

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Erwin Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Stalling Lane Erwin, TN 37650	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51371</p> <p>Based on medical record review, observations, and interviews the facility failed to ensure 1 resident (Resident #322) of 9 residents were treated with dignity during the lunch meal service when residents at the same table were not served the meal at the same time.</p> <p>The findings include:</p> <p>Review of the medical record revealed Resident #322 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Dementia, and Psychotic Disorder.</p> <p>Review of the comprehensive care plan for Resident #322 dated 2/28/2025, revealed .Self-Care Deficit . Feeding .Provide assistance with ADLs [activities of daily living] .</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #322 scored a 4 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment. Further review revealed the resident was dependent upon staff assistance with eating.</p> <p>Review of the medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including Dementia, Cognitive Communication Deficit, and Need for Assistance with Personal Care.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #53 scored a 1 on the BIMS assessment which indicated severe cognitive impairment. Further review revealed the resident required substantial/ maximal assistance from staff with eating.</p> <p>Review of the comprehensive care plan for Resident #53 dated 1/9/2025, revealed .ADL self-care performance deficit r/t [related to] Dementia .requires partial/mod [moderate] assist [assistance] from staff .</p> <p>During a dining observation on 3/17/2025 at 12:31 PM, in the secure dining room, revealed 9 residents seated in the dining room for the lunch meal. Further observation revealed Resident #322 was seated at the dining room table with Resident #53 when Certified Nursing Assistant (CNA) A placed the meal tray in front of Resident #53 at 12:33 PM and Resident #53 began eating his meal (feeding himself without difficulty after the meal tray was setup by staff).</p> <p>(continued on next page)</p>

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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/17/2025 at 12:36 PM, CNA A stated meal trays were dispersed to the residents in no specific order and Resident #322 would get her meal tray .when he got to her tray on the cart .[he] was working his way down [all the meal trays] .</p> <p>During an observation on 3/17/2025 at 12:42 PM, revealed CNA B entered the dining room to assist with meal service and placed Resident #322's meal tray in front of her (9 minutes after Resident #53 received his meal tray) and the resident began eating her meal (feeding herself without difficulty after the meal tray was setup by staff).</p> <p>During an interview on 3/17/2025 at 12:43 PM, Licensed Practical Nurse (LPN) C confirmed Resident #322's meal tray was not delivered timely and Resident #322 was not served the lunch meal until 12:42 PM. LPN C stated .[he] realized residents not being served their meals at the same time was a dignity concern .</p> <p>During an interview on 3/19/2025 at 8:35 AM, the Director of Nursing (DON) confirmed it was the facility's expectation for residents seated at the same table to be served at the same time to promote dignity with dining.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51734</p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to implement a person-centered care plan related to vision impairment for 1 resident (Resident #68) of 19 residents reviewed for care plans.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Comprehensive Care Plan Procedures, dated 2/2/2024, revealed .It is the policy of this facility to develop and implement a comprehensive person-centered care plan .for each resident .to meet a resident's medical .nursing .needs and all services that are identified in the residents' comprehensive assessment .</p> <p>Review of the medical record revealed Resident #68 was admitted to the facility on [DATE] with diagnoses including Dementia, Glaucoma, and Need for Personal Care.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #68 scored a 5 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment. Further review revealed the resident had vision impairment and required supervision or touching assistance with eating, personal hygiene, and mobility.</p> <p>Review of the comprehensive care plan for Resident #68 revised 1/22/2025, revealed the resident's problem of vision impairment was not developed on the care plan.</p> <p>During an interview on 3/18/2025 at 8:21 AM, Certified Nursing Assistant (CNA) D stated Resident #68 required assistance with opening food items during meal service, toileting, and personal hygiene due to his vision impairment.</p> <p>During an interview on 3/18/2025 at 8:24 AM, CNA E stated Resident #68 had vision impairment and required assistance with meals and activities of daily living.</p> <p>During an interview on 3/19/2025 at 1:52 PM, the Licensed Practical Nurse (LPN) MDS Coordinator confirmed Resident #68 had vision impairment and the resident's vision impairment was not developed on the care plan.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>48100</p> <p>Based on facility policy review, observations, and interviews, the facility failed to ensure garbage and refuse were properly contained in 1 of 2 dumpsters (dumpster A) and failed to ensure the outside dumpster area was maintained in a sanitary and orderly condition.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Disposal of Garbage and Refuse, dated 12/20/2024, revealed .refuse containers and dumpsters kept outside the facility shall .have tightly fitting lids, doors, or covers .surrounding area shall be kept clean so that accumulation of debris .are minimized .garbage should not accumulate or be left outside the dumpster .</p> <p>During an observation of the outside dumpster area and interview on 3/17/2025 at 12:15 PM, with the Certified Dietary Manager (CDM), revealed 2 dumpsters for waste disposal. Further observation revealed dumpster A's front right sliding door was propped open which exposed the dumpster's contents to potential pests and the elements. Continued observation of the area behind dumpster A revealed 1 broken wooden chair, 9 broken wooden pallets (wet and rotted), 1 broken shower chair, 1 basketball goal, 13 five-gallon buckets (empty), 6 cardboard boxes (wet and disintegrating), and 4 broken wheelchairs. The CDM confirmed dumpster A's contents were not properly contained and the area behind dumpster A was not maintained in a sanitary or orderly condition.</p> <p>During an interview on 3/17/2025 at 12:22 PM, the Maintenance Director (MD), stated the items stored behind dumpster A was considered .garbage . and needed to be .hailed off . to the landfill. The MD stated the reason the discarded items was stored behind dumpster A and not removed from the facility grounds was .he had been busy with other things .and had a lot going on . The MD confirmed the outside dumpster area was not maintained in a sanitary or orderly condition.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100</p> <p>Based on facility policy review, observation, and interview, the facility failed to offer hand hygiene assistance prior to meals for 2 residents (Residents #53 and #25) of 9 residents observed in the secure unit dining room.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Meal Supervision and Assistance, dated 12/20/2024, revealed .Be sure the resident's hands are washed before and after he or she has started .finished the meal .</p> <p>Review of the medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including Dementia, Cognitive Communication Deficit, and Need for Assistance with Personal Care.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #53 scored a 1 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment. Further review revealed the resident required substantial/ maximal assistance with personal hygiene.</p> <p>Review of the comprehensive care plan for Resident #53 revised 1/9/2025, revealed .ADL [activities of daily living] self-care performance deficit r/t [related to] Dementia .requires partial/mod [moderate] assist from [the] staff to maximize independence .</p> <p>Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including Dementia, Cognitive Communication Deficit, and Muscle Weakness.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #25 scored a 6 on the BIMS assessment which indicated severe cognitive impairment. Further review revealed the resident was dependent upon staff assistance for personal hygiene.</p> <p>Review of the comprehensive care plan for Resident #25 revised 12/21/2024, revealed .Self-Care Deficit . Dressing .Feeding .Provide assistance with ADLs .</p> <p>During an observation on 3/17/2025 at 12:33 PM, in the secure unit dining room, revealed Certified Nursing Assistant (CNA) A placed the meal tray in front of Resident #53 and setup the meal tray for the resident to eat. CNA A failed to assist Resident #53 with hand hygiene before the meal tray was delivered and before the resident began eating the meal.</p> <p>During an observation on 3/17/2025 at 12:37 PM, revealed CNA A placed the lunch meal tray in front of Resident #25 and setup the meal tray for the resident to eat. CNA A failed to assist Resident #25 with hand hygiene before the meal tray was delivered and before the resident began eating the meal.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/17/2025 at 12:42 PM, Licensed Practical Nurse (LPN) C confirmed hand hygiene assistance was not provided to Resident #25 and Resident #53 before the lunch meal was served and before the residents began eating their meal.</p> <p>During an interview on 3/19/2025 at 8:35 AM, the Director of Nursing (DON) confirmed it was the facility's expectation for the staff to offer hand hygiene assistance to all residents prior to meal service.</p>		