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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445270 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/15/2024 |
| NAME OF PROVIDER OR SUPPLIER Tennessee Veterans Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 345 Compton Road Murfreesboro, TN 37130 | |

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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831</p> <p>Based on facility policy review, Quality Assurance Performance Improvement Plan review, QAPI Meeting Minutes review, medical record review, observation, and interview, the facility failed to ensure all residents were free from neglect for 5 of 12 residents (Resident #7, Resident #9, Resident #12, Resident #13, and Resident #14) who required wound care. The facility's failure to provide goods and services for residents resulted in Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident) when Resident #7 did not receive wound care as ordered by the physician for a wound identified on 12/17/2023 as excoriation (skin is scraped or abraded) to the bilateral buttocks that progressed to an unstageable wound (wound is covered by dead tissue and the base of the wound is obscured-cannot be visualized) noted on 1/2/2024, when Resident #9 did not receive wound care as ordered by the physician for a R (right) calf wound identified on 10/12/2023 as an unstageable wound which required antibiotics and a R heel wound identified on 10/5/2023 as a DTI (Deep Tissue Injury) severe pressure ulcer that occurs when soft tissue is damaged by pressure or shear) which progressed to an unstageable wound, when Resident #12 did not receive wound care as ordered by the physician for a left (L) calf wound identified as an unstageable wound which required antibiotics on 1/27/2024, and transfer to the hospital on 2/6/2024, when Resident #13 did not receive wound care as ordered by the physician for a R heel wound that was identified as a unstageable pressure ulcer which required antibiotics for infection, the facility also failed to identify Resident #13 had developed unstageable wounds on his L and R ischium and failed to implement wound care after the initial treatment for 3 days after identification of the wounds, and when Resident #14 did not receive treatments as ordered by the physician for a diabetic ulcer to his R 2nd toe which became infected and required transfer to the hospital for amputation on 4/23/2024.</p> <p>The Administrator and the Director of Clinical Services were notified of the IJ on 5/15/2024 at 7:27 PM in the Conference room.</p> <p>The facility was cited at F-600 at a scope and severity of L, which constitutes Substandard Quality of Care.</p> <p>The Immediate Jeopardy was effective on 10/22/2023 and is ongoing.</p> <p>A partial extended survey was conducted on 5/15/2024.</p> <p>The facility is required to submit a plan of correction (POC)</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>The findings include:</p> <p>Review of the facility's policy titled, Abuse & Neglect of Residents and Misappropriation of Residents' Property, dated 2/20/2013, revealed, .Abuse means knowingly causing physical harm or recklessly causing serious physical harm to a resident .for staff convenience, excessively, as a substitute for treatment, or in amounts that preclude habilitation and treatment. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being .Neglect means recklessly failing to provide a resident with any treatment, care, goods, or service necessary to maintain the health or safety of the resident when the failure results in serious physical harm to the resident .The facility will strive to identify, correct and intervene in situations in which abuse, neglect .In an effort to identify events, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation .Any staff receiving such allegation must immediately make the Administrator aware, if he/she was not the person initially reported to. The Administrator will be responsible for assuring that all such alleged violations are thoroughly investigated, while preventing further potential abuse, neglect or misappropriation during the investigative process .Steps will be taken to prevent further harm to the resident while the investigation is in progress .If the alleged violation is verified, appropriate corrective action will be taken .Analyze the occurrences to determine what changes are needed .</p> <p>Review of the facility policy titled, Pressure Ulcer Policy, dated 1/7/2013 revealed, .residents who are admitted without pressure ulcers do not develop pressure ulcers .and residents who are admitted with pressure ulcers receive the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing .Residents who are unable to self turn and/or reposition will be turned and/or repositioned by facility staff periodically throughout the day to alleviate pressure .Residents who are incontinent will be changed and cleaned periodically by staff .When a facility acquired pressure ulcer is identified, a Licensed Nurse will evaluate the wound which will include staging and/or appearance and initial measurements. The Nurse will notify the attending Physician, Responsible Party and Interdisciplinary Team. The Nurse will obtain treatment orders from the Physician at the time of notification .</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Review of the facility policy titled, Skin/Wound Management Guidelines dated 2/20/2013 revealed, .Perineal erosion .diaper rash or 'red bottom' is the erosion of skin caused by excessive moisture and/or the irritants in urine and feces .keep the area clean and dry .prevent urine and feces contact with the skin .</p> <p>INTERVENTIONS .Reposition bed bound residents every 2 hours. Residents in wheelchairs or Geri chairs or residents with HOB [head of bed] > [greater than] 30 degrees should be repositioned every hour .Keep clean and dry; minimize excess moisture on skin .Proper handling, bathing .TREATMENT .Cleanse with wound cleanser .Change dressing every day and PRN [as needed] non-adherence and/or soilage, until resolved .</p> <p>SUSPECTED DEEP TISSUE INJURY AND STAGE I PRESSURE ULCER .area of persistent redness in lightly pigmented skin tones whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. There is no depth in a Stage I .Suspected Deep Tissue Injury is a purple or [NAME] localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/ or shear .The area may be .painful, firm, mushy, boggy [a tissue texture that is characterized by sponginess], warmer or cooler as compared to adjacent tissue .objective is to relieve pressure, shear, and friction, and to keep the area clean .If continence is a factor .If the patient is incontinent, cleanse the skin . following each incontinent episode .Minimize excess moisture on skin .bathing .Ulcer should resolve with pressure reduction strategies .Document all care .STAGE II PRESSURE ULCER OR PATIAL THICKNESS WOUNDS .partial thickness loss of dermis presenting as a shallow ulcer with red pink wound bed, without slough [non-viable tissue that can form in a wound when dead cells and bacteria accumulate, usually yellow or white]. May also present as intact or open/ruptured serum-filled blister .Cleanse wound with wound cleanser or normal saline .Assess the patient .Turning schedule-while it is common to establish a 2 hour time frame for turning, some 'at risk' patients require more frequent turning-up to every hour-to prevent further breakdown .Proper positioning-use pillows/sheets between knees and ankles .'Suspend Heels' from the bed surface .Minimize excess moisture on skin .Monitor patients for signs/symptoms of infection. If the wound does not progress within 2-4 weeks, contact a physician for further evaluation .Document all care .STAGE III PRESSURE ULCER OR FULL THICKNESS WOUNDS .full thickness tissue loss .Cleanse with wound cleanser .If obvious signs or symptoms of infection, use sliver calcium alginate [dressing that is highly absorbent and creates a conformable gel]pad or rope and cover with bordered [absorptive dressing with three layers which holds the dressing in place and maintains a moist environment] dressing and change daily .Monitor patient for signs/symptoms of infection (periwound erythema, induration, malodorous [having a bad odor] drainage .Contact a physician to evaluate wounds .Pressure Reduction .For chair bound patients: limit sitting if patient is cognitively or physically unable to reposition self; position patient off wound in sitting .</p> <p>CLINICAL OUTCOMES/GOALS .Pressure ulcer will demonstrate improvement by a decrease in size and or amount of nonviable tissue .in 2-4 weeks .STAGE IV PRESSURE ULCER OR FULL THICKNESS WOUNDS .full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar [dead tissue within a wound] may be present on some parts of the wound bed .Stage IV pressure ulcers can be life threatening, so careful monitoring is very important .If obvious signs or symptoms of infection, use sliver calcium alginate pad or rope and cover with bordered dressing and change daily .Chemical debriders may be used in conjunctions with dressings to remove heavy sough [slough] or eschar. *Not recommended on heels or feet, if eschar is intact, (patient with diabetes, PVD [peripheral vascular disease] or other circulatory problems .</p> <p>UNSTAGEABLE PRESSURE ULCER or FULL THICKNESS WOUNDS WITH ESCHAR OR SLOUGH .full thickness tissue loss in which the base of the ulcer is covered by slough .and/ or eschar .in the wound bed .If stable heel ulcer with eschar .If slough or eschar present use small amount of a chemical debrider .Santyl .to facilitate debridement then apply hydrogel gauze and cover with bordered dressing and change daily. Assess for decline or s/s [signs/symptoms] of infection .Moderate or Heavy drainage .slough or eschar .use small amount of a chemical debrider .apply Calcium Alginate and cover with border dressing change daily, assess for decline or .infection .If obvious signs or symptoms of infection, use silver calcium alginate pad or rope and cover with bordered dressing and change daily .If the patient is incontinent, follow skin/wound management protocol for perineal erosion assessment or incontinence .Minimize excess moisture on skin .</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Review of the facility policy titled, CLINICAL POLICIES Activities of Daily Living Policy dated 1/7/2013 revealed, .Residents who are unable to perform bathing, dressing, or grooming will have these tasks completed for them by facility staff at least daily and as needed. Bathing may be in the form of a shower, whirlpool bath or bed bath .Residents may be placed on a scheduled toileting or check and change program depending on their ability and current needs .</p> <p>Review of the facility policy titled, .Infection Control Program . dated 4/25/2024 revealed, .[Named Facility] has established and will maintain an Infection Control program that is designed to provide a safe, sanitary and comfortable environment and to help prevent the development .of .infections .The ICP will work closely with the Interdisciplinary Team as well as facility Medical Director and Medical staff to determine patterns of infection or to prevent a pattern from occurring. The ICP will make periodic random rounds throughout the facility to ensure Infection Control policies and procedures are being followed and to identify any opportunities for staff education .</p> <p>Review of the facility policy titled, .Quality Assurance Performance Improvement . revision date 11/2020 revealed, .The QAPI [Quality Assurance and Performance Improvement] program is an avenue for employees, residents, and families to resolve issues and provide input regarding the quality of care and operational efficiency. By maintaining and improving quality the QAPI program has a direct impact on the resident's quality of life .It is the organization's responsibility to identify and correct problems .Analyze the data collected to identify performance indicators signaling a deviation from expected performance .Study the issue to determine the underlying causes and contributing factors .Develop and implement corrective actions .Monitor data released to the issue to determine if they are sustaining corrections and make revisions as needed .</p> <p>Review of the QAPI Plan dated 11/27/2023 revealed, .In House Pressure .Problem Pressure ulcer/Injury . Cause: CNTs [Certified Nurse Technicians]/Nurse not identifying and reporting new skin issues to wound care, and inconsistent treatment plan/orders .How: Evaluate current wound nurse. Weekly wound meetings to monitor progress. Revision/Review of treatment plans/order by treatment nurse and MD [Medical Director]. Who: Treatment Nurse DON [Director of Nursing] QA [Quality Assurance] Nurse .New wound care nurse . Monitor wound sizes and treatments .Provided unit managers with current interventions in place .Made common treatment options for basic wounds to floor staff .</p> <p>Review of the QAPI Minutes dated 1/30/2024 revealed, .NEW BUSINESS FOR THIS MEETING .There has been a change in the Wound Care nurse .position .</p> <p>Review of the QAPI Minutes dated 4/16/2024 revealed, .Old/Ongoing Business .Wound Care .Areas that still need improvement .ADL [activities of daily living] Charting .New charting .an increase in staffing turnover has resulted in an increase with missing and inaccurate documentation. We are currently flagging in worsened ADL .worsened incontinence .Assessment Charting .weekly skin assessments .has shown a decline .</p> <p>Review of the QAPI Meeting Minutes revealed 6 wound infections on 11/2023, 4 wound infections on 12/2023, 4 wound infections on 1/2024, 3 wound infections on 2/2024, 3 wound infections on 3/2024, and 8 wound infections on 4/2024. The Wound Infection list revealed an increase in wound infections over the last 5 months after the Performance Improvement Plan (PIP) was put into place on 11/2023.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses which included Unspecified Dementia with Mood Disturbances and Type 2 Diabetes Mellitus with Diabetic Neuropathy.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 revealed, a Brief Interview of Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment. Continued review revealed .Risk for Pressure Ulcers/Injuries .Yes .Skin and Ulcer/Injury Treatments .Pressure reducing device for chair .Pressure reducing device for bed .</p> <p>Review of the medical record revealed Resident #7 had excoriation that progressed to an unstageable wound to the bilateral buttocks that was not present on admission and developed in-house.</p> <p>Review of the Treatment Administration Record (TAR) dated 12/2023 for Resident #7 revealed, .Apply skin prep to left heel and cover with border foam dressing daily and prn. every day shift for boggy heel .[Start] 12/12/2023 .[End] 12/26/2023 . Continued review revealed there was no documentation of wound care performed on 12/16/2023, 12/17/2023, 12/23/2023, and 12/24/2023 .</p> <p>Review of the TAR dated 12/2023 for Resident #7 revealed, .Bilateral buttocks: Cleanse with wound cleanser, pat dry, apply triad [cream used to adhere to wet, eroded skin] generously and leave open to air daily and as needed. every day shift for excoriation .[Start] 12/17/2023 .[End] 12/18/1013 . Continued review revealed there was no documentation of wound care performed on 12/17/2023.</p> <p>Review of the facility progress notes dated 12/17/2023 at 2:34 AM, revealed LPN H documented, .CNA notified writer of skin concern during resident's bed bath. upon skin assessment, writer notes excoriation [a raw, irritated area of the skin due to incontinence] to bilateral buttocks. Sites have blanch-able redness with denuded skin to center .Site cleansed with wound cleanser, patted dry, and applied Triad Hydrophilic Wound Dressing Cream [adheres to moist wound bed and protects periwound skin] and left open to air .</p> <p>Review of the TAR dated 12/2023 for Resident #7 revealed, .Bilateral buttocks: Cleanse with wound cleanser, pat dry, apply triad generously and leave open to air daily and as needed. DO NOT APPLY DRESSING OF ANY KIND OR TAPE TO AREA! every day shift for excoriation .[Start] 12/18/2023 .[End] 12/26/2023 . Continued review revealed there was no documentation of wound care performed on 12/23/2023 and 12/24/2023.</p> <p>Review of the TAR dated 12/2023 for Resident #7 revealed, .Cleanse bilateral buttocks with wound cleanser, pat dry, apply skin prep to peri wound, apply medihoney [a mixture of two honeys that accelerates the process of wound healing] and alginate [a calcium dressing used for heavy drainage] to wound bed and cover with bordered dressing daily and as needed every day shift for wound .[Start] 12/29/2023 .[End] 1/9/2024 . Continued review revealed there was no documentation of wound care performed on 12/30/2023 and 12/31/2023.</p> <p>Review of the TAR dated 1/2024 for Resident #7 revealed, .Cleanse bilateral buttocks with wound cleanser, pat dry, apply skin prep to peri wound, apply medihoney and alginate to wound bed and cover with bordered dressing daily and as needed every day shift for wound .[Start] .12/30/2023 .[End] 1/9/2024 . Continued review revealed there was no documentation of wound care performed on 1/2/2024 and 1/5/2024.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Review of the TAR dated 1/2024 for Resident #7 revealed, .Cleanse bilateral buttocks with wound cleanser, pat dry, apply skin prep to peri wound, apply medihoney and alginate to wound bed and cover with bordered dressing daily and as needed every day shift for wound .[Start] .1/10/2024 .[End] 1/18/2024 . Continued review revealed there was no documentation of wound care performed on 1/14/2024.</p> <p>Resident #7 had excoriation to the buttocks, a total of 12 treatments were not documented over 12/12/2023 through 1/14/2024, and Resident #9's wound declined to an unstageable ulcer/injury.</p> <p>Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Essential (Primary) Hypertension, and Encephalopathy.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #9 revealed, a BIMS score could not be conducted related to resident rarely/never understood. Continued review revealed, . Determination of Pressure Ulcer/Injury Risk .A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device .Yes .Risk of Pressure Ulcers/Injuries .Is this resident at risk of developing pressure ulcers .Yes .Unhealed Pressure Ulcers/Injuries .Yes .Number of Stage 3 pressure ulcers .1 . Pressure reducing device for bed .Yes .</p> <p>Review of the medical record revealed Resident #9 had a DTI to the posterior thigh that was not present on admission and developed in-house.</p> <p>Review of the TAR dated 10/2023 for Resident #9 revealed, .DTI to posterior thigh, clean with wound cleanser, pat dry, apply skin prep, cover with border foam dressing, daily and prn .[Start]10/17/2023 .[End] 12/4/2023 . Continued review revealed there was no documentation of wound care performed on 10/22/2023 and 10/29/2023.</p> <p>Review of the TAR dated 11/2023 for Resident #9 revealed, .DTI to posterior thigh, clean with wound cleanser, pat dry, apply skin prep, cover with border foam dressing, daily and prn .[Start] 10/17/2023 .[End] 12/4/2023 . Continued review revealed there was no documentation of wound care performed on 11/11/2023, 11/12/2023, 11/18/2023, 11/19/2023, 11/24/2023, 11/25/2023, and 11/26/2023.</p> <p>Review of the TAR dated 12/2023 for Resident #9 revealed, .DTI to posterior thigh, clean with wound cleanser, pat dry, apply skin prep, cover with border foam dressing, daily .[Start] 10/17/2023 .[End] 12/4/2023 . Continued review revealed there was no documentation of wound care performed on 12/3/2023.</p> <p>Review of the medical record revealed Resident #9 had a DTI to the right heel that progressed to an unstageable wound that was not present on admission and developed in-house.</p> <p>Review of the TAR dated 10/2023 for Resident #9 revealed, .DTI to right heel, clean with wound cleanser, pat dry, apply skin prep, cover with border foam dressing daily and prn .[Start] 10/17/2023 .[End] 12/22/2023 . Continued review revealed there was no documentation of wound care performed on 10/22/2023 and 10/29/2023.</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Tennessee Veterans Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 345 Compton Road Murfreesboro, TN 37130 | |
| 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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Review of the TAR dated 3/2024 for Resident #9 revealed, .Unstageable to right heel: cleanse with normal saline, pat dry, plurogel [water-soluble burn and wound dressing gel] and Hydrofera Blue to wound bed cover with border foam dressing, daily .[Start] 3/14/2024 .[End] 3/28/2024 . Continued review revealed there was no documentation of wound care performed on 3/16/2024, 3/17/2024, and 3/23/2024.</p> <p>Review of the TAR dated 3/2024 for Resident #9 revealed, .Unstageable to right heel: cleanse with normal saline, pat dry, plurogel and Hydrofera Blue to wound bed cover with border foam dressing, daily .[Start] 3/29/2024 .[End] 4/12/2024 . Continued review revealed there was no documentation of wound care performed on 3/31/2024.</p> <p>Review of the TAR dated 4/2024 for Resident #9 revealed, .Unstageable to right heel: cleanse with normal saline, pat dry, plurogel [biocompatible and water-soluble material that softens debris for removal] and Hydrofera Blue to wound bed cover with border foam dressing, daily .[Start] 3/29/2024 .[End] 4/12/2024 . Continued review revealed there was no documentation of wound care performed on 4/6/2024 and 4/7/2024.</p> <p>Review of the TAR dated 4/2024 for Resident #9 revealed, .Right heel: Cleanse with normal saline, pat dry, apply small amount of hydrogel and silver collagen [topical wound treatment], then silver alginate [wound dressing that combines silver and alginate to help wound heal] and cover with border foam dressing QOD [every other day] .[Start] 4/14/2024 .[End] 4/29/2024 . Continued review revealed there was no documentation of wound care performed on 4/14/2024.</p> <p>Resident #9 had a DTI to the right heel, a total of 37 treatments were not documented from 10/17/2023 to 4/14/2024, and Resident #9's wound declined to an unstageable ulcer/injury.</p> <p>Review of the medical record revealed Resident #9 had a wound to the left buttocks that was not present on admission and developed in-house.</p> <p>Review of the TAR dated 10/2023 for Resident #9 revealed, .Left buttocks: Cleanse with wound cleanser, pat dry, apply skin prep to peri wound, apply skin prep to peri wound, apply small amount of hydrogel and alginate to wound bed, cover with boarder dressing every day shift every other day for unstageable .[Start] 9/29/2023 .[End] 10/10/2023 . Continued review revealed there was no documentation of wound care performed on 10/7/2023.</p> <p>Review of the TAR dated 10/2023 for Resident #9 revealed, .Left buttocks: Cleanse with wound cleanser, pat dry, apply skin prep to peri wound, apply small amount Thera Honey Gel and alginate to wound bed, cover with boarder dressing, change daily .[Start] 10/11/2023 .[End] 12/4/2023 . Continued review revealed there was no documentation of wound care performed on 10/14/2023, 10/15/2023, 10/22/2023, and 10/29/2023.</p> <p>Review of the TAR dated 11/2023 for Resident #9 revealed, .Left buttocks: Cleanse with wound cleanser, pat dry, apply skin prep to peri wound, apply small amount Thera Honey Gel and alginate to wound bed, cover with boarder dressing, change daily .[Start] 10/11/2023 .[End] 12/4/2023 . Continued review revealed there was no documentation of wound care performed on 11/11/2023, 11/12/2023, 11/18/2023, 11/19/2023, 11/24/2023, 11/25/2023, and 11/26/2023.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Review of the TAR dated 12/2023 for Resident #9 revealed, .Left buttocks: Cleanse with wound cleanser, pat dry, apply small amount of Thera Honey Gel and alginate to wound bed, cover with boarder dressing, change daily and prn .[Start] 10/11/2023 .[End] 12/4/2024 . Continued review revealed there was no documentation of wound care performed on 12/3/2023.</p> <p>Review of the TAR dated 12/2023 for Resident #9 revealed, .Left buttocks: Cleanse with wound cleanser, pat dry, apply skin prep, cover with boarder dressing, change daily and prn .[Start] 12/5/2023 .[End] 12/13/2023 . Continued review revealed there was no documentation of wound care performed on 12/9/2023.</p> <p>Resident #9 had a wound to the left buttocks, a total of 14 treatments were not documented from 9/29/2023 to 12/9/2023.</p> <p>Review of the medical record revealed Resident #9 had an unstageable wound to the right calf that was not present on admission and developed in-house.</p> <p>Review of the TAR dated 10/2023 for Resident #9 revealed, .Unstageable Pressure Wounds to right calf, clean with wound cleanser, pat dry, apply skin prep, apply DermaGran [ointment for use on abrasions, skin tears, partial-thickness pressure ulcers and preventative skin care] and cover with border foam dressing daily and prn every day shift for Unstageable .[Start] 10/17/2023 .[End] 10/23/2023 . Continued review revealed there was no documentation of wound care performed on 10/22/2023.</p> <p>Review of the TAR dated 10/2023 for Resident #9 revealed, .Unstageable Pressure Wound to right calf, clean with wound cleanser, pat dry, apply Thera Honey and Hydrofera Blue, cover with border foam dressing daily .[Start] 10/24/2023 .[End] 11/1/2023 . Continued review revealed there was no documentation of wound care performed on 10/29/2023.</p> <p>Review of the TAR dated 11/2023 for Resident #9 revealed, .Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to unstageable right calf topically every day shift for unstageable ulcer .[Start] 11/2/2023 .[End] 12/4/2023 . Continued review revealed there was no documentation of wound care performed on 11/11/2023, 11/12/2023, 11/18/2023, 11/19/2023, 11/24/2023, 11/25/2023, and 11/26/2023.</p> <p>Review of the TAR dated 11/2023 for Resident #9 revealed, .Unstageable Pressure Wound to right calf with wound cleanser, pat dry, apply Santyl and Hydrofera Blue, cover with border foam dressing daily and prn . [Start] 11/2/2023 .[End] 12/4/2023 . Continued review revealed there was no documentation of wound care performed on 11/11/2023, 11/12/2023, 11/18/2023, 11/19/2023, 11/24/2023, 11/25/2023, and 11/26/2023.</p> <p>Review of the TAR dated 12/2023 for Resident #9 revealed, .Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to unstageable right calf topically every day shift for unstageable ulcer .[Start] 11/2/2023 .[End] 12/4/023 . Continued review revealed there was no documentation of wound care performed on 12/3/2023.</p> <p>Review of the TAR dated 12/2023 for Resident #9 revealed, .Stage 2 Pressure Wound to right calf, clean with wound cleanser, pat dry, apply hydrogel and Hydrofera Blue, cover with border foam dressing daily . [Start] 12/5/2023 .[End] 12/18/2023 . Continued review revealed there was no documentation of wound care performed on 12/9/2023.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>Review of the TAR dated 12/2023 for Resident #9 revealed, .Stage 2 Pressure Wound to right calf, clean with wound cleanser, pat dry, apply hydrogel, cover with border foam dressing daily and prn .[Start] 12/19/2023 .[End] 1/11/2023 . Continued review revealed there was no documentation of wound care performed on 12/24/2023.</p> <p>Review of the TAR dated 12/2023 for Resident #9 revealed, .Unstageable Pressure Wound to right calf, clean with wound cleanser, pat dry, apply Santyl and Hydrofera Blue, cover with border foam dressing daily . [Start] 11/2/2023 .[End] 12/4/2023 . Continued review revealed there was no documentation of wound care performed on 12/3/2023.</p> <p>Review of the TAR dated 1/2024 for Resident #9 revealed, .Stage 2 Pressure Wound to right calf, clean with wound cleanser, pat dry, apply hydrogel, cover with border foam dressing daily .[Start] 12/19/2023 .[End] 1/11/2024 . Continued review revealed there was no documentation of wound care performed on 1/6/2024 and 1/7/2024.</p> <p>Resident #9 had an unstageable to the left calf, a total of 22 treatments were not documented from 10/17/2023 to 1/7/2024, and Resident #9's wound declined to an unstageable ulcer/injury.</p> <p>Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses which included Heart Failure, Pneumonia, Unspecified Osteoarthritis, and Chronic Kidney Disease, Stage 3.</p> <p>Resident #12 had an unst [TRUNCATED]</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46532</p> <p>46831</p> <p>Based on facility policy review, facility document review, medical record review, and interview, the facility failed to report injuries of unknown origin to the State Survey Agency (SSA) for 2 of 9 (Residents #9 and #10) sampled residents. Resident #9 sustained a right displaced tibia (shin bone) fracture identified on 10/3/2023, and Resident #10's sustained a subtrochanteric right femur fracture (proximal femur fractures located within 5 centimeters of the lesser trochanter of the right femur) identified on 11/5/2023.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Abuse & Neglect of Residents and Misappropriation of Residents' Property, dated 2/20/2013, revealed, .Abuse means knowingly causing physical harm or recklessly causing serious physical harm to a resident by physical contact with the resident or by use of physical or chemical restraint, medication, or isolation as punishment, for staff convenience, excessively, as a substitute for treatment, or in amounts that preclude habilitation and treatment. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being .The facility will strive to identify, correct and intervene in situations in which abuse, neglect .In an effort to identify events, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation, possible sign include: Suspicious bruising, verbal statements alleging abuse-verbal, physical, mental, injuries of unknown origin-those that may be of suspicious appearance, be recurrent in nature, or that cannot be attributed to a resident's known behavior patterns .Any alleged violations involving mistreatment, neglect, abuse, or misappropriation including injuries of unknown source, must be reported immediately to the Administrator .Any staff receiving such allegation must immediately make the Administrator aware, if he/she was not the person initially reported to. The results of any investigation will be reviewed by the Administrator within 24hrs [hours] of the incident or date of discovery, and reported to the Department of Health within prescribed timeframes .If the alleged violation is verified, appropriate corrective action will be taken .Analyze the occurrences to determine what changes are needed, if any to policies and procedures to prevent further occurrences. Analysis of further staff training and/or monitoring needs related to residents' rights, resident care needs of the confused or behaviorally. Complete, detailed documentation will be made of alleged violations, investigations, and outcome, and maintained on file. The record will be available at all times when requested by the Department of Health .</p> <p>Review of the facility's undated document titled, [Named Facility] Abuse and Neglect Prevention Program, revealed, .Regardless of title .Reporting: The facility must report allegations of abuse to the State Department of Health, the local Police Department, Adult Protective Services and the Ombudsman. There are specific timeframes. All abuse will be reported within two hours of NOTIFICATION .</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of medical record revealed Resident #9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Fracture of Shaft of Right Tibia, Initial Encounter for Closed Fracture, Muscle Weakness, Recurrent, and Aphasia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #9 revealed a Brief Interview for Mental Status (BIMS) score of 8 which indicated moderately impaired cognition. Continued review of the MDS revealed Resident #9 required extensive assistance 1 person assist for locomotion on and off the unit. Further review revealed vision impaired, Upper extremity (shoulder, elbow, wrist, hand) impaired on one side, Lower extremity (hip, knee, ankle, foot) impaired one side, and Wheelchair Yes.</p> <p>Review of the undated Comprehensive Care Plan for Resident #9 revealed, .8/16/2013 The ability to transfer to and from a bed to chair (or wheelchair). My usual functional ability is dependent. Provide assistance as needed. I transfer via [named mechanical lift] .10/3/2023 left w/c [wheelchair] padded .9/26/23 wheel cover to right w/c [wheelchair] wheel .Encourage resident to keep space from walls and doorways .Encourage resident to use caution when self-propelling through doorways .</p> <p>Review of Incident Report dated 10/3/2023 at 10:35 AM, completed by Previous Interim Director of Nursing (DON) revealed, .Nursing Description: Called to Resident's [Resident #9's] room by wound care nurse related R [Right] lower leg and bruising noted to L [Left] upper arm. R [Right] lower leg noted to swollen at knee cap and warm to touch, discolored, and slight bruising with various stages of healing noted along the lower part of skin, NP [Nurse Practitioner] aware an STAT [immediately] X-ray ordered as well as doppler [a noninvasive test that can be used to measure the blood flow through your blood vessels]. The bruising noted to L [left] upper arm is 4 inch linear pattern that resembles a blood pressure cuff .Resident [Resident #9] is mainly non-verbal but answers questions with yes or no and Hey. Resident [Resident #9] denied falling. Resident [Resident #9] stated No No when asked if any one hurt his leg. When assessing L [left] upper arm I asked resident [Resident #9] if this is where they take your blood pressure and resident [Resident #9] responded with Hey, Hey which traditionally indicates agreement .Description: X-ray confirmed mild placed fx [fracture] tibia; Resident [Resident #9] sent to ER [emergency room] and returned and returned same day with knee immobilizer .</p> <p>During an interview on 5/1/2024 at 4:26 PM, Nurse Practitioner X stated, .I was told [Named Resident #9] hit his leg on his wheelchair .I questioned that injury .</p> <p>During an interview on 5/2/2024 at 9:27 AM, The Administrator stated, .I am the abuse coordinator, and the DON and Social Service Director are my back up abuse coordinators. Abuse should be reported within 2 hours and that includes injuries of unknown origin. I didn't report [Named Resident #9]'s injury because I felt like we figured out the cause of the injury within 2 hours .</p> <p>The facility could not provide an investigation to show that a root cause was found of Resident #9's injury.</p> <p>Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, and Dementia.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the Quarterly MDS dated [DATE] for Resident #10 revealed a BIMS score of 6 which indicated severely impaired cognition. Further review revealed, .chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) .dependent-helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity .</p> <p>Review of the Comprehensive Care Plan dated 10/27/2023 for Resident #10 revealed, .ADL [Activities of Daily Living] and Self-Care: Transfer: I require limited to total assistance with transfers .</p> <p>Review of the Incident Report dated 11/5/2024 at 2:01 PM, completed by Registered Nurse (RN) OO for Resident #10 revealed, .Nursing Description: x-ray determined rt [right] hip fx [fracture] unknown origin. Resident Description: Resident Unable to give Description .no record of incident or fall .</p> <p>During an interview on 5/7/2023 at 6:09 PM, The Administrator stated, .Myself and the previous Interim DON came up with different scenarios on how the injury could have occurred for [Named Resident #10] and decided the fracture was from a transfer. Neither CNA (CNA EE and MM) were involved in the reenactment of the scenarios. I did not look at the cameras to see who went in [Named Resident #10]'s room, because we knew who was assigned to her that night .We still don't know exactly how [Named Resident #10]'s injury occurred .</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46532</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to conduct a thorough investigation and take appropriate corrective actions for 2 of 2 (Residents #9 and #10) sampled residents reviewed for injuries of unknown origin. The facility's failure to conduct a thorough investigation related to Resident #9's right displaced tibia (shin bone) fracture identified on 10/3/2023, and Resident #10's subtrochanteric right femur fracture (proximal femur fracture located within 5 centimeters of the lesser trochanter of the right femur) identified on 11/5/2023, resulted in an Immediate Jeopardy related to Resident #9 and #10. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.</p> <p>The Administrator and Director of Clinical Services were notified of the Immediate Jeopardy on 5/15/2024 at 7:27 PM in the Conference Room.</p> <p>The facility was cited at F-610 with a scope and severity of J, which is Substandard Quality of Care.</p> <p>The Immediate Jeopardy was effective 10/3/2023 and is on-going. A partial extended survey was conducted on 5/15/2024.</p> <p>The facility is required to submit a Plan of Correction.</p> <p>The findings include:</p> <p>(continued on next page)</p> |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of the facility's policy titled, Abuse & Neglect of Residents and Misappropriation of Residents' Property, dated 2/20/2013, revealed, .The facility will strive to identify, correct and intervene in situations in which abuse, neglect .In an effort to identify events, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation, possible sign include: Suspicious bruising .injuries of unknown origin-those that may be of suspicious appearance, be recurrent in nature, or that cannot be attributed to a resident's known behavior patterns .Any alleged violations involving mistreatment, neglect, abuse, or misappropriation including injuries of unknown source, must be reported immediately to the Administrator .Any staff receiving such allegation must immediately make the Administrator aware, if he/she was not the person initially reported to. The Administrator will be responsible for assuring that all such alleged violations are thoroughly investigated, while preventing further potential abuse, neglect or misappropriation during the investigative process .Interviewing the resident victim .Interviewing the alleged perpetrator .Interviewing all persons with firsthand knowledge of alleged incident. Physical examination of resident victim for evidence of abuse or neglect .Photographing evidence where appropriate. Obtaining written statements from victim, witnesses, other persons with reported knowledge as appropriate. Videotaping or, at a minimum audio recording interviews with resident victim where possible, appropriate and with permission of resident. Collecting, reviewing, and retaining pertinent facility documentation which may have a bearing on a full and proper investigation (e.g [for example].. schedules, work assignments, policies and procedures). Steps will be taken to prevent further harm to the resident while the investigation is in progress: Any employees/volunteer/contractor alleged to be involved in suspected abuse, neglect or misappropriation will be removed from direct care until completion of the investigation .The results of any investigation will be reviewed by the Administrator within 24hrs [hours] of the incident or date of discovery, and reported to the Department of Health within prescribed timeframes .If the alleged violation is verified, appropriate corrective action will be taken .Analyze the occurrences to determine what changes are needed, if any to policies and procedures to prevent further occurrences. Analysis of further staff training and/or monitoring needs related to residents' rights, resident care needs of the confused or behaviorally disturbed resident .Complete, detailed documentation will be made of alleged violations, investigations, and outcome, and maintained on file. The record will be available at all times when requested by the Department of Health .</p> <p>Review of the facility's policy titled, Accident Policy, dated 5/30/2018, revealed, .Accident refers to any unexpected or unintentional incident, which may result in injury or illness to a Resident .Avoidable accident means that an accident occurred because a facility failed to identify environmental hazards, identify a Resident's individual risk for accidents, evaluate and analyze the hazards/risk, implement interventions and monitor the effectiveness of the interventions implemented .The Interdisciplinary Team (IDT) will review the plan of care with each accident to evaluate the efficacy of interventions that have been implemented. [Named Facility] have mechanisms in place to alert the Administrator and Director of Nurses of incidents and accidents. The Licensed Nurse on duty is responsible for notifying the Physician and Responsible Party when an accident occurs .Licensed nurses on duty are responsible for completing the incident report and initial investigation. Licensed Nurses on duty are also responsible for placing an immediate intervention for the current accident. The Interdisciplinary Team (IDT) is responsible for reviewing and tracking/trending of accidents. The IDT will also evaluate the efficacy and appropriateness of interventions that are implemented. The evaluation will take place post accidents and periodically thereafter. The IDT is responsible for intervention revisions to the comprehensive plan of care .</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of medical record revealed Resident #9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Muscle Weakness, Recurrent, and Aphasia. Continued review revealed a Fracture of Shaft of Right Tibia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #9 revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderately impaired cognition. Continued review of the MDS revealed Resident #9 required extensive assistance of 1 person assist for locomotion on and off the unit. Further review revealed vision impaired, Upper extremity (shoulder, elbow, wrist, hand) impaired on one side, Lower extremity (hip, knee, ankle, foot) impaired one side, and required a wheelchair for mobility.</p> <p>Review of the undated Comprehensive Care Plan for Resident #9 revealed, .8/16/2013 The ability to transfer to and from a bed to chair (or wheelchair). My usual functional ability is dependent. Provide assistance as needed. I transfer via [by way of] [named mechanical lift] .10/3/2023 left w/c [wheelchair] padded .9/26/23 [2023] wheel cover to right w/c [wheelchair] wheel .Encourage resident to keep space from walls and doorways .Encourage resident to use caution when self-propelling through doorways .</p> <p>Review of the Incident Report dated 10/3/2023 at 10:35 AM, completed by Previous Interim Director of Nursing (IDON) revealed, .Nursing Description: Called to Resident's [Resident #10's] room by wound care nurse related [to] R [Right] lower leg and bruising noted to L [Left] upper arm. R [Right] lower leg noted to be swollen at knee cap and warm to touch, discolored, and slight bruising with various stages of healing noted along the lower part of skin, NP [Nurse Practitioner] aware .STAT [immediately] X-ray ordered as well as doppler [a noninvasive test that can be used to measure the blood flow through your blood vessels]. The bruising noted to L [left] upper arm is 4 inch linear pattern that resembles a blood pressure cuff .Resident [Resident #9] is mainly non-verbal but answers questions with yes or no and Hey. Resident [Resident #9] denied falling. Resident [Resident #9] stated No No [No No] when asked if anyone hurt his leg. When assessing L [left] upper arm I asked resident [Resident #9] if this is where they take your blood pressure and resident [Resident #9] responded with Hey, Hey [Hey, Hey] which traditionally indicates agreement . Description: X-ray confirmed mild displaced fx [fracture] tibia; Resident [Resident #9] sent to ER [emergency room] and returned same day with knee immobilizer .</p> <p>During an interview on 5/1/2024 at 8:20 AM, the Director of Clinical Services stated, .[Named Resident #9] propels with the right leg in wheelchair and sometimes gets caught in doorways. I was unable to find the investigation related to the injury of unknown origin .</p> <p>During an interview on 5/1/2024 at 4:26 PM, Nurse Practitioner X stated, .I was told [Named Resident #9] hit his leg on his wheelchair .I questioned that injury .</p> <p>During an interview on 5/2/2024 at 9:27 AM, the Administrator confirmed that the investigation could not be located related to Resident #9's injury of unknown origin.</p> <p>The facility was unable to provide documentation that a complete and thorough investigation was completed for Resident #9's injury of unknown.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>During an interview on 5/14/2024 at 2:35 PM, Registered Nurse (RN) NNN stated, .I was treating a small wound on [Named Resident #9] buttock. I took the blankets off [Named Resident #9] and noticed the right leg below the knee was swollen, red, and was warm to touch. I notified the charge nurse. The charge nurse said nothing had been reported to her. [Named Resident #9]'s leg was not like that the day before when she [RN NNN] was providing wound care. The injury was to [Named Resident #9]'s nondominant side. [Named Resident #9] could not move his right leg or arm at all. [Named Resident #9]'s right leg was always elevated when he was in his wheelchair, and he would push with his left side. [Named Resident #9] would not have been able to use his right side to maneuver in his wheelchair. I don't think the fracture could have come from him turning in his wheelchair. I was never interviewed by anyone at the facility, and I don't believe an investigation was conducted regarding how [Named Resident #9] obtained his fracture .</p> <p>Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, and Dementia.</p> <p>Review of the Quarterly MDS dated [DATE] for Resident #10 revealed a BIMS score of 6 which indicated severely impaired cognition. Further review revealed, .chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) .indicated dependent-helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity .</p> <p>Review of the Comprehensive Care Plan dated 10/27/2023 for Resident #10 revealed, .ADL [Activities of Daily Living] and Self-Care: Transfer: I require limited to total assistance with transfers .</p> <p>Review of the Daily Staffing Sheets revealed Certified Nursing Assistant (CNA) EE was assigned to Resident #10 on 11/4/2023 and 11/5/2023 on the 7:00 AM-7:00 PM shifts. Continued review revealed CNA MM was assigned to Resident #10 on 11/4/2023 on the 7:00 PM-7:00 AM shift.</p> <p>Review of the Incident Report dated 11/5/2024 at 2:01 PM, completed by Registered Nurse (RN) OO for Resident #10 revealed, .Nursing Description: x-ray determined rt [right] hip fx [fracture] unknown origin. Resident Description: Resident Unable to give Description .no record of incident or fall .</p> <p>During an interview on 5/7/2023 at 6:09 PM, the Administrator stated, .Myself and the previous Interim DON came up with different scenarios on how the injury could have occurred for [Named Resident #10] and decided the fracture was from a transfer. Neither CNA (CNA EE and MM) were involved in the reenactment of the scenarios. I did not look at the cameras to see who went in [Named Resident #10]'s room, because we knew who was assigned to her that night. I did not do any trainings regarding resident transfers after my investigation. We still don't know exactly how [Named Resident #10]'s injury occurred . Surveyor asked the Administrator was a statement taken from CNA MM since he provided care to Resident #10 on 11/4/2023 on the 7:00 PM-7:00 AM shift. The Administrator then confirmed that there was not a statement from CNA MM in the investigation file.</p> <p>The facility was unable to provide documentation that a complete and thorough investigation was conducted for Resident #10's injury of unknown origin. The facility could not provide the written statement that CNA MM provided, staff trainings were not conducted regarding properly transferring residents, and neither CNA EE or MM were involved in demonstrating how they (CNA EE and MM) transferred Resident #10 during their shifts.</p> | | |

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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>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** 46532</p> <p>Based on facility policy review, medical record review, facility investigation review, and interview the facility failed to revise the comprehensive care plan to add interventions for abuse for 3 of 7 (Resident #3, #4, and #21) sampled residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Clinical Comprehensive Care Plans Policy, dated 3/1/2016, revealed, . [Named Facility] will utilize information gathered from the Minimum Data Set, family, and Resident interviews/assessments to develop, review and revise the Resident's Comprehensive Pan of Care. The Comprehensive Plan of Care will be individualized and include measurable objectives and timelines to meet the Resident's medical, nursing, mental, and psychological needs .The Care Planning/Interdisciplinary Team, in coordination with the Resident, his/her family or representative, develops and maintains a comprehensive plan of care for each Resident that identifies the Resident's unique problems/weakness, strengths, preferences, goals and interventions for Resident's to attain the highest level of functioning .The Comprehensive Plan of Care will be reviewed and revised if warranted at least quarterly. The Comprehensive Plan of Care will be updated/revise as warranted by condition changes .</p> <p>Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses which included Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbances, Alzheimer's Disease with Late Onset, and Essential (Primary) Hypertension.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 revealed, a Brief Interview of Mental Status (BIMS) score of 13 which indicated no cognitive impairment. Continued review revealed no concerns for behaviors noted.</p> <p>Review of the Comprehensive Care Plan for Resident #3 dated 6/29/2023 revealed no interventions for resident-to resident abuse involving Residents #3 and #21.</p> <p>Review of the Facility Reported Investigation (FRI) dated 8/3/2023, revealed .At approximately 1945 the facility had a resident to resident incident occur .[Resident #21] hit her roommate [Resident #3] .[Resident #21] ambulated to the end of roommates bed and picked up a pool noodle and hit [Resident #3] on the right arm with a foam pool noodle .residents were immediately separated .[Resident #21] was placed on 1:1 OBS (observation), RP (representative), MD (Medical Director) notified .Murfreesboro PD (Police Department) notified, APS (Adult Protective Services) notified .[Resident #21] kept on 1:1 .[Resident #3] had follow-up visits by Social Services and this Administrator .[Resident #21] seen by Psych Services with no mental stress noted .[Resident #21] was transported the following afternoon .where she is still a patient .</p> <p>Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease with Late Onset, Restlessness and Agitation, and Dementia in Other Diseases Classified Elsewhere.</p> <p>(continued on next page)</p> | | |

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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 Quarterly MDS assessment dated [DATE] for Resident #21 revealed, a BIMS score was unable to be performed related to cognitive impairment. Continued review revealed no behaviors noted prior to this incident.</p> <p>Review of the Comprehensive Care Plan revealed no revision regarding resident-to-resident abuse involving Residents #3 and #21.</p> <p>During an interview on 5/15/2024 at 9:15 AM, the MDS Coordinator stated, .Resident #21 care plan should have been updated. All care plans should be updated after any incident that involved a resident .</p> <p>Review of medical record revealed Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Major Depressive Disorder, Post Traumatic Stress Disorder, and Macular Degeneration.</p> <p>Review of the Quarterly MDS dated [DATE] for Resident #4 revealed a BIMS score of 14 which indicates no cognitive impairment. Further review revealed bed mobility to be limited assistance with one-person physical assist, transfer was supervision with one-person physical assist, eating was supervision with setup help only, and indwelling catheter.</p> <p>Review of the FRI revealed Resident #4 reported that on 9/12/2023 three CNAs came into his room at lunch time and was rough when moving his foley catheter (a medical device that helps drain urine from your bladder) from one side of bed to the other. Resident #4 also reported that the CNAs swung his legs to a sitting position and told him that it was time to eat when he did not want to eat. All alleged staff members involved were suspended immediately and removed from the facility. All three CNAs were placed on Do Not Return.</p> <p>Review of the Comprehensive Care Plan for Resident #4 revealed no revision to add interventions for the incident regarding allegations of employee-to-resident abuse involving Resident #4 and three Certified Nursing Assistants (CNA).</p> <p>During an interview on 5/2/2024 at 9:01 AM, The Social Service Director (SSD) stated, .The MDS Coordinator is responsible for updating incidents on the care plan. I know the employee to resident incident is not on the care plan for [Named Resident #4]. The MDS Coordinator should have added the incident to [Named Resident #4]'s care plan the next day [10/4/2023] during the morning meeting .</p> <p>During an interview on 5/7/2024 at 9:27 AM, The Administrator stated, .The MDS Coordinator is responsible for updating abuse on care plans. Care Plans are updated during our morning meetings. The MDS Coordinator should have added the incident to [Named Resident #4]'s care plan .</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724</p> <p>Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure 2 (Resident #1 and Resident #14) of 5 sampled residents received their showers and baths as scheduled.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Resident Rights, dated 10/2022 revealed, .[Named Facility] must treat you with respect and dignity and care for you in a manner and in an environment that promotes maintenance or enhancement of your quality of life, recognizing each resident's individuality .[Named Facility] must protect and promote your rights .must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source .</p> <p>Review of the facility policy titled, CLINICAL POLICIES Activities of Daily Living Policy dated 1/7/2013 revealed, .Residents who are unable to perform bathing, dressing, or grooming will have these tasks completed for them by facility staff at least daily and as needed. Bathing may be in the form of a shower, whirlpool bath or bed bath .</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnosis which included Atherosclerotic Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus, and rash and other nonspecific skin eruption.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Continued review of the MDS revealed no behaviors over the last seven days. Further review of the MDS revealed Resident #1 required extensive assistance . personal hygiene, and total dependence for bathing.</p> <p>Review of the daily assignment sheets revealed Resident #1 was scheduled to receive a shower on Monday, Wednesday, and Friday.</p> <p>Review of the bathing task documentation revealed Resident #1 received a shower 5 times from 8/1/2023 to 8/30/2023. Continued review of the bathing task documentation revealed Resident #1 received 1 bed bath from 8/1/2023 to 8/31/2023. Resident #1 was scheduled to receive a shower 13 times over the month of 8/2023.</p> <p>Resident #1 did not receive a shower or bed bath for 5 days from 8/6/2023 to 8/10/2023 and 7 days from 8/22/2023 to 8/28/2023.</p> <p>Review of the bathing task documentation revealed Resident #1 received a shower 6 times from 9/1/2023 to 9/30/2023. Continued review of the bathing task documentation revealed Resident #1 received 11 bed baths from 9/1/2023 to 9/30/2023. Resident #1 was scheduled to receive a shower 13 times from 9/1/2023 to 9/30/2023.</p> <p>Resident #1 did not receive a shower or bed bath for 5 days from 9/9/2023 to 9/13/2023 and 5 days from 9/21/2023 to 9/25/2023.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the bathing task documentation revealed Resident #1 received a shower 3 times from 10/1/2023 to 10/31/2023. Continued review of the bathing task documentation revealed Resident #1 received 3 bed baths from 10/1/2023 to 10/31/2023. Resident #1 was scheduled to receive a shower 13 times from 10/1/2023 to 10/31/2023.</p> <p>Resident #1 did not receive a shower or bed bath for 11 days from 10/1/2023 to 10/11/2023 and 6 days from 10/21/2023 to 10/26/2023.</p> <p>Review of the bathing task documentation revealed Resident #1 received a shower 4 times from 11/1/2023 to 11/30/2023. Continued review of the bathing task documentation revealed Resident #1 received 1 bed bath from 11/1/2023 to 11/30/2023. Resident #1 was scheduled to receive a shower 13 times from 11/1/2023 to 11/30/2023.</p> <p>Resident #1 did not receive a shower or bed bath for 8 days from 11/1/2023 to 11/8/2023 and 7 days from 11/24/2023 to 11/30/2023.</p> <p>Review of the bathing task documentation revealed Resident #1 received a shower 8 times from 12/1/2023 to 12/31/2023. Continued review of the bathing task documentation revealed Resident #1 received 2 bed baths from 12/1/2023 to 12/31/2023. Resident #1 was scheduled to receive a shower 13 times from 12/1/2023 to 12/31/2023.</p> <p>Resident #1 did not receive a shower or bed bath for 9 days from 12/2/2023 to 12/10/2023.</p> <p>Review of the bathing task documentation revealed Resident #1 received a shower 8 times from 1/1/2024 to 1/31/2024. Continued review of the bathing task documentation revealed Resident #1 received 1 bed bath from 1/1/2024 to 1/31/2024. Resident #1 was scheduled to receive a shower 14 times from 1/1/2024 to 1/31/2024.</p> <p>Resident #1 did not receive a shower or bed bath for 7 days from 1/1/2024 to 1/7/2024 and 5 days from 1/13/2024 to 1/17/2024.</p> <p>Review of the bathing task documentation revealed Resident #1 received a shower 2 times from 2/1/2024 to 2/29/2024. Continued review of the bathing task documentation revealed Resident #1 received 3 bed baths from 2/1/2024 to 2/29/2024. Resident #1 was scheduled to receive a shower 12 times from 2/1/2024 to 2/29/2024.</p> <p>Resident #1 did not receive a shower or bed bath for 9 days from 2/3/2024 to 2/11/2024 and 9 days from 2/21/2024 to 2/29/2024.</p> <p>Review of the bathing task documentation revealed Resident #1 received a shower 7 times from 3/1/2024 to 3/31/2024. Continued review of the bathing task documentation revealed Resident #1 received 7 bed baths from 3/1/2024 to 3/31/2024. Resident #1 was scheduled to receive a shower 13 times over the month of 3/2024.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the care plan dated 4/9/2024 revealed, .Focus ADL [Activities of Daily Living] AND SELF-CARE: I have an ADL Self Care Performance Deficit .Interventions/Tasks .EATING .My usual functional ability is set-up/clean-up assistance. Provide assistance as needed .SHOWER/BATHE SELF .My usual functional ability is dependent. Provide assistance as needed .SKIN POTENTIAL: I am at risk for the development of pressure ulcers and other skin integrity impairments related to my .diabetes .have sensitive skin and episodes of rashes .Check me approximately every 2 hours and as needed for toileting needs .Keep bed linen clean, dry, and free of wrinkles .</p> <p>Review of the bathing task documentation revealed Resident #1 received a shower 8 times from 4/1/2024 to 4/30/2024. Continued review of the bathing task documentation revealed Resident #1 received 2 bed baths from 4/1/2024 to 4/30/2024. Resident #1 was scheduled to receive a shower 13 times over the month of 4/2024.</p> <p>Resident #1 did not receive a shower or bed bath for 4 days from 4/26/2024 to 4/29/2024.</p> <p>Review of the Annual MDS dated [DATE] revealed Resident #1 had a BIMS score of 15 which indicated no cognitive impairment. Review of the MDS revealed Resident #1 required assistance with toileting hygiene, substantial assistance required with personal hygiene, and shower/bathe self not attempted.</p> <p>During observation and interview on 4/30/2024 at 9:40 AM, Resident #1 was sitting up in his wheelchair with headphones on watching his television. Resident #1 was unshaven and stated, .I can't raise my arms up to shave, the staff have to help me with shaving .I have trouble getting my showers .the last one I got was a week ago on Monday .I am suppose to get one 3 times a week .If you complain about it they either think you are lying or your senile .I use to take showers two times a day .I would like to get my showers three times a week .</p> <p>During an interview on 4/30/2024 at 4:20 PM Family Member (FM) DDDD stated, .he had a fungus to his bottom .he doesn't get his showers and linens changed .I have complained many times to the Administrator . I can only come on Sundays and I do send him a text weekly nothing really gets any better .he is living large if he gets his bath or shower once per week .they just provide sloppy care .my dad can't lift his hands up to shave himself .</p> <p>During an interview on 5/1/2024 at 10:35 AM, Resident #1 stated, .no shower today it is my shower day .I was lucky to get help to get up this morning .the nurse had to help me off the toilet this morning .oh they helped me put on clean clothes but no shower .my last bath was 4/22/2024. Resident #1 recalled the name of the Certified Nursing Assistant [CNA] who provided his shower on 4/22/2024.</p> <p>Review of the staffing assignments and bathing task verified this was the last time he received a shower.</p> <p>During an interview on 5/2/2024 at 9:10 AM, Social Service Director (SSD) stated, .We changed [Named Resident #1] to a day shift for his shower I did follow up with him for a little while .</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 5/2/2024 at 9:20 AM, the Administrator stated, .[Resident #1]'s shower was moved from evening shift to day shift .I talked to the nurse on the end of his hall and the techs .I have not seen him visibly get a shower. I think his shower is on Monday, Wednesday, and Friday .I get a weekly text from his daughter every Sunday about concerns .I have got text about his showers .she said something about the doctor looking at him due to some skin issues .I have never seen his daughter .I am not sure if he will refuse his baths .</p> <p>During an interview on 5/1/2024 at 4:16 PM, Nurse Practitioner (NP) X stated, .He would at times express to me that he didn't get his showers .</p> <p>During an interview on 5/1/2024 at 8:10 PM, Registered Nurse (RN) FFFF stated, .I normally work nights .the CNAs receive their assignment, and the showers are on the assignment sheets .I have never known of [Named Resident #1] refusing care .we have times when staff just don ' t show up .we have several agency staff .staff turn over has been really high .</p> <p>During an interview on 5/2/2024 at 3:35 PM, the Director of Clinical Services stated, .we probably going to confirm the shower concerns related to [Named Resident #1]. I know we had a discussion about his showers, but I can't find anything documented .</p> <p>During an interview on 5/6/2024 at 9:58 AM, the Director of Nursing (DON) stated, .I was aware that showering was an issue .we have so much agency staff that effects our continuity of care .</p> <p>During an interview on 5/6/2024 at 10:07 AM, CNA C stated, [Named Resident #1] does not refuse care. His showers were on nights and now he is on day shift. He has to have help with shaving. He cannot lift his hand up that high .</p> <p>During an interview on 5/7/024 a 10:49 AM, the DON stated, .a resident should get a shower anytime they request one .showers are usually 3 x week unless the resident prefers something different .</p> <p>During an interview on 5/9/2024 at 9:50 AM, the Quality Assurance (QA) nurse stated, .we did recognize during some a QAPI [Quality Assurance Performance Improvement] meetings that bathing documentation was not being completed .</p> <p>During a telephone interview on 5/13/2024 at 12:19 PM, FM DDDD stated, .I was there last Sunday .call lights going off .no one to be found .I went to nurses' desk, no one there .[Named Resident #1] said the last shower he got lasted about 30 seconds .he barely got wet .I hear another resident receives special treatment .they make sure he gets a bath or staff will be fired .why is there a lack of care for my Dad .I hear this guy has a private room, treated like a King .if staff don't do everything he wants they will get fired .</p> <p>Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction due to Unspecified Occlusion or Stenosis or Right Middle Cerebral Artery, Type 2 Diabetes Mellitus without complications, Vascular Dementia, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant side, Dysphagia, and readmitted on [DATE] with diagnoses which included Type 2 Diabetes Mellitus with Foot Ulcer, and Peripheral Vascular Disease.</p> <p>(continued on next page)</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the daily assignment sheets revealed Resident #14 was scheduled to receive a shower on Tuesday, Thursday, and Sunday.</p> <p>Review of the bathing task documentation revealed Resident #14 received a shower 3 times from 2/1/2024 to 2/29/2024. Continued review of the bathing task documentation revealed Resident #14 received 9 bed baths from 2/1/2024 to 2/31/2024. Resident #14 was scheduled to receive a shower 13 times over the month of 2/2024.</p> <p>Resident #1 did not receive a shower or bed bath for 4 days from 2/15/2024 to 2/18/2024 and 5 days from 2/1/2024 to 2/5/2024.</p> <p>Review of the bathing task documentation revealed Resident #14 received no showers from 3/1/2024 through 3/31/2024. Continued review of the bathing task documentation revealed Resident #14 received 11 bed baths from 3/1/2024 to 3/31/2024. Resident #14 was scheduled to receive a shower 13 times over the month of 3/2024.</p> <p>Resident #14 did not receive a shower or bed bath for 6 days from 3/12/2024 to 3/17/2024.</p> <p>Review of the bathing task documentation revealed Resident #14 received no showers from 4/1/2024 to 4/20/2024 when he was discharged to the hospital. Continued review of the bathing task documentation revealed Resident #14 received 11 bed baths from 4/1/2024 to 4/20/2024. Resident #14 was scheduled to receive a shower 8 times from 4/1/2024 to 4/20/2024.</p> <p>Resident #14 did not receive a shower or bed bath for 5 days from 4/5/2024 to 4/9/2024.</p> <p>Review of the Annual MDS assessment dated [DATE] for Resident #14 revealed a BIMS score of 12 which indicated moderately impaired cognition. Continued review of the MDS revealed Resident #14 was dependent for shower/bathe and personal hygiene and Resident #14 was frequently incontinent of urine and bowel. Further review of the MDS revealed Resident #14 had an infection of the foot and a Diabetic foot ulcer.</p> <p>Resident #14 readmitted on [DATE] and received another bed bath on 4/30/2024.</p> <p>Review of the bathing task documentation revealed Resident #14 received no showers from 5/1/2024 to 5/8/2024. Continued review of the bathing task documentation revealed Resident #14 received 6 bed baths from 5/1/2024 to 5/8/2024. Resident #14 was scheduled to receive a shower 3 times from 5/1/2024 to 5/8/2024.</p> <p>Observation and interview on 5/2/2024 at 3:30 PM, Resident #14 was unable to give me any details related to his bathing care. Resident #14's hair was disheveled, nails were dirty, and he was unshaven.</p> <p>During an interview on 5/13/2024 at 12:38 PM, FM CCCC stated, .I come over the weekends .[Resident #14] is not always shaven .different staff all the time .I don't get to come often .</p> |

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| <p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46532</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to implement an effective pain management regimen for 1 of 6 (Resident #10) sampled residents reviewed for pain management. Resident #10, who was cognitively impaired and vulnerable, remained in the facility and experienced moderate to severe pain without effective pain management for approximately 15 hours before being transferred to the hospital. Resident #10 sustained a subtrochanteric right femur fracture (proximal femur fractures located within 5 centimeters of the lesser trochanter of the right femur). The facility's failure to provide effective pain management resulted in an Immediate Jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.</p> <p>The Administrator and Director of Clinical Services were notified of the Immediate Jeopardy on 5/15/2024 at 2:00 PM in the Conference Room.</p> <p>The facility was cited at F-697 with a scope and severity of J, which is Substandard Quality of Care.</p> <p>The Immediate Jeopardy was effective 11/4/2023 and is on-going. A partial extended survey was conducted on 5/15/2024.</p> <p>The facility is required to submit a Plan of Correction.</p> <p>The findings include:</p> <p>(continued on next page)</p> |

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| <p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of the facility's policy titled, Pain Management Policy, dated 1/7/2013, revealed, .Policy Interpretation and Implementation: Pain is an individual's unpleasant sensory or emotional experience. It is considered a highly subjective personal experience. Pain is exactly whatever the person experiencing it says it is. Pain exists whenever the person experiencing the pain says it does .The comprehensive pain assessment will include the following: Description/type of pain .Location of pain, Frequency of pain, Intensity/Severity of pain using an acceptable standardized pain for cognitive status on a scale from 1 to 10, When pain is at its best or worst, Current pain level at time of assessment, Nonverbal signs of pain (grimacing/distorted facial expression .frowning/scowling, tightly shut lips .wrinkled brow, turned down mouth, tearing, moaning, grunting .crying, screaming .rubbing body parts .fidgeting .irritability), Aggravating factors/factors that increase pain, Alleviating factors (medication, relaxation, position changes, heat, cold, massage, meditation, other), Time of day when pain is worse .Effects of pain changes in daily activities or habits .Current treatment and pain medications, Response to treatment/recent changes in treatment, Individual preference regarding pain .Facility staff that assess and screen for pain shall use one of the 10 point scales taking into consideration the resident's preference, verbal ability, fixed beliefs about pain, cognitive status and ability to describe pain. The licensed nurse is accountable for the assessment, but other caretakers/team members can assist in ongoing assessment of pain and report finding to the assigned nurse . [Named facility] medical staff have defined the following: Mild pain as a rating of 1 to 3, Moderate pain from 4-6, Severe pain as 7 to 10. Licensed nursing staff will assess the resident on an ongoing basis each shift to obtain a baseline pain numerical score rating. If the resident is on scheduled pain medication this screen shall be completed 1 to 2 hours following the administration of scheduled dose along with an arousal assessment to determine the level of sedation the resident may be experiencing. A pain assessment can be completed anytime the nurse determines is needed and documented in the progress notes .If the presence of pain is identified and the resident has numerical score of 3 or greater the medical staff will be contacted and orders for treatment obtained. The effectiveness of routine scheduled pain medication regime will be evaluated as effective by the absence of breakthrough pain and the need for PRN [as needed] pain medications .PRN medication is used by the medical staff as one intervention in a comprehensive plan to treat intermittent or breakthrough pain . Licensed nursing staff will assess the resident for the presence of pain symptoms and evaluate the need for PRN medications using the appropriate pain scale .the nurse will document on the [Named facility] PRN Pain Medication Assessment the date, time, reason of administration of the pain medication, and the pre-medication pain score using the pain scale appropriate for cognitive status .The licensed nurse will re-assess the resident for response 30 minutes to one hour post PRN medication administration to determine effectiveness. The nurse will document on the [Named facility] PRN Pain Medication Assessment a numerical post medication administration pain score and the arousal scale. The arousal scale that shall be utilized by the licensed nurse is as follows: 1=wide awake, 2=drowsy, 3=dozing intermittently, 4=only awakens when aroused, 5=asleep .If the PRN medication is not effective in relieving the pain as described above the licensed nursing staff shall contact the medical staff for further instructions and document into the progress note .</p> <p>Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing, and Dementia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #10 revealed a Brief Interview of Mental Status (BIMS) score of 6, which indicated severely impaired cognition. Further review revealed Resident #10 experienced frequent, mild pain during the lookback period.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of the Comprehensive Care Plan dated 10/27/2023 for Resident #10 revealed, .Pain and Discomfort: I am at risk for episodes of pain/discomfort related to my impaired mobility/weakness and the aging process . I will not have any s/s [signs/symptoms] pain/discomfort go undetected or untreated through the next review date .Administer medication for pain as ordered. Observe for effectiveness .Notify MD [Medical Director] of any new/acute episode of pain as needed. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Nurse to assess for and document pain as per facility protocol. Observe for/document for side effects of pain medication. Observe for/record/report to Nurse any s/sx [signs and symptoms] of non-verbal pain including but not limited to Vocalizations (grunting, moans, yelling out, silence); Mood/behavior changes (more irritable, restless, aggressive, squirmy, constant motion; Eyes (wide open/narrow, slit/shut, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Observe for record/report to Nurse resident complaints of pain or requests for pain treatment .</p> <p>Review of the Medication Administration Record (MAR) revealed on 11/4/2023 at 10:18 PM, Resident #10 had a pain level of 8 out of 10 (severe pain) and was given Tylenol (an analgesic used to treat minor aches and pain) 325 milligrams (mg). Continued review revealed on 11/5/2023 at 5:19 AM, Resident #10 had a pain level of 7 out of 10 (severe pain) and was given Tylenol 325 mg.</p> <p>There was no documentation of an evaluation for possible cause of severe pain and no documentation for follow up related to effectiveness/pain relief obtained by Resident #10.</p> <p>Review of the Named X-ray Company Patient Report dated 11/5/2023 for Resident #10 revealed Mobile Images conducted an X-ray at 12:40 PM. Further review revealed, .Findings: Two views of the right hip demonstrate an acute, oblique [a muscle neither parallel nor perpendicular to the long axis of a limb], displaced, angulated [an angular position, formation or shape] subtrochanteric fracture .</p> <p>Review of Named Hospital AAAA medical record dated 11/5/2023, revealed Resident #10 received Morphine (opiate used to treat moderate to severe pain) 2mg (milligrams)/1 mL (milliliter) and required surgical repair of a right femur fracture.</p> <p>Review of Progress Note dated 11/5/2023 at 4:03 AM revealed, .[Resident #10] c/o pain to R [right] thigh during HS [night] med [medication] pass. [Resident #10] kept stating You think I am crazy, so do I, I do not know what is causing this! I feel as if I can't even talk! .gave PRN Tylenol .</p> <p>There was no documentation to show Resident #10's pain was re-assessed following the administration of Tylenol and no documentation of assessment to evaluate the cause of pain on 11/5/2023 at 4:03 AM.</p> <p>Review of Progress Note dated 11/5/2023 at 6:11 AM revealed, .Nurse checked on [Resident #10] who was still having a large amount of pain to R [right] thigh. Upon inspection nurse noted a large, firm area that was warm to touch .Nurse notified [Named RN HH] and on call NP who ordered a doppler to RLE [Right Lower Extremities]. Tylenol was not effective .</p> <p>No other pain management interventions were initiated.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of the Progress Note dated 11/5/2023 at 8:00 AM revealed, .The nurse assessed resident @ [at] 0735 [7:35 AM] [Resident #10] had c/o pain from R leg, leg swollen and warm to touch, upon movement resident cries out in pain. Nurse supervisor called into room to assess resident, Md [medical doctor] called and instructed to order stat Xray .</p> <p>Resident #10 continued to have severe pain with no other pain interventions initiated.</p> <p>Review of the Progress Note dated 11/5/2023 at 1:39 PM revealed, .late entry. 07:30 [7:30 AM] I was called to bedside by resident's nurse. [Resident #10] was complaining of rt [right] leg pain. It was noted in shift change report that a doppler had been ordered to rule out a clot [blood clot]. There was some swelling noted of the upper leg. Resident [Resident #10] stated her knee hurt. She also cried out when we tried to examine her hip. NP was notified and a stat [immediately] hip Xray ordered. No bruising was noted but our exam was brief due to her pain .</p> <p>No additional pain medication/intervention was initiated, and Resident #10 remained in the facility experiencing moderate to severe pain without effective pain management for approximately 15 hours before being transferred to the hospital.</p> <p>Review of the EMS (Emergency Medical Service) Report dated 11/5/2023 revealed, call received at 1:08 PM, dispatched at 1:09 PM, on scene at 1:19 PM, at patient at 1:22 PM, and left facility at 1:32 PM.</p> <p>Review of RN HH's statement dated 11/5/2023 revealed, .At 0600 [6:00 AM] on 11/5/2023 [Named Licensed Practical Nurse (LPN) FF] came and told me to come look at [Named Resident #10]'s hip stated that [Named Resident #10] was in much more pain in the morning than the night before. We went and looked at her hip. We noticed it was swollen, and she screamed if we touched it. I told [Named LPN FF] to call the NP to get an order for a hip Xray and/or doppler. [Named LPN FF] called NP immediately and got an order for a doppler .</p> <p>During a telephone interview on 5/1/2024 at 4:16 PM, the NP stated, .I thought [Named Resident #10] had a fall .She had advanced dementia and was unable to report whether she had a fall .broke her leg .a staff member thought she was having pain .</p> <p>During an interview on 5/6/2024 at 9:58 AM, RN YYY stated, .I expect the nursing staff to notify the NP to assess and get an order for pain medication if a resident is complaining of pain. If pain increases and continues, I expect the nursing staff to reach out to the NP again to see if resident can be sent to the hospital . RN YYY was asked by Surveyor if she would allow a resident to stay in the facility for approximately 15 hours complaining of severe, increased pain. RN YYY stated, .I would not expect a resident to remain in the facility that long if the resident is complaining of increased pain. I would expect my staff to call the NP to have the resident sent to the hospital .</p> <p>During an interview on 5/6/2024 at 12:55 PM, the Previous Interim Director of Nursing (IDON) stated, . Resident #10 complained of pain that night on 11/4/2023. Then a second time later on in the morning on 11/5/2023 . The Previous IDON was asked by Surveyor if she would allow a resident to stay in the facility for approximately 15 hours complaining of severe, increased pain. The Previous IDON stated, .I can't speak for staff, but I would have sent [Named Resident #10] out sooner. [Named Resident #10]'s pain seemed to have been chronic, and I would have notified the NP or MD to have resident sent to the ER. I was unaware that (Named Resident #10) had been in pain that long .</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>During an interview on 5/6/2024 at 1:15 PM, LPN FF stated, .I had shown up for my shift on 11/4/2024 for 7 [7:00] PM to 7 [7:00] AM. I walked into [Named Resident #10]'s room to give her roommate her medication. A male Certified Nursing Assistant [CNA] .[CNA MM] was in the room, and he told me that [Named Resident #10] was complaining of pain. I did look at [Named Resident #10]'s hip and nothing appeared wrong, but I didn't do a full assessment like range of motion [ROM] or anything. [Named Resident #10] said her leg was stiff and that she was having some pain. I gave [Named Resident #10] the 1st dose of Tylenol 325 mg around 10 [10:00 PM] something that night. We were short staffed that night, and I had to finish giving medication, so I didn't get back around to check on [Named Resident #10] until about 4 [4:00] AM when I gave her the 2nd dose of Tylenol 325 mg because she was still in pain. [Named Resident #10] would grimace when being changed. I didn't like the way her hip was looking when I checked on her that time. There were no falls reported from the previous shift. The previous shift could have possibly thought it was a blood clot. The CNA [CNA MM] didn't report any signs of previous pain until I was overheard speaking with the charge nurse. RN HH spoke with the NP and suggested a doppler or X-ray be ordered. The NP ordered a doppler to start to check for a blood clot. The swelling had increased in the hip area. I felt more could have been done and an x-ray should have been done sooner .</p> <p>LPN FF did not reassess Resident #10 ' s pain level until approximately 6 hours after the Tylenol was administered.</p> <p>During an interview on 5/6/2024 at 3:01 PM, LPN GG stated, .I worked the 7AM-7 PM [7:00 AM-7:00 PM] shift on 11/5/2023. I heard Resident #10 scream and went to the room to see what was going on. That was around about 7:30ish AM. A CNA [CNA EE] was providing care to [Named Resident #10]. I assessed [Named Resident #10]'s leg and could tell something was displaced. The right leg appeared to be shorter than the left leg. I went to get my supervisor, and she agreed that something wasn't right with that right leg. [Named Resident #10] complained of pain when being moved. The previous nurse said it was a possible blood clot, and the area was red and warm to touch. No note was left regarding the care for [Named Resident #10]. I called the NP and got orders for the X-ray. I called the X-ray order in no later than 9 AM. The X-ray was completed that afternoon which determined a hip fracture, and [Named Resident #10] was sent out to the ER .</p> <p>During an interview on 5/6/2024 at 3:38 PM, CNA KK stated, .I worked the next day on 11/5/2023, and [Named Resident #10] complained of pain when CNA EE was attempting to provide care. You could hear [Named Resident #10] cry out .</p> <p>During an interview on 5/6/2024 at 6:53 PM, CNA LL stated, .The next day [11/5/2023] staff reported that [Named Resident #10] had been complaining of pain .</p> <p>During an interview on 5/7/2023 at 9:38 AM via email, Named X-ray Company Dispatch Associate stated, . [Named LPN GG] called the order for the Rt [right] Hip Xray into us on 11/05/2023 at 11:42 AM EST [Eastern Standard Time] [10:42 AM Central Standard Time (CST)]. This exam was ordered as STAT [immediately]. Our tech arrived at 12:30 PM EST [11:30 AM CST] for the exam .</p> <p>The Xray for Resident #10 was ordered approximately 2 hours after the NP was notified and gave the order.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>During an interview on 5/7/2023 at 9:48 AM, CNA NN stated, .I did not have [Named Resident #10] that night on 11/4/2023. I worked the 7 PM-7 AM [7:00 PM- 7:00 AM] shift. A guy [CNA MM] had her that night .The CNA [CNA MM] went into [named Resident 10]'s room to change her that night, and [Named Resident #10] would not allow him to touch her because she was in pain .</p> <p>During an interview on 5/8/2023 at 9:50 AM, Family Member (FM) ZZZ stated, .The House Supervisor called and said [Named Resident #10] was being sent out to the ER .I could tell [Named Resident #10] had hip rotation .you could tell that [Named Resident #10]'s hip was broken. The hip was very tender to touch. The hospital had to give [Named Resident #10] Morphine due to the amount of pain she was in .</p> | | |

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| <p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>46831</p> <p>Based on the Board of Examiners of Nursing Home Administrators (BENHA) review, job description review, policy review, and interview, Administration failed to provide oversight of staff to ensure an adequate and thorough investigation was conducted to determine a root cause for Residents #9 and Resident #10's major injuries of unknown origin. Administration also failed to provide oversight and supervision of staff to prevent resident neglect when they failed to ensure physician's orders for wound care were followed for Residents #7, #9, #12, #13, and #14. Administration failed to provide oversight and supervision to ensure nursing staff provided effective pain management when Resident #10 sustained a major injury and experienced unresolved severe pain. Administration failed to provide oversight and supervision to conduct effective Quality Assurance Performance Improvement (QAPI) meetings to develop and implement corrective action plans for identified quality deficiencies. Administration's failure to provide oversight and supervision resulted in Immediate Jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.</p> <p>The Administrator and the Director of Clinical Services was notified of the Immediate Jeopardy (IJ) for F-835 on 5/15/2024 at 7:27 PM, in the Conference room.</p> <p>The facility was cited Immediate Jeopardy at F-600 (which is substandard quality of care), F-835 and F-867 at a scope and severity of L.</p> <p>The facility was cited Immediate Jeopardy at F-610, and F-697, at a scope and severity of J, which is substandard quality of care.</p> <p>The Immediate Jeopardy was effective on 10/3/2023 and is ongoing. A partial extended survey was conducted on 5/15/2024.</p> <p>The facility is required to submit a plan of correction (POC).</p> <p>The findings include:</p> <p>Review of the BENHA form revealed the facility had the same Administrator for the last 24 months. The current Administrator was hired on 4/19/2022.</p> <p>Review of the facility's signed JOB DESCRIPTION AND PERFORMANCE STANDARDS for the position titled, Administrator, dated 4/19/2022, revealed, .The purpose of this position is to establish and maintain systems that are effective and efficient to operate the facility in a manner to safely meet residents' needs in compliance with federal, state, and local requirements .The primary functions and responsibilities of this position are as follows .1) Operate the facility in accordance with the established policies and procedures of the governing body in compliance with federal, state, and local regulations .35) Assume responsibility for identification, investigation, and follow up on concerns identified in the facility Quality Indicator report .36) Assume responsibility for implementation of an affective Quality Assurance program .</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445270 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/15/2024 |
| NAME OF PROVIDER OR SUPPLIER Tennessee Veterans Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 345 Compton Road Murfreesboro, TN 37130 | |
| 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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Review of the facility's unsigned JOB DESCRIPTION AND PERFORMANCE STANDARDS for the position titled, Director of Nursing Service/Vice President of Nursing Service, revealed, .The purpose of this position is to provide nursing management, set resident care standards for all direct care providers and provide compete supervision and management for the nursing department .The primary functions and responsibilities of this position are as follows .8) Analyze Quality Indicator reports, identify concerns and implement corrective action to improve resident care .9) Assume responsibility for analysis of incident and accident investigation reports to determine cause(s) and implement corrective action(s), when appropriate .20) Assume responsibility for nursing service compliance with federal, state and local regulations .35) Assume responsibility for identification, investigation, and follow up on concerns identified in the facility Quality Indicator report .36) Assume responsibility for implementation of an affective Quality Assurance program .</p> <p>During an interview on 5/2/2024 at 9:27 AM, the Administrator confirmed that the investigation could not be located related to Resident #9's injury of unknown origin.</p> <p>During an interview on 5/6/2024 at 10:05 AM, the Director of Nursing (DON) confirmed there was missed documentation on the Treatment Administration Record (TAR) and identified there was a concern the wound care treatments were not being done on the weekends. Continued interview revealed the DON confirmed she had not been in the facility herself on the weekends. Further interview revealed, the DON asked the Administrator for a weekend treatment nurse but was not allowed to have one.</p> <p>During an interview on 5/7/2023 at 6:09 PM, the Administrator stated, .Myself and the previous Interim DON came up with different scenarios on how the injury could have occurred for [Named Resident #10] and decided the fracture was from a transfer. Neither CNA [Certified Nursing Assistant-CNA EE and MM] were involved in the reenactment of the scenarios. I did not look at the cameras to see who went into [Named Resident #10]'s room, because we knew who was assigned to her that night. I did not do any training regarding resident transfers after my investigation. We still don't know exactly how [Named Resident #10]'s injury occurred . This surveyor asked the Administrator was a statement taken from CNA MM since he provided care to Resident #10 on 11/4/2023 on the 7:00 PM-7:00 AM shift. The Administrator then confirmed that there was not a statement from CNA MM in the investigation file.</p> <p>During an interview on 5/15/2024 at 6:45 PM, the Administrator was asked what he had done to ensure the Performance Improvement Plan (PIP) related to wound care was successfully completed. The Administrator replied, .Well, we have room rounds .we discuss weight loss .I was involved in the Quality Assurance[QA] discussions . The Administrator was asked how he monitored to ensure the wound care was completed. The Administrator stated, .The QA nurse made some wound rounds, and we addressed complaints .nothing else outside of looking at wound reports and morning meetings .</p> <p>Administration failed to provide oversight and supervision of staff to ensure physician's orders for wound care were followed for Residents #7, #9, #12, #13, and #14.</p> <p>Refer to F-600</p> <p>Administration failed to provide oversight of staff to ensure an adequate and thorough investigation was conducted to determine a root cause for Residents #9 and Resident #10's major injuries of unknown origin.</p> <p>Refer to F610</p> <p>(continued on next page)</p> | | |

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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 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Administration failed to provide oversight and supervision to ensure nursing staff provided effective pain management when Resident #10 sustained a major injury and experienced unresolved severe pain.</p> <p>Refer to F697</p> <p>Administration failed to provide oversight and supervision to conduct an effective Quality Assurance Performance Improvement (QAPI) meeting to develop and implement corrective action plans for identified quality deficiencies.</p> <p>Refer to F867</p> |

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| <p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>46831</p> <p>Based on facility policy review, job description, Quality Assurance Performance Improvement (QAPI) Plan review, QAPI Meeting Minutes review, and interview, the QAPI committee failed to ensure an effective QAPI program that identified quality deficiencies and implement performance improvement activities to address quality concerns related to resident neglect, thorough investigations for adverse events which included major injuries of unknown origin and providing effective pain management. The QAPI committee failed to provide oversight that established and implemented policies and procedures to assure the facility was administered in a manner to use its resources effectively and efficiently. The census on entrance was 114.</p> <p>The facility's failure resulted in an Immediate Jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.</p> <p>The Administrator and the Director of Clinical Services was notified of the IJ on 5/15/2024 at 7:27 PM in the Conference room.</p> <p>The facility was cited Immediate Jeopardy at F-600, F-835, and F-867, at a scope and severity of L.</p> <p>The facility was cited Immediate Jeopardy at F-610, and F-697, at a scope and severity of J.</p> <p>The facility was cited Immediate Jeopardy at F-600 at a scope and severity of L, and F-610 and F-697 at a scope and severity of J, which is substandard quality of care.</p> <p>The Immediate Jeopardy was effective on 10/3/2024 and is ongoing. A partial extended survey was conducted on 5/15/2024.</p> <p>The facility is required to submit a Plan of Correction (POC).</p> <p>The findings include:</p> <p>Review of the facility policy titled, Operations Policies, Quality Assurance Performance Improvement, revised 11/2020 revealed, .The QAPI program is an avenue for employees, residents, and families to resolve issues and provide input regarding the quality of care and operational efficiency. By maintaining and improving quality the QAPI program has a direct impact on the resident's quality of life .It is the organization's responsibility to identify and correct problems which require: Analyze the data collected to identify performance indicators signaling a deviation from expected performance .Study the issue to determine the underlying causes and factors .Develop and implement corrective actions .Monitor data related to the issue to determine if they are sustaining corrections and make revisions as needed .Performance Improvement Project (PIPs) .will be documented and tracked continuously while the project is active .</p> <p>(continued on next page)</p> | | |

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| <p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Review of the facility's signed JOB DESCRIPTION AND PERFORMANCE STANDARDS for the position titled, Administrator, dated 4/19/2022, revealed, .The purpose of this position is to establish and maintain systems that are effective and efficient to operate the facility in a manner to safely meet residents' needs in compliance with federal, state, and local requirements .The primary functions and responsibilities of this position are as follows .1) Operate the facility in accordance with the established policies and procedures of the governing body in compliance with federal, state, and local regulations .35) Assume responsibility for identification, investigation, and follow up on concerns identified in the facility Quality Indicator report .36) Assume responsibility for implementation of an affective Quality Assurance program .</p> <p>Review of the facility's unsigned JOB DESCRIPTION AND PERFORMANCE STANDARDS for the position titled, Director of Nursing Service/Vice President of Nursing Service, revealed, .The purpose of this position is to provide nursing management, set resident care standards for all direct care providers and provide compete supervision and management for the nursing department .The primary functions and responsibilities of this position are a follows .8) Analyze Quality Indicator reports, identify concerns and implement corrective action to improve resident care .9) Assume responsibility for analysis of incident and accident investigation reports to determine cause(s) and implement corrective action(s), when appropriate .20) Assume responsibility for nursing service compliance with federal, state and local regulations .35) Assume responsibility for identification, investigation, and follow up on concerns identified in the facility Quality Indicator report .36) Assume responsibility for implementation of an affective Quality Assurance program .</p> <p>Review of the QAPI Plan dated 11/27/2023, revealed the facility identified problems with pressure ulcers/injuries that included Certified Nurse Technicians/Nurses not identifying and reporting new skin issues to wound care and inconsistent treatment plan/orders for wounds. A Performance Improvement Plan (PIP) was implemented to evaluate the current wound care nurse, conduct weekly wound meetings to monitor progress, review treatment plans/orders, monitor wound sizes and treatments, provide Unit Managers with current interventions in place, and provide floor staff with common treatment options for basic wounds.</p> <p>Review of the QAPI Meeting Minutes from 11/2023 through 4/2024, revealed an increase in wound infections over the last 5 months after the PIP was put into place on 11/27/2023.</p> <p>During an interview on 5/9/2024 at 9:50 AM, the Quality Assurance/Infection Nurse (QA) nurse stated, .we opened a PIP on 11/27/2023 due to the number of wounds the facility had was trending up .the root cause was inconsistent treatments .sometimes it was the way the orders were put in .the wounds were not improving .not proper treatments performed by the prior wound care nurse .she is no longer here .the TAR [Treatment Administration Record] is the main place where wound documentation would be .I do talk to residents if they bring something to me .the prior wound nurse was not receptive to any feedback .</p> <p>During an interview on 5/15/2024 at 6:45 PM, the Administrator was asked what he had done to ensure the PIP related to wound care was completed and successful. The Administrator stated, .Well, we have room rounds .we discuss weight loss .I was involved in the QA discussions . The Administrator was asked how he monitored that the wound care was completed. The Administrator stated, .the QA nurse made some wound rounds, and we addressed complaints .nothing else outside of looking at wound reports and morning meetings .</p> <p>(continued on next page)</p> | | |

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| <p>F 0867</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>The QAPI committee failed to maintain oversight and implement policies and procedures to prevent resident neglect for 5 residents who required wound care per physician orders.</p> <p>Refer to F600</p> <p>The QAPI committee failed to provide oversight that established and implemented policies and procedures to ensure adverse events which include major injuries of unknown origin are investigated thoroughly.</p> <p>Refer to F610</p> <p>The QAPI committee failed to maintain oversight and implement policies and procedures to ensure an effective pain management program to prevent prolonged pain was established in the facility.</p> <p>Refer to F697</p> <p>The QAPI committee failed to provide oversight that established and implemented policies and procedures to assure the facility was administered in a manner to use its resources effectively and efficiently.</p> <p>Refer to F835</p> | | |