STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445280	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Post-Acute and Rehabilitation Center	3051 Buffalo Road Lawrenceburg, TN 38464

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 - Some	Provide and implement an infection prevention and control program. Based on policy review, Infection Control Nurse job description review, facility Infection Control Program document review, Instructions for Humalog sheets review, medical record review, observation, and interview, the facility failed to establish and implement a program to identify, report, investigate, and control infections and communicable diseases when the Infection Preventionist (IP)/Assistant Director of Nursing (ADON) failed to track organisms being treated in the facility, monitor for outbreaks and cross contamination, and when 1 of 3 staff (Licensed Practical Nurse (LPN) B) failed to properly clean an insulin pen during medication administration. This had the potential to affect 88 of 88 residents in the facility. The findings include: 1. Review of the facility policy titled, ?Infection Prevention and Control Program, dated 6/20/2025, revealed .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.The designated Infection Preventionist is responsible for the oversight of the program and serves as a consultant to our staff on infectious diseases.surveillance, and epidemiological investigations of exposures of infectious diseases.Surveillance: A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff. Review of the undated facility policy titled, Infection Surveillance, revealed .purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections.Data to be collected, including how often and the type of data to be documented, including: The infection site, pathogen.The facility will communicate to staff and/or prescribing practitioners information related to infection rates and outcomes in order to revise interventions/approaches and/or re-evaluate medical intervention as indicated .All resident and infections will be tracked. Review of the undated facility policy titled, Insulin Pen, revealed It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing.Procedure.Gather supplies needed . Perform hand hygiene .Don gloves .Remove the pen cap from the insulin pen.Wipe the rubber seal with an alcohol pad.Screw the pen needle onto the insulin pen. Review of the INSTRUCTIONS FOR USE HUMALOG.KwikPen.insulin lispro. revealed .Pull the Pen Cap straight off .Wipe the rubber seal with an alcohol swab .Check the liquid in the Pen .Select a new Needle.Prime before each injection . 2. Review of the Infection Control Nurse job description dated 4/1/2025, revealed .The primary purpose of your job position is to plan, organize, develop, coordinate, and direct our infection control program and its activities in accordance with federal state and local standards guidelines, and regulations that govern such programs, as may be directed by the Administrator.Maintain computerized infection control tracking and trending logs.for all facility infections. 3. Review of the facility's infection tracking report dated 12/2025, revealed a total of 29 resident infections and only 4 of the 29 infections were tracked by organism. Review of the facility's infection tracking report dated 1/2026, revealed a total of 29 resident infections and only 5 of the 29 infections were tracked by organism. Review of the facility's infection tracking report dated 2/2026, revealed a total of 23 resident infections and only 1 of the 23 infections was tracked by organism. During an interview on 2/24/2026 at 3:31 PM, the Infection Control Nurse (ICN) was asked should you (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	track resident infections by organism. The ICN stated, Yes. The ICN was asked where do you track resident infections. The ICN stated, On a spreadsheet but it's not consistent, there are blanks on those reports. The ICN was asked should all resident infections be tracked by organism for accurate monitoring and tracking and trending. The ICN stated, Yes, the organism should be on there. 4. Observation and interview during medication administration, at the [NAME] medication cart, on 2/24/2026 at 11:11 AM, revealed LPN B removed an insulin pen and supplies from the drawer of the medication cart, performed hand hygiene, donned gloves, removed the cap from the insulin pen, and twisted a needle onto the pen. LPN B failed to clean the rubber seal of the insulin pen with an alcohol pad before twisting on the needle. LPN B entered Resident #80's room and administered the ordered dose of insulin. LPN B removed the needle from the insulin pen and placed it in the sharp's container, removed gloves, performed hand hygiene, and returned to the medication cart. LPN B placed the cap back on the insulin pen and placed the insulin pen back in the drawer of the medication cart. LPN B failed to clean the insulin's rubber seal with an alcohol pad before putting the cap back on. LPN B was asked what should be done before capping the insulin pen with the needle and before placing the top back on the insulin pen after use. LPN B stated, I do not know .I will find out. LPN B walked away from the [NAME] medication cart and returned. LPN B stated, .before recapping, need to clean with alcohol, and I failed to clean with the alcohol pad before placing the cap on . During an interview on 2/25/2026 at 11:31 AM, the Director of Nursing (DON) was asked during use of the insulin pen when should staff clean or disinfect the rubber seal. The DON stated, Prior to placing the needle on the insulin pen and after each use.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to provide dental services for 1 of 3 (Resident #17) sampled residents reviewed for dental services. The findings include: 1. Review of the facility undated policy titled, Dental Services, revealed .It is the policy of this facility to assist residents in obtaining routine .and emergency dental care .'Routine dental services' means an annual inspection of the oral cavity for signs of disease .smoothing of broken teeth .'Emergency dental services' includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist .The Social Services Director maintains contact information for providers of dental services that are available to the facility residents .The facility will if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from dental services location. 2. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE], with diagnoses including Diabetes, Depression, and Hypertension. Review of the quarterly Minimum Data Set, dated [DATE], revealed Resident #17 scored a 15 on the Brief Interview for Mental Status assessment (BIMS), which indicated she was cognitively intact. The resident had no broken teeth and no mouth or facial pain, discomfort, or difficulty chewing. Review of the medical record revealed Resident #17 received services from (named) dental provider #2 on 5/20/2025 and 6/26/2025 and needed 2 teeth to be extracted. Review of the (Named) dental provider #2 progress note dated 7/10/2025, revealed .Pt [Patient] had extractions today. Monitor Pt. x [times] 24 [hours].Surgical Extraction.Quantity 2. The facility was unable to provide any documentation of dental services after 7/10/2025. During an interview on 2/23/2026 at 10:40 AM, Resident #17 was asked if she received dental care at the facility. Resident #17 confirmed she had teeth extracted by a dental provider but had what she described as half a tooth left and the provider has not returned to extract the other half of the tooth. Resident #17 was asked did the facility say why the dentist did not come back. Resident #17 stated No one here has told me. The tooth has a sharp point that needs to come out.it rubs my tongue. During a cell phone interview on 2/24/2026 at 2:26 PM, Resident #17's daughter was asked to tell this surveyor about the resident's dental concerns. Resident #17's daughter stated, . My mother has not seen the dentist since July 2025. I called the social worker to see why my mother has not seen the dentist and [Resident #17] needs a tooth extracted [pulled]. The last dentist [named dental provider #2] said that they needed to return to pull another tooth. When I called the facility, I spoke with social service at the facility .The social service worker never called me back. Resident #17's daughter was asked if she was given a reason why the dentist had not returned for the tooth extraction. Resident #17's daughter stated, The social worker has not gotten back to me, but my mother's tooth needs to be pulled . Resident #17's daughter stated the problem with her [Resident #17] tooth made it difficult for her mother to eat. During an interview on 2/25/2026 at 8:40 AM, the Social Service Director (SSD) confirmed that there is a dental service that comes onsite to give dental care to residents. The SSD was asked who is responsible for making sure the residents are seen by a dentist. The SSD stated, That is me . The SSD was asked how do you ensure every resident is seen by a dentist. The SSD stated, By the staff, or the residents let me know if an issue, then I reach out to dental or the NP [Nurse Practitioner]. The SSD confirmed residents should be seen twice a year by dental services. The SSD was asked if she had spoken with Resident #17's daughter. The SSD stated, Yes, she [Resident #17's daughter] mentioned to me that Resident #17 had a piece of tooth in her gum and wanted to be seen by the dentist.this conversation was the end of January 2026 [the SSD was not able to give a day in January 2026] . The SSD was asked if she notified [named dental provider #2] of the daughter's request. The SSD stated, No. The SSD was asked what should have been done when you were notified in January that Resident #17 had a piece of tooth that needed to be removed and had (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested to see the dentist. The SSD stated, I should have either worked on getting Resident #17 out to a local dentist or see if [named dental provider #2] would do an emergency visit. The SSD was asked when did [named dental provider #2]'s contract end. The SSD stated, When a contract was signed with [named dental provider #1] in February. I reached out to [named dental provider #1] yesterday [2/24/2026] . The SSD was asked when was the first time you reached out to [named dental provider #1] to see when they were coming. The SSD stated, .when you asked me [2/24/2026] about her [Resident #17's] dental visits. The facility failed to ensure Resident #17 received promptly needed dental assistance when neither (named) dental services #2, nor (named) dental services #1, were notified of Resident #17's dental problem and request she be seen and no attempt was made to seek outside services if neither dental provider was available. During an interview on 2/25/2026 at 11:26 AM, the Director of Nursing (DON) was asked if a resident needed a tooth extracted and the facility was notified by the family that the resident needed a tooth extracted what did she expect staff to do. The DON stated, Notify the NP to see if anything she [the NP] needed to address and notify dental [a dental provider] to see if they [a dental provider] could come in the facility .I would start at Social Services notifying dental to see if they could come in and see the resident. The DON was asked how soon dental should be notified by Social Services. The DON stated, I would think when notified by the family.I would expect staff to reach out to dentist the day of or the day after the notification.