after the readmission from the hospital), in Resident #94's room, revealed Resident #94 sitting up in bed with a PICC line present to the right upper extremity.</p> <p>During an observation on 6/24/2025 at 12:33 PM, in Resident #94's room, revealed Resident #94 was reclined in the bed with a PICC line present to the right upper extremity.</p> <p>During an interview on 6/25/2025 at 10:40 AM, the Interim Director of Nursing (DON) confirmed the expectation for updating the care plan was within 7 days of re-admission. The Interim DON confirmed the facility failed to revise and update Resident #94's comprehensive care plan to indicate the resident's PICC line to the right upper arm after readmission into the facility.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interviews, the facility failed to ensure medications were stored and secured properly for 1 resident (Resident #74) of 92 residents observed for accidents and hazards.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Administration of Medications, dated 2/13/2023, revealed .the facility will ensure medications are administered safely and appropriately .</p> <p>Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including Malignant Neoplasm of the Bladder, Muscle Weakness, and Need for Assistance with Personal Care.</p> <p>Review of the comprehensive care plan for Resident #74 dated 5/8/2025, revealed the resident had physical limitations and required assistance with activities of daily living (ADL). Further review revealed there was no documentation of Resident #74's ability to safely store and self-administer medications without staff supervision.</p> <p>Review of a 5-day Minimum Data Set (MDS) assessmet dated 5/31/2025, revealed Resident #74 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Continued review revealed Resident #74 had impairment to both upper extremities and required setup and clean up staff assistance with eating and personal hygiene.</p> <p>Review of a Physician's Order for Resident #74 dated 6/22/2025, revealed .Antacid (Calcium Carbonate) Oral Tablet Chewable 500 MG [milligrams] .Give 3 tablets by mouth every 4 hours as needed for indigestion/heartburn . Further review revealed no physician's order present for the resident to self-administer medications.</p> <p>During an observation on 6/23/2025 at 11:40 AM, in Resident #74's room, revealed Resident #74 was lying in bed with 3 round tablets located in a medicine cup stored on top of the over-bed table.</p> <p>During an observation and interview with Registered Nurse (RN) D on 6/23/2025 at 11:43 AM, in Resident #74's room, revealed Resident #74 was lying in bed with 3 round tablets located in a medicine cup stored on top of the over-bed table. RN D confirmed the 3 tablets located in the medicine cup stored on the Resident #74's over the bed table were antacid tablets and should not be left at the bedside for the resident to self-administer the medications. RN D stated Resident #74 could not self-administer medications safely.</p> <p>During an interview on 6/25/2025 at 9:03 AM, the Interim Director of Nursing (DON) stated it was the facility's expectation for medications to not be stored at the resident's bedside and there were no current residents who had the ability to self-administer medications in the facility. The Interim DON confirmed Resident #74 did not have the ability to self-administer medications and the facility failed to ensure the 3 antacid tablets for Resident #74 were stored properly.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure oxygen therapy was administered at the physician prescribed rate for 1 resident (Resident #36) of 7 residents reviewed for oxygen therapy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Oxygen Administration, revised 6/24/2025, revealed .To ensure that oxygen is administered and stored safely within the facility .oxygen order should be written for specific liter flow required by the resident .</p> <p>Review of the medical record revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Heart Disease, and Dependence on Supplemental Oxygen.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #36 scored an 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated moderate cognitive impairment. Further review revealed the resident required assistance with personal hygiene and used oxygen therapy.</p> <p>Review of the comprehensive care plan for Resident #36 dated 5/21/2025, revealed the resident used oxygen therapy with interventions including oxygen settings at 2 liters per minute (LPM) as needed (PRN) via (by way of) nasal cannula, give as ordered by the physician. Further review revealed to observe the resident for signs and symptoms of respiratory distress.</p> <p>Review of an Order Summary Report for Resident #36 dated 6/23/2025, revealed .Oxygen at 2 liters/minute via [by way of] nasal cannula as needed .oxygen sat [saturation] rates every shift notify MD [Medical Doctor] if <90% [less than 90 percent] .</p> <p>During an observation and interview on 6/23/2025 at 11:09 AM, in Resident #36's room, revealed Resident #36 was lying in bed with a nasal cannula in place with oxygen infusing to the resident via concentrator machine with the rate dial on 1.5/LPM and not the physician prescribed 2/LPM. Resident #36 stated his oxygen rate was prescribed at 2/LPM.</p> <p>During an observation on 6/24/2025 at 1:05 PM, in Resident #36's room, revealed Resident #36 was lying in bed with a nasal cannula in place with oxygen infusing to the resident via concentrator machine with the rate dial on 1.5/LPM and not the physician prescribed 2/LPM.</p> <p>During an observation and interview with Licensed Practical Nurse (LPN) B on 6/24/2025 at 1:15 PM, in Resident #36's room, revealed Resident #36 was lying in bed with a nasal cannula in place with oxygen infusing to the resident via concentrator machine with the rate dial on 1.5/LPM and not the physician prescribed 2/LPM. LPN B confirmed Resident #36's oxygen rate was set on 1.5/LPM via the oxygen concentrator machine and the resident did not receive the physician's order of oxygen of 2/LPM.</p> <p>During an interview on 6/24/2025 at 2:02 PM, the Nurse Practitioner (NP) stated there was no risk to Resident #36 receiving oxygen at 1.5/LPM instead of 2/LPM. The NP confirmed oxygen therapy was to be administered at the prescribed rate ordered by the medical provider.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure the pharmacy provided an accurate physician prescribed medication for 1 resident (Resident #73) of 3 residents observed for medication administration.</p> <p>The findings include:</p> <p>Review of the Pharmacy Services Agreement, dated 8/10/1999 and continued as current agreement, revealed .Responsibilities of the Pharmacy .maintain accurate drug profiles, consistent with the information provided to the Pharmacy, on each facility resident served by pharmacy .</p> <p>Medical record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, Osteoarthritis, and Glaucoma.</p> <p>Review of the current Physician Recapitulation Orders revealed, .Vitamin D3 oral capsule 1.25 mg (milligrams) by mouth one time a day every Tuesday for supplement .</p> <p>During an observation on 6/24/2025 at 7:18 AM, Registered Nurse (RN) A retrieved a medication card containing Vitamin D2 from the medication cart to Administer to Resident #73. Continued observation revealed RN A notified the Interim Director of Nursing of the incorrect medication.</p> <p>During an interview and review of the Vitamin D2 medication card for Resident #73 on 6/25/2025 at 8:38 AM, the Interim Director of Nursing confirmed the medication card dated 5/21/2025 contained the Vitamin D2. Continued interview confirmed the pharmacy had not delivered the correct medication of Vitamin D3 which had been prescribed by the physician.</p> <p>During an interview on 6/25/2025 at 10:22 AM, the Pharmacy Consultant confirmed Vitamin D2 was delivered to the facility on 5/21/2025 and was unsure why the incorrect medication was sent to the facility. The Pharmacy Consultant confirmed the incorrect medication was delivered to the facility.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on facility policy review, facility documentation review, observation, and interview, the facility failed to maintain a clean and sanitary kitchen which had the potential to affect 92 of 92 residents.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Food Safety and Sanitation, dated 4/30/2025, revealed .Cleaning Schedule .The Director of Food and Nutrition Services shall .ensure that the Food and Nutrition Services department is maintained in a clean and sanitary manner in accordance with regulatory requirements .Equipment and Utensil Cleaning and Sanitization - A potential cause of foodborne outbreaks is improper cleaning (washing and sanitizing) of equipment and protecting equipment from contamination via splash, dust, grease .Cleaning Fixed Equipment - When cleaning fixed equipment .that cannot readily be immersed in water .the removable parts must be washed and sanitized and non-removable parts cleaned with detergent and hot water, rinsed, air-dried and sprayed with a sanitizing solution (at the effective concentration) .</p> <p>Review of the facility policy titled, Food Safety and Sanitation .Ware Washing - Dish Machine/Manual Process, dated 4/30/2025, revealed .The Director of Food and Nutrition Services is responsible for ensuring that the department is maintained according to the standards of sanitation and in compliance with federal, state and local requirements .Food and Nutrition Services associates are trained in the proper use, cleaning and sanitation of ware washing equipment and sinks .Ware washing equipment is reassembled after cleaned and sanitized according to manufacturer's instructions .There is a facility process that includes reporting and follow up for maintenance issues .Low Temp [temperature] Dish Machine .The machine will be broken down and cleaned appropriately each day .</p> <p>Review of the facility policy titled, Food Safety, dated 5/1/2025, revealed .Cold Food Storage .Ambient temperatures in freezers remain at 0* [degrees] F [Fahrenheit] or lower and all food is frozen solid .</p> <p>Review of the facility policy titled, Food Safety and Sanitation .Effective Use of Quaternary Sanitizers and Disinfectants Policy, dated 5/6/2025, revealed .Equipment and Utensil Cleaning and Sanitization - A potential cause of foodborne outbreaks is improper cleaning (washing and sanitizing) of equipment and protecting equipment from contamination via splash, dust, grease .Manual Washing and Sanitizing - A 3-step process is used to manually wash, rinse, and sanitize dishware correctly .Sanitizing Bucket Method .Prepare color coded buckets with appropriate solutions as identified .Green - Detergent Bucket .Red - Sanitizing Bucket .Blue - Rinse Bucket .Fill [NAME] Detergent Bucket with soap and water .Fill the Red Sanitizing Bucket using the Quaternary sanitizer dispenser and record the ppm [parts per million] before .microfiber cloth is placed in the bucket .When a food contact surface and/or cart requires cleaning and sanitizing, follow the steps .Removed the microfiber cloth from the Detergent Bucket and clean the surface, removing all particles from the area being cleaned .Fully rinse .using clean water from the Blue Rinse Bucket .Pull clean microfiber cloth from the Red Sanitizing Bucket, wring excess solution .Coat surface well .Allow the surface to air dry for a minimum of one minute .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of a handwritten facility document titled, Ice Machine Cleaning, dated 6/3/2023 - 3/26/2025, revealed the ice machine was cleaned in the dietary department every 3 months. Continued review revealed the ice machine was last cleaned on 3/26/2025.</p> <p>Review of the kitchen's Daily Cleaning Logs dated 6/8/2024-6/22/2025, revealed the kitchen and equipment which included the can opener, microwave, sinks, utility carts, floors, and stove was documented as cleaned twice daily.</p> <p>During an observation of the kitchen with the Certified Dietary Manager (CDM) on 6/23/2025 from 10:30 AM - 11:15 AM, revealed the following items:</p> <p>-</p> <p>at 10:32 AM, the ice machine was soiled with dust and unknown loose black, brown, and white debris on the outside rim of the machine. A black substance was observed around the inside rim of the ice machine which could easily be removed by a paper towel when wiped across the inside rim of the ice machine. A small gap of the inside rim of the door of the ice machine contained a large amount of an unknown black substance.</p> <p>-</p> <p>at 10:36 AM, the small walk-in refrigerator contained a digital thermometer which was inoperable. No other thermometers were noted available in the refrigerator (the dietary staff had documented the daily temperatures were within acceptable parameters).</p> <p>-</p> <p>at 10:39 AM, an unknown black substance was scattered over a large area of the floor under and around the dish machine.</p> <p>-</p> <p>at 10:40 AM, the top, front, and sides of the dish machine was noted with various dried food debris, and multiple unknown loose dark brown, black, and white particles and accumulated grime.</p> <p>-</p> <p>at 10:42 AM, the lower level of the table which held the dish machine and the drainage pipe underneath the dish machine were visibly soiled with dirt, debris, and accumulated grime.</p> <p>-</p> <p>at 10:45 AM, the stove knobs were observed with a yellowish and brown substance and a build up of grease around the knobs and front surface of the stove. The stove front was observed with spattered grease and food particles on the front and side surfaces of the stove.</p> <p>-</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure proper infection control practices were followed related to urinary catheter bag storage for 1 resident (Resident #94) of 10 residents reviewed for urinary catheters.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Indwelling Urinary Catheter (Foley) Management, dated 9/10/2024, revealed .the facility will ensure that residents admitted with a urinary catheter will have the following areas addressed .protocols that adhere to professional standards of practice and infection prevention and control procedures .ongoing monitoring for changes in condition .CAUTI's (catheter associated Urinary Tract Infections) .</p> <p>Review of the facility's policy titled, General Urinary Catheter Maintenance Guidelines, dated 6/6/2019, revealed .Do not rest the [urinary] catheter bag on the floor .</p> <p>Review of the medical record revealed Resident #94 was admitted to the facility on [DATE] with diagnosis including Retention of Urine, Acute Kidney Failure, and Obstructive and Reflux Uropathy (ineffective urine flow capabilities in the urinary tract).</p> <p>Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #94 scored a 5 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment. Further review revealed the resident required substantial or maximal assistance with toileting hygiene and had an indwelling urinary catheter.</p> <p>Review of the Physician's Orders for Resident #94 dated 6/13/2025, revealed .[urinary] catheter care every shift .indwelling [urinary] catheter to straight drainage .</p> <p>Review of the comprehensive care plan for Resident #94 dated 6/17/2025, revealed .dependent on staff for meeting .physical and social needs related to physical limitations .has an Activities of Daily Living (ADL) deficit related to musculoskeletal impairment .had an indwelling urinary catheter .catheter care every shift . check tubing for kinks .</p> <p>During an observation on 6/24/2025 at 8:45 AM and at 12:33 PM, in Resident #94's room, revealed Resident #94 was lying in the bed with the urinary catheter drainage bag stored directly on the floor slightly underneath the left side of the bed.</p> <p>During an observation and interview with Licensed Practical Nurse (LPN) B on 6/24/2025 at 12:36 PM, in Resident #94's room, revealed Resident #94 was lying in the bed with the urinary catheter drainage bag stored directly on the floor slightly underneath the left side of the bed. LPN B confirmed the urinary catheter bag was on the floor and should not be stored directly on the floor to maintain infection control practices.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Greeneville		STREET ADDRESS, CITY, STATE, ZIP CODE 725 Crum Street Greeneville, TN 37743	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/25/2025 at 8:55 AM, the Interim Director of Nursing (DON) stated the staff were to ensure residents with urinary catheter drainage bags were stored below the bladder and hung from a fixed surface to ensure the drainage bag was stored off the floor. The Interim DON confirmed infection prevention and control practices were not maintained when Resident #94's urinary catheter drainage bag was stored directly on the floor.</p>		