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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review, observations, and interviews, the facility failed to maintain kitchen equipment in good repair to store food under sanitary conditions and at proper temperatures to prevent foodborne illnesses, which had the potential to affect 71 of 73 residents. The findings include: Review of the facility's undated policy titled, Sanitation and Food Safety: Food Storage, revealed .Food storage areas are maintained within optimal temperature ranges .Freezers -10-0 F [Fahrenheit] .Food stock and prepared food products are stored at safe temperature ranges at all times . Review of the facility's undated policy titled, Sanitation and Food Safety: Equipment Failure and Repair, revealed .Dining services equipment shall be maintained in a good state of repair . During the initial tour of the dietary department on 5/4/2026 at 10:06 AM, the walk-in freezer was observed to have an external and internal temperature reading of 9 degrees Fahrenheit. Further observation revealed accumulation of ice throughout the unit, including on the floor, shelving, interior door surfaces, fan housing, and exterior of food packaging for two bags of queso cheese. Continued observation revealed ice buildup on the freezer floor prevented the freezer door from closing completely, which left a visible gap along the seal. The freezer door was observed to be in disrepair, with a broken gasket seal, visible condensation, and warping of the door structure, which prevented proper closure. Review of a Project Proposal dated 3/25/2026, revealed [NAME] Company had provided an estimate for the repair of the freezer door totaling $6,926.00 with a lead time (time to prepare materials for installation) of 6 to 7 weeks. Review of a maintenance statement dated 5/4/2026, revealed the Maintenance Director received verbal confirmation from the [NAME] President of Operations to move forward on repairs to the freezer door on 5/4/2026, after the state of door was brought to the facility's attention by this surveyor. During an interview on 5/4/2026 at 10:09 AM, the Dietary Manager (DM) confirmed the freezer temperature was out of range, the freezer door did not close properly, ice was accumulated on the floor, shelving and food packaging, and the freezer door was in disrepair. The DM stated the freezer door had been in disrepair for approximately two months, and the ice accumulation interfered with proper closure. During an interview on 5/5/2026 at 10:29 AM, the DM stated manual removal of accumulated ice was required to improve door function on a temporary basis. During an interview on 5/6/2026 at 10:35 AM, the Maintenance Director stated the freezer door had been in disrepair since approximately February 2026 but had gotten worse recently. The Maintenance Director further stated a work order for repair of the freezer door had been placed in March 2026, and bids were collected for the repair. The Maintenance Director stated the bid was approved on 5/4/2026.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to maintain infection control practices when staff failed to implement and use Enhanced Barrier Precautions (EBP) for 1 resident (Resident #20) of 5 residents reviewed for EBP. The findings include:Review of the facility's policy titled, Enhanced Barrier Precautions, dated 8/2025, revealed .The facility should use Enhanced Barrier Precautions (EBP) .during high-contact resident care activities .EBP are indicated for residents with .wounds and/or indwelling medical devices .wounds generally include chronic wounds .examples of chronic wounds include .pressure ulcers, diabetic foot ulcers, unhealed surgical wounds .indwelling medical device examples include .urinary catheters .examples of high-contact resident care activities requiring gown and glove use include .dressing .bathing .changing briefs .Review of the medical record revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Rheumatoid Arthritis, and Chronic Kidney Disease. Further review revealed Resident #20 was readmitted to the facility on [DATE] after a hospitalization.Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #20 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.Review of the current Physician's Orders for Resident #20 dated 5/6/2026, revealed an order was present for an indwelling foley catheter. Further review revealed there was no Physician's Order for EBP.During an observation on 5/6/2026 at 9:49 AM, revealed a sign posted outside Resident #20's door which indicated EBP as follows: .Wear gloves and a gown for the following High-Contact Resident Care Activities .Dressing .Transferring .Changing briefs . and the sign was labeled for the resident in B bed (which was not Resident #20). Certified Nursing Assistant (CNA) A and CNA B were observed performing a transfer with a mechanical lift for Resident #20 in the resident's room, and a foley catheter drainage bag was visible. CNA A and CNA B wore gloves but did not don gowns.During an interview on 5/6/2026 at 9:51 AM, CNA A stated EBP is used for residents with a catheter, open wounds, tube feeding, and other things .EBP means we wear gloves and gown when giving care .[Resident #20] should be on EBP because he [Resident #20] has a catheter . CNA A confirmed she [CNA A] and CNA B wore gloves but did not don a gown when transferring Resident #20 to bed.During an interview on 5/6/2026 at 9:54 AM, CNA B stated .EBP means we wear gloves and a gown when it's called for .we are supposed to wear gowns if the resident has a tube, wound, catheter .we use EBP whenever we give them care where we're touching them .[Resident #20] has a catheter and should be on EBP . CNA B confirmed she [CNA B] and CNA A wore gloves but did not don a gown when transferring Resident #20 to bed.During an interview on 5/6/2026 at 10:30 AM, the Director of Nursing/Infection Preventionist (DON/IP) confirmed Resident #20 did not have an order for EBP and confirmed the resident should be under EBP due to having an indwelling urinary device (urinary catheter). The DON confirmed the CNAs were trained on EBP and the reasons EBP was needed and should have used EBP for Resident #20 as they were aware he (Resident #20) had an indwelling foley catheter.