

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Ahc Waverly		STREET ADDRESS, CITY, STATE, ZIP CODE 895 Powers Blvd Waverly, TN 37185	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>38439</p> <p>Based on policy review, observation, and interview, the facility failed to maintain or enhance residents' dignity and respect during dining when 3 of 12 (Certified Nursing Assistance (CNA) A, B, C), failed to knock and/or announce self when entering resident rooms and failed to use courtesy titles when addressing residents during dining.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Promoting/Maintaining Resident Dignity Policy, dated 11/20/2023 revealed, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality .All staff members are involved in providing care and services to residents to promote and maintain resident dignity and respect resident rights .</p> <p>2. Observation during dining on the 300 hall on 7/15/24 at 11:44 AM, revealed, CNA A removed a tray from the meal cart, knocked and entered Resident #2's room and stated, I got lunch darling . placed the tray on the over the bed table, exited the room. Then CNA A returned to the meal cart, removed a tray from the meal cart and entered Resident #36's room and stated, I got lunch hun [short for honey] . placed the tray on the over the bed table and then exited the room.</p> <p>3. Observation during dining on the 300 hall on 7/17/24 at 7:15 AM, revealed CNA B removed a tray from the meal cart, entered Resident #34's room and stated, [Named Resident #34], you ready to eat baby . Resident #34 stated, It is cold in here can you light a fire . CNA B stated, I can't start a fire buddy . CNA B set up the tray and exited Resident #34's room.</p> <p>Observation during dining on the 300 hall on 7/17/2024 at 7:15 AM, revealed CNA B removed a tray from the meal cart, entered Resident #1's room and stated, Hey, buddy . placed the tray on the over the bed table, exited the room and went to the nurse's station. CNA B returned to Resident #1's room and attempted to wake the resident and stated, Hey, buddy . and then exited the room. CNA B failed to knock when entering or reentering the resident's room.</p> <p>Observation during dining on the 300 hall on 7/17/24 at 7:48 AM, revealed, CNA B removed a tray from the meal cart, entered Resident #36's room, set up the meal tray and exited the room. CNA B failed to knock and/or announce herself when entering the resident's room.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 445251	Facility ID: 445251 If continuation sheet Page 1 of 14

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Observation during dining on 7/17/24 at 7:55 AM, revealed CNA C removed a tray from the meal cart, entered Resident #30's room, placed the tray on the over the bed table, assisted with repositioning the resident in the bed and stated, Stretch your legs out buddy ., set up the meal tray and exited the room. CNA L failed to knock and/or announce herself when entering the resident's room.</p> <p>During an interview with on 7/18/24 at 11:17 AM, the Administrator was asked what staff should do before entering a resident's room. The Administrator confirmed that staff should knock and/or announce themselves before entering a resident's room. The Administrator was asked how should staff address residents when speaking to them. The Administrator confirmed that staff should address residents by their preferred name and should not be addressed by pet names.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047</p> <p>Based on facility policy, medical record review, and interview the facility failed to follow Physician Order for 2 of 5 (Resident #23 and #213) sampled residents reviewed.</p> <p>The findings include:</p> <p>1. Review of the facility's titled, [Named Pharmacy] Delivery Services, dated 11/2021, revealed .Night delivery is provided to each facility on a pre-set schedule .This delivery consists of medications .the Charge Nurse should compare the medication label and the pharmacy label to the physician order .to identify discrepancies .delivered medications match the orders .</p> <p>Review of the facility's policy titled, Medication Administration, dated 8/4/2023, revealed Medications shall be administered by licensed medical or nursing personnel acting within the scope of their practice and per the Physician's Signed Order. While administering medications the nurse shall observe the 8 Rights of Medication Administration .Right Dose .Right Time .Review the EMAR [Electronic Medication Administration Record] to identify the medication to be administered .Report discrepancy to Nurse Management .</p> <p>Review of the facility's policy titled, Medication Administration: Medication, Controlled and Biological Storage, Night/Emergency Box and Backup Pharmacy, dated 9/5/2023, revealed .[named pharmacy] contracts with a local pharmacy in the community where each facility is located to provide medications .The nurse should check the facility's night box/l-Stat for a starter dose. If medication is not available in the night box, the medication should be ordered from the back-up pharmacy .</p> <p>Review of the facility's order titled, Physician Verbal Order Policy, dated 4/18/2024, revealed .To provide guidance on physician verbal orders .Immediately communicate read-back of the orders to the physician . Follow through with orders by appropriate contact or notifications (.pharmacy) .</p> <p>2. Review of the medical record revealed Resident #23 was admitted on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Anxiety, Depression, and Osteoporosis.</p> <p>Review of the Care Plan dated 2/6/2024, revealed Resident #23 had . Anxiety Disorder .Medication as ordered .</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #23 was cognitively intact and received Antianxiety medication.</p> <p>Review of the Physician Order dated 7/12/2024, revealed .Xanax [an antianxiety medication] 0.25 mg[milligram] tablet [1 Tablet] .Oral Two Times Daily .</p> <p>Review of the Medication Administration Record (MAR) revealed the Resident had missed administrations of Xanax 0.25 mg on 7/12/202 thru 7/15/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/15/2024 at 10:25 AM, Resident #23 stated, . the shift key nurses [agency nurses], some of them not pulling all my meds .</p> <p>During an interview on 7/16/2024 at 4:05 PM, the Regional Nurse Consultant (RNC) was asked what the shaded area on the MAR with the nurses initial on it mean. The RNC stated, It means the nurse has acknowledge that the resident did not receive the medication, should be an excuse on the MAR. The RNC confirmed the 7/2024 MAR notes stated the Xanax 0.25 mg was unavailable from 7/12/2024 thru 7/15/2024.</p> <p>During an interview on 7/18/2024 at 8:20 AM the Interim Director of Nurses (DON) was asked to explain why Resident #23 was not receiving Xanax as ordered. The Interim DON stated, If the nurse is not paying attention . those type of meds are ordered for so many days and we believe the provider did not realize 0.25 mg was not what the resident normally gets . The Interim Don was asked what the nurse should have done for the days Resident #23 did not receive her scheduled Xanax dose. The Interim DON stated, I assumed they said to the resident, they do not have an order .They should have called the doctor when the resident asked for the medication. It is very difficult working with agency nurses, hard to educate, it is a headache. The Interim DON was asked should the resident receive her ordered medication on those days. The Interim DON stated, I was not aware, they should have called me.</p> <p>During an interview on 7/18/2024 at 8:31 AM and 9:47 AM, the Interim DON was asked to explain the missed dosages on Xanax on the 7/2024 MAR. The Interim DON presented a copy of a narcotic sheet labeled with Resident #23's name and .Alprazolam tab 0.5mg Take one tab [tablet] two times daily ., with signatures of staff which indicated the resident received the medication once per day on 7/12/2024 thru 7/14/2024. The Interim DON confirmed based on documentation the resident was given Xanax 0.5mg once per day for a Xanax 0.25 mg twice per day physician order. The Interim DON stated I think they were so use to giving the 0.5 mg that they did not look to see that the order had been changed. They should have looked at the order and notified the doctor to get a confirmation whether 0.25 mg or 0.5mg should be administered. The Interim DON confirmed the Physician orders were not followed.</p> <p>3. Review of the medical record revealed Resident # 213 was admitted to the facility on [DATE], with diagnoses including Osteomyelitis of Vertebra, Intraspinal Abscess and Granuloma, and Discitis.</p> <p>Review of the medical record revealed the MDS was incomplete as the Resident was admitted on [DATE].</p> <p>Review of the Care Plan dated 7/9/2024, revealed Resident #213 was .At Risk for Infection .Medications as ordered .</p> <p>Review of the signed Physician Order revealed Resident #213 had an order for .Vancomycin 1.5 gram/150 ml [milliliter] in 0.9 % [percent] sodium chloride intravenous Every 12 Hours .Route: Intravenous Piggyback ., dated 7/9/2024.</p> <p>Review of the signed Physician Order revealed Resident #213 had an order for .Cefepime [an antibiotic] 2000 mg[milligram] in NS [Normal Saline] 10 ml IVPB [Intravenous Piggy Back] infuse every 8 hours . dated 7/9/2024.</p> <p>Review of the 7/2024 MAR revealed Resident #213 did not receive the Vancomycin and the Cefepime on 7/11/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/17/2024 at 2:39 PM, the RNC confirmed Resident #213 did not receive the Vancomycin on 7/11/2024. The RNC was asked why the resident did not get the Vancomycin. The RNC stated, .it is under the administration note that the medication was unavailable . The RNC was asked should the medication be available for use. The RNC stated, I am not going to say it was not available. I am going to say the nurse did not know where the medication was located. The RNC was asked should the nurse have known where the antibiotic was located. The RNC stated, Yes. The nurse should have notified the provider if she had a medication that was not available. I do not know if she did not know where the medication was or if it was truly not available .he got the med [medication] on the other shift. The nurse should have notified the provider the medication was not given . The RNC confirmed the resident should have gotten the Vancomycin as ordered and the Physician Order was not followed.</p> <p>During an interview on 7/18/24 at 8:42 AM, The Interim DON confirmed the missed dose of Cefepime 2 gram on 7/11/2024 should have been administered and the Physician Order was not followed.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49269</p> <p>Based on policy review, medical record review, observation and interview the facility failed to obtain physician's orders for a resident with dialysis, failed to assess and monitor dialysis sites for thrill, bruit, and infection, and failed to follow/implement individualized care plan for 1 of 1 (Resident #263) sampled residents for dialysis.</p> <p>Findings include:</p> <p>1. Review of the facility's policy Dialysis dated 10/9/2023, revealed .Residents who have End Stage Renal Disease [ESRD] and receive dialysis shall be provided care consistent with professional standards of practice, the physicians/practitioner's orders, and in accordance with the resident goals and preferences . Vascular Access [is] a connection made between an artery and a vein to provide good blood flow for dialysis. Bruit [is] a constant rumbling sound such as swishing or whoosh sound heard via stethoscope placed on the access .Thrill [is] a steady vibration or rumbling sensation felt at the AV [Arteriovenous] graft/fistula site . Medical conditions shall be monitored and managed to prevent complications .Licensed nurses shall participate in the management of medical conditions by following physicians orders, assessing the resident, and reporting changes in condition or behavior to the physician .Infection control practices shall be followed . Documentation shall include .Skin integrity at the access site [document every shift] .Presence of thrill and bruit of the AV graft/fistula [document every shift] .Evidence of infection, bleeding, and other complications .</p> <p>2. Review of the medical record revealed Resident #263 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, Deep Vein Thrombosis of Lower Extremity, Hypertension, Malnutrition, and Dependence on Renal Dialysis.</p> <p>Review of the Dialysis Communication forms dated 7/5/2024, 7/8/2024, 7/10/2024, 7/12/2024, 7/15/2024, and 7/17/2024 had a fax received date and time of 7/17/2024 at 2:29 PM on each communication form from the [named Dialysis clinic].</p> <p>Review of the Care plan dated 7/8/2024, revealed .Dialysis M-W-F at [named clinic] . Do not take blood pressure on arm with shunt/fistula .Monitor access site for bruit and thrill. Notify MD immediately of absent bruit and/or thrill, with follow-up as indicated .Monitor access site for signs and symptoms of infection or bleeding .Monitor for changes in blood pressure, report abnormal findings to MD with follow up as indicated .</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #263 was cognitively intact. Resident was assessed for dialysis.</p> <p>Review of the Physician's Orders dated 7/17/2024 revealed Dialysis Monday, Wednesday, Friday .Monitor Fistula/Graft 2 Times Daily for bleeding .Monitor for thrill and bruit 2 times Daily .Post-Dialysis Weight 3 Times Weekly .Pre Dialysis Weight 3 Times Weekly .Remove Pressure Dressing 3 Times Weekly 2-4 hours after dialysis .Vital Signs T/P/R [Temperature/Pulse/Respiration] and B/P [Blood Pressure] 3 Times Weekly obtain post dialysis vital signs .</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility was unable to provide documentation of Physician's Orders for dialysis assessing and monitoring prior to 7/17/2024.</p> <p>Review of the July 2024 Treatment Administration Record revealed the following treatments with no documentation for dates 7/3/2024 through 7/16/2024:</p> <p>Monitor for thrill and bruit two times daily</p> <p>Post-dialysis Weight three times weekly</p> <p>Pre-dialysis weight three times weekly</p> <p>Remove pressure dressing three times weekly 2-4 hours after dialysis</p> <p>Vital signs T/P/R and B/P [Temperature, Pulse, Respirations, Blood Pressure] Three times weekly obtain post dialysis vital signs</p> <p>The facility was unable to provide documentation of dialysis access sites monitored each shift for thrill, bruit, and infections.</p> <p>Observation in the resident's room on 7/17/2024 3:57 PM, revealed Resident #263 with a permacath [dialysis access site] to right-sided chest wall and dialysis shunt to left upper arm with 2 band aids noted.</p> <p>The facility was unable to provide physician's orders and a care plan to assess and monitor Resident's permacath.</p> <p>During an interview on 7/17/2024 4:08 PM, the Interim Director of Nursing (DON) was asked the process for monitoring Dialysis residents. The Interim DON confirmed that facility staff completes a Dialysis Communication form and sends the form with residents to dialysis. The Interim DON confirmed that the Dialysis Clinic completes and sends the communication form to the facility with the resident or faxes the communication form to the facility. The Interim DON was asked if staff had been assessing and monitoring Resident #263's dialysis sites prior to 7/17/2024. The Interim DON stated, Yes. The Interim DON was asked, where staff should complete documentation of assessment. The Interim DON confirmed that site monitoring should be documented on the Treatment Administration Record (TAR) in the electronic medical record.</p> <p>During an interview on 7/17/2024 at 4:40 PM, the Regional Nurse Consultant confirmed that she is unable to provide any documentation related to assessing and monitoring of dialysis sites related to Resident #263, or any communication to dialysis clinics for dates 7/3/2024 through 7/16/2024.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49269</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored and secured when 1 of 3 staff members (Registered Nurse (RN) A) left the medication cart unlocked, unattended, and out of sight for 1 of 7 (100 Hall medication cart) medication storage areas and when medications were left unsecured and unattended, at the bedside, in Resident #41's and Resident #52's room.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's policy titled, Medication Administration: Medication, Controlled and Biological Storage, Night/Emergency Box and Backup Pharmacy, dated 9/5/2023, revealed .It is the policy of this facility to ensure all medications housed on our premises shall be stored in the pharmacy and/or medication rooms according to the manufacture's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .All drugs and biologicals shall be stored in locked compartments [.medication carts .] .During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart . Observation on 7/17/2024 7:41 AM revealed 100 Hall medication cart left unlocked, unattended, and out of sight of the staff. <p>During an interview at the 100 Hall medication cart on 7/17/2024 at 7:42 AM, the Administrator confirmed the 100 Hall medication cart should not be left unlocked, unattended, and out of sight of staff.</p> <p>During an interview on 7/17/2024 at 7:43 AM, RN A confirmed she should not have left the 100 Hall medication unlocked, unattended, and out of sight.</p> <ol style="list-style-type: none"> Review of the medical record revealed Resident #41 was admitted to the facility on [DATE], with diagnoses including Stroke, Gastroesophageal Reflux Disease, Urinary Tract Infection, Anxiety, and Depression. <p>Review of the admission MDS assessment dated [DATE], revealed Resident 41 BIMS score of 14 which indicated cognitively intact and the resident required moderate assistance from staff to perform Activities of Daily Living.</p> <p>Observation in the Resident #41's room on 7/15/2024 at 10:11 AM, revealed a medication cup with one oblong yellow tablet, one round white tablet, one green/glue capsule noted at bedside on dresser.</p> <ol style="list-style-type: none"> Review of the medical record revealed Resident #52 was admitted to the facility on [DATE], with diagnoses including Malnutrition, Anxiety, Bipolar, and Gastroesophageal Reflux Disease. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderately cognitively impairment. Resident #52 required supervision of staff to perform Activities of Daily Living, and received antipsychotic, antianxiety, and opioid medications.</p> <p>Observation in Resident #52's room on 7/15/24 at 9:56 AM, 10:08 AM, and 10:24 AM, revealed one small white tablet and one blue capsule pill inside of a medication cup, on the resident's bedside dresser.</p> <p>During an observation and interview in Resident #52's room on 7/15/2024 at 10:24 AM, Licensed Practical Nurse (LPN B) was asked if the medications should be at bedside. LPN B stated, No, they should not be at bedside.</p> <p>During an interview on 7/15/2024 at 10:28 AM, LPN B was asked about medications being left at resident's bedside. LPN B stated .That was me that left those at his bedside. LPN B was asked if she removed the medications from the resident's room. LPN B stated, The Social Worker brought the medications to me, and I placed them back on the cart because he didn't want to take them.</p> <p>During an interview on 7/18/2024 at 11:09 AM, the Interim DON confirmed that medications should not be left at resident's bedside during medication administration.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49269</p> <p>Based on policy review, observation, and interview the facility failed to ensure food was stored, prepared, and served under sanitary conditions related to unlabeled, undated, food items, expired foods, and dirty metal carts, food containers, food carts, floors, and nourishment refrigerators.</p> <p>The finding include:</p> <p>1. Review of the facility's policy titled, Dietary: Food Storage, dated [DATE], revealed .Food shall be stored in accordance with professional standards for food service .staple items such as flour, sugar, and cornmeal should be stored in clean, closed containers .All stored items should have an expiration date or a purchase/delivery date .Open Date .ready- to-eat .food .shall be clearly marked at the time the original container is opened .</p> <p>Review of the facility's policy titled, Dietary: Cleaning, dated [DATE], revealed .Adequate cleaning and sanitizing shall minimize the risk of food born illnesses .</p> <p>2. Observation in the kitchen on [DATE] at 8:48 AM, revealed:</p> <p>A 4-tier metal cart with food particles and a dried dark brown substance on the cart.</p> <p>On the top shelf of the 4-tier metal cart was 2 loaves of undated bread, 8 packages of undated hamburger buns, 1 opened pack of hamburgers containing 2 buns, and 1 open package of hoagie buns containing 4 hoagies.</p> <p>On the second shelf of the 4-tier metal cart was a pack of garlic bread containing 15 slices of bread with a use by date of [DATE].</p> <p>The kitchen cornmeal, flour, and sugar containers had old food particles around the opening of the containers, and dark brown areas to these containers.</p> <p>Meal delivery carts #2, #3, #4, and #5 had food particles and old dried spillage noted to bottom and sides of cart.</p> <p>Standing water, grease, dirt, and food particles on the kitchen floors.</p> <p>3. Observation in the ,d+[DATE] hall Employee Break Room on [DATE] at 8:00AM, of the Resident nourishment mini refrigerator revealed:</p> <p>a. An undated glass of orange juice that was fermented.</p> <p>b. Spilled liquids in the inside and shelving areas.</p> <p>c. Review of the The Med Room Refrigerator/Freezer Temp Log, dated [DATE], revealed no temperature documentation for [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE].</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Ahc Waverly		STREET ADDRESS, CITY, STATE, ZIP CODE 895 Powers Blvd Waverly, TN 37185	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 8:06 AM, the Interim Director of Nursing confirmed, the nourishment refrigerators should be kept clean, food and liquids should be dated, and the temperature logs should be completed daily.</p> <p>During an interview on [DATE] at 11:02 AM, the Certified Dietary Manager and the Registered Dietician confirmed all foods should be labeled and dated, no food or liquids should be expired, kitchen should be clean and maintained, and the resident nourishment mini refrigerator should be clean.</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure a safe, sanitary, and comfortable environment for 6 of 60 (Resident #6, #21, #22, #35, #36, and #45) resident shared bathrooms observed.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Infection Prevention and Control Program, dated 11/20/2023, revealed, .All reusable items and equipment requiring .cleaning .or disinfection shall be cleaned in accordance with our current procedures governing the cleaning and disinfection of soiled or contaminated equipment .The reusable equipment shall be decontaminated using a germicidal detergent prior to storing for reuse .</p> <p>Review of the facility's undated cleaning list titled, ENVIRONMENTAL CLEANING INFECTION CONTROL COMPLIANCE LOG, revealed, .ITEM TO BE CLEANED .HOYERS .FREQUENCY .AFTER USE .METHOD OF CLEANIG .DISINFECTANT WIPES .RESPONSIBLE .CNA'S .</p> <p>2. Review of the medical record revealed Resident #21 was admitted on [DATE], with diagnoses including Traumatic Brain Injury, Depression, Gastrostomy, Aphasia, and Impulse Disorder.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #21 was severely cognitively impaired, dependent on staff for showering/bathing, toileting, and incontinent of both bowel and bladder.</p> <p>Review of the medical record revealed Resident #45 was admitted on [DATE], with diagnoses including Traumatic Brain Compression, Hydrocephalus, Aphasia, Bipolar Disorder, and Impulse Disorder.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed the resident was moderately cognitively impaired, dependent on staff for toileting hygiene, showering/bathing, and incontinent of both bowel and bladder.</p> <p>Observation in Resident #21 and Resident #45's shared bathroom on 7/15/24 at 10:17 AM, 2:35 PM, and on 7/16/2024 at 7:53 AM, revealed 3 gray wash basins, 1 gray bedpan stacked inside of each other sitting on top of the lid of a potty chair, unlabeled and uncontained.</p> <p>During an interview and observation in Resident #21 and Resident #45's shared bathroom on 7/16/24 8:00 AM, Certified Nurse Assistant (CNA) D was asked how residents' personal items such as wash basins and bed pans should be stored in a shared resident bathroom. CNA D confirmed that resident personal items should be labeled and stored in plastic bags.</p> <p>3. Review of the medical record revealed Resident #22 was admitted to the facility 8/9/2019, with diagnoses including Muscle Weakness, Unsteadiness on Feet, Anemia, Difficulty Walking, and Dementia.</p> <p>(continued on next page)</p>		

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<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 dated [DATE], revealed Resident #22 was cognitively intact and required set up or clean up assisting for toileting hygiene and eating.</p> <p>Review of the medical record revealed Resident #36 was admitted to the facility 5/4/2022, with diagnoses including Heart Failure, Muscle Weakness, Unsteadiness on Feet, Obesity, Rheumatoid Arthritis, and Abnormality of Gait and Mobility.</p> <p>Review of quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #36 was cognitively intact, required set up or cleanup assistance for eating.</p> <p>Observation in Resident #22 and Resident #36's shared bathroom on 7/15/2024 at 10:23 AM, 11:50 AM, and at 3:51 PM, revealed 1 plastic medication cup, 2 clear plastic dietary drinking glasses, 1 plastic maroon dietary bowl, and 1 white dietary bowl, sitting on the ledge of the bathroom mirror all stacked inside each other.</p> <p>During an interview and observation in Resident #22 and Resident #36's shared bathroom on 7/16/2024 at 8:00 AM, revealed 1 plastic medication cup, 2 clear plastic dietary drinking glasses, 1 plastic maroon dietary bowl, and 1 white dietary bowl, sitting on the ledge of the bathroom mirror all stacked inside each other. CNA D was shown the soiled dietary items in Resident #22 and Resident #36's shared bathroom and was asked where these items should be. CNA D stated, They should be in dietary.</p> <p>4. Review of medical record revealed Resident #6 was admitted on [DATE], with diagnoses including Cerebral Palsy, Depression, and Anxiety.</p> <p>Review of admission MDS dated [DATE], revealed Resident #6 was moderately cognitively impaired and required maximal for oral hygiene and dependent on staff for personal hygiene including oral care.</p> <p>Medical record review revealed Resident #35 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Anxiety, Depression, and Hypertension.</p> <p>Review of admission MDS dated [DATE], revealed cognitively intact and required supervision for oral hygiene and moderate assistance for personal hygiene.</p> <p>Observation in Resident #6 and Resident #35's shared bathroom on 7/15/24 at 10:20 AM, 2:55 PM, and on 7/16/2024 at 4:39 PM, revealed a tube of toothpaste and a toothbrush on the sink behind the faucet unlabeled and uncontained, a plastic denture cup upside down in the corner on the floor unlabeled and uncontained, a soiled adult brief on the floor beside the commode, beside the trash can.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. During an interview with on 7/18/24 at 11:17 AM, the Administrator was asked how often trash should be emptied. The Administrator confirmed that the trash should be emptied at a minimum of one time daily or more often if needed. The Administrator confirmed that all trash should be contained in the trash receptacles and no trash overflowing or on the floor, around the base of the receptacles. The Administrator was asked how should wash basins and bedpans be stored in a shared resident bathroom. The Administrator confirmed wash basins and bedpans should be labeled with the resident's name and in a plastic bag when not in use. The Administrator confirmed the soiled dietary serving items should not be in resident's bathrooms and should be in the dietary department. The Administrator was asked how resident toothbrushes should be stored in a shared bathroom. The Administrator confirmed toothbrushes should be stored in a holder and labeled and denture cups should be stored upright and labeled.</p>		