STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445308	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trenton Health and Rehabilitation Center, LLC	2036 Highway 45 Bypass Trenton, TN 38382

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047 Based on policy review, medical record review, and interview, the facility failed to ensure residents were free from fall accident hazards for 1 of 3 (Resident #42) sampled residents reviewed for falls. The staff failed to the ensure the foot pedals where on the wheelchair and the resident's feet could rest on the foot pedals during wheelchair mobility. The finding include: 1. Review of the facility policy titled, Accident and Incident prevention of Residents, dated July 2017, revealed .Our facility strives to make the facility as free from accidents and incidents as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . 2. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE], with diagnoses including Dementia, Anxiety, Depression, Abnormal Posture, Neurocognitive Disorder with Lewy Bodies, and Adult Failure to Thrive. Review of the Incident Note dated 8/20/2024, revealed .Resdt [resident] unable to self propel. Feet went under wc [wheelchair] and resdt [resident] fell out of chair . Review of the quarterly Minimum Data Set, dated dated dated [DATE], revealed Resident #42 had a Brief Interview for Mental Status score of 0, which indicated the resident was severely cognitively impaired and was dependent upon staff for wheelchair mobility. During an interview on 12/10/2024 at 2:49 PM, the Director of Nursing (DON) confirmed Resident #42 had a fall on 8/20/2024. The DON confirmed staff should have placed the resident's feet on the wheelchair's foot pedals before wheelchair mobility, which the staff failed to do. Resident #42 had a fall as a result of the staff's failure to ensure the resident's feet were placed on the wheelchair's foot pedals during wheelchair mobility.

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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50408 Based on policy review, medical record review, observation, and interview, the facility failed to follow physician orders for oxygen and provide necessary respiratory care consistent with professional standards of practice for 2 of 3 (Resident #35 and #39) sampled residents reviewed for oxygen therapy. The findings include: 1. Review of the undated facility policy titled, Oxygen Administration, revealed .Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration .The following equipment and supplies will be necessary when performing this procedure . Portable oxygen cylinder (strapped to the stand) .Humidifier bottle .Regulator . Review of the facility policy titled, Infection Prevention and Control Program, dated October 2018, revealed . An infection prevention .is established and maintained to provide safe, sanitary and comfortable environment . 2. Review of medical record revealed Resident #35 was admitted on [DATE], and readmitted on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, and Dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #35 was mildly cognitively impaired and was assessed for oxygen therapy. Review of the Physician's orders dated 10/4/2024, revealed .O2 @ 2L BNC every day and night shift related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE . Review of the October, November, and December 2024 Medication Administration Record revealed oxygen at 2 liters BNC was documented as administered. Observation in the Resident's room on 12/10/2024 at 2:10 PM, 3:58 PM, and 4:00 PM, revealed Resident was sitting up in bed, oxygen at 3.5 liters/BNC. During an interview on 12/10/2024 at 4:18 PM, the Director of Nursing (DON) confirmed that oxygen should be set at the correct rate and that physician orders should be followed. 3. Review of the medical record revealed Resident #39 was admitted on [DATE], with diagnoses including Chronic Respiratory Failure, Cerebral Infarction, and Hemiplegia. Review of the Physicians Order dated 6/13/2024 revealed . O2 @ 2L/MIN BNC CONT. [continuous] SOB [short of breath]/SUPPLEMENTAL every day and night shift related to Chronic respiratory failure . Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated Resident #39 was cognitively intact. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations in Resident #39's room on 12/9/2024 at 8:56 AM, 1:33 PM, and 3:49 PM, revealed 02 at 2l/min with the water humidifier bottle sitting. During an interview on 12/11/24 at 8:35 AM, the DON was asked should the oxygen humidified water bottle be on the floor. The DON stated, No, It should be held on the concentrator machine. [NAME], [NAME] (50408)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047 Based on policy review, observation, and interview, the facility failed to ensure food was properly stored and labeled, and failed to ensure the kitchen equipment was clean. The facility had a census of 49 with 48 of those residents receiving a food tray from the Kitchen. The findings include: 1. Review of the facility policy titled, Food Storage, dated [DATE], revealed Food items should be stored, thawed, and prepared in accordance with good sanitary practice. Any expired or outdated food products should be discarded. During a power failure, frozen and refrigerated foods are properly handled .All products should be dated upon receipt and when they are prepared. Use 'use-by-dates on all food stored in refrigerators .Remember to cover, label, and date! Any expired or outdated food products should be discarded .Label and date all storage containers or bins . Review of the facility policy titled, Sanitation Criteria/Forms, dated [DATE], revealed .Check every piece of equipment for cleanliness inside, outside, top, bottom, and sides . Review of the facility policy titled, Cleaning Schedules, dated [DATE], revealed .The Dietary staff shall maintain the sanitation of the Dietary Department through compliance with written, comprehensive cleaning schedules . 2. Observation in the Kitchen on [DATE] at 8:05 AM, revealed the following: a. a thick black buildup of an unknown substance on the inside of the standing oven. b. a brown buildup of an unknown substance on the inside of the doors of the standing oven. c. a black, shiny buildup of an unknown substance on 3 of the cooking stoves. 3. Observation in the Kitchen refrigerator, and in the dry food storage area on [DATE] at 9:33 AM, revealed: a. a container of cottage cheese with an unreadable open date and a use by date of [DATE]. b. a container of potato salad with a use by date of [DATE]. c. a plastic bag of opened bologna with no expiration date. d. a plastic bag of cheese slices with no opened date, no expiration date or use by date. e. an unlabeled, undated plastic container which contained a white substance described by Dietary Manager (DM) as sugar. f. a plastic container of thickener with no use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] 09:33 AM, the DM confirmed food items should be labeled to identify what it is, with an open date, and with a use by date. The DM confirmed food items passed the use by date should be discarded and not on the shelf for use. 4. Observation in the Kitchen on [DATE] at 8:41 AM, revealed the following: a. a thick black buildup of an unknown substance on the inside of the standing oven. b. a brown buildup of an unknown substance on the inside of the doors of the standing oven. c. a black, shiny buildup of an unknown substance on 3 of the cooking stoves. During an interview on [DATE] at 8:41 AM, the DM confirmed inside the standing oven there was a thick buildup of a black unknown substance, and it should not be there. The DM confirmed the standing oven doors had a buildup of a brown unknown substance, and it should not be there. The DM confirmed 3 of the cooking stove's eyes had a black, shiny buildup on them and it should not be there.

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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** 49269 Based on policy review, medical record review, observation and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained when 1 of 2 staff (Licensed Practical Nurse (LPN A) failed to perform proper hand hygiene during medication administration, and when 1 of 1 staff (LPN B) failed to perform proper hand hygiene during wound care. The findings include: 1. Review of the facility policy titled, Handwashing/Hand Hygiene, dated 8/2019, revealed .This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .Use an alcohol-based hand rub .or alternatively soap (antimicrobial or non-antimicrobial) and water for the following situations .After removing gloves .Hand hygiene is the final step after removing and disposing of personal protective equipment .Washing Hands .Rinse hands with water and dry thoroughly with a disposable towel .Use towel to turn off faucet . 2. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE], with diagnoses including Dementia, Diabetes, Dysphagia, and Gastrostomy Status. Review of the Physician's Order dated 12/9/2024, revealed Gabapentin, used to treat neuropathy pain, 300mg 1 capsule via (by way of) PEG-Tube (Percutaneous Endoscopic Gastrostomy Tube inserted in the stomach to provide nutrients, hydration, and medication) two times a day related to Trigeminal neuralgia . Observation during medication administration on 12/10/2024 at 9:17 AM, revealed LPN A administered Gabapentin 300mg via Peg tube to Resident #16. LPN A removed gown and gloves, entered the resident's bathroom, and washed hands with soap and water. LPN A turned the faucet off with the left bare hand and dried her hand with a paper towel. LPN A failed to use a towel to turn off the water faucet. 3. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Heart Failure, and Unstageable Pressure Ulcer. Review of the admission Minimum Data Set, dated dated dated [DATE], revealed a Brief Interview for Mental Status score of 9, which indicated moderate cognitive impairment. Review of the Physician's Order dated 11/15/2024, revealed APPLY SURE PREP TO ALL TOES ON BOTH FEET AND RIGHT HEEL Q SHIFT FOR PROTECTION. KEEP SOCK ON RIGHT FOOT WHILE IN BED AS RESIDENT WILL ALLOW. Review of the Physician's Order dated 12/4/2024, revealed CLEANSE TOP OF LEFT DORSAL FOOT WITH HIBICLENS [antimicrobial soap used to cleanse wounds] AND NORMAL SALINE. PAT DRY. PAINT ESCHAR AND PERIWOUND TO TOP OF LEFT FOOT WITH BETADINE [a topical used to reduce bacteria] DAILY, APPLY NONADHERENT DRESSING AND WRAP DAILY UNTIL RESOLVED. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Order dated 12/6/2024, revealed CLEANSE LEFT HEEL WITH WOUND CLEANSER, PAT DRY, APPLY COLLAGEN THEN ALGINATE WITH SILVER, ABD PAD AND WRAP WITH KERLIX. CHANGE DAILY AND AS NEEDED UNTIL RESOLVED. Observation on 12/10/2024 at 4:08 PM, revealed LPN B in the hallway, preparing to do wound care for Resident #7. LPN B donned gloves, stuck her hand in the pocket of her scrub top and obtained the key to the cart, unlocked the cart, opened a drawer on the cart, obtained gauze pads from a multi pack container, and placed the gauze in a cup and placed the cup on a barrier on top of the treatment cart. LPN B then removed more gauze from the package and placed it in a second cup and placed it on the barrier on top of the cart. LPN B wet the gauze in the first cup with Hibiclens and wet the gauze in the second cup with Betadine, finished setting up treatment supplies, and removed her gloves. LPN B gathered the treatment supplies and placed them in plastic bags, knocked on the door and entered Resident #7's room. LPN B placed the treatment supplies on the over the bed table, entered the bathroom, washed her hands with soap and water, then turned the faucet off with her bare left bare hand, and dried her hands with a paper towel. LPN B donned a gown, and gloves positioned Resident #7, removed the dressing from the resident's Left foot, cleaned the wound to the top of the left foot with saline and Hibiclens gauze, painted the wound with the betadine-soaked gauze and completed wound care to the left foot as ordered. LPN B removed gloves, donned new gloves and applied sure prep to the toes on both feet, removed her gown and gloves, entered the bathroom and washed her hands with soap and water, turned off the faucet with her bare left hand, then dried her hands. LPN B donned gloves and removed trash from the room. LPN B failed to use a towel to turn off the water faucet and failed to use proper hand hygiene. 4. During an interview on 12/11/2024 at 8:11 AM, the Director of Nursing confirmed that faucet should not been turned off with bare hands and staff should perform hand hygiene in between changing gloves.