STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445275	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Jefferson City	336 West Old Andrew Johnson Hwy Jefferson City, TN 37760

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** 50216 Based on facility policy review, record review, observation, and interview, the facility failed to create person-centered care plans for 2 residents (Resident #23 and #25) of 26 residents reviewed for care plans. The finding include: Review of the facility's policy titled Comprehensive Care Plans and Revisions, dated 8/22/2023, showed .the facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team .facility should monitor the resident over time to help identify changes in the resident condition that may warrant and update to the person-centered plan of care . Resident #23 was admitted to the facility on [DATE], with diagnoses including Heart Failure, Respiratory Failure, Alzheimer's Disease, and Obstructive Sleep Apnea. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #23 was cognitively intact. Review of Resident #23's care plan dated 2/2/2024, showed there was no intervention related to the resident's preference to wear the nasal cannula in her mouth. During an observation and interview on 3/24/2024 at 11:55 AM, Resident #23 was observed lying in her bed with the oxygen nasal cannula in her mouth. The tubing was attached to the oxygen concentrator. Resident #23 stated she liked having it in her mouth better than her nose. During observation and interview on 3/25/2024 at 2:55 PM, Resident #23 was observed sitting on the side of the bed with the nasal cannula in her mouth. The resident stated she liked it better that way. During an interview on 3/25/2024 at 3:00 PM, Licensed Practical Nurse (LPN) #1 stated Resident #23 wore the nasal cannula in her mouth. LPN #1 also stated the facility staff had educated Resident #23 on how to wear the nasal cannula, but the resident did not comply. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2024 at 1:49 PM, the Director of Nursing (DON) stated she did not know Resident #23 preferred to wear her nasal cannula in her mouth. The DON confirmed if it was the resident's preference it should have been on the care plan. Resident #25 admitted to the facility on [DATE] with diagnoses including Acute Respiratory Failure, Bipolar Disorder, Anxiety Disorder, and Muscle Weakness. Review of the medical record showed Resident #25 did not have a diagnosis of Dementia. Review of a quarterly MDS assessment dated [DATE], showed Resident #25 was cognitively intact. Review of Resident #25's care plan dated 2/22/2024, showed behavior problem .interventions: Match your body language to your words - frown and shake your head. People with dementia are better at reading non-verbal cues. Don't accidently encourage inappropriate behavior by sending mixed signals . During an interview on 3/26/2024 at 10:15 AM, the Licensed Social Worker (LSW) stated she was responsible for developing Resident #25's care plan. The LSW confirmed Resident #25 did not have a diagnosis of Dementia and the interventions on the behavior care plan were not person centered. During an interview on 3/26/2024 at 2:04 PM, the DON confirmed the care planned interventions were not person-centered for Resident #25 and the resident did not have a diagnosis of Dementia.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, medical record review, observation, and interviews, the facility failed to ensure tube feeding formula was appropriately labeled for 1 resident (Resident #43) of 1 resident sampled for tube feeding. The findings include: Review of the undated [fiber-fortified tube feeding formula] manufacturers' guidelines, showed .hang no longer than 24 hours . Resident #43 was admitted to the facility on [DATE] with diagnoses including Protein-Calorie Malnutrition, Gastrostomy (tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications), and Dysphasia (difficulty swallowing). Review of an admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #43 had moderate cognitive impairment, had a feeding tube, and received 51% or more calories through tube feeding. Review of a physician order dated 3/14/2024, showed .Enteral Feed .off at 5 am, on at 9 am [fiber-fortified tube feeding formula] at 60 ml/hr [milliliters/hour] .via pump . Review of Resident #43's care plan revised 3/18/2024, showed .resident requires tube feeding .dependent with tube feeding . Review of Resident #43's Medication Administration Record (MAR) dated 3/2024, showed Licensed Practical Nurse (LPN) #3 had signed the enteral tube feeding formula and had been initiated on 3/24/2024 (no defined time). During an observation on 3/24/2024 at 11:10 AM, showed the enteral tube feeding formula was infusing via pump and had not been labeled with the date or the time. During an interview on 3/24/2024 at 11:15 AM, Resident #43 stated the tube feeding had been initiated that morning (time unknown). During an interview on 3/24/2024 at 11:30 AM, LPN #3 stated the tube feeding formula for Resident #43 was initiated that morning (3/24/2024) and verified the tube feeding formula had not been appropriately labeled with the date or the time. LPN #3 did not know the specific time the tube feeding formula was initiated. During an interview on 3/26/2024 at 3:30 PM, Director of Nursing (DON) stated it was her expectation when an enteral tube feeding is initiated, the enteral formula bottle will be labeled with date and time. DON confirmed the LPN did not label the tube feeding formula with date and time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40606 Based on facility policy review, observation, and interview the facility failed to maintain sanitary kitchen equipment which had the potential to effect 97 residents in the facility. The findings include: Review of the facility policy titled, Sanitation and Maintenance revised 4/26/2023, showed .when cleaning fixed equipment .the non-removable parts .cleaned with detergent and hot water, rinsed and air dried . Procedures for cleaning equipment are readily available .All equipment is .cleaned and sanitized according to manufacturer's instructions .Fixed .equipment in the foodservice area will be .sanitary .Physical facilities are cleaned as often as necessary to keep them clean . During the initial kitchen observation on 3/24/2024 at 10:10 AM, with the Food Service Manager (FSM) showed the outside of the left dishwasher door was 1/3 covered with a dried light brown film from the bottom of door up to the handle. The burners of the gas stove were observed to have dried brown/black food debris present on all; the stove's drip pans had multiple blackened pieces of pasta and other food debris present. The stoves' griddle was observed to be in an unsanitary condition with layer of dried brown/black food debris noted on the right-side of the metal splashguard between the griddle and gas stove. The Left side of the metal splashguard was observed to have been covered with yellowish-brown, sticky substance which also had brown specks of food debris which resembled breading. The double convection oven was observed to have dried brown food debris splatter on the exterior surface of the door handles and atop of both doors of the bottom convection oven. Further observation showed the can opener blade had a dried, thick layer of an unknown brown substance; no shards of metal were present on the blade. The flour and powdered sugar bins were noted to have multiple specks of various colored food debris present on the tops of both bins, and the powdered sugar had a scoop present inside of the bin. Review of the facility's menu for the month of March 2024 showed on week 4-day 6 (Friday) of the menu plan, pasta had been served. Review of the weekly cleaning schedule dated 3/17/2024, showed the dish machine, stove top and grill, deep fryer, and oven/doors were initialed as completed. During an interview on 3/24/2024 at 11:12 AM, the FSM stated it was her expectation the kitchen equipment was cleaned daily and deep cleaned weekly. The FSM confirmed the kitchen equipment was in an unsanitary condition.

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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** 48100 Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure a nasal cannula was stored in a sanitary manner for 1 resident (Resident #78) of 10 residents observed for oxygen use and the facility failed to follow infection control practices for 1 resident (Resident #59) of 4 residents reviewed for medication administration. The findings include: Review of the facility's policy titled, Administration of Medications, dated 8/24/2023, showed .the facility will ensure medications are administered safely and appropriately . Review of the facility policy titled Oxygen Administration (Safety, Storage, Maintenance), dated 2/27/2024, showed .Store oxygen and respiratory supplies in a bag labeled with resident's name when not in use . Resident #78 was admitted to the facility on [DATE], with diagnoses including Aftercare for Joint Replacement and Chronic Obstructive Pulmonary Disease (COPD). Review of the medical record, showed Resident #78 did not have any recent respiratory infections. Resident #78's physician orders dated 3/14/2024, showed an order for continuous oxygen at 2 liters per minute per nasal cannula. During an observation on 3/25/2024 at 10:09 AM, showed an oxygen nasal cannula lying on the floor under Resident #78's bed. Resident #78 was not in the room at the time. The nasal cannula tubing was attached to an oxygen concentrator. There was a plastic storage bag on the oxygen concentrator labeled 3/21 (3/21/2024). During an observation on 3/25/2024 at 2:36 PM, Resident #78 was seated in a wheelchair with a nasal cannula in her nose. The nasal cannula tubing was attached to the oxygen concentrator behind the resident. A plastic storage bag was attached to the oxygen concentrator. A portable oxygen tank on a cart with a tubing curled up and attached was also in the room. During an interview on 3/25/2024 at 2:40 PM, Licensed Practical Nurse (LPN) #1 stated if an oxygen nasal cannula was on the floor, it was not supposed to be used again. The nasal cannula would need to be replaced. LPN #1 stated she had not changed the nasal cannula for Resident #78 that day. LPN #1 also stated if a nasal cannula was removed from the resident it was to be rolled up and placed in a plastic storage bag attached to the oxygen concentrator or portable tank. During an interview on 3/25/2024 at 2:43 PM, the Physical Therapist Assistant (PTA) stated when she transported Resident #78 to her room, she observed the nasal cannula attached to the oxygen concentrator lying on the bed. The PTA stated she removed the nasal cannula attached to the portable oxygen tank and replaced it with the nasal cannula lying on the bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2024 at 1:49 PM, the Director of Nursing (DON) confirmed the nasal cannula should have been replaced after it was observed on the floor and not placed back on the resident. Resident #59 was admitted to the facility on [DATE] with diagnoses including Atrial Fibrillation, Major Depressive Disorder, and Chronic Pain Syndrome. Review of the physician recapitulation orders dated 3/2024, showed Resident #59 had ordered Citalopram (anti-depressant) 20mg (milligrams) once a day, Buspirone (anti-anxiety) 10mg three times a day, Apixaban (anti-coagulant) 5mg two times a day, and Hydrocodone-Acetaminophen (pain reliever) 5/325mg every six hours. During a medication administration observation and interview on 3/25/2024 at 8:31 AM, showed LPN #1 had pushed 3 medication (Citalopram, Buspirone, Apixaban) tablets through the blister packets onto her bare hands, placed the tablets into the medication cup. LPN #1 had obtained Hydrocodone (pain reliever) from the narcotic box, pushed one tablet through the blister packet and the pill fell on to the surface of the medication cart. LPN #1 picked up the medication (Hydrocodone) with her bare hands and placed the medication into the medication cup. Further observation showed LPN #1 administered prepared medications to Resident #59. LPN #1 stated she knew she was not supposed to administer medications that way [using her bare hands] but it was easier to use her bare hands to place the medications into the cup. LPN #1 confirmed infection control practices had not been followed during the medication administration for Resident #59.