STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445272	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mabry Health Care	1340 N Grundy Quarles Hwy Po Box 7 Gainesboro, TN 38562

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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy reviews, medical record reviews, observations, and interview, the facility failed to implement the comprehensive care plan's fall interventions for 2 residents (Residents #1 and #66) of 4 residents reviewed for accidents. The findings include: Review of the facility's policy titled, Guidelines For Incidents/Accidents/Falls, dated 6/2023, revealed .The resident has a care plan put into place with interventions . Based on the results of the incident/accident/fall, the residents care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place . Each fall needs a new care plan intervention .Review of the facility's policy titled, Baseline Care Plan Assessment/Comprehensive Care Plans, dated 3/2021, revealed . The comprehensive care plan will further expand on the resident's risks, goals and interventions using the person-centered plan of care approach for each resident . in an effort to achieve the highest level of functioning and the greatest degree of comfort, safety .for the resident .Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Dementia, Diabetes Mellitus, and Hypertension. Review of the Significant Change in Status (SCSA) Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of the comprehensive care plan for Resident #1 revealed .at risk for falls . with an intervention dated 2/17/2026, .gripper strips [non-skid strips] to both sides of the bed .Review of the medical record revealed Resident #66 was admitted to the facility on [DATE], with diagnoses including Diabetes Mellitus, Schizophrenia, Dementia, and Hypertension.Review of a quarterly MDS assessment dated [DATE], revealed Resident #66 scored a 5 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the comprehensive care plan for Resident #66 revealed .at risk for falls . with an intervention dated 2/5/2026, .anti-roll back to wheelchair . and an intervention dated 2/8/2026, .non-skid strips to floor next to bed .During observations on 5/4/2026 at 11:00 AM and 5/5/2026 at 2:55 PM, revealed Resident #1 did not have non-skid strips on either side of the bed as stated on the care plan.During observations on 5/4/2026 at 11:05 AM and 5/5/2026 at 2:45 PM, revealed Resident #66 did not have non-skid strips next to the bed as stated on the care plan.During an observation on 5/6/2026 at 5:00 PM, revealed Resident #66 was in a wheelchair that did not have an anti-roll back device as stated on the care plan.During an observation and interview on 5/6/2026 at 5:25 PM, the Administrator confirmed there were no non-skid strips next to the beds for Resident #1 or Resident #66, the wheelchair Resident #66 was sitting in did not have an anti-roll back device, and confirmed these items were listed on both resident's comprehensive care plan.

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

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