STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445277	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Starr Regional Health & Rehabilitation	886 Hwy 411 North Etowah, TN 37331

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 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, observations, and interviews, the facility failed to maintain infection control by storing oral hygiene equipment in an unsanitary manner for 2 residents (Residents #52 and #31), failed to use proper Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP) for 1 resident (Resident #51), and failed to administer medications in a sanitary manner for 1 resident (Resident #6) of 54 residents reviewed in the facility.The findings include:Review of the facility's policy titled, Medication Administration ., dated 1/2018, revealed .Medications are administered as prescribed in accordance with good nursing principles and practices .Review of the facility's policy titled, Enhanced Barrier Precautions (EBP), dated 12/2022, revealed .Enhanced Barrier Precautions .infection control interventions designed to reduce transmission of resistant organisms .use of gown and gloves during high-contact resident care activities .high contact resident activities .wound care .gloves and gowns will be used by all staff .performing the high-contact care .Review of the facility's policy titled, Oral Hygiene, dated 10/2023, revealed .objective .to lessen occurrence of mouth infections .brush teeth .dry resident's face .remove all equipment, clean and replace in bedside unit .Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Chronic Pain, and Osteoarthritis.Review of a comprehensive care plan dated 11/11/2025, revealed Resident #52 had interventions including .oral care: usual performance is substantial/maximum assist as needed .Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #52 scored a 2 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment, and was dependent on staff assistance for oral hygiene.Review of the medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including Dementia, Heart Failure, and Crohn's Disease.Review of a comprehensive care plan dated 11/5/2025, revealed Resident #31 had broken teeth and interventions including .assist resident with mouthcare daily and PRN [as needed] .Review of an admission MDS assessment dated [DATE], revealed Resident #31 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact, and was independent with oral hygiene.During observations on 1/12/2026 at 11:40 AM, 1/13/2026 at 10:39 AM, and 1/14/2026 at 9:30 AM, the shared room of Residents #31 and #52 contained a metal shelf above the sink. Continued observation revealed 2 toothbrushes lay on the shelf together and were touching, were not labeled with resident identifiers, and were uncovered.During an observation and interview on 1/14/2026 at 11:10 AM, the Administrator confirmed the shared room of Residents #31 and #52 contained 2 resident toothbrushes laying on the shelf above the sink together and were touching, were not labeled with resident identifiers, and were uncovered. The Administrator stated the toothbrushes should be labeled and in toothbrush containers.Review of the medical record revealed Resident #51 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Chronic Pain, and Osteoarthritis.Review of a quarterly MDS assessment dated [DATE], revealed Resident #51 had short and long-term memory loss, and had severe impairment for cognitive skills for daily decision making.Review of the current Physician's Orders for Resident #51 revealed an order dated 1/12/2026, .Enhanced Barrier (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Precautions for Chronic Wounds .During an observation of wound care on 1/13/2026 at 9:03 AM, revealed Licensed Practical Nurse (LPN) A performed wound care for Resident #51 in the resident's room. Continued observation revealed LPN A failed to don a gown prior or during the wound care as indicated for a resident in EBP.During an interview on 1/14/2026 at 11:26 AM, the Director of Nursing (DON) confirmed LPN A failed to follow infection control practices for EBP by not wearing a gown during direct contact wound care for Resident #51.Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Lung Disease, and Legal Blindness.Review of a quarterly MDS assessment dated [DATE], revealed Resident #6 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact.During an observation on 1/13/2026 at 8:21 AM, revealed Registered Nurse (RN) A prepared medications for Resident #6. During the preparation, a medicine tablet (escitalopram) (an antidepressant medication) fell from the package into an open drawer of the medication cart. Continued observation revealed RN A picked up the tablet and placed it into the medicine cup with the other prepared medications. Further observation during the medication administration with RN A, revealed a medicine tablet (potassium chloride) (potassium medication supplement) fell from the package onto the top of the medication cart. RN A picked up the tablet and placed it into the medicine cup with the other prepared medications. RN A continued placing medications into the medicine cup, then administered the medications to Resident #6, including the 2 tablets that had dropped.During an interview on 1/13/2026 at 8:45 AM, RN A confirmed the 2 medicine tablets that fell into the medication cart drawer and onto the top of the medication cart should have been discarded and not administered to Resident #6.During an interview on 1/14/2026 at 11:26 AM, the DON confirmed RN A did not follow infection control practices for the medication administration.