

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/02/2024
NAME OF PROVIDER OR SUPPLIER  River Grove Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1520 Grove St Box 190 Loudon, TN 37774	

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 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782</b></p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to maintain resident's dignity during meal assistance for 1 resident (Resident #5) of 4 residents observed for meals.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Resident Rights, dated 3/22/2022, revealed, .The resident has a right to be treated with respect and dignity .</p> <p>Medical record review revealed Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Traumatic Brain Injury, Hemiplegia Affecting Right Dominant Side, Cognitive Communication Deficit, Muscle Wasting and Atrophy, and Altered Mental Status.</p> <p>Medical record review of a comprehensive care plan dated 5/17/2023, revealed Resident #5 had .ADL [Activities of Daily Living] self-care performance deficit r/t [related to] Hemiplegia, TBI [Traumatic Brain Injury], contractures, impaired mobility, cognitive deficit .EATING: The resident requires extensive assist from staff to eat .</p> <p>Medical record review of the physician's orders for Resident #5 dated 3/7/2024, revealed, .Dietary .Regular, Nectar [a liquid that is slightly thicker than water], Puree [modified food that has been ground to a pudding like consistency] .</p> <p>Medical record review of the physician's orders for Resident #5 dated 3/19/2024, revealed, .Assist with meals/meal supervision .</p> <p>Review of a significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #5 had severe cognitive impairment, impaired range of motion to the bilateral upper and lower extremities, and was dependent on staff for eating.</p> <p>During an observation in Resident #5's room on 4/30/2024 at 7:55 AM, Resident #5 was being fed the breakfast meal by Certified Nursing Assistant (CNA) B. CNA B stood over the resident, beside the bed, to feed Resident #5 the breakfast meal. CNA B removed the bedside table from the resident's reach and exited the room to obtain additional silverware.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview outside Resident #5's room on 4/30/2024 at 7:58 AM, CNA B stated staff that fed residents were to be seated in a chair beside the resident's bed to maintain positioning at the resident's eye level. CNA B confirmed she was not seated at the resident's eye level and further stated she should have been seated in a chair next to Resident #5's bed while feeding the resident. CNA B returned to Resident #5's room after the interview to continue assisting Resident #5 with the breakfast meal.</p> <p>During a second observation in Resident #5's room on 4/30/2024 at 8:02 AM, CNA B fed the resident oatmeal. CNA B continued to stand over the resident, beside the bed, while feeding the resident.</p> <p>During an interview on 4/30/2024 at 10:00 AM, the Director of Nursing confirmed it was her expectation that staff were seated and at eye level with the resident during feeding to maintain the resident's dignity.</p>

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<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** 50407</b></p> <p>Based on facility policy review, review of Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, medical record review, and interviews, the facility failed to accurately complete a [NAME] Data Set (MDS) assessment for 3 residents (Resident #16, #8, and #20) of 27 residents reviewed.</p> <p>The findings include:</p> <p>Review of the facility policy titled, RAI Assessment - MDS 3.0 Completion, dated 3/23/2022, revealed, . Residents are assessed, using a comprehensive assessment process, in order to identify care needs . According to federal regulations, the facility conducts .a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State .</p> <p>Review of the Centers for Medicare &amp; Medicaid Services Long-Term Care Facility RAI 3.0 User's Manual dated 10/2023, revealed, .Code .renal dialysis which occurs at the nursing home or at another facility .Code residents identified as being in a hospice program for terminally ill persons where .services is provided for . terminal illnesses .</p> <p>Medical record review revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including Dementia, Muscle Weakness, Chronic Kidney Disease, Myocardial Infarction, Congestive Heart Failure, and Cerebrovascular Accident.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #16 scored an 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment and the resident did not receive hospice services.</p> <p>Medical record review of a Physician's Order for Resident #16 dated 12/19/2023, revealed .Hospice .</p> <p>Review of a hospice note for Resident #16 dated 4/24/2024, revealed .[named hospice company] .Plan of Care .Diagnosis .CVA [stroke] .</p> <p>During an interview on 5/1/2024 at 5:15 PM, MDS Coordinator A stated Resident #16 received hospice services and confirmed the MDS assessment dated [DATE] was inaccurate.</p> <p>49568</p> <p>Medical record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Diabetes, End Stage Renal Disease, and Dependence on Renal Dialysis.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #8 scored a 10 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Continued review revealed Dialysis was documented on Resident #8's MDS assessment.</p> <p>Medical record review of a comprehensive care plan dated 3/6/2024, revealed Resident #8 .has renal failure Stage 5 chronic kidney disease and requires Dialysis 3 times a week .</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/29/2024 at 11:30 AM, Resident #8 stated he received dialysis three times weekly.</p> <p>During an interview on 5/1/2024 at 4:10 PM, MDS Coordinator A confirmed Resident #8 received dialysis and the quarterly MDS assessment dated [DATE] was inaccurate.</p> <p>41782</p> <p>Medical record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including Diabetes, Asthma, Morbid Obesity, Sleep Apnea, Atrial Fibrillation, and Chronic Kidney Disease.</p> <p>Medical record review of a Physician's Order for Resident #20 dated 11/30/2022, revealed .Hospice . Continued review revealed the hospice order was discontinued on 7/13/2023 .Reason .Condition resolved .</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #20 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact and received hospice care.</p> <p>During an interview on 5/1/2024 at 10:10 AM, Resident #20 stated she was receiving hospice, but it was discontinued .6 months to a year ago .because they said I wasn't dying .</p> <p>During an interview on 5/1/2024 at 10:13 AM, the Director of Nursing (DON) confirmed Resident #20's hospice services was discontinued on 7/13/2023 and the quarterly MDS dated [DATE] was inaccurate.</p> <p>During an interview on 5/1/2024 at 10:18 AM, MDS Coordinator A confirmed Resident #20 no longer received hospice services and the quarterly MDS assessment dated [DATE] was inaccurate.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50407</p> <p>Based on facility policy review, medical record review and interviews, the facility failed to develop a comprehensive care plan to address hospice services for 1 resident (Resident # 16) and failed to involve the resident and/or resident representative in the care planning process for 1 resident (Resident #72) of 27 residents reviewed for care plans.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Comprehensive Care Plans, revised 2/2024, revealed .The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to .Family members . others desired by the resident .The comprehensive care plan will be .revised by the interdisciplinary team .</p> <p>Medical record review revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including Dementia, Muscle Weakness, Chronic Kidney Disease, Myocardial Infarction, Congestive Heart Failure, and Cerebrovascular Accident.</p> <p>Medical record review of a Physician's Order for Resident #16 dated 12/19/2023, revealed .Hospice .</p> <p>Medical record review of the comprehensive care plan for Resident #16 revealed a care plan had not been developed to reflect hospice services.</p> <p>During an interview on 5/1/2024 at 5:15 PM, Minimum Data Set (MDS) Coordinator A stated Resident #16 received hospice services and confirmed a comprehensive care plan had not been developed to reflect hospice services.</p> <p>50216</p> <p>Medical record review revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Diabetes and Vascular Dementia.</p> <p>Review of an admission MDS assessment dated [DATE], revealed Resident #72 scored a 1 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment.</p> <p>During an interview on 4/30/2024 at 10:27 AM, Resident #72's resident representative stated they had not been invited or participated in an initial care plan conference.</p> <p>During an interview on 5/1/2024 at 1:00 PM, the Social Service Assistant and Regional Licensed Social Worker (RLSW) stated residents and resident representatives were invited to the care planning conference. The RLSW stated the facility did not have any documentation to verify Resident #72 or the resident's representative had been invited or attended the initial care conference.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38810</p> <p>Based on facility policy review, medical record review, observations, and interviews, the facility failed to follow a physician's order for 1 resident (Resident #59) related to tube feeding and water flush rates of 3 residents reviewed for tube feeding.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Care and Treatment of Feeding Tube, dated 5/31/2023, revealed .it is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice .to prevent complications .feeding tubes will be utilized according to physician orders .periodic evaluation of the amount of feeding being administered for consistency with practitioner's orders .</p> <p>Medical record review revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including Cerebral Palsy, Epilepsy, and Autistic Disorder.</p> <p>Medical record review of the Physician's Order for Resident #59 dated 5/3/2023, revealed .Enteral Feeding [medical device/tube used to provide nutrition to people who cannot obtain nutrition by mouth] .Administer . Jevity 1.2 .at Rate 45ml [milliliters]/hr [hour] for 22hrs [hours]/day .</p> <p>Medical record review of a comprehensive care plan dated 5/30/2023, revealed Resident #59 .has . peg tube [percutaneous endoscopic gastrostomy- a tube surgically placed in the abdomen for feeding] .</p> <p>Medical record review of the Physician's Order for Resident #59 dated 7/20/2023, revealed .Hydration . Provide 25/ml/hour via [by] PEG tube .</p> <p>Medical record review of the Registered Dietician's note for Resident #59 dated 4/17/2024, revealed . currently receiving Jevity 1.2 @ [at] 45 ml/hour x 22 hours per day with a 25 ml water flush every hour .</p> <p>During an observation on 4/30/2024 at 9:40 AM, Resident #59 was observed lying in the bed with Jevity 1.2 infusing at 60ml/hr and a water flush was infusing at 45ml/hr via peg tube.</p> <p>During an observation and interview on 5/1/2024 at 8:22 AM, in Resident #59's room, Registered Nurse (RN) A confirmed Jevity 1.2 was infusing at 60ml/hr with water flush infusing at 45ml/hr. RN A confirmed the physician's order was for Jevity 1.2 at 45 ml/hr with a water flush at 25 ml/hr. RN A stated she worked on 4/28/2024 and the tube feeding was infusing at the correct rate of 45 ml/hr with a water flush at 25 ml/hr.</p> <p>During an interview on 5/1/2024 at 10:18 AM, Nurse Pracitioner A stated Resident #59's Jevity 1.2 infusing at a rate of 60ml/hr and a water flush infusing at a rate of 45 ml/hr for a short time did not cause the resident any complications.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/1/2024 at 5:15 PM, the Director of Nursing confirmed the facility failed to follow Physician Orders related to tube feeding and water flush rates for Resident #59.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50480</p> <p>Based on facility policy review, medical record review, observations, and interviews the facility failed to ensure an oxygen tank was stored in a secure location for 1 resident (Resident #38) and failed to obtain an order for oxygen administration for 1 resident (Resident #386) of 3 residents reviewed for oxygen storage and oxygen administration.</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, Oxygen Safety, revealed, .Handling Oxygen Cylinders . Protect cylinders from damage by not storing .where objects may strike them or fall .</p> <p>Review of the facility policy titled, Oxygen Administration, dated 3/24/2024 revealed, .oxygen is administered under orders of a physician .</p> <p>Medical record review revealed Resident #38 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease and Atherosclerotic Heart Disease.</p> <p>Medical record review of the Physician's Orders for Resident #38 dated 3/25/2024, revealed, .Oxygen 2 L [liters]/ [per] min [minute] via [by] NC [nasal cannula]. May remove for personal hygiene, ADLs [activities of daily living], and/or transport .</p> <p>Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #38 received oxygen therapy at the facility.</p> <p>During an observation on 4/29/2024 at 12:32 PM, in Resident #38's room, revealed Resident #38 was lying in bed resting. Resident #38 received 2 liters oxygen (O2) via nasal cannula that was delivered from an oxygen concentrator. There was a 2000 pound per square inch (psi) O2 tank that was approximately 3/4 full leaning against the wall of the resident's room unsecured and not in use.</p> <p>During an observation on 4/30/2024 at 7:59 AM, in Resident #38's room, revealed Resident #38 was lying in bed resting. Resident #38 received 2 liters O2 via nasal cannula that was delivered from an oxygen concentrator. There was a 2000 pound per square inch (psi) O2 tank that was approximately 3/4 full leaning against the wall of the resident's room unsecured and was not in use.</p> <p>During an observation on 4/30/2024 at 11:00 AM, in Resident #38's room, revealed Resident #38 was lying in bed resting. Resident #38 received 2 liters O2 via nasal cannula that was delivered from an oxygen concentrator. There was a 2000 pound per square inch (psi) O2 tank that was approximately 3/4 full leaning against the wall of the resident's room unsecured and was not in use.</p> <p>During an interview on 5/1/2024 at 5:15 PM, the Director of Nursing (DON) stated her expectation was for oxygen tanks to be stored in a secured location and not in a resident's room without a secured canister.</p> <p>49568</p> <p>(continued on next page)</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>Medical record review revealed Resident #386 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Major Depressive Disorder, and Chronic Kidney Disease.</p> <p>Medical record review of a comprehensive care plan dated 4/24/2024, revealed Resident #386 had . Respiratory/Pulmonary .has altered respiratory status/difficulty breathing related to utilizes O2, acute respiratory failure .Administer oxygen as ordered .</p> <p>Medical record review of a current Physician's Order dated 4/2024, revealed Resident #386 did not have an order for use (or administration) of Oxygen.</p> <p>During an observation and interview on 4/29/2024 at 11:00 AM, in the resident's room, Resident #386 was lying in bed with eyes closed and oxygen was infusing at 2 liters per minute (LPM). Resident #386 stated she had been using oxygen since admission to facility.</p> <p>During an observation on 4/30/2024 at 7:20 AM, Resident #386 was lying in bed with oxygen infusing at 2 LPM via nasal cannula.</p> <p>During an observation on 5/1/2024 at 8:15 AM, Resident #386 was lying in bed with oxygen infusing at 2 LPM via nasal cannula.</p> <p>During an observation and interview on 5/1/2024 at 10:40 AM, in Resident #386's room, the Assistant Director of Nursing (ADON) confirmed Resident #386 had oxygen infusing at 2 LPM via nasal cannula. The ADON confirmed Resident #386 did not have a physician's order for oxygen administration and it was her expectation anyone receiving oxygen had a physician's order.</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>50407</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure expired medications were not available for resident use in 1of 4 medication carts observed.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Destruction of Unused Drugs, revised 4/24/2024, revealed .all .expired drugs shall be disposed of .</p> <p>During an observation and interview of the unit 2 hall medication cart on 4/30/2024 at 8:40 AM, with Licensed Practical Nurse (LPN) A, revealed 1 box of Ferrous Gluconate (medication used to treat iron deficiency anemia) 324 mg (milligram) which contained 87 tablets with an expiration date of 1/2024. LPN A confirmed the medication was expired and was available for resident use.</p> <p>During an interview on 5/1/2024 at 5:15 PM, the Director of Nursing (DON) confirmed expired medications were to be removed from the medication cart and discarded.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50216</p> <p>Based on facility policy review, observations, and interview the facility failed to ensure food items were sealed properly, failed to keep cleaning products away from open food containers, failed to ensure cooking equipment was maintained in a sanitary condition, and failed to ensure expired food items were not available for resident use which had the potential to effect 87 of 91 residents.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Food Safety and Foodborne Illness Prevention, dated [DATE], revealed . Facility staff shall inspect all food, food products, and beverages .and ensure timely and proper storage .Dry food storage .in a clean, dry area, off the floor and clear of ceiling sprinkler, sewer/waste disposal pipes and vents .Refrigerated storage .Labeling, dating, and monitoring refrigerated foods, including, but not limited to leftovers, so it is used by its use-by-date, or frozen (where applicable)/discarded .Keeping foods covered or in tight containers .</p> <p>During an observation of the kitchen on [DATE] at 10:35 AM, with the Certified Dietary Manager (CDM) revealed the following food items were not sealed and left open to air:</p> <p>One 28-ounce (oz) bottle of lemon pepper seasoning</p> <p>One 18-oz bottle of paprika</p> <p>One 5-oz bottle of basil leaves</p> <p>One 20-oz bottle of chili powder</p> <p>One 16-oz bottle of celery seed</p> <p>One 20-oz bottle of 17-Seasoning.</p> <p>During an observation on [DATE] at 10:40 AM, with the CDM, revealed on the shelf where the spice containers were stored was an unmarked and unlabeled red bucket which contained a cloth and a semi-clear liquid. The CDM stated the bucket contained sanitizing cleaner solution used for cleaning, and it was supposed to be on the second shelf not the top shelf near the spice containers.</p> <p>During an observation of the clean dish storage area on [DATE] at 10:55 AM, with the CDM, revealed the following:</p> <p>4 of 4 muffin pans had a copper/brown colored substance on the front and back of each pan.</p> <p>28 of 28 baking sheet pans had a caked on black substance around the outside edges and brown substance on the front and back of the pans.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/02/2024
NAME OF PROVIDER OR SUPPLIER  River Grove Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1520 Grove St Box 190 Loudon, TN 37774	

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 - Many</p>	<p>During an observation of the E-F hall refrigerator on [DATE] at 11:15 AM, with the CDM, revealed 3 sandwiches were stored in the refrigerator with a use by date of [DATE] and available for resident consumption.</p> <p>During an interview on [DATE] at 11:25 AM, the CDM confirmed spice containers were to be fully sealed after each use, the sanitizing cleaner should not have been placed near the spice containers, and the cooking equipment was not maintained in a sanitary condition. The CDM confirmed the sandwiches stored in the E-F hall refrigerator were past the use by date of [DATE] and were available for resident consumption.</p> <p>During an interview [DATE] 4:00 PM the Administrator stated the expectation was for the kitchen to be maintained in a sanitary condition, food items be sealed properly, and food items be discarded if expired.</p>